Volume 2 of 4

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2020–June 30, 2021

Plan-Specific Evaluation Reports

(Appendices A through CC)

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

April 2022

Table of Contents

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix A:
Performance Evaluation Report
Aetna Better Health of California
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Aetna Better Health of California ("Aetna" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Aetna provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Aetna's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

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

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

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

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

- Blue Shield of California Promise Health Plan
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California
- UnitedHealthcare Community Plan

Aetna became operational in Sacramento and San Diego counties to provide MCMC services effective January 1, 2018. As of June 2021, Aetna had 14,976 members in Sacramento County and 20,576 in San Diego County—for a total of 35,552 members.[1] This represents 3 percent of the beneficiaries enrolled in Sacramento County and 3 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

The most recent audits A&I conducted for Aetna were from April 19, 2021, through April 30, 2021, for the review period of April 1, 2019, through March 31, 2021. At the time this MCP-specific evaluation report was produced, the final audit reports were not available. HSAG will include a summary of the 2021 audits in Aetna's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

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

The HSAG auditor determined that Aetna followed the appropriate specifications to produce valid rates; however, the auditor noted some gaps in encounter data during the measurement year due to failed file loads from Independent Practice Associations (IPAs). These encounter data gaps did not impact administrative measure reporting, but they did impact reporting of hybrid measures that require claims or encounter data for the eligible population criteria. The hybrid samples for these measures were based on initial data runs that did not include all the IPA encounter data; when the data were corrected, the eligible populations increased. The eligible population increases for the *Controlling High Blood Pressure—Total*, *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*, and both *Prenatal and Postpartum Care* measures were less than 5 percentage points, which was within the allowable error percentage; therefore, the hybrid rates for these measures were *Reportable*. The eligible population increases for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures ranged from 13 to 21 percentage points, depending on the indicator and age stratifications, resulting in a biased sample; therefore, Aetna had to report the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure rates using the administrative methodology.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.18 for Aetna's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.18:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.16 present the performance measure results and findings by domain, and Table 3.17 and Table 3.18 present the measurement year 2020 performance measure findings for the domains combined.
- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 and Table 3.2 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 and Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 27, 2021.

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:

- *Child and Adolescent Well-Care Visits—Total*
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	26.84%	Not Comparable
Childhood Immunization Status—Combination 10	S	**17.16%**	S
Developmental Screening in the First Three Years of Life—Total	28.57%	34.78%	6.21
Immunizations for Adolescents—Combination 2	S	**29.55%**	S
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	52.43%	**53.57%**	1.14
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**52.82%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**47.60%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	S	Not Comparable
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	—	41.67%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	24.22%	Not Comparable
Childhood Immunization Status—Combination 10	25.97%	**37.45%**	11.48
Developmental Screening in the First Three Years of Life—Total	34.94%	33.33%	-1.61
Immunizations for Adolescents—Combination 2	S	**20.47%**	S

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	64.51%	**40.63%**	-23.88
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**38.63%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**31.59%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	25.64%	Not Comparable
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	—	49.70%	Not Comparable

Findings—Children's Health Domain

Table 3.3 and Table 3.4 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.3 and Table 3.4:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.3—Children's Health Domain Measurement Year 2020 Performance Measure Findings Aetna—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.4—Children's Health Domain Measurement Year 2020 Performance Measure Findings Aetna—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.5 and Table 3.6 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.5—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	NA	**36.67%**	Not Comparable
*Cervical Cancer Screening^*	39.90%	**35.67%**	-4.23
Chlamydia Screening in Women—Ages 16–20 Years	62.50%	60.71%	-1.79
Chlamydia Screening in Women—Ages 21–24 Years	55.71%	61.02%	5.31
Chlamydia Screening in Women—Total	57.84%	60.89%	3.05
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	S	S	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	2.48%	4.28%	1.80
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	S	17.82%	S
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.46%	17.84%	-2.62
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S	10.00%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	25.53%	28.33%	2.80
*Prenatal and Postpartum Care—Postpartum Care^*	75.68%	**63.64%**	-12.04
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	77.03%	**64.46%**	-12.57

Table 3.6—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	NA	**30.37%**	Not Comparable
*Cervical Cancer Screening^*	38.20%	**34.06%**	-4.14
Chlamydia Screening in Women—Ages 16–20 Years	45.90%	43.33%	-2.57
Chlamydia Screening in Women—Ages 21–24 Years	72.64%	60.23%	-12.41
Chlamydia Screening in Women—Total	62.87%	**54.41%**	-8.46

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	S	S	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.08%	4.14%	0.06
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	19.07%	15.98%	-3.09
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.19%	23.17%	-1.02
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S	7.45%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	33.68%	22.98%	-10.70

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Prenatal and Postpartum Care—Postpartum Care^*	79.55%	**66.03%**	-13.52
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	79.55%	**75.00%**	-4.55

Findings—Women's Health Domain

Table 3.7 and Table 3.8 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.7 and Table 3.8:

- For both reporting units, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Breast Cancer Screening—Total*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*
- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.7—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Aetna—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	14	21.43%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	14	0.00%

Table 3.8—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Aetna—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	14	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	14	14.29%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.9 and Table 3.10 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.9 and Table 3.10:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.9—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.00%	**53.13%**	-1.87
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.00%	**37.50%**	-2.50
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**81.73%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	NA	NA	Not Comparable
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.89%	6.26%	2.37
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	4.21%	4.41%	0.20
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	S	S

Table 3.10—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	61.11%	60.40%	-0.71
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.00%	41.61%	1.61
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**76.69%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	NA	NA	Not Comparable
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	14.05%	30.46%	16.41
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	10.49%	14.46%	3.97
Screening for Depression and Follow-Up Plan—Ages 65+ Years	15.04%	10.06%	-4.98

Findings—Behavioral Health Domain

Table 3.11 and Table 3.12 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.11 and Table 3.12:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- For both reporting units, HSAG did not include both *Follow-Up Care for Children Prescribed ADHD Medication* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures
- For both reporting units, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for this measure for both reporting units were too small (less than 30) for the MCP to report valid rates.

Table 3.11—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Aetna—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	3	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.12—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Aetna—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	5	40.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.13 and Table 3.14 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.13 and Table 3.14:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.13—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 150 for the *Plan All-Cause Readmissions* measures and less than 30 for all other measures) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	54.48	41.31	Not Tested
Asthma Medication Ratio—Total	NA	NA	Not Comparable
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	48.98%	**51.96%**	2.98
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S	S	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	41.22%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	6.49%	Not Comparable
Plan All-Cause Readmissions—Expected Readmissions—Total	NA	9.84%	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	NA	0.66	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%	0.00%	0.00
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.14—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 150 for the *Plan All-Cause Readmissions* measures and less than 30 for all other measures) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's

de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	39.37	31.19	Not Tested
Asthma Medication Ratio—Total	NA	65.71%	Not Comparable
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	66.86%	**61.34%**	-5.52
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S	S	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	41.41%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	8.30%	Not Comparable
Plan All-Cause Readmissions—Expected Readmissions—Total	NA	10.32%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	NA	0.80	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S	0.00%	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.15 and Table 3.16 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.15 and Table 3.16:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- For both reporting units, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 150 for the *Plan All-Cause Readmissions* measure; less than 30 for all other measures) for the MCP to report valid rates:
  - *Asthma Medication Ratio—Total*
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Plan All-Cause Readmissions—Observed Readmissions—Total*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- For Sacramento County, HSAG did not include the *Asthma Medication Ratio—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.15—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Aetna—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	1	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	3	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	1	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	3	0.00%

Table 3.16—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Aetna—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	3	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	3	0.00%

Performance Measure Findings—All Domains

Table 3.17 and Table 3.18 present a summary of Aetna's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.17 and Table 3.18:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- For both reporting units, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 150 for the *Plan All-Cause Readmissions* measure; less than 30 for all other measures) for the MCP to report valid rates:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening—Total*
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*

- *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
- *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*
- Both *Follow-Up Care for Children Prescribed ADHD Medication* measures
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:

- *Asthma Medication Ratio—Total* for Sacramento County
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* for both reporting units

Table 3.17—Measurement Year 2020 Performance Measure Findings for All Domains Aetna—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	14	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	26	11.54%
Measurement Year 2020 Rates Below Minimum Performance Levels	13	14	92.86%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	26	0.00%

Table 3.18—Measurement Year 2020 Performance Measure Findings for All Domains Aetna—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	15	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	26	7.69%
Measurement Year 2020 Rates Below Minimum Performance Levels	12	15	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	26	11.54%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Aetna's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

Aetna conducted two PDSA cycles to improve the MCP's performance on the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure in both reporting units.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, Aetna conducted a phone outreach campaign to Asian/Pacific, Caucasian, and Chinese members who had not received their HbA1c testing. If unsuccessful at reaching the member on the first call, the MCP would call up to two additional times on two different days. While Aetna reported an increase in HbA1c testing across all three groups, the MCP did not achieve its PDSA cycle goal. The MCP stated that few members accepted scheduling assistance; however, other members refused to receive the testing due to various reasons, including preference to self-manage, confirmation of completing HbA1c testing previously, COVID-19 pandemic concerns, and indicating that they no longer had pre-diabetes.

Aetna indicated that starting the intervention sooner would have allowed the MCP more time to conduct secondary follow-up with eligible members who were unreachable after three outreach call attempts and the ability to schedule these members before the end of the intervention period. The MCP also noted that many members delayed preventive and screening services due to COVID-19 pandemic concerns, which may have contributed to the unexpected high refusal rate of members reached.

Aetna determined to adopt the intervention methodology and to track the time spent conducting the outreach to determine if building a care coordination outreach team is warranted. Additionally, the MCP plans to mine alternative contact information from claims and encounters data and by working with primary care provider offices.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, Aetna conducted outreach calls to members living with diabetes to promote regular and timely HbA1c testing, provide education about the importance of diabetes self-management, and transfer them to member services for assistance with scheduling an office visit. While Aetna reported in increase in HbA1c testing, the MCP did not achieve its PDSA cycle goal. Aetna reported having challenges reaching members, even after multiple attempts, and that some members had no voicemail option or the MCP had wrong or nonworking phone numbers for members. When the MCP was able to leave a HIPAA-compliant message for the member to call back, Aetna received no return calls. The MCP indicated that moving forward, it will work with other departments within the MCP to obtain more accurate member contact information.

Aetna determined to continue this intervention with the following changes:

- Determine target groups for outreach based on measurement year 2020 performance measure results.
- Gather alternative member contact information prior to conducting the outreach rather than on the backend.
- Explore partnering with labs to ensure easy access to appointments for members.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Aetna reported:

- Conducting a member outreach campaign in both Sacramento and San Diego counties to improve rates for measures focused on well-care visits, preventive services, and screening services. Aetna began conducting outreach via interactive voice response (IVR) calls regarding influenza, adult preventive care, and well-child visits. The MCP reported making 188,913 IVR calls related to influenza and 19,164 calls regarding adult preventive care. Aetna also sent mailers to members with information about adult and child preventive services. The MCP received approval from DHCS in February 2021 for a new outreach script; however, the MCP determined to put the intervention on hold until it can gather member communication preferences. Aetna also indicated that the MCP will begin sending its women's health mailer to members semiannually rather than annually.
- Planning a member outreach campaign regarding the availability of behavioral health services in both Sacramento and San Diego counties using IVR calls. The MCP reported putting this intervention on hold until it can gather member communication preferences. Additionally, Aetna is working to identify a telehealth vendor that can provide behavioral health services to its members.
- Conducting a member outreach campaign in both Sacramento and San Diego counties via IVR calls, targeting members with diabetes who had not received an HbA1c test, eye exam, or nephropathy screening, to encourage these members to follow up with their providers. Aetna reported making 581 IVR calls and mailing diabetes booklets to these members to provide them with diabetes information, including how to manage their diabetes, knowing their numbers, and managing medications. Aetna indicated that a change in the MCP's leadership resulted in the MCP pausing its large-scale implementation of an in-home diabetes management kit. The MCP is establishing a new timeline for distribution of the kits.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Aetna's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.19 and Table 3.20 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.19—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Aetna—Sacramento County

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

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

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

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

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

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

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

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	81.77	38.21	Not Tested	41.31
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	NA	Not Comparable	6.49%

Table 3.20—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Aetna—San Diego County

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

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

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

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

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

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

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

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	64.44	29.65	Not Tested	31.19
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	5.77%	Not Comparable	8.30%

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG did not compare the measurement year 2020 SPD rates to the measurement year 2020 non-SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure due to higher or lower rates not indicating better or worse performance for this measure. For the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure, HSAG could not compare the measurement year 2020 SPD rates to the measurement year 2020 non-SPD rates for either reporting unit because the denominator for at least one population was too small (less than 150) for the MCP to report a valid rate.

Strengths—Performance Measures

The HSAG auditor determined that Aetna followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for Aetna:

- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, three of 14 measures in the Women's Health domain for Sacramento County (21 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020:
  - *Contraceptive Care—All Women—LARC—Ages 21–44 Years*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years*
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, two of five measures in the Behavioral Health domain for San Diego

County (40 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020:

- *Screening for Depression and Follow-Up Plan—Ages 12–17 Years*
- *Screening for Depression and Follow-Up Plan—Ages 18–64 Years*

Opportunities for Improvement—Performance Measures

To ensure it identifies any failed data loads right away, Aetna should implement better monitoring and oversight processes for its encounter data so that all encounter data are included for performance measure reporting.

Across all domains, 13 of 14 rates in Sacramento County (93 percent) and 12 of 15 rates in San Diego County (80 percent) were below the minimum performance levels in measurement year 2020. Aetna should assess the factors, which may include COVID-19, that affected the MCP'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.

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

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

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

5. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Note that based on Aetna's population size, the MCP was unable to identify a specific sub-population with a demonstrated health disparity; therefore, DHCS approved Aetna to conduct its 2020–22 Health Equity PIP for the MCP's entire member population.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 PIPs, as well as HSAG's validation findings from the review period.

Diabetes Control Performance Improvement Project

Using its MCP-specific data, Aetna identified improving members' diabetes control as the topic for its 2020–22 PIP.

HSAG validated modules 1 and 2 for the MCP's *Diabetes Control* PIP. Upon initial review of the Module 1, HSAG determined that Aetna met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, Aetna incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Aetna met all validation criteria for Module 2 in its initial submission.

Aetna's *Diabetes Control* PIP SMART Aim measures the percentage of members ages 18 to 75 years living with diabetes whose most recent HbA1c levels are greater than 9 percent or who are missing a test result or did not have a test completed. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Aetna's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Aetna determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, Aetna selected improving rate of well-child visits for children 3 to 11 years of age for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits* PIP. Upon initial review of the Module 1, HSAG determined that Aetna met most required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the narrowed focus baseline specifications and data collection methodology. After receiving technical assistance from HSAG, Aetna incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

Aetna met all validation criteria for Module 2 in its initial submission.

Upon initial review of the Module 3, HSAG determined that Aetna met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure is appropriate for the intervention.
- Ensuring that the data collection process is appropriate for the intervention effectiveness measure and that it addressed data completeness.

At the end of the review period for this report, Aetna was still in the process of incorporating HSAG's feedback into Module 3; therefore, HSAG includes no final validation results for Module 3 in this report.

Aetna's *Well-Child Visits* PIP SMART Aim measures the percentage of members ages 3 to 11 years who were assigned to the PIP medical group partners and complete well-child visits. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Aetna's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

Aetna successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. Aetna has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Aetna's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Aetna submitted the MCP's PNA report to DHCS on August 18, 2021, and DHCS notified the MCP via email on August 21, 2021, that DHCS approved the report as submitted. While Aetna submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Aetna's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By July 1, 2021, increase the *Controlling High Blood Pressure* measure rate among African-American and Asian members.	Yes	Worse	Changing for 2021
2	By July 1, 2021, meet the 50th percentile for the *Use of Opioids at High Dosage in Persons Without Cancer* measure.	No	Better	Changing for 2021
3	By December 2020, improve the *Getting Needed Care* Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] 2020 scores for both the adult and child populations.	No	Better	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By May 31, 2022, decrease the prevalence of hypertension among African-American and Asian members in Sacramento and San Diego counties.	Yes	Changed from 2020
2	By May 2022, decrease the percentage of members with an opioid substance use disorder.	No	Changed from 2020
3	By December 2021, improve the *Rating of Health Plan* CAHPS 2021 scores for both adult and child populations.	No	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Based on HSAG's assessment of Aetna's delivery of quality, accessible, and timely care through the activities described in the MCP's 2019–20 MCP-specific evaluation report, HSAG included no recommendations in Aetna's 2019–20 MCP-specific evaluation report. Therefore, Aetna had no recommendations for which it was required to provide the MCP's self-reported actions.

2020–21 Recommendations

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

- To ensure it identifies any failed data loads right away, Aetna should implement better monitoring and oversight processes for the MCP's encounter data so that all encounter data are included for performance measure reporting.
- 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 MCP'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 the next annual review, HSAG will evaluate Aetna's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix AA:
Performance Evaluation Report
Santa Clara Family Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Santa Clara Family Health Plan ("SCFHP" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that SCFHP provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in SCFHP's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

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

SCFHP became operational in Santa Clara County to provide MCMC services effective February 1997. As of June 2021, SCFHP had 272,477 members.[1] This represents 79 percent of the beneficiaries enrolled in Santa Clara County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

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

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of SCFHP. A&I conducted the audits from March 9, 2021, through March 19, 2021. The Medical Audit portion was a reduced scope audit, evaluating five categories rather than six. A&I evaluated SCFHP's compliance with its DHCS contract and assessed the MCP's implementation of its CAP from A&I's prior audits of SCFHP. DHCS issued the final audit reports on July 20, 2021, which is outside the review period for this report; however, HSAG includes the information from the reports because A&I conducted the audits during the review period for this report. Note that the CAPs from the 2019 and 2020 audits are still open.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SCFHP
Audit Review Period: March 1, 2020, through February 28, 2021

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

Strengths—Compliance Reviews

A&I identified no findings in the Case Management and Coordination of Care, Member's Rights, Quality Management, and State Supported Services categories during the 2021 Medical and State Supported Services Audits of SCFHP.

Opportunities for Improvement—Compliance Reviews

SCFHP should continue working with DHCS to fully resolve the findings from the 2019, 2020, and 2021 Medical Audits. During the 2021 audits, A&I identified a repeat finding in the Access and Availability of Care category related to the MCP needing to develop and implement policies and procedures to monitor and ensure that all transportation providers in the MCP's network are enrolled in MCMC.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of SCFHP, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Santa Clara Family Health Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for SCFHP's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Oct 12, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	43.92%	Not Comparable
Childhood Immunization Status—Combination 10	66.91%	57.91%	-9.00
Developmental Screening in the First Three Years of Life—Total	20.51%	22.85%	2.34
Immunizations for Adolescents—Combination 2	46.72%	43.31%	-3.41
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	89.29%	80.54%	-8.75
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	74.21%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	72.26%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	33.89%	Not Comparable
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	—	76.73%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
SCFHP—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	4	50.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	66.72%	59.78%	-6.94
*Cervical Cancer Screening^*	61.07%	**59.85%**	-1.22
Chlamydia Screening in Women—Ages 16–20 Years	53.41%	52.84%	-0.57
Chlamydia Screening in Women—Ages 21–24 Years	66.12%	63.37%	-2.75
Chlamydia Screening in Women—Total	59.19%	**57.43%**	-1.76
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.47%	2.28%	-0.19
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.47%	4.98%	-0.49
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.91%	14.81%	0.90
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.39%	26.05%	1.66

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	14.61%	18.86%	4.25
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	9.65%	13.95%	4.30
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	33.15%	32.57%	-0.58
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.18%	23.33%	4.15
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	19.10%	27.43%	8.33
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	19.42%	24.52%	5.10
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	50.56%	52.57%	2.01
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.09%	46.90%	4.81
*Prenatal and Postpartum Care—Postpartum Care^*	85.16%	84.67%	-0.49
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	93.19%	92.70%	-0.49

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
SCFHP—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	19	31.58%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	63.57%	64.15%	0.58
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	49.87%	50.40%	0.53
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**74.08%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.84%	45.57%	5.73
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	46.03%	49.28%	3.25
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	59.22%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	46.60%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	45.15%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.21%	0.85%	0.64
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	1.51%	2.22%	0.71
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.17%	1.36%	1.19

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
SCFHP—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	38.84	28.91	Not Tested
Asthma Medication Ratio—Total	62.31%	64.25%	1.94
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	31.14%	34.31%	3.17
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.15%	12.45%	-0.70
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	8.08%	7.23%	-0.85
Controlling High Blood Pressure—Total	—	57.42%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.30%	9.55%	1.25

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Plan All-Cause Readmissions—Expected Readmissions—Total	9.09%	9.70%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.91	0.98	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%	0.00%	0.00
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%	0.00%	0.00

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
SCFHP—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	7	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of SCFHP's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains SCFHP—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	3	16	18.75%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	10	37	27.03%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	16	18.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	37	16.22%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of SCFHP's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

SCFHP conducted one PDSA cycle to improve the MCP's performance on both *Cervical Cancer Screening* and *Chlamydia Screening in Women* measures and one PDSA cycle to improve the MCP's performance on the *Cervical Cancer Screening* measure.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, SCFHP conducted outreach calls to members who had not scheduled and completed their cervical cancer and chlamydia screenings. While SCFHP did not meet the PDSA SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective, the MCP reported an increase in screenings and attributed the improvement to the intervention. The intervention consisted of three call attempts conducted by a female staff member using a script. SCFHP indicated that COVID-19 was a barrier to some members being willing to schedule their screenings, as some expressed concern about going to their providers' offices during COVID-19 and while the stay-at-home order was in effect. SCFHP stated that moving forward, the MCP will:

- Work with the MCP's Provider Network Operations Team more closely to educate providers about the importance of screening for cervical cancer and chlamydia and submitting a claim for the services.
- Use member incentives and conduct outreach call campaigns for both cervical cancer and chlamydia screenings during the next measurement year.
- Modify the SMART objective measure for the next PDSA cycle from a process-based measure to an outcome-based measure to help improve the pace at which members book their appointments and subsequently increase cervical cancer and chlamydia screening rates.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, SCFHP conducted warm outreach calls to Caucasian, Asian Indian, and Filipino members who had not completed their cervical cancer screenings. SCFHP originally planned to make two call attempts to each member; however, during this PDSA cycle the MCP only made one call to each member. While SCFHP did not meet the PDSA SMART

objective, the MCP reported successfully contacting members in the targeted populations and that some members agreed to schedule their own appointment or have the MCP schedule it. SCFHP indicated that a delay in producing the data needed to conduct the intervention resulted in the MCP only having time to make one outreach attempt to each member. Additionally, the MCP reported that the two clinic partners had to prioritize COVID-19 efforts over in-person preventive visits, affecting SCFHP's ability to schedule appointments for cervical cancer screenings. SCFHP stated that moving forward, the MCP will:

- Conduct analyses to determine the causes for less engagement with the Filipino population compared to the Caucasian and Asian Indian populations.
- Focus on an outcome-based measure to determine if warm outreach calls to members would increase the number of cervical cancer screening appointments scheduled.
- Share with providers a list of their members who declined a cervical cancer screening so the providers can follow up with these members.
- Work with the two clinic partners to conduct follow-up calls to schedule members for their screenings once these clinics are able to prioritize in-person preventive visits.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, SCFHP reported implementing the following strategies:

Telephonic Outreach

SCFHP conducted outreach calls to members with a diagnosis of asthma, diabetes, or hypertension. SCFHP used telephone scripts to inform these members about telehealth appointment options and provide information about the MCP's 24/7 nurse advice line. SCFHP shared telehealth best practices with provider groups and promoted telehealth visits in its provider newsletter. The MCP also disseminated a tip sheet to its provider networks that promoted telehealth, addressed billing practices for preventive medical service visits, and suggested using a combination of telehealth and in-person activities to ensure services are provided to members in a timely manner.

SCFHP reported that of the members outreached, 324 appointments for medication refills were scheduled, 166 calls were made to the MCP's nurse advice line, and 3,753 telehealth appointments were scheduled. SCFHP noted that members encountered the following barriers to receiving timely care via telehealth appointments:

- Lack of awareness of telehealth visits as an option for appointments based on some members having low health literacy or language barriers.
- Lack of access to transportation, technology, healthy and nutritious foods, or to an area where physical activity can be safely performed.
- Homelessness or housing challenges.

To increase telehealth utilization, SCFHP indicated the MCP plans to:

- Continue member outreach calls.
- Add information on telehealth availability to member mailings.
- Encourage and remind providers to outreach to members who are overdue for screenings.
- Expand its video remote interpreting services and collaborate with SCFHP's Provider Network Operations Team to help educate providers on the availability of these interpreter services.

Pharmacy Benefit Promotion

In its November 2020 provider newsletter, SCFHP promoted 90-day medication supplies and mail order pharmacy benefits. Additionally, during member outreach calls, SCFHP offered members diagnosed with hypertension prescriptions for blood pressure cuffs. SCFHP reported that 9,986 Medi-Cal providers used e-prescribing for 121,743 Medi-Cal members from October 1, 2020, to December 31, 2020, and that 79 members with hypertension received prescriptions for blood pressure cuffs. The MCP also reported that some medical records of members with asthma, diabetes, and hypertension included documentation of 90-day medication supplies and use of the mail order pharmacy benefit.

SCFHP reported learning that members may not be aware of the mail order pharmacy benefit and may face additional barriers due to language, low health literacy, and low technology literacy.

SCFHP indicated that the MCP will continue to:

- Promote 90-day medication supplies and mail order pharmacy benefits to members.
- Encourage providers to adopt e-prescribing and increase refills to 90-day supplies.
- Work with its pharmacy and case management teams to reach members who are not refilling their medications.
- Call members to provide education on the importance of refilling medications in a timely manner, adhering to instructions from their doctors, and making lifestyle modifications that can help them manage their conditions.

Virtual Class Promotion

SCFHP promoted virtual health education class availability in the MCP's October 2020 provider newsletter and used Spanish- and Vietnamese-speaking staff to outreach to members with the respective language preference, while taking into consideration each member's cultural background. The target population comprised members with asthma, diabetes, or hypertension. During outreach calls, SCFHP assisted members with scheduling their doctor's appointments and signing up for virtual classes on chronic illness self-management, asthma management, stress management, and healthy lifestyles. SCFHP reported some success with members enrolling in the virtual classes.

The MCP reported the following lessons learned:

- Most health education vendors did not provide in-person classes due to the COVID-19 pandemic.
- Virtual classes were challenging for some members because of lack of access to technology and low technology literacy.
- Most virtual classes were only available in English and/or Spanish, causing a barrier for some members to participate.

SCFHP indicated that the MCP will:

- Continue to promote virtual health education classes to members and providers in addition to working with vendors to add more languages to their virtual class offerings.
- Hire staff who speak other threshold languages (Mandarin, Cantonese, and Tagalog) to improve linguistic support for members.
- Work with the case management department to educate high-risk members on how to manage their conditions at home, including topics such as lifestyle modification, medication adherence, getting timely care, and health plan benefits.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In SCFHP's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations SCFHP—Santa Clara County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	36.28	27.70	Not Tested	28.91
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.39%	9.26%	1.13	9.55%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only. For SCFHP, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for this measure.

Strengths—Performance Measures

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

HSAG identified the following notable measurement year 2020 performance measure results for SCFHP:

- The rates for the following measures were above the high performance levels:
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Prenatal and Postpartum Care—Postpartum Care*
- Across all domains for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 10 of 37 rates (27 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020

Opportunities for Improvement—Performance Measures

Across all domains, the rates for three measures were below the minimum performance levels in measurement year 2020, and SCFHP's performance declined significantly for six measures from measurement year 2019 to measurement 2020. Two of the three measures with rates below the minimum performance levels and three of the six measures for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020 were in the Women's Health domain.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, SCFHP should assess the factors, which may include COVID-19, that affected the MCP'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.

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

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

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results SCFHP—Santa Clara County

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

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

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

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	52.15	42.08	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.94%	8.29%	-0.64
Plan All-Cause Readmissions—Expected Readmissions—Total	9.72%	9.68%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.92	0.86	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

SCFHP determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—adolescent well-care visits in Network 20.

HSAG validated Module 1 for the MCP's *Adolescent Well-Care Visits* Health Equity PIP. Upon initial review of the module, HSAG determined that SCFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, SCFHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

SCFHP's *Adolescent Well-Care Visits* Health Equity PIP SMART Aim measures the percentage of members ages 18 to 21 years assigned to the PIP provider partners who complete adolescent well-care visits. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in SCFHP's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

SCFHP determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, SCFHP selected lead screening in children for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Lead Screening in Children* PIP. Upon initial review of the modules, HSAG determined that SCFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.

- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

After receiving technical assistance from HSAG, SCFHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. At the end of the review period for this report, SCFHP was still in the process of incorporating HSAG's feedback into Module 2; therefore, HSAG includes no final validation results for Module 2 in this report.

SCFHP's *Lead Screening in Children* PIP SMART Aim measures the percentage of members assigned to the PIP provider group partners who complete one or more capillary or venous lead blood test by their second birthday. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in SCFHP's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

SCFHP successfully met all validation criteria for Module 1 for both PIPs. The validation findings show that the MCP built a strong foundational framework for both PIPs. SCFHP has progressed to Module 2 for both PIPs, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Opportunities for Improvement—Performance Improvement Projects

Based on SCFHP's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

SCFHP submitted the MCP's final PNA report to DHCS on August 1, 2021, and DHCS notified the MCP via email on August 4, 2021, that DHCS approved the report as submitted. While SCFHP submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with SCFHP's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2021, reduce overall emergency room utilization for the SPD sub-population.	No	Better	Ended in 2020
2	By June 30, 2021, increase the *Controlling High Blood Pressure—Total* measure rates among racial/ethnic groups.	Yes	Worse	Ended in 2020
3	By June 30, 2021, increase the *Cervical Cancer Screening* measure rates among racial/ethnic groups.	Yes	Better	Changing for 2021

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By December 31, 2022, increase the *Controlling High Blood Pressure—Total* measure rate for the Black population.	Yes	Changed from 2020
2	By December 31, 2022, increase the *Cervical Cancer Screening* measure rates for Asian Indian and Filipino members ages 21 to 64 years.	Yes	Changed from 2020
3	By December 31, 2022, increase the well-visit rate for members ages 3 to 21 years.	No	New in 2021

#	Objective Summary	Health Disparity (Yes/No)	Status
4	By December 31, 2023, improve the percentage of "Always" and "Usually" responses for the adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] *Getting Needed Care* measure.	No	New in 2021

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from SCFHP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of SCFHP's self-reported actions.

Table 7.1—SCFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve the findings from the 2019 and 2020 Medical Audits.	SCFHP has been in communication with the DHCS Compliance Unit to resolve the findings from the 2019 and 2020 Medical Audits.
2. Update the MCP's process to implement calculations that verify dual eligibility in monthly enrollment spans and to ensure that dual-eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.	Following the HEDIS 2020 (measurement year 2019) audit, SCFHP implemented dual eligibility calculations in monthly enrollment spans for HEDIS measurement year 2020. The following logic was used: ♦ Only members with Medicare A and B, or Medicare C were excluded. ♦ Members who have Medi-Cal with SCFHP but commercial health care coverage with another plan at the end of the HEDIS year were also excluded. ♦ Members with only Medicare Part A, Part B, or Part D were not excluded. This logic was applied according to the continuous enrollment requirements across all measures, including but not limited to MCAS measures (i.e., *Breast Cancer Screening—Total*, *Cervical Cancer Screening*, *Comprehensive Diabetes Care—Hemoglobin*

2019–20 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	A1c [HbA1c] Poor Control [>9.0 Percent]—Total, *Controlling High Blood Pressure—Total*, both *Prenatal and Postpartum Care* measures) and applicable Cal MediConnect measures. During the HEDIS measurement year 2020 audit, SCFHP's auditor signed off on this logic after conducting primary source verification on a random sample of members to confirm proper dual eligibility status.
3. Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP.	SCFHP determined that the member incentive did not improve immunization series completion and concluded that a gift card valued at $30 may not be adequate to motivate members' parents/guardians. SCFHP adapted additional interventions to test outreach methods and an increased gift card amount as stated in the last module of the *Childhood Immunization Status—Combination 3* Disparity PIP. SCFHP chose to adapt the intervention emphasizing not only immunization completion, but also well-care visit completion in order to achieve optimal health outcomes of prevention and screening in children. SCFHP launched a well-care visit incentive for children ages 0 to 15 months as part of the adapted intervention in 2020. The following outreach methods were adapted: ♦ Reminder letters were mailed to non-compliant members' parents/guardians. Letters were designed to be more visually appealing using color and large font. The same gift card amount of $30 was used due to budgetary reasons; however, SCFHP offered a wide variety of gift cards from which members could select.

2019–20 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	♦ SCFHP promoted well-care visits and immunizations in member newsletters, which were mailed to members' homes in October 2020 and January 2021. In the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP, SCFHP's *Childhood Immunization Status—Combination 3* measure rate for Vietnamese members in Network 60 improved from measurement year 2017 to measurement year 2018. As of measurement year 2020, *Childhood Immunization Status—Combination 3* is no longer an MCAS measure and was replaced by *Childhood Immunization Status—Combination 10*. SCFHP monitors the *Childhood Immunization Status—Combination 10* measure rate ongoing. The *Childhood Immunization Status—Combination 10* measure rates were 66.91 percent and 57.91 percent in measurement years 2019 and 2020, respectively (See Table 3.1.). SCFHP has achieved the NCQA Medicaid 95th percentile and ranked first compared to other Medi-Cal plans in measurement year 2019. The rate for this measure for measurement year 2020 was significantly affected by COVID-19, which is also reflected in overall county immunization rates. SCFHP will continue to monitor and improve the outcomes.
4. Apply the lessons learned from the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP and *Controlling High Blood Pressure* PIP to facilitate improvement for future PIPs.	For the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP, SCFHP learned that additional outreach methods would be beneficial to facilitate improvement for future PIPs. SCFHP has implemented outreach calls and member mailers to broaden member engagement.

2019–20 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	For the 2017–19 *Controlling High Blood Pressure* PIP, the tested member interventions, such as incentives and health education mailers, were key factors to get members' high blood pressure under control. SCFHP chose to abandon the interventions, which focused on the member for health education mailings and an incentive, because SCFHP found that providers play a more critical role in educating members with high blood pressure. In fact, health care providers play a critical role in educating members on self-management of high blood pressure. Using the lessons learned from the above two PIPs, SCFHP adopted the following approach to facilitate the improvement on current and future PIPs: ♦ Broaden member engagement through mailings and outreach calls. ♦ Motivate members through incentives. ♦ Engage health care providers to develop strategies, as the providers play a critical role in educating members about health care services and ensure the completion of services. SCFHP currently applied the above approaches learned to facilitate the improvement for PIPs for *Lead Screening in Children* and *Adolescent Well-Care Visits*.

Assessment of MCP's Self-Reported Actions

HSAG reviewed SCFHP's self-reported actions in Table 7.1 and determined that SCFHP adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. SCFHP:

- Confirmed that the MCP is working with DHCS to fully resolve all findings from the 2019 and 2020 A&I Medical Audits.
- Described the MCP's process changes to verify dual eligibility in monthly enrollment spans and ensure that dual-eligible members are being appropriately included and excluded in performance measure reporting.
- Provided details about how the MCP monitored the adapted intervention from the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP and adaptations the MCP made to the intervention to improve child immunization rates.
- Described lessons learned from both 2017–19 PIPs and how the MCP is applying those lessons to current PIPs.

2020–21 Recommendations

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

- Continue working with DHCS to fully resolve the findings from the 2019, 2020, and 2021 Medical Audits of SCFHP.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate SCFHP's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix B:
Performance Evaluation Report
AIDS Healthcare Foundation
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted PSP, AIDS Healthcare Foundation ("AHF" or "the PSP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that AHF provides to its members. HSAG provides a summary of the PSP-specific results and findings for each activity and an assessment of the PSP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this PSP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in AHF's 2021–22 PSP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Population-Specific Health Plan Overview

AHF is a PSP operating in Los Angeles County, providing services primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Due to AHF's unique membership, some of the PSP's contracted requirements are different from MCP contract requirements. AHF became operational in Los Angeles County to provide MCMC services effective April 1995. As of June 2021, AHF had 714 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCMC plans. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCMC plans to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for AHF. HSAG's compliance review summaries are based on final audit reports issued on or before the end of the review period for this report (June 30, 2021).

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of AHF. A&I conducted the audits from February 8, 2021, through February 19, 2021. The Medical Audit was a limited-scope audit and did not include A&I review of the Administrative and Organizational Capacity category. Additionally, A&I examined the PSP's compliance with its DHCS contract and reviewed documents AHF submitted to DHCS in response to the 2020 Medical Audit CAP.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of AHF
Audit Review Period: January 1, 2020, through December 31, 2020

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

Strengths—Compliance Reviews

A&I identified no findings in the Member's Rights and State and Supported Services categories during the 2021 Medical and State Supported Services Audits of AHF.

Opportunities for Improvement—Compliance Reviews

AHF has the opportunity to 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.

3. Population-Specific Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs and PSPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs and PSPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's and PSP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month

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

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

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

progress update on the interventions and/or strategies. Additionally, DHCS will require MCPs and PSPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP/PSP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP and PSP contracts authorize DHCS to impose sanctions on MCPs and PSPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs and PSPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

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

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

Performance Measure Results

After validating the PSP's performance measure rates, HSAG assessed the results. See Table 3.1 for AHF's performance measure results for measurement years 2019 and 2020.

Note the following regarding Table 3.1:

- 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 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.

  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.
- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG compares a high performance level and minimum performance level for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* measure only because for all other measures either no national benchmarks existed or DHCS did not hold the PSP accountable to meet the minimum performance levels.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Table 3.1—Measurement Years 2019 and 2020 Performance Measure Results AHF—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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 in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Nov 8, 2021.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Women's Health Domain			
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 21–44 Years	NA	NA	Not Comparable
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	NA	NA	Not Comparable
Behavioral Health Domain			
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.00%	51.23%	51.23%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	NA	NA	Not Comparable
Acute and Chronic Disease Management Domain			
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total**	S	22.00%	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years**	26.23%	31.37%	5.14
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	69.70%	Not Comparable
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years**	S	S	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	NA	NA	Not Comparable

Measurement Year 2019 Quality Monitoring Summary

To allow MCPs, PSPs, and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities. Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of AHF's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

AHF conducted two PDSA cycles to increase the number of members who complete their retinal eye exams.

For the first PDSA cycle, AHF tested whether offering a $20 incentive would motivate members to complete their retinal eye exams. Although the intervention resulted in some members completing their retinal eye exams, the PSP did not achieve the PDSA goal. AHF indicated experiencing challenges related to clinical staff members having to prioritize COVID-19-related care; however, the education program manager was able to coordinate training for non-clinical staff on how to use the retinal eye exam camera. The PSP noted that it experienced delays in implementation because the retinal eye exam camera did not work properly upon arrival, and AHF had to contact the manufacturer to make repairs. AHF noted the following potential changes for the second PDSA cycle:

- Training staff to use the retinal eye exam cameras during a previously scheduled monthly meeting.

- Distributing more retinal eye exam cameras to health care centers that have a high number of patients diagnosed with diabetes.
- Including the retinal eye exam during annual wellness visits.
- Having members who receive their retinal eye exams at the health care center complete the survey at the health care center upon receiving their gift cards.
- Creating a document that is accessible to all necessary PSP staff that shows the progression of each member's gift card status.

For the second PDSA cycle, AHF tested whether including the retinal eye exam during the annual wellness visit, coupled with the $20 incentive, would motivate members to complete their retinal eye exam. AHF reported seeing improvement in the number of members completing their retinal eye exams and that the PSP exceeded the PDSA goal. AHF noted that it mailed incentive forms to the best available address, emailed some forms, and sent gift cards to members quickly via an online portal.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, AHF reported:

- Mailing a form to members due for a colon cancer screening to complete and return to the PSP upon completion of their screening. The form included information about an incentive being offered to members who returned the completed form. Using a gap-in-care list that identified members eligible for a screening, AHF made follow-up calls to confirm receipt of the form and incentive information. The PSP reported that several forms were returned because of inaccurate addresses and as a result, AHF's member services staff initiated a project to update all member contact information in collaboration with medical staff to ensure staff were populating the system with mailing address information instead of a member's primary address. AHF indicated that a very low number of members returned a completed form.
- Mailing a referral form to members due for a colon cancer screening to either schedule an appointment with the listed gastroenterologist or obtain written consent to receive an at-home colon cancer screening test. AHF indicated that while some members did not want to receive services at the health care center due to COVID-19 concerns, the PSP reported success with some members getting their colonoscopy and some completing the at-home screening test. When scheduling colonoscopy appointments, AHF provided information about the health care center's COVID-19 safety protocols, including wearing a mask, having an option to wait outside or in the car, and offering several sanitation stations throughout the facility. The PSP reported that it had some challenges disseminating the at-home colon cancer screening test order forms to the primary care providers (PCPs). To address this challenge, AHF facilitated a meeting with providers to discuss a process for ensuring that the PCPs complete the order forms.
- Having a project coordinator contact members due for a colon cancer screening who did not have screening appointments scheduled or orders for an at-home colon cancer screening test. Additionally, the PSP established an interdisciplinary task force to foster a

cohesive environment to develop ideas for maximum member satisfaction and to implement and monitor interventions.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs and PSPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs and PSPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP/PSP, excluding the ongoing PIPs.

In AHF's 2021–22 PSP-specific evaluation report, HSAG will provide a high-level summary of the PSP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Strengths—Performance Measures

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

For measures for which HSAG compared rates to benchmarks and for which HSAG compared measurement year 2020 rates to measurement year 2019 rates:

- The rate for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* measure exceeded the high performance level.
- The rate for the *Screening for Depression and Follow-Up Plan—Ages 18–64 Years* measure improved significantly from measurement year 2019 to measurement year 2020.

Opportunities for Improvement—Performance Measures

Based on performance measure results, HSAG identified no opportunities for improvement for AHF in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Note that based on AHF's specialized population and population size, DHCS approved AHF to select the 2020–22 PIP topics based on PSP-specific data rather than requiring AHF to identify topics related to the two required topic categories.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the PSP's module submissions for the 2020–22 PIPs, as well as HSAG's validation findings from the review period.

Controlling High Blood Pressure Performance Improvement Project

AHF determined to resume one of the PSP's 2019–21 PIP topics for its 2020–22 PIP—controlling high blood pressure.

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

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, AHF incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the PSP met all validation criteria for Module 1.

AHF's *Controlling High Blood Pressure* PIP SMART Aim measures the percentage of members with controlled blood pressure (≤139/89 mmHg). This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in AHF's 2021–22 PSP plan-specific evaluation report.

HIV Viral Load Suppression Performance Improvement Project

Based on PSP-specific data, AHF selected HIV viral load suppression for its other 2020–22 PIP topic.

HSAG validated modules 1 and 2 for the PSP's *HIV Viral Load Suppression* PIP. Upon initial review of the modules, HSAG determined that AHF met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim run chart.
- Logically linking the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.

After receiving technical assistance from HSAG, AHF incorporated HSAG's feedback into both modules. Upon final review, HSAG determined that the PSP met all validation criteria for

Module 1. At the end of the review period for this report, AHF was in the process of meeting all Module 2 validation criteria; therefore, HSAG includes no final validation results for Module 2 in this report.

AHF's *HIV Viral Load Suppression* PIP SMART Aim measures the percentage of members with a compliant viral load (<200 copies/mL). This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in AHF's 2021–22 PSP plan-specific evaluation report.

Strengths—Performance Improvement Projects

AHF successfully met all validation criteria for Module 1 for both PIPs. The validation findings show that the PSP built a strong foundational framework for both PIPs. AHF has progressed to Module 2 for both PIPs, in which the PSP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Opportunities for Improvement—Performance Improvement Projects

Based on AHF's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

AHF submitted the PSP's final PNA report to DHCS on July 19, 2021, and DHCS notified the PSP via email on July 23, 2021, that DHCS approved the report as submitted. While AHF submitted the PNA report and DHCS sent the email outside the review period for this PSP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs and PSPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with AHF's 2021 PNA Action Plan objectives and the PSP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the PSP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By July 1, 2021, increase HIV viral load suppression among members.	No	Worse	Continuing into 2021
2	By July 1, 2021, increase retinal eye exam screenings among members diagnosed with diabetes.	No	Worse	Continuing into 2021
3	By July 1, 2021, increase the percentage of members who perceive to have good communication with their doctors.	No	Worse	Continuing into 2021
4	By July 1, 2021, increase the percentage of members with controlled blood pressure.	No	Better	Continuing into 2021
5	By July 1, 2021, increase the percentage of members who perceive to be getting needed care from the PSP.	No	Better	Continuing into 2021
6	By July 1, 2021, increase the percentage of correct documented member email addresses in the business intelligence portal.	No	Better	Continuing into 2021
7	By July 1, 2021, increase the percentage of staff and providers who complete the cultural competency training.	No	Better	Ended in 2020
8	By July 1, 2021, increase HIV viral load suppression among Hispanic/Latinx members.	Yes	Better	Continuing into 2021

Table 5.2 provides the following:

- High-level summaries of the PSP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By July 1, 2022, increase HIV viral load suppression among members.	No	Continued from 2020
2	By July 1, 2022, increase retinal eye exam screenings among members diagnosed with diabetes.	No	Continued from 2020
3	By July 1, 2022, increase the percentage of members who perceive to have good communication with their doctors.	No	Continued from 2020
4	By July 1, 2022, increase the percentage of members with controlled blood pressure.	No	Continued from 2020
5	By July 1, 2022, increase the percentage of members who perceive to be getting needed care from the PSP.	No	Continued from 2020
6	By July 1, 2022, increase the percentage of correct documented email addresses in the business intelligence portal.	No	Continued from 2020
7	By July 1, 2022, increase HIV viral load suppression among Hispanic/Latinx members.	Yes	Continued from 2020

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from AHF's July 1, 2019, through June 30, 2020, PSP-specific evaluation report, along with the PSP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of AHF's self-reported actions.

Table 6.1—AHF's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, PSP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to AHF	Self-Reported Actions Taken by AHF during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Colorectal Cancer Screening* and *Diabetes Retinal Eye Exam* PIPs.	AHF created a monthly monitoring report showing progress and real-time areas for improvement. Results are presented annually at the Quality Management Committee meeting.
2. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.	*Colorectal Cancer Screening* PIP: The PSP signed a contract with an at-home colon cancer screening test company to add an at-home test as an option for enrollees. *Diabetes Retinal Eye Exam* PIP: The PSP purchased retinal eye exam cameras for each of the four largest AHF health care centers to conduct diabetic retinal eye exams with other scheduled visits. The PSP's quality improvement team coached the information technology team about how to accurately run monthly data so that the target population has a consistent denominator with a rolling year-to-date rate.

Assessment of PSP's Self-Reported Actions

HSAG reviewed AHF's self-reported actions in Table 6.1 and determined that AHF adequately addressed HSAG's recommendations from the PSP's July 1, 2019, through June 30, 2020, PSP-specific evaluation report. AHF stated how the PSP is continuing to monitor the interventions from the 2017–19 PIPs. Additionally, AHF provided a summary of how the PSP has applied lessons learned from the PIPs.

2020–21 Recommendations

Based on the overall assessment of AHF's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the PSP work with DHCS to fully resolve the findings from the 2021 Medical Audit. The PSP should thoroughly review all findings and implement the actions recommended by A&I.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix BB:
Performance Evaluation Report
SCAN Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted PSP, SCAN Health Plan ("SCAN" or "the PSP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that SCAN provides to its members. HSAG provides a summary of the PSP-specific results and findings for each activity and an assessment of the PSP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this PSP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in SCAN's 2021–22 PSP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Population-Specific Health Plan Overview

SCAN is a full-scope MCP delivering services to beneficiaries with specialized health care needs under the PSP model in Los Angeles, Riverside, and San Bernardino counties.

SCAN is a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) that contracts with DHCS to provide services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties. SCAN provides all services in the Medi-Cal State Plan, including home- and community-based services, to SCAN members assessed at the nursing facility-level of care and in nursing home custodial care. SCAN members must be at least 65 years of age, live in the service area, have Medicare Parts A and B, and have full-scope Medi-Cal with no share of cost. SCAN does not enroll individuals with end-stage renal disease.

SCAN has been licensed in California since November 30, 1984, in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, and became operational to provide MCMC services in Los Angeles County effective 1985. The PSP expanded into Riverside and San Bernardino counties in 1997.

In 2006, DHCS, at the direction of CMS, designated SCAN as an MCP. SCAN then functioned as a social health maintenance organization (HMO) under a federal waiver which expired at the end of 2007.

In 2008, SCAN entered a comprehensive risk contract with the State. SCAN receives monthly capitation from both Medicare and Medi-Cal, pooling its financing to pay for all services. DHCS amended SCAN's contract in 2008 to include the same federal and State requirements that exist for MCPs.

As of June 2021, SCAN had 8,559 members in Los Angeles County, 2,096 in Riverside County, and 1,455 in San Bernardino County—for a total of 12,110 members in the three counties combined.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

DHCS allows SCAN to combine data for Los Angeles, Riverside, and San Bernardino counties for reporting purposes. For this report, these three counties are considered a single reporting unit.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCMC plans. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCMC plans to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SCAN. HSAG's compliance review summaries are based on final audit reports issued on or before the end of the review period for this report (June 30, 2021).

Table 2.1 summarizes the results and status of the virtual A&I Medical Audit of SCAN. A&I conducted the audits from March 1, 2021, through March 10, 2021. During the audit, A&I examined documentation to determine SCAN's implementation and effectiveness of the CAP from the 2020 Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SCAN
Audit Review Period: March 1, 2020, through February 28, 2021

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

Strengths—Compliance Reviews

A&I identified no findings in five of the six categories reviewed during the 2021 Medical Audit.

Opportunities for Improvement—Compliance Reviews

SCAN has the opportunity to 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.

3. Population-Specific Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs and PSPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs and PSPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's and PSP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month

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

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

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

progress update on the interventions and/or strategies. Additionally, DHCS will require MCPs and PSPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP/PSP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP and PSP contracts authorize DHCS to impose sanctions on MCPs and PSPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs and PSPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of SCAN, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for SCAN Health Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the PSP's performance measure rates, HSAG assessed the results. See Table 3.1 for SCAN's performance measure results for measurement years 2019 and 2020.

Note the following regarding Table 3.1:

- 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 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.

  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.
- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures either because no national benchmarks existed for these measures or because DHCS did not hold the PSP accountable to meet minimum performance levels for the measures:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Controlling High Blood Pressure—Total*
  - *Screening for Depression and Follow-Up Plan—Ages 65+ Years*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Table 3.1—Measurement Years 2019 and 2020 Performance Measure Results SCAN—Los Angeles/Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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.

Not Comparable = A measurement year 2019–20 rate difference cannot be calculated because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Nov 9, 2021.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Women's Health Domain			
Breast Cancer Screening—Total	83.48%	77.35%	-6.13
Behavioral Health Domain			
Screening for Depression and Follow-Up Plan—Ages 65+ Years	17.81%	25.75%	7.94
Acute and Chronic Disease Management Domain			
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total**	14.11%	20.55%	6.44
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	13.27%	13.45%	0.18
Controlling High Blood Pressure—Total	—	66.42%	Not Comparable
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	1.94%	1.65%	-0.29

Measurement Year 2019 Quality Monitoring Summary

To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities. Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of SCAN's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

SCAN conducted two PDSA cycles to increase the number of members who receive their annual influenza (flu) vaccine.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, the PSP planned to hire three temporary bilingual care navigators to test whether conducting Spanish telephonic member outreach at a select medical group to provide education about the flu virus and vaccine would result in an increase in the number of vaccinated members. SCAN noted that because of a lack of funding, the PSP was only able to hire two care navigators. Additionally, staff members were redirected to other outreach activities which resulted in them being unable to focus on Spanish-language outreach at the select medical group.

SCAN indicated that the PSP did not achieve the PDSA goal and reported many challenges, including:

- Members' beliefs that the flu is not serious.
- Members thinking that they will have to pay for the vaccine.
- Members prioritizing safety from COVID-19 over going to the clinic to get the flu vaccine as well as prioritizing the COVID vaccine over the flu vaccine.
- Members' distrust in the medical/health system.
- Members' fears about side effects from the vaccine.
- Members not wanting to get the vaccine because friends or family members are not receiving it.
- Members believing myths or having misconceptions about the flu vaccine.
- Members having a previous negative reaction/allergy to the vaccine.
- Members' lack of transportation.

SCAN indicated plans to reach out directly to the flu vaccination champion at the medical group to see if they can collaborate on a final push for vaccinations that will result in prompt late-season vaccinations. Because of resource constraints, SCAN is unable to hire additional

care navigators for this intervention; therefore, the PSP will focus its efforts on members who are eligible for the COVID-19 vaccination.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, SCAN expanded the telephonic outreach to members at high risk for hospitalization and to a select physician group in addition to the medical group the PSP partnered with for the first PDSA cycle. Although SCAN reached a high number of members who prefer the Spanish language, the PSP did not achieve the PDSA goal. SCAN reported learning that it is important to:

- Ensure that the care navigators hired to conduct outreach to the target population are reserved for the outreach intended and are not pulled to work on other projects or conduct outreach to other populations.
- Hire more staff members if additional outreach is planned.
- Allocate funding for each project separately to provide the best opportunity for each project's success.

SCAN indicated that for the 2021–22 flu season, instead of using the care navigators, the PSP will hire additional Spanish-speaking peer advocates who can engage members using motivational interviewing and strengths-based health coaching.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, SCAN reported:

- Conducting outbound calls to members with chronic conditions/diseases and disabilities to address preventive care, chronic care, behavioral health, and social services needs. SCAN prioritized members with the highest risks and used the annual health risk assessment (HRA) and other data to identify care needs and resources to support members' access, social, educational, and overall health needs. SCAN indicated that clinical teams conducted outreach calls to the highest-need members, while non-clinical staff members conducted calls to all other members. SCAN reported creating a team to help meet member social support needs (e.g., meals, groceries, masks, technology). The PSP researched available community supports, educated members about these supports, and reported that the PSP implemented a workgroup to identify barriers to care based on various member data. To assist with members' access to prescription medications, SCAN invoked an emergency benefit for medication refills which allowed pharmacies to manually override the "Refill Too Soon" claim rejection at the point-of-sale and also encouraged members to choose the prescription mail order option so they did not have to leave their home to get their medications. SCAN indicated challenges with some staff having to take time out of their usual work tasks to support the outreach efforts.
- Conducting outreach calls to members with diabetes, chronic obstructive pulmonary disease, and disabilities to educate them about the importance of being seen for needed appointments and ensure these members had access to their primary care providers

(PCPs) and specialists. SCAN asked the members if they had completed their appointments and whether the appointments were in-person, via phone, or via telehealth format. During the calls, the PSP asked about access to care challenges and helped members resolve identified issues. SCAN also informed members about what providers were doing to reduce the risk of COVID-19 exposure for members choosing to be seen in-person. To support providers' use of telehealth appointments, SCAN disseminated a provider tip sheet with information about conducting visits via telehealth.

- Designing and conducting targeted COVID-19 outreach to address access to preventive service needs and health disparities. SCAN targeted members with chronic conditions and disabilities who were at highest risk. SCAN reported implementing several strategies, including:
  - Developed a dedicated COVID-19 phone number for members to call to receive help with access to vaccines and other COVID-19-related concerns.
  - Formed a COVID-19 vaccine planning workgroup to address issues related to the vaccine (i.e., general vaccine information dissemination, appointment scheduling, side effects, vaccine hesitancy, and promotion of equitable distribution).
  - Developed COVID-19 talking points for staff to use when communicating with members.
  - Partnered with community-based organizations and hospitals to find available COVID-19 vaccine appointments for the most vulnerable members and provided transportation and registration help.
  - Collaborated with provider groups, pharmacies, and community partners on vaccine distribution and gave providers actionable data relevant to members with high needs.
  - Conducted several "Teletalks" with members that included Hispanic and Black health care professionals to discuss COVID-19 vaccines and answer questions.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs and PSPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs and PSPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP/PSP, excluding the ongoing PIPs.

In SCAN's 2021–22 PSP-specific evaluation report, HSAG will provide a high-level summary of the PSP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Strengths—Performance Measures

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

HSAG identified the following notable measurement year 2020 performance measure results for SCAN:

- The rates were above the high performance levels for the two measures HSAG compared to benchmarks:
  - *Breast Cancer Screening—Total*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total*
- The rate for the *Screening for Depression and Follow-Up Plan—Ages 65+ Years* measure improved significantly from measurement year 2019 to measurement year 2020.

Opportunities for Improvement—Performance Measures

While the PSP's performance declined significantly from measurement year 2019 to measurement year 2020 for the *Breast Cancer Screening—Total* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* measures, since in measurement year 2020 the rates for both measures exceeded the high performance levels and the PSP had no rates below the minimum performance levels, HSAG identified no opportunities for improvement for the PSP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Note that based on SCAN's specialized population, DHCS approved SCAN to select one PIP topic based on PSP-specific data instead of the child and adolescent health focus area.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the PSP's module submissions for the 2020–22 PIPs, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

SCAN determined to resume the PSP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—diabetes control among Spanish-speaking members.

HSAG validated modules 1 and 2 for the PSP's *Diabetes Control* Health Equity PIP. SCAN met all validation criteria for both modules in its initial submissions.

SCAN's *Diabetes Control* Health Equity PIP SMART Aim measures the percentage of Spanish-speaking members diagnosed with diabetes who have HbA1c levels greater than 9 percent. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in SCAN's 2021–22 PSP plan-specific evaluation report.

Breast Cancer Screening Performance Improvement Project

SCAN determined to resume the PSP's 2019–21 PSP-specific PIP topic for its 2020–22 PSP-specific PIP—breast cancer screening.

HSAG validated modules 1 and 2 for the PSP's *Breast Cancer Screening* PIP. SCAN met all validation criteria for Module 1 in its initial submission. Upon initial review of Module 2, HSAG determined that SCAN met some required validation criteria; however, HSAG identified opportunities for improvement related to prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table. At the end of the review period for this report, SCAN was still in the process of incorporating HSAG's feedback into Module 2; therefore, HSAG includes no final validation results in this report.

SCAN's *Breast Cancer Screening* PIP SMART Aim measures the percentage of eligible members who complete their breast cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in SCAN's 2021–22 PSP plan-specific evaluation report.

Strengths—Performance Improvement Projects

SCAN successfully met all validation criteria for modules 1 and 2 for the *Diabetes Control* Health Equity PIP. The validation findings show that the PSP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Diabetes Control* Health Equity PIP. SCAN

has progressed to Module 3, in which the PSP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Additionally, SCAN successfully met all validation criteria for Module 1 for the *Breast Cancer Screening* PIP. The validation findings show that the PSP built a strong foundational framework for the *Breast Cancer Screening* PIP. SCAN has progressed to Module 2, in which the PSP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Opportunities for Improvement—Performance Improvement Projects

Based on SCAN's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

SCAN submitted the PSP's final PNA report to DHCS on August 11, 2021, and DHCS notified the PSP via email on the same date that DHCS approved the report as submitted. While SCAN submitted the PNA report and DHCS sent the email outside the review period for this PSP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs and PSPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with SCAN's 2021 PNA Action Plan objectives and the PSP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Align training with the incentive program and provide digital options to maintain engagement with physicians during COVID-19, with a goal of completing at least 14 physician trainings by December 31, 2020.	No	Unknown	Ended in 2020
2	By December 31, 2020, improve member understanding of medication management and adherence by evaluating 100 percent of HRAs in which the member indicated non-adherence and developing focused interventions to improve medication adherence for these members.	No	Unknown	Ended in 2020
3	By December 31, 2020, scale up the concierge service model from the pilot phase (five medical groups) to the entire network (67 medical groups).	No	Unknown	Ended in 2020
4	Reduce the percentage of members reporting a negative impact on quality of life due to pain interference.	No	Unknown	Ended in 2020
5	By June 30, 2021, decrease the percentage of Spanish-speaking members with poorly controlled diabetes.	Yes	Unknown	Ended in 2020

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By December 31, 2022, increase the percentage of Spanish-speaking members with controlled diabetes.	Yes	New in 2021
2	By March 31, 2022, increase the number of members assisted with accessing care and/or closing gaps in care.	No	New in 2021
3	By March 31, 2022, increase the portion of the population who use online health education.	No	New in 2021
4	By March 31, 2022, reduce the performance gap of medication adherence measures for Black and Spanish-speaking members.	Yes	New in 2021
5	By March 31, 2022, increase the percentage of Spanish-speaking members who receive the annual flu vaccine.	Yes	New in 2021
6	By March 31, 2022, reduce the COVID-19 vaccination disparity among Black and Spanish-speaking members.	Yes	New in 2021

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from SCAN's July 1, 2019, through June 30, 2020, PSP-specific evaluation report, along with the PSP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of SCAN's self-reported actions.

Table 6.1—SCAN's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, PSP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the interventions the PSP planned to adapt and continue to test in order to achieve optimal outcomes beyond the life of the 2017–19 *Statin Use in Persons with Diabetes* Disparity PIP and *Cholesterol Medication Adherence* PIP.	SCAN continues to monitor interventions including: ♦ Conducting oversight and engaging in ongoing collaboration with the vendor to ensure continuous process improvement. ♦ Tailoring education to meet the needs of members.
2. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the interventions and to strengthen future quality improvement efforts.	SCAN continues to engage and strategize, using lessons learned to ensure continuous improvement including data collection and analysis of the population to enable initiatives addressing disparities and health inequities. Although COVID-19 posed a serious risk to our members, SCAN implemented several programs to support and ensure continued services and interventions including: ♦ Preventive Services—Outbound calls to members to assess their needs and ensure they continued to receive their

2019–20 External Quality Review Recommendations Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	health care and long-term services and supports as well as medication. ♦ Chronic Disease Care—Outbound calls to ensure members continued to access care from their PCP and/or specialist ♦ Behavioral Health—Focused on members with barriers to accessing care.

Assessment of PSP's Self-Reported Actions

HSAG reviewed SCAN's self-reported actions in Table 6.1 and determined that SCAN adequately addressed HSAG's recommendations from the PSP's July 1, 2019, through June 30, 2020, PSP-specific evaluation report. SCAN indicated the PSP's actions related to the adapted interventions from the 2017–19 PIPs. Additionally, SCAN acknowledged the PSP's commitment to continuous improvement using lessons learned from the 2017–19 PIPs and listed three programs the PSP has implemented to support member access to needed services.

2020–21 Recommendations

Based on the overall assessment of SCAN's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that the PSP work with DHCS to fully resolve the three findings A&I identified in the Member's Rights category during the 2021 Medical Audit. The PSP should thoroughly review all findings and implement the actions recommended by A&I.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix C:
Performance Evaluation Report
Alameda Alliance for Health
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Alameda Alliance for Health ("AAH" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that AAH provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in AAH's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

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

AAH became operational in Alameda County to provide MCMC services effective 1996. As of June 2021, AAH had 283,159 members.[1] This represents 81 percent of the beneficiaries enrolled in Alameda County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

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

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of AAH. A&I conducted the audits from April 13, 2021, through April 23, 2021. A&I examined documentation for contract compliance and assessed the MCP's implementation of its CAP from the 2019 A&I Medical and State Supported Services Audits. DHCS issued the final audit reports on August 17, 2021, which is outside the review period for this report; however, HSAG includes the information from the reports because A&I conducted the on-site audits during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of AAH
Audit Review Period: June 1, 2019, through March 31, 2021

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

Follow-Up on 2018 A&I Medical and State Supported Services Audits

A&I conducted Medical and State Supported Services Audits of AAH in June 2018, covering the review period of June 1, 2017, through May 31, 2018. HSAG provided a summary of the audit results and status in AAH's 2018–19 and 2019–20 MCP-specific evaluation reports. At the time these previous MCP-specific evaluation reports were published, AAH's CAP was in process and under DHCS review. A letter from DHCS dated December 7, 2020, stated that AAH provided DHCS with additional information regarding the CAP and that DHCS had evaluated the information and closed the CAP. The letter indicated that DHCS would assess the effectiveness of the CAP and to what extent AAH has operationalized the proposed corrective actions during subsequent audits.

Strengths—Compliance Reviews

A&I identified no findings in the Quality Management category during the April 2021 Medical Audit of AAH. Additionally, AAH fully resolved all findings from the 2018 Medical and State Supported Services Audits of the MCP, resulting in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

AAH should continue to work with DHCS to fully resolve the findings from the 2019 Medical and State Supported Services Audits. Additionally, AAH should work with DHCS to resolve the findings from the 2021 Medical and State Supported Services Audits. During the 2021 Medical Audit, A&I identified repeat findings in the Utilization Management, Case Management and Coordination of Care, Member's Rights, and Administrative and Organizational Capacity categories. AAH should thoroughly review all findings and implement the actions recommended by A&I.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

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

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

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for AAH's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Oct 5, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	39.47%	Not Comparable
Childhood Immunization Status—Combination 10	52.80%	57.91%	5.11
Developmental Screening in the First Three Years of Life—Total	32.67%	37.38%	4.71
Immunizations for Adolescents—Combination 2	55.23%	50.61%	-4.62
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	93.70%	**70.83%**	-22.87
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**70.83%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	67.50%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	45.64%	Not Comparable
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	—	69.34%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
AAH—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	62.82%	**56.19%**	-6.63
*Cervical Cancer Screening^*	63.54%	**60.94%**	-2.60
Chlamydia Screening in Women—Ages 16–20 Years	59.11%	57.55%	-1.56
Chlamydia Screening in Women—Ages 21–24 Years	59.62%	60.93%	1.31
Chlamydia Screening in Women—Total	59.34%	59.09%	-0.25
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.41%	3.44%	-0.97
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.53%	4.78%	-0.75

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	19.74%	17.69%	-2.05
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.11%	22.48%	-2.63
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	8.00%	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	3.25%	6.55%	3.30
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	28.38%	25.14%	-3.24
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.86%	19.65%	2.79
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	7.43%	12.57%	5.14
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.46%	15.49%	3.03
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	45.27%	48.57%	3.30
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	39.49%	42.26%	2.77
*Prenatal and Postpartum Care—Postpartum Care^*	79.56%	82.99%	3.43
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	88.08%	91.67%	3.59

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
AAH—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	19	15.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	19	26.32%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	69.74%	72.83%	3.09
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	54.94%	56.40%	1.46
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**72.26%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	40.49%	47.74%	7.25
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	50.55%	52.86%	2.31
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	57.59%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	36.65%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	36.65%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.07%	S	S

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	2.38%	2.09%	-0.29
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	S	S

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
AAH—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	44.11	31.51	Not Tested
Asthma Medication Ratio—Total	59.93%	68.24%	8.31
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	28.22%	**41.46%**	13.24
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.96%	12.18%	-0.78
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	51.34%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.94%	10.91%	-0.03
Plan All-Cause Readmissions—Expected Readmissions—Total	10.26%	10.32%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.07	1.06	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.88%	2.69%	-1.19
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.

- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
AAH—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of AAH's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*

- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains AAH—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	3	16	18.75%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	8	37	21.62%
Measurement Year 2020 Rates Below Minimum Performance Levels	6	16	37.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	37	21.62%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of AAH's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

AAH conducted two PDSA cycles to improve well-child visit compliance for members ages 3 to 6 years.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, AAH partnered with eight clinics with low well-child visit rates to conduct telephonic outreach to educate parents and guardians about the importance of well-child visits and offer a gift card incentive to encourage parents and guardians to schedule an

appointment for their child. All eight clinics reported improvement in their well-child visit rates following the intervention testing. AAH reported the following challenges:

- Providers did not review the gap-in-care reports that AAH sent.
- Providers had difficulty contacting the parents/guardians.
- Parents/guardians did not return the providers' calls.
- Parents/guardians forgot about the scheduled appointments.
- Clinics were not able to collect qualitative member data.

AAH indicated that the providers reported that the member incentive motivated parents/guardians to schedule and complete the well-child visits. AAH also indicated plans to change the intervention to use a third-party vendor to distribute the incentives and develop a standardized script for the telephonic outreach.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, AAH continued conducting the telephonic outreach and reported improved well-child visit compliance at all eight clinic partners. AAH reported the following challenges:

- Parents/guardians were non-responsive.
- Parents/guardians were reluctant to go into the providers' offices during the pandemic.
- Clinics ran out of gift cards to provide to the members.
  - In response to this challenge, AAH developed a process for replenishing the gift card supply at the clinic sites.

AAH indicated that the member incentive motivated parents/guardians to schedule and complete the well-child visits. The MCP also reported that AAH's relationship with the clinics was strengthened by partnering with them on implementing the member outreach intervention.

COVID-19 Quality Improvement Plan Summary

In its COVID-10 QIP, AAH reported:

- Implementing the following strategies targeting Asian and Pacific Islander members with hypertension, diabetes, and hyperlipidemia:
  - Worked with community partners to promote disease management classes and other resources to these members.
  - Distributed self-management tools in the most prevalent Asian and Pacific Islander non-threshold languages.
  - Integrated disease self-management referrals into the MCP's case management programs.
  - Partnered with a federally qualified health center (FQHC) to which the majority of the MCP's Asian and Pacific Islander members are assigned to pilot an intervention that

promoted blood pressure monitoring at home during the pandemic. AAH reported providing blood pressure cuffs to members in the target population, that some of these members were seen for follow-up visits with their primary care provider (PCP), and that most of the members seen by their PCPs were determined to have controlled blood pressure. The FQHC gave positive feedback to AAH, stating that providing members with blood pressure cuffs to use at home allowed the PCPs to safely monitor and treat members with hypertension via telemedicine appointments. AAH indicated that once the MCP receives final pilot evaluation results, it will determine whether to adopt, adapt, or abandon this intervention.

- Implementing the following strategies to improve asthma medication ratio compliance for African-American members ages 21 to 44 years:
  - Partnered with providers to conduct asthma workshops.
  - Collaborated with pharmacies to provide phone consultations to support members in complying with their asthma medication regimen.
  - Integrated culturally sensitive best practices into asthma workshops and consultations.
  - Had the MCP's complex case managers work with providers to:
    - Develop a call script that when finalized will be used to conduct telephonic outreach to members.
    - Educate members on the importance of using their asthma controller medications and offering help with how to self-manage their asthma.
    - Develop a provider toolkit that when finalized will be sent to the assigned PCPs of the target population.
    - Create an asthma educational video that when finalized will be made available to members online via the MCP's website.
- Planning to implement the following strategies targeting African-American adult male members with uncontrolled HbA1c levels:
  - Partner with local barber shops to conduct point-of-care testing for members and provide a member incentive.
    - This intervention was put on hold due to COVID-19.
  - Initiate a text messaging campaign reminding members to complete their annual HbA1c test.
    - This intervention was put on hold due to the Telephone Consumer Protection Act.
  - Develop and send diabetes educational materials to members.
    - The educational materials are still in the review and approval process.
- Implementing the following strategies targeting African-American adult male members with uncontrolled HbA1c levels:
  - Sent monthly gap-in-care reports to providers.
  - Developed an African-American Advisory Workgroup.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In AAH's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
AAH—Alameda County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	60.02	28.54	Not Tested	31.51
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.23%	10.18%	2.05	10.91%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

HSAG identified the following notable measurement year 2020 performance measure results for AAH:

- The rates for the following measures were above the high performance levels:
  - Both *Antidepressant Medication Management* measures
  - *Childhood Immunization Status—Combination 10*

- Across all domains, the rates for eight of 37 measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates (22 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment—Total*
  - *Asthma Medication Ratio—Total*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years*
  - *Developmental Screening in the First Three Years of Life—Total*
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years*

Opportunities for Improvement—Performance Measures

Across all domains, six of 16 measures for which HSAG compared rates to benchmarks (38 percent) were below the minimum performance levels. For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, AAH's performance declined significantly for eight of 37 measures (22 percent), with five of these eight measures in the Women's Health domain.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, AAH should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

AAH determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, AAH identified breast cancer screening among African-American members as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

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

- Providing the description and rationale for the selected narrowed focus and reporting baseline data that support an opportunity for improvement.
- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Clearly labeling the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

After receiving technical assistance from HSAG, AAH incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. At the end of the review period for this report, AAH was in the process of meeting all validation criteria for Module 2; therefore, HSAG includes no final validation results for Module 2 in this report.

AAH's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of African-American members who complete their breast cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in AAH's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

AAH determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, AAH selected well-care visits for members ages 3 to 21 for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Child and Adolescent Well-Care Visits* PIP. Upon initial review of the modules, HSAG determined that AAH met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

After receiving technical assistance from HSAG, AAH incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2.

AAH's *Child and Adolescent Well-Care Visits* PIP SMART Aim measures the percentage of members ages 3 to 21 years who are assigned to the PIP provider partners and complete their well-care visits. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in AAH's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

AAH successfully met all validation criteria for Module 1 for the *Breast Cancer Screening* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Breast Cancer Screening* Health Equity PIP. AAH has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, AAH successfully met all validation criteria for modules 1 and 2 for the *Child and Adolescent Well-Care Visits* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Child and Adolescent Well-Care Visits* PIP. AAH has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on AAH's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

AAH submitted the MCP's final PNA report to DHCS on July 16, 2021, and DHCS notified the MCP via email on July 26, 2021, that DHCS approved the report as submitted. While AAH submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with AAH's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2022, outreach to 100 Asian and Pacific Islander members with hypertension, hyperlipidemia, and/or diabetes through educational materials, classes, or other supports.	Yes	Better	Ended in 2020
2	By June 30, 2022, connect 100 Hispanic (Latinx) members with healthy weight resources.	Yes	Unknown	Ended in 2020
3	By December 31, 2021, increase annual participation of Hispanic (Latinx) and Black (African-American) children ages 0 to 18 years in the Asthma Start in-home case management program.	Yes	Worse	Continuing into 2021
4	By December 31, 2021, achieve the measurement year 2019 minimum performance level for the *Asthma Medication Ratio–Total* measure for Black (African-American) adults ages 21 to 44 years.	Yes	Worse	Changing for 2021
5	By December 31, 2021, improve the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] rate for getting a check-up or routine care appointment as soon as needed for adults and children.	No	Worse	Changing for 2021
6	By December 31, 2021, improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates for Black (African-American) and White members to the measurement year 2019 minimum performance level.	Yes	Worse	Changing for 2021
7	By December 31, 2021, improve the CAHPS rate for providing needed information (through written materials and the Internet) for adults.	No	Unknown	Ended in 2020

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	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	Continued from 2020
2	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	Changed from 2020
3	By December 31, 2022, improve the 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	Changed from 2020
4	By December 31, 2022, increase the *Child and Adolescent Well-Care Visits—Total* measure rate for two identified providers.	No	Changed from 2020
5	By December 31, 2022, improve the *Breast Cancer Screening—Total* measure rate among Black (African-American) women ages 52 to 74 years.	Yes	New in 2021

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from AAH's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of AAH's self-reported actions.

Table 6.1—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical and State Supported Services Audits.	In 2019 and 2020, AAH updated policy documents and workflows, provided training for all staff members and network providers, and worked with our delegate partners in addressing all findings. ♦ In October 2020, AAH provided supporting documents to DHCS related to our 2018 CAP, and on December 7, 2020, DHCS accepted and closed this CAP. ♦ In January 2020, AAH provided supporting documents to DHCS related to our 2019 CAP but has not received an official CAP closure notification.
2. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Diabetes HbA1c Testing* Disparity PIP and *Children/Adolescent Access to Primary Care Physicians* PIP.	*Diabetes HbA1c Testing* Disparity PIP ♦ **Community Partnership:** Due to management turnover and competing priorities at the clinic partner, AAH faced barriers in fully implementing point-of-care testing at the clinic. ♦ AAH recognized the need to adapt the previous strategy by identifying a new provider or community partner to engage

2019–20 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	our Black (African-American) diabetic male population. ♦ In 2020, AAH's quality improvement team launched a program to engage the target population and identified an opportunity to partner with local barber shops and provide free haircuts to diabetic members who completed an HbA1c test, blood pressure screening, and member education on colon cancer screening. ■ In Quarter 4 2020, due to COVID-19, the initiative was put on hold with a plan to revisit this initiative in Quarter 3 2021. ♦ **Member Engagement:** In 2019, the MCP scheduled 32 of 80 appointments for men who had not received their annual HbA1c test. Of note, not all 32 scheduled appointments resulted in a visit or HbA1c test. ♦ AAH learned important lessons, including that telephone outreach was more successful with this population than other populations. ♦ AAH's quality improvement team is working with the disease management team to develop a robust strategy that will offer support to this target population through telephone outreach and case management. *Children/Adolescent Access to Primary Care Physicians* PIP ♦ **Member Engagement:** By December 31, 2020, AAH was able to engage 734 members between the ages of 3 and 21 years to receive a member incentive after a well-child exam at one of the nine participating provider locations.

2019–20 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	■ Of the 734 members, 441 (60 percent) of the gift cards were given to members between 12 and 21 years of age. ♦ **Population Health Strategy:** The adolescent population is included in the MCP's current DHCS Priority PIP, which is focused on the *Child and Adolescent Well-Care Visits—Total* measure. ♦ The adolescent population is also part of AAH's Population Health Strategy. Currently, in 2021, the MCP is working with three providers to help improve their compliance rate for the *Child and Adolescent Well-Care Visits—Total* measure. The MCP learned of a birthday card initiative from a DHCS collaboration discussion presentation. The MCP sent out birthday cards to members who are due for their annual well-child visit. At the completion of the visit, the member receives a gift card.
3. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.	*Lessons Learned:* ♦ It is important to provide members a choice when offering a gift card incentive. Based on the feedback we received from our provider partners, AAH now offers a variety of gift cards. ♦ The importance of partnering with multiple delegates or providers when implementing an intervention. During the pandemic, there was a reluctance by some providers to engage in PIPs due to the COVID-19 burden. Therefore, it is important to have multiple provider partners to work with to continue a quality improvement project. ♦ AAH adapted the DHCS-developed preventive care postcards. The postcards aim to educate targeted members to

2019–20 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	receive preventive care services in lieu of reminder letters. ■ Pending DHCS approval, AAH will begin using the postcards to engage members to receive services including initial health assessments, well-child exams, adult physicals, and mammograms. ♦ Partner with community organizations to conduct telephone outreach to pediatric members. The MCP is currently working with a community organization to conduct phone outreach to members ages 0 to 5 years who have not received the appropriate preventive care services.

Assessment of MCP's Self-Reported Actions

HSAG reviewed AAH's self-reported actions in Table 6.1 and determined that AAH adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. AAH noted the status of the MCP as resolving all findings from the 2018 and 2019 A&I Medical and State Supported Services Audits and described ongoing efforts related to the MCP's 2017–19 *Diabetes HbA1c Testing* Disparity and *Children/Adolescent Access to Primary Care Physicians* PIPs. AAH provided details regarding how the MCP adapted the interventions from the PIPs, including changes made based on lessons learned.

2020–21 Recommendations

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

- Continue to work with DHCS to fully resolve the findings from the 2019 Medical and State Supported Services Audits.
- 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.

- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate AAH's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix CC:
Performance Evaluation Report
UnitedHealthcare Community Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, UnitedHealthcare Community Plan ("UHC" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that UHC provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in UHC's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

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

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

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California

UHC became operational in San Diego County to provide MCMC services effective October 1, 2017. As of June 2021, UHC had 23,664 members.[1] This represents 3 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for UHC from July 19, 2021, through July 30, 2021, for the review period of June 1, 2019, through May 31, 2021. At the time this MCP-specific evaluation report was produced, the final audit reports were not available. HSAG will include a summary of the 2021 audits in UHC's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of UHC, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for UnitedHealthcare Community Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for UHC's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 31, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	22.94%	Not Comparable
Childhood Immunization Status—Combination 10	27.27%	40.27%	13.00
Developmental Screening in the First Three Years of Life—Total	23.50%	25.60%	2.10
Immunizations for Adolescents—Combination 2	29.82%	**28.85%**	-0.97
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	86.13%	83.21%	-2.92
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	72.51%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	71.78%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	17.39%	Not Comparable
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	—	36.98%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
UHC—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	NA	**53.57%**	Not Comparable
*Cervical Cancer Screening^*	50.61%	**52.55%**	1.94
Chlamydia Screening in Women—Ages 16–20 Years	66.67%	59.68%	-6.99
Chlamydia Screening in Women—Ages 21–24 Years	69.68%	63.29%	-6.39
Chlamydia Screening in Women—Total	68.57%	62.05%	-6.52

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	S	2.62%	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.80%	4.37%	-2.43
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	19.92%	16.43%	-3.49
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.67%	23.21%	-5.46
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.94%	9.80%	0.86
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.94%	6.12%	-2.82
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.99%	28.57%	-9.42

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Prenatal and Postpartum Care—Postpartum Care^*	74.87%	79.76%	4.89
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	89.01%	**87.85%**	-1.16

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Breast Cancer Screening—Total*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*
- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
UHC—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	14	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	14	21.43%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	63.30%	54.91%	-8.39
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	41.28%	**36.99%**	-4.29
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	85.57%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	NA	NA	Not Comparable
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.88%	11.97%	5.09
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	8.24%	12.39%	4.15
Screening for Depression and Follow-Up Plan—Ages 65+ Years	5.91%	6.33%	0.42

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures

- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
  - *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures
- HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
UHC—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	5	40.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 150 for the *Plan All-Cause Readmissions* measures and less than 30 for all other measures) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	42.45	32.36	Not Tested
Asthma Medication Ratio—Total	NA	**57.58%**	Not Comparable
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	33.65%	**43.09%**	9.44
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S	S	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	55.96%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	10.48%	Not Comparable
Plan All-Cause Readmissions—Expected Readmissions—Total	NA	10.48%	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	NA	1.00	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%	0.00%	0.00
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 150 for the *Plan All-Cause Readmissions* measure and less than 30 for all other measures) for the MCP to report valid rates:
  - *Asthma Medication Ratio—Total*
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Plan All-Cause Readmissions—Observed Readmissions—Total*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures;

therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All three *Plan All-Cause Readmissions* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
UHC—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	3	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	3	33.33%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of UHC's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 150 for the *Plan All-Cause Readmissions* measure and less than 30 for all other measures) for the MCP to report valid rates:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening—Total*
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
  - *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
  - *Plan All-Cause Readmissions—Observed Readmissions—Total*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains UHC—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	15	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	26	11.54%
Measurement Year 2020 Rates Below Minimum Performance Levels	7	15	46.67%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	26	15.38%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of UHC's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

UHC conducted two PDSA cycles to improve the MCP's performance on the *Cervical Cancer Screening* measure.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, UHC created a provider quality toolkit that included the *Cervical Cancer Screening* measure specification and documentation requirements, information about incentive programs, and information about how to access monthly reporting and member care

gap reports. The MCP mailed the toolkit to 11 provider offices and reviewed it with provider staff members via webinar. Although the MCP did not reach its PDSA cycle goal for closing care gaps, UHC reported that providers who received the toolkit and webinar training had a higher rate of care gap closure than providers who did not receive the toolkit and webinar training. The MCP noted the barrier of members being hesitant to visit clinics for their screenings due to fears of contracting COVID-19. Additionally, the MCP noted the following lessons learned:

- It is important that all clinic practitioners receive the coding and documentation information.
- It would be helpful to record the toolkit training for clinic staff members' ongoing access.

UHC determined to expand this intervention to include a recorded, self-paced, interactive training that providers and support staff members can access at any time.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, UHC developed a cervical cancer screening training module using an interactive, self-paced instructional design platform that providers can access online. UHC reported being unable to promote the interactive training module to providers or conduct the pre- and post-test training evaluation with training participants; however, the MCP was able to identify themes related to provider preferences and feedback that it will use to improve the training content. Additionally, UHC will be able to offer opportunities for providers to earn continuing education credits. The MCP noted the following lessons learned:

- It is important to allow enough time for intervention design, approval processes, and stakeholder feedback.
- When implementing a wide-scale project, focus on incremental objectives.

UHC indicated that its markets outside California expressed interest in this intervention, and the MCP will be adapting the training contents to add other MCAS measures.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, UHC reported:

- Conducting provider outreach following the release of a newly developed Pediatric Provider Toolkit that includes resources for promoting pediatric wellness. UHC was one of several organizations involved in supporting the distribution of this toolkit. The MCP conducted outreach to ensure that new providers know how to access and use the toolkit information and also integrated introduction of the toolkit into its provider training and orientation process. Some providers reported that based on other priorities, they were not yet able to download the toolkit; however, UHC indicated that the toolkit was downloaded 100 times. The MCP also reported having to rely on training designated staff members at each provider location rather than conducting group trainings on-site in the provider offices due to COVID-19 protocols.

- Conducting provider educational sessions to review the content of the Pediatric Provider Toolkit. UHC held webinars with providers, conducted presentations at the Provider Advisory Committee meetings, and provided a summary of the educational sessions during the MCP's quality practice meetings. The MCP reported the following lessons learned:
  - Patient letters are the best mechanism for sending well-child visit reminders.
  - Continuous reiteration of the toolkit information to providers is needed.
  - Providers were appreciative of the tools included in the toolkit, including the patient letters and call scripts.
- Planning to host a town hall meeting with providers to discuss use of the Pediatric Provider Toolkit and relevant clinical practices when using the toolkit resources; however, due to COVID-19 priorities, the MCP instead engaged in one-on-one conversations with providers regarding the toolkit.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In UHC's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
UHC—San Diego County

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

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

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

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

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

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

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

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	58.55	31.21	Not Tested	32.36
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	10.66%	Not Comparable	10.48%

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG did not compare the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure due to a higher or lower rate not indicating better or worse performance for this measure. Additionally, HSAG could not compare the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure because the denominator for the SPD population was too small (less than 150) for the MCP to report a valid rate.

Strengths—Performance Measures

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

HSAG identified the following notable measurement year 2020 performance measure results for UHC:

- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the rates for the following measures improved significantly from measurement year 2019 to measurement year 2020:
  - *Childhood Immunization Status—Combination 10*
  - *Screening for Depression and Follow-Up Plan—Ages 12–17 Years*
  - *Screening for Depression and Follow-Up Plan—Ages 18–64 Years*

Opportunities for Improvement—Performance Measures

Across all domains, UHC has the most opportunities for improvement in the Women's Health domain, with three measures in this domain having rates below the minimum performance levels and three additional measures having rates that declined significantly from measurement year 2019 to measurement year 2020. For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, UHC should assess the factors, which may include COVID-19, that affected the MCP'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.

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

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

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

5. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.

    - Final key driver diagram.
- MCMC plans provide narrative summaries to address the following:
    - Project conclusions.
    - Intervention testing conclusions.
    - Plans for spreading successful intervention(s), as applicable.
    - Challenges encountered.
    - Lessons learned and information gained.
    - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Note that based on UHC's population size, the MCP was unable to identify a specific sub-population with a demonstrated health disparity; therefore, DHCS approved UHC to conduct its 2020–22 Health Equity PIP for the MCP's entire member population.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 PIPs, as well as HSAG's validation findings from the review period.

Cervical Cancer Screening Performance Improvement Project

UHC determined to resume the MCP's 2019–21 PIP topic for its 2020–22 PIP—cervical cancer screening.

HSAG validated Module 1 for the MCP's *Cervical Cancer Screening* PIP. Upon initial review of the module, HSAG determined that UHC met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the narrowed focus baseline specifications and data collection methodology. After receiving technical assistance from HSAG, UHC incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

UHC's *Cervical Cancer Screening* PIP SMART Aim measures the percentage of eligible women ages 24 to 64 years who complete a cervical cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in UHC's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

UHC determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, UHC selected child and adolescent well-care visits for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Child and Adolescent Well-Care Visits* PIP. Upon initial review of the modules, HSAG determined that UHC met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Clearly labeling the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.

- Logically linking the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.

After receiving technical assistance from HSAG, UHC incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. At the end of the review period for this report, UHC was still in the process of incorporating HSAG's feedback into Module 2; therefore, HSAG includes no final validation findings for Module 2 in this report.

UHC's *Child and Adolescent Well-Care Visits* PIP SMART Aim measures the percentage of members ages 3 to 21 years who complete a well-care visit. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in UHC's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

UHC successfully met all validation criteria for Module 1 for both PIPs. The validation findings show that the MCP built a strong foundational framework for both PIPs. UHC has progressed to Module 2 for both PIPs, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Opportunities for Improvement—Performance Improvement Projects

Based on UHC's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

UHC submitted the MCP's PNA report to DHCS on August 10, 2021, and DHCS notified the MCP via email on the same date that DHCS approved the report as submitted. While UHC submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with UHC's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Increase HEDIS care gap closure using a concierge-like program that addresses any social determinants of health that may impede the member's ability to complete a primary care provider visit.	No	Unknown	Ended in 2020
2	Increase HEDIS care gap closure for the *Prenatal and Postpartum Care—Postpartum Care* and *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—* Total measures, and reduce hospital readmission rates among high-risk populations using Mom's Meals.	Yes	Unknown	Ended in 2020
3	Increase HEDIS care gap closure by implementing a more integrated population health management approach to our members diagnosed with diabetes, hypertension, and asthma, and in need of postpartum care.	No	Unknown	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	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	New in 2021
2	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	Changed from 2020
3	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	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Based on HSAG's assessment of UHC's delivery of quality, accessible, and timely care through the activities described in the MCP's 2019–20 MCP-specific evaluation report, HSAG included no recommendations in UHC's 2019–20 MCP-specific evaluation report. Therefore, UHC had no recommendations for which it was required to provide the MCP's self-reported actions.

2020–21 Recommendations

Based on the overall assessment of UHC's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that UHC assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate UHC's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix D:
Performance Evaluation Report
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan ("Anthem Blue Cross" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Anthem Blue Cross provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Anthem Blue Cross' 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Anthem Blue Cross operated in 28 counties during the July 1, 2020, through June 30, 2021, review period for this report. Anthem Blue Cross, a full-scope MCP, delivers services to its members under the Two-Plan Model in eight counties, the Regional model in 18 counties, the Geographic Managed Care (GMC) model in one county, and the San Benito model in one county.

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

Anthem Blue Cross' Two-Plan Model

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

Table 1.1—Anthem Counties Under the Two-Plan Model

County	Commercial Plan	Local Initiative Plan
Alameda	Anthem Blue Cross	Alameda Alliance for Health
Contra Costa	Anthem Blue Cross	Contra Costa Health Plan
Fresno	Anthem Blue Cross	CalViva Health
Kings	Anthem Blue Cross	CalViva Health
Madera	Anthem Blue Cross	CalViva Health
San Francisco	Anthem Blue Cross	San Francisco Health Plan
Santa Clara	Anthem Blue Cross	Santa Clara Family Health Plan
Tulare	Health Net Community Solutions, Inc.	Anthem Blue Cross

Anthem Blue Cross' Geographic Managed Care Model

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

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

Anthem Blue Cross' Regional Model

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

Anthem Blue Cross' Enrollment

Table 1.2 shows the counties in which Anthem Blue Cross provides MCMC services, Anthem Blue Cross' enrollment for each county, the MCP's total number of members, and the percentage of beneficiaries in the county enrolled in Anthem Blue Cross as of June 2021.[1]

Table 1.2—Anthem Blue Cross Enrollment as of June 2021

County	Enrollment as of June 2021	Percentage of Beneficiaries in the County Enrolled in Anthem Blue Cross
Alameda	67,362	19%
Alpine	157	70%
Amador	5,479	78%
Butte	23,475	35%
Calaveras	5,494	50%
Colusa	5,010	57%
Contra Costa	32,226	13%
El Dorado	11,863	36%
Fresno	123,939	28%
Glenn	2,774	25%
Inyo	2,582	57%
Kings	21,446	40%
Madera	23,316	36%
Mariposa	3,721	80%
Mono	1,923	67%
Nevada	13,281	59%
Placer	33,456	61%
Plumas	2,920	52%
Sacramento	195,608	40%

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

County	Enrollment as of June 2021	Percentage of Beneficiaries in the County Enrolled in Anthem Blue Cross
San Benito	9,474	100%
San Francisco	20,403	12%
Santa Clara	73,774	21%
Sierra	378	63%
Sutter	22,714	65%
Tehama	10,060	43%
Tulare	107,364	48%
Tuolumne	6,277	54%
Yuba	18,011	63%
Total	**844,487**	

Performance Measure Reporting

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

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

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

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

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for Anthem Blue Cross in 2019 for the review period of October 1, 2018, through September 30, 2019. HSAG included a summary of these audits in Anthem Blue Cross' 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of Anthem Blue Cross during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of Anthem Blue Cross from August 16, 2021, through August 27, 2021, for the review period of October 1, 2019, through July 31, 2021. HSAG will include a summary of these audits in Anthem Blue Cross' 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

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

The HSAG auditor determined that Anthem Blue Cross followed the appropriate specifications to produce valid rates; however, the MCP's integration of its HEDIS platform to support all Medicaid lines of business resulted in a large volume of supplemental data sources, some of which ultimately did not impact the measures under the scope of the audit. Additionally, Anthem Blue Cross had difficulty obtaining proof-of-service documentation for some of its data sources resulting in some of the data not being approved to use for reporting.

For future performance measure reporting, Anthem Blue Cross should:

- Implement additional quality control processes to ensure supplemental data are appropriately compiled and available for reporting.
- Develop a summary document for its supplemental data sources which identifies the Roadmap attachments that apply to multiple data sources, and provide these attachments separately and only once to consolidate the documentation and ensure a more efficient review.
- 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 under the scope of the audit.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.108 for Anthem Blue Cross' performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.108:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.96 present the performance measure results and findings by domain, and Table 3.97 through Table 3.108 present the measurement year 2020 performance measure findings for the domains combined.
- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.12 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 through Table 3.12:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—Total*

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Oct 29, 2021.

- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:

- *Child and Adolescent Well-Care Visits—Total*
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	33.74%	Not Comparable
Childhood Immunization Status—Combination 10	49.88%	44.77%	-5.11

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Developmental Screening in the First Three Years of Life—Total	22.24%	28.02%	5.78
Immunizations for Adolescents—Combination 2	44.04%	38.87%	-5.17
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	**69.34%**	-12.66
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	71.78%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	70.32%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	32.45%	Not Comparable
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	—	62.40%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	37.78%	Not Comparable
Childhood Immunization Status—Combination 10	44.35%	39.66%	-4.69
Developmental Screening in the First Three Years of Life—Total	33.79%	36.65%	2.86
Immunizations for Adolescents—Combination 2	36.50%	**35.52%**	-0.98
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	**59.12%**	-22.88
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**62.04%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**59.12%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	35.29%	Not Comparable
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	—	69.55%	Not Comparable

Table 3.3—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	38.40%	Not Comparable
Childhood Immunization Status—Combination 10	33.82%	**32.60%**	-1.22
Developmental Screening in the First Three Years of Life—Total	32.42%	27.38%	-5.04
Immunizations for Adolescents—Combination 2	36.50%	**35.66%**	-0.84
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	**65.94%**	-16.06
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**67.64%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**65.69%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	33.20%	Not Comparable
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	—	62.85%	Not Comparable

Table 3.4—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	34.63%	Not Comparable
Childhood Immunization Status—Combination 10	33.82%	**31.14%**	-2.68
Developmental Screening in the First Three Years of Life—Total	4.97%	S	S
Immunizations for Adolescents—Combination 2	35.04%	**36.74%**	1.70
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	83.94%	1.94
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	76.16%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	68.86%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	38.40%	Not Comparable
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	—	57.37%	Not Comparable

Table 3.5—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	54.01%	Not Comparable
Childhood Immunization Status—Combination 10	38.20%	45.26%	7.06
Developmental Screening in the First Three Years of Life—Total	49.30%	36.85%	-12.45
Immunizations for Adolescents—Combination 2	61.80%	56.38%	-5.42
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	82.73%	0.73
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	78.59%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	73.48%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	30.98%	Not Comparable
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	—	74.95%	Not Comparable

Table 3.6—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	40.29%	Not Comparable
Childhood Immunization Status—Combination 10	33.82%	38.20%	4.38
Developmental Screening in the First Three Years of Life—Total	42.28%	29.40%	-12.88
Immunizations for Adolescents—Combination 2	26.76%	**29.93%**	3.17
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	**77.62%**	-4.38
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**69.59%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	69.83%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	41.55%	Not Comparable
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	—	75.17%	Not Comparable

Table 3.7—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	38.46%	Not Comparable
Childhood Immunization Status—Combination 10	33.82%	**36.01%**	2.19
Developmental Screening in the First Three Years of Life—Total	35.17%	29.07%	-6.10
Immunizations for Adolescents—Combination 2	31.87%	**31.63%**	-0.24
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	81.75%	-0.25

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**71.29%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	69.59%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	37.76%	Not Comparable
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	—	67.95%	Not Comparable

Table 3.8—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	47.48%	Not Comparable
Childhood Immunization Status—Combination 10	33.82%	**30.90%**	-2.92
Developmental Screening in the First Three Years of Life—Total	55.13%	39.88%	-15.25
Immunizations for Adolescents—Combination 2	39.66%	39.66%	0.00
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	88.32%	6.32
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	85.89%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	82.24%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	26.86%	Not Comparable
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	—	66.03%	Not Comparable

Table 3.9—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	42.09%	Not Comparable
Childhood Immunization Status—Combination 10	33.82%	**28.82%**	-5.00
Developmental Screening in the First Three Years of Life—Total	47.08%	45.84%	-1.24
Immunizations for Adolescents—Combination 2	24.29%	**20.49%**	-3.80
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	**74.94%**	-7.06
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**65.69%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**57.91%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	44.83%	Not Comparable
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	—	78.05%	Not Comparable

Table 3.10—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	39.28%	Not Comparable
Childhood Immunization Status—Combination 10	49.68%	46.36%	-3.32
Developmental Screening in the First Three Years of Life—Total	33.25%	26.25%	-7.00
Immunizations for Adolescents—Combination 2	46.23%	45.98%	-0.25
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	**48.42%**	-33.58
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**59.37%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**56.93%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	34.04%	Not Comparable
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	—	66.42%	Not Comparable

Table 3.11—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	38.17%	Not Comparable
Childhood Immunization Status—Combination 10	44.28%	47.45%	3.17
Developmental Screening in the First Three Years of Life—Total	35.74%	26.88%	-8.86
Immunizations for Adolescents—Combination 2	43.80%	44.53%	0.73
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	**75.67%**	-6.33
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**70.80%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	67.40%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	44.95%	Not Comparable
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	—	71.82%	Not Comparable

Table 3.12—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	40.71%	Not Comparable
Childhood Immunization Status—Combination 10	35.04%	39.42%	4.38
Developmental Screening in the First Three Years of Life—Total	17.81%	3.51%	-14.30
Immunizations for Adolescents—Combination 2	45.50%	44.77%	-0.73
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.00%	84.18%	2.18
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	82.00%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	79.56%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	35.88%	Not Comparable
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	—	67.84%	Not Comparable

Findings—Children's Health Domain

Table 3.13 through Table 3.24 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.13 through Table 3.24:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.13—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.14—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.15—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	4	50.00%

Table 3.16—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.17—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

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

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

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

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.20—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.21—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.22—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—San Francisco County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	4	50.00%

Table 3.23—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	4	50.00%

Table 3.24—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Tulare County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.25 through Table 3.36 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.25—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	49.04%	**43.56%**	-5.48
*Cervical Cancer Screening^*	54.01%	**52.31%**	-1.70
Chlamydia Screening in Women—Ages 16–20 Years	64.05%	58.17%	-5.88
Chlamydia Screening in Women—Ages 21–24 Years	69.14%	64.03%	-5.11
Chlamydia Screening in Women—Total	66.45%	60.94%	-5.51
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.82%	3.26%	-1.56
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.08%	3.45%	-0.63
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	21.77%	17.77%	-4.00
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.06%	18.09%	-1.97
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	3.75%	6.74%	2.99
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	35.19%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.75%	19.53%	2.78
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.50%	15.35%	2.85

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	35.48%	48.15%	12.67
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.00%	40.23%	4.23
*Prenatal and Postpartum Care—Postpartum Care^*	73.97%	79.08%	5.11
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	86.62%	**82.97%**	-3.65

Table 3.26—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	50.44%	**44.92%**	-5.52
*Cervical Cancer Screening^*	57.18%	**49.63%**	-7.55
Chlamydia Screening in Women—Ages 16–20 Years	63.89%	61.61%	-2.28
Chlamydia Screening in Women—Ages 21–24 Years	71.26%	69.31%	-1.95
Chlamydia Screening in Women—Total	66.77%	64.89%	-1.88
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.30%	2.84%	0.54
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.55%	3.87%	-0.68
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.21%	16.18%	-0.03
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.55%	20.86%	-0.69
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	14.89%	20.39%	5.50
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.93%	15.13%	5.20
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	38.30%	38.16%	-0.14
*Prenatal and Postpartum Care—Postpartum Care^*	67.16%	**73.96%**	6.80
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	84.31%	**79.29%**	-5.02

Table 3.27—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	49.67%	**50.74%**	1.07
*Cervical Cancer Screening^*	51.58%	**54.74%**	3.16
Chlamydia Screening in Women—Ages 16–20 Years	55.22%	52.89%	-2.33
Chlamydia Screening in Women—Ages 21–24 Years	68.52%	63.01%	-5.51
Chlamydia Screening in Women—Total	62.03%	**58.21%**	-3.82
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	1.87%	1.68%	-0.19
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.70%	3.91%	0.21
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.12%	14.50%	-0.62
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.17%	24.75%	-0.42
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.32%	2.48%	1.16
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	6.75%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.51%	9.26%	2.75
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.25%	8.83%	1.58

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.04%	38.04%	4.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	35.01%	36.54%	1.53
*Prenatal and Postpartum Care—Postpartum Care^*	68.86%	**74.70%**	5.84
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	80.54%	**86.13%**	5.59

Table 3.28—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	52.06%	**53.08%**	1.02
*Cervical Cancer Screening^*	54.50%	**61.07%**	6.57
Chlamydia Screening in Women—Ages 16–20 Years	52.78%	52.57%	-0.21
Chlamydia Screening in Women—Ages 21–24 Years	73.99%	68.32%	-5.67
Chlamydia Screening in Women—Total	63.73%	60.81%	-2.92
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.27%	3.61%	0.34
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.77%	4.80%	-1.97
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.02%	15.82%	-2.20
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.92%	25.51%	-2.41
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	17.50%	13.26%	-4.24
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.42%	9.09%	3.67

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	43.33%	37.14%	-6.19
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.08%	46.59%	4.51
*Prenatal and Postpartum Care—Postpartum Care^*	78.51%	84.36%	5.85
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	90.83%	91.10%	0.27

Table 3.29—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	50.60%	**52.35%**	1.75
*Cervical Cancer Screening^*	63.17%	**60.68%**	-2.49
Chlamydia Screening in Women—Ages 16–20 Years	46.60%	53.20%	6.60
Chlamydia Screening in Women—Ages 21–24 Years	63.55%	57.10%	-6.45
Chlamydia Screening in Women—Total	55.24%	**55.15%**	-0.09
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	1.18%	1.42%	0.24
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.45%	4.28%	-1.17
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.11%	13.97%	-1.14
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.70%	25.57%	-2.13
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.50%	5.65%	-5.85
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.73%	10.00%	0.27
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.15%	38.26%	-2.89
*Prenatal and Postpartum Care—Postpartum Care^*	68.28%	**74.55%**	6.27
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	87.59%	**87.81%**	0.22

Table 3.30—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	49.98%	**46.32%**	-3.66
*Cervical Cancer Screening^*	54.99%	**51.83%**	-3.16
Chlamydia Screening in Women—Ages 16–20 Years	44.55%	43.83%	-0.72
Chlamydia Screening in Women—Ages 21–24 Years	56.22%	55.36%	-0.86
Chlamydia Screening in Women—Total	50.25%	**49.12%**	-1.13
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.18%	2.64%	0.46
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.16%	3.91%	-0.25
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	20.97%	22.00%	1.03
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.30%	24.57%	-1.73
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.21%	8.62%	2.41
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.21%	9.16%	2.95

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	30.23%	34.62%	4.39
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.41%	39.32%	1.91
*Prenatal and Postpartum Care—Postpartum Care^*	75.91%	81.75%	5.84
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	77.62%	**83.45%**	5.83

Table 3.31—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	51.93%	**47.96%**	-3.97
*Cervical Cancer Screening^*	55.47%	**58.88%**	3.41
Chlamydia Screening in Women—Ages 16–20 Years	47.41%	43.50%	-3.91
Chlamydia Screening in Women—Ages 21–24 Years	55.77%	52.05%	-3.72
Chlamydia Screening in Women—Total	51.01%	**46.99%**	-4.02
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.78%	2.86%	0.08
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.27%	4.55%	0.28
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	26.05%	25.12%	-0.93
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.12%	24.82%	-1.30
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.47%	9.48%	2.01
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.16%	8.29%	0.13

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	21.82%	40.00%	18.18
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.13%	39.81%	2.68
*Prenatal and Postpartum Care—Postpartum Care^*	65.69%	80.05%	14.36
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	84.91%	**84.43%**	-0.48

Table 3.32—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	56.97%	**51.58%**	-5.39
*Cervical Cancer Screening^*	57.18%	63.28%	6.10
Chlamydia Screening in Women—Ages 16–20 Years	67.69%	62.79%	-4.90
Chlamydia Screening in Women—Ages 21–24 Years	67.59%	61.96%	-5.63
Chlamydia Screening in Women—Total	67.64%	62.39%	-5.25
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.54%	2.34%	-0.20
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.86%	4.70%	-0.16
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.74%	15.27%	-1.47
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.50%	22.46%	-2.04
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.70%	0.93%	0.23
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	11.93%	13.59%	1.66
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.36%	12.54%	4.18
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	4.57%	5.04%	0.47

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	27.84%	40.22%	12.38
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	28.31%	32.85%	4.54
*Prenatal and Postpartum Care—Postpartum Care^*	72.02%	77.62%	5.60
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	84.43%	**86.13%**	1.70

Table 3.33—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	57.24%	**49.19%**	-8.05
*Cervical Cancer Screening^*	57.42%	**59.61%**	2.19
Chlamydia Screening in Women—Ages 16–20 Years	36.63%	38.05%	1.42
Chlamydia Screening in Women—Ages 21–24 Years	53.33%	54.81%	1.48
Chlamydia Screening in Women—Total	46.19%	**47.18%**	0.99
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	S	S	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.97%	5.58%	0.61
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.78%	17.66%	2.88
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.02%	29.20%	-0.82
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S	15.96%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.50%	43.62%	6.12
*Prenatal and Postpartum Care—Postpartum Care^*	65.74%	89.17%	23.43
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	88.89%	90.83%	1.94

Table 3.34—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's

de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	58.32%	**46.75%**	-11.57
*Cervical Cancer Screening^*	57.28%	**53.35%**	-3.93
Chlamydia Screening in Women—Ages 16–20 Years	53.68%	47.22%	-6.46
Chlamydia Screening in Women—Ages 21–24 Years	59.43%	50.90%	-8.53
Chlamydia Screening in Women—Total	56.91%	**49.20%**	-7.71
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.32%	S	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.79%	2.92%	-2.87
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.93%	13.10%	-0.83
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.69%	19.04%	-2.65
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.50%	15.96%	-0.54
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	11.65%	13.83%	2.18
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	33.98%	30.85%	-3.13
*Prenatal and Postpartum Care—Postpartum Care^*	67.80%	**74.77%**	6.97
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	84.75%	**81.08%**	-3.67

Table 3.35—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	56.11%	**48.53%**	-7.58
*Cervical Cancer Screening^*	54.26%	**51.82%**	-2.44
Chlamydia Screening in Women—Ages 16–20 Years	56.93%	53.43%	-3.50
Chlamydia Screening in Women—Ages 21–24 Years	61.84%	60.47%	-1.37
Chlamydia Screening in Women—Total	59.41%	**57.00%**	-2.41
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.33%	2.03%	-0.30
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.01%	4.65%	-0.36
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.52%	13.13%	-1.39
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	23.95%	22.15%	-1.80
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	10.79%	15.95%	5.16
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	36.36%	34.15%	-2.21
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	18.72%	25.97%	7.25
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	33.33%	29.27%	-4.06
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	21.37%	25.15%	3.78

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	45.45%	56.10%	10.65
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.41%	47.65%	6.24
*Prenatal and Postpartum Care—Postpartum Care^*	77.37%	79.08%	1.71
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	86.13%	**87.83%**	1.70

Table 3.36—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	60.52%	**58.28%**	-2.24
*Cervical Cancer Screening^*	66.94%	69.81%	2.87
Chlamydia Screening in Women—Ages 16–20 Years	53.97%	57.22%	3.25
Chlamydia Screening in Women—Ages 21–24 Years	71.40%	69.75%	-1.65
Chlamydia Screening in Women—Total	62.22%	63.39%	1.17
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.66%	2.36%	-0.30
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.76%	5.09%	-0.67
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.49%	18.47%	-0.02
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.62%	29.49%	-1.13
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	16.77%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.74%	12.34%	2.60
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.77%	7.94%	1.17

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	39.73%	44.10%	4.37
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	43.35%	48.19%	4.84
*Prenatal and Postpartum Care—Postpartum Care^*	82.97%	84.18%	1.21
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	91.24%	90.75%	-0.49

Findings—Women's Health Domain

Table 3.37 through Table 3.48 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.37 through Table 3.48:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- For Contra Costa, Madera, San Benito, and San Francisco counties, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*

Table 3.37—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	19	42.11%

Table 3.38—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	15	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	15	13.33%

Table 3.39—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	19	15.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	19	10.53%

Table 3.40—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	19	5.26%

Table 3.41—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	15	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	15	6.67%

Table 3.42—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	19	10.53%

Table 3.43—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	19	21.05%

Table 3.44—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	19	15.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	19	31.58%

Table 3.45—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	15	6.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	15	0.00%

Table 3.46—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—San Francisco County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	15	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	15	20.00%

Table 3.47—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	19	10.53%

Table 3.48—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Tulare County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	19	26.32%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	19	5.26%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.49 through Table 3.60 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.49 through Table 3.60:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.49—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.99%	**52.18%**	0.19
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	35.46%	39.09%	3.63
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**75.25%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	36.56%	39.39%	2.83
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	59.38%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	43.75%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	43.75%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.72%	11.42%	4.70
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.39%	0.89%	0.50
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	S	S

Table 3.50—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.28%	65.28%	6.00
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	42.27%	47.15%	4.88
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**68.12%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.13%	38.57%	-0.56
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.64%	14.52%	3.88
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.56%	1.02%	0.46
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Table 3.51—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.50%	54.24%	3.74
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	34.15%	**36.63%**	2.48
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**75.71%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	35.04%	30.11%	-4.93

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	33.33%	S	S
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	52.21%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	35.29%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**34.56%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	8.60%	10.12%	1.52
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.88%	1.53%	0.65
Screening for Depression and Follow-Up Plan—Ages 65+ Years	1.86%	1.80%	-0.06

Table 3.52—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	48.51%	**47.75%**	-0.76
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	30.20%	**36.52%**	6.32
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**76.67%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	50.00%	57.58%	7.58
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	S	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.22%	0.24%	0.02
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Table 3.53—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	41.86%	**52.87%**	11.01
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	30.23%	**33.33%**	3.10
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**78.57%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	53.13%	48.72%	-4.41
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.45%	8.53%	7.08
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	2.14%	2.36%	0.22
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	S	S

Table 3.54—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.19%	53.70%	-0.49
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	37.12%	39.37%	2.25
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**77.42%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	46.50%	45.70%	-0.80
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	64.71%	55.88%	-8.83
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	49.59%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	30.89%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**30.89%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.16%	5.82%	2.66
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.64%	1.85%	1.21
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	1.46%	S

Table 3.55—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.65%	59.52%	3.87
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.05%	42.00%	1.95
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**74.50%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	44.29%	43.00%	-1.29
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	45.00%	48.98%	3.98
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	45.29%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	31.18%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**26.47%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.43%	9.68%	6.25
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.82%	2.46%	1.64
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	2.59%	S

Table 3.56—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.63%	56.48%	1.85
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.88%	39.67%	0.79
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**77.66%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	30.13%	30.37%	0.24
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	38.30%	35.87%	-2.43

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	52.78%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	37.70%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**33.73%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.85%	10.66%	3.81
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	5.49%	5.13%	-0.36
Screening for Depression and Follow-Up Plan—Ages 65+ Years	10.07%	6.36%	-3.71

Table 3.57—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	45.59%	**51.43%**	5.84
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	29.41%	**30.00%**	0.59
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	NA	NA	Not Comparable
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	7.73%	11.46%	3.73
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S	0.73%	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	NA	22.22%	Not Comparable

Table 3.58—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.81%	53.85%	-1.96
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	46.12%	**37.91%**	-8.21
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	85.27%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	NA	NA	Not Comparable
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.94%	14.22%	3.28
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.61%	3.08%	2.47
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	3.76%	S

Table 3.59—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.16%	**48.57%**	-2.59
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	32.37%	**36.86%**	4.49
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**76.05%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.34%	32.31%	-7.03
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	45.45%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	S	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**S**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	2.02%	4.96%	2.94
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.61%	1.92%	1.31
Screening for Depression and Follow-Up Plan—Ages 65+ Years	2.47%	7.76%	5.29

Table 3.60—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Anthem Blue Cross—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	45.01%	**47.23%**	2.22
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	30.83%	**32.75%**	1.92
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**76.71%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	38.89%	45.41%	6.52

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	43.14%	53.49%	10.35
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	55.20%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	42.40%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	42.40%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.27%	2.78%	1.51
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.33%	1.64%	1.31
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	1.86%	S

Findings—Behavioral Health Domain

Table 3.61 through Table 3.72 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.61 through Table 3.72:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- For the following reporting units, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Alameda County
  - Contra Costa County
  - Kings County
  - Madera County
  - San Benito County
  - San Francisco County
  - Santa Clara County
- For San Benito and San Francisco counties, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- For San Benito County, HSAG did not include the *Screening for Depression and Follow-Up Plan—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

- For the following reporting units, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Contra Costa County
  - Kings County
  - Madera County
  - San Benito County
  - San Francisco County
- For San Benito County, HSAG did not include the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.61—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	6	33.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Table 3.62—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	6	33.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Table 3.63—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.64—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	6	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	3	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Table 3.65—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	6	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	3	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	6	16.67%

Table 3.66—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.67—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.68—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Table 3.69—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	4	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.70—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—San Francisco County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	5	60.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.71—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	6	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	4	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Table 3.72—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Tulare County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.73 through Table 3.84 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.73 through Table 3.84:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.73—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.00	34.63	Not Tested
Asthma Medication Ratio—Total	59.25%	69.08%	9.83

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	42.09%	**45.50%**	3.41
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.74%	10.58%	-1.16
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	49.88%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.81%	10.12%	-0.69
Plan All-Cause Readmissions—Expected Readmissions—Total	10.06%	10.57%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.07	0.96	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	8.01%	6.84%	-1.17
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.74—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	44.56	31.76	Not Tested
Asthma Medication Ratio—Total	65.68%	79.18%	13.50

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	47.20%	**44.53%**	-2.67
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.11%	13.27%	1.16
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	45.99%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.08%	9.06%	-2.02
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%	9.83%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.18	0.92	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	13.37%	11.82%	-1.55
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.75—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	44.15	32.68	Not Tested
Asthma Medication Ratio—Total	61.06%	**61.95%**	0.89

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	54.50%	**51.82%**	-2.68
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	8.79%	7.36%	-1.43
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	50.85%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.24%	9.08%	-0.16
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%	9.65%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.98	0.94	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.30%	3.31%	-0.99
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.76—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.52	34.41	Not Tested
Asthma Medication Ratio—Total	70.00%	71.36%	1.36
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	48.91%	**39.66%**	-9.25
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	17.87%	19.30%	1.43
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	62.04%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.64%	9.24%	-1.40
Plan All-Cause Readmissions—Expected Readmissions—Total	9.39%	9.95%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.13	0.93	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S	S	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.77—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	43.67	31.02	Not Tested
Asthma Medication Ratio—Total	65.89%	72.54%	6.65
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	54.74%	**42.34%**	-12.40
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.20%	9.96%	-3.24
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	62.04%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.20%	7.48%	-0.72
Plan All-Cause Readmissions—Expected Readmissions—Total	9.33%	9.37%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.88	0.80	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S	S	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.78—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	43.75	32.53	Not Tested
Asthma Medication Ratio—Total	64.23%	68.09%	3.86

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	34.79%	36.98%	2.19
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.36%	10.35%	-1.01
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	54.01%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.80%	9.80%	0.00
Plan All-Cause Readmissions—Expected Readmissions—Total	9.65%	9.66%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.02	1.01	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.20%	3.19%	-1.01
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.79—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	52.13	40.74	Not Tested
Asthma Medication Ratio—Total	62.32%	65.50%	3.18

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	42.82%	**45.01%**	2.19
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	15.79%	15.51%	-0.28
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	52.31%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.51%	8.91%	0.40
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%	9.63%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.91	0.93	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.51%	6.73%	-0.78
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.80—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	53.28	39.57	Not Tested
Asthma Medication Ratio—Total	58.38%	64.89%	6.51
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	33.82%	**40.63%**	6.81
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.54%	11.18%	-0.36
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	0.00%	S	S
Controlling High Blood Pressure—Total	—	61.07%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.47%	10.25%	0.78
Plan All-Cause Readmissions—Expected Readmissions—Total	9.58%	9.96%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.99	1.03	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	10.03%	8.89%	-1.14
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	S	Not Comparable

Table 3.81—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 150 for the *Plan All-Cause Readmissions* measures and less than 30 for all other measures) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	54.27	44.57	Not Tested
Asthma Medication Ratio—Total	68.35%	77.14%	8.79
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	40.34%	**43.97%**	3.63
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S	S	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	50.19%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	NA	Not Comparable
Plan All-Cause Readmissions—Expected Readmissions—Total	NA	NA	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	NA	NA	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%	S	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.82—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.65	33.40	Not Tested
Asthma Medication Ratio—Total	46.74%	**60.23%**	13.49

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	28.71%	**41.81%**	13.10
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.38%	15.50%	-0.88
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	47.69%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.58%	12.40%	0.82
Plan All-Cause Readmissions—Expected Readmissions—Total	10.30%	10.79%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.12	1.15	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	13.59%	14.04%	0.45
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.83—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	41.38	30.62	Not Tested
Asthma Medication Ratio—Total	60.22%	66.67%	6.45
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	31.63%	36.39%	4.76
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	6.84%	12.46%	5.62
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	S	Not Comparable
Controlling High Blood Pressure—Total	—	49.88%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.58%	10.39%	1.81
Plan All-Cause Readmissions—Expected Readmissions—Total	9.44%	10.14%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.91	1.03	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S	S	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	S	Not Comparable

Table 3.84—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Anthem Blue Cross—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	34.39	25.53	Not Tested
Asthma Medication Ratio—Total	65.82%	69.43%	3.61

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	33.82%	35.77%	1.95
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.04%	13.04%	-1.00
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	62.77%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.41%	9.45%	1.04
Plan All-Cause Readmissions—Expected Readmissions—Total	9.21%	9.60%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.91	0.99	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	2.06%	2.05%	-0.01
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.85 through Table 3.96 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.85 through Table 3.96:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- For the following reporting units, HSAG did not include the *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Alameda County
  - Contra Costa County
  - Fresno County
  - Kings County
  - Madera County
  - Region 1
  - Region 2
  - San Benito County
  - San Francisco County
  - Santa Clara County
  - Tulare County
- For San Benito County, HSAG did not include the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure were too small (less than 150) for the MCP to report a valid rate.
- For all reporting units, HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.

- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.85—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.86—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.87—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.88—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.89—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.90—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.91—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.92—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	6	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	6	16.67%

Table 3.93—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.94—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—San Francisco County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	5	20.00%

Table 3.95—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Anthem Blue Cross—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	5	20.00%

Table 3.96—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
Anthem Blue Cross—Tulare County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Performance Measure Findings—All Domains

Table 3.97 through Table 3.108 present a summary of Anthem Blue Cross' measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.97 through Table 3.108:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ For the following reporting units, HSAG did not include the *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:

- Alameda County
- Contra Costa County
- Fresno County
- Kings County
- Madera County
- Region 1
- Region 2
- San Benito County
- San Francisco County
- Santa Clara County
- Tulare County

♦ For Contra Costa, Madera, San Benito, and San Francisco counties, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:

- *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
- *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
- *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
- *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*

♦ For the following reporting units, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:

- Alameda County

- Contra Costa County
- Kings County
- Madera County
- San Benito County
- San Francisco County
- Santa Clara County

- For San Benito and San Francisco counties, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- For San Benito County, HSAG did not include the *Plan All-Cause Readmissions—Observed Readmissions—Total* and *Screening for Depression and Follow-Up Plan—Ages 65+ Years* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small for the MCP to report valid rates.
- For all reporting units, HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Plan All-Cause Readmissions* measures
  - All three *Screening for Depression and Follow-Up Plan* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
  - Both *Well-Child Visits in the First 30 Months of Life* measures

- For the following reporting units, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Contra Costa County
  - Kings County
  - Madera County
  - San Benito County
  - San Francisco County
- For San Benito County, HSAG did not include the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.97—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	34	11.76%
Measurement Year 2020 Rates Below Minimum Performance Levels	7	16	43.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	9	34	26.47%

Table 3.98—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	15	13.33%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	30	10.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	10	15	66.67%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	30	10.00%

Table 3.99—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	35	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	15	16	93.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	35	11.43%

Table 3.100—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	15	6.67%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	34	2.94%
Measurement Year 2020 Rates Below Minimum Performance Levels	8	15	53.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	34	5.88%

Table 3.101—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	15	6.67%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	30	10.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	9	15	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	30	10.00%

Table 3.102—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	35	11.43%
Measurement Year 2020 Rates Below Minimum Performance Levels	9	16	56.25%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	35	8.57%

Table 3.103—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	35	11.43%
Measurement Year 2020 Rates Below Minimum Performance Levels	10	16	62.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	35	14.29%

Table 3.104—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	36	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	6	16	37.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	36	27.78%

Table 3.105—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	14	14.29%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	27	11.11%
Measurement Year 2020 Rates Below Minimum Performance Levels	11	14	78.57%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	27	3.70%

Table 3.106—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—San Francisco County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	15	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	29	13.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	11	15	73.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	29	20.69%

Table 3.107—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	34	14.71%
Measurement Year 2020 Rates Below Minimum Performance Levels	10	16	62.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	34	14.71%

Table 3.108—Measurement Year 2020 Performance Measure Findings for All Domains Anthem Blue Cross—Tulare County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	16	6.25%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	8	35	22.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	16	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	35	5.71%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Anthem Blue Cross' SWOT analysis and COVID-19 QIP. Note that while MCPs and PSPs submitted their final SWOT information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Strengths, Weaknesses, Opportunities, Threats Analysis Summary

Anthem Blue Cross reported that it implemented the following quality improvement strategies related to its SWOT analysis, which targeted the *Breast Cancer Screening—Total* measure:

- Partnered with a federally qualified health center (FQHC) in Fresno County to implement a coordinated tiered member outreach process that involved the primary care provider (PCP), mammogram provider, and Anthem Blue Cross' quality improvement staff and health educator. Anthem Blue Cross' outreach team engaged with members multiple times until the members completed their breast cancer screenings, and both the PCP and

mammogram provider had electronic documentation of the results. The MCP targeted outreach to members who missed their scheduled appointments and provided these members with information about how to obtain member incentives. The MCP reported that the intervention resulted in some success in members scheduling and receiving their mammograms. Anthem Blue Cross reported the following challenges and lessons learned:

- Using gap-in-care reports and effectively coordinating efforts with PCPs and mammogram providers supported timely member outreach.
- County restrictions due to COVID-19 cases affected members' ability to schedule their mammograms.
- Members were hesitant to receive 3D mammograms immediately after receiving their COVID-19 vaccines due to possible swelling of lymph nodes that could affect mammogram readings.
- It was helpful to leverage additional PCP operations support staff for updating the member contact list with the most current information and ensuring that mammogram orders are aligned with other member outreach and recall activities.

- Continued to develop partnerships with community-based organizations, including faith-based and non-profit groups, to promote awareness of breast cancer and breast cancer screening. The MCP actively used social media outlets and shared resources to expand information reach to other public spaces and domains. Anthem Blue Cross updated its breast health digital media kit and shared this information with community partners. Health educators actively worked to schedule meetings with community-based organizations to expand sharing of breast cancer screening resources through various media sources, promotoras in Fresno and Kings counties, community health workers, and health care navigators. Anthem Blue Cross reported the following challenges and lessons learned:
  - Due to COVID-19 county restrictions, the MCP's partnerships with faith-based organizations are only in the preliminary stages.
  - Shared activities with community-based organizations that are implemented over shorter periods of time are more feasible due to these organizations planning their awareness campaigns more than six months in advance..
- Continued to offer virtual breast cancer screening health education classes to members via social media and webinars.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Anthem Blue Cross reported:

- Developing outreach processes to improve education delivery to all members about the importance of completing their initial health assessment (IHA), especially during the pandemic. Anthem Blue Cross revised the MCP's member outreach interactive voice response (IVR) scripts and the new member welcome packet to include information about the importance of having an initial provider visit to address any needs identified through the member's IHA. The MCP also developed a follow-up educational outreach protocol for new members enrolled past the 90-day period who have not completed an IHA. Anthem Blue

Cross reported learning that careful collaboration is required with projects involving member-facing materials due to possible administrative and approval process delays within the MCP and from DHCS.

- Conducting an educational campaign to targeted providers via learning café webinars and Anthem Blue Cross' provider portal regarding the use of blood lead screening care gap reports as well as information about workflow improvement and data collection and analysis. The MCP targeted providers and members ages 0 to 24 months in Alameda and Fresno counties. While it was Anthem Blue Cross' goal for providers to use the blood lead screening care gap reports to improve member outreach and access to screening, the MCP learned that most clinics were unable to include blood lead screening in their monitoring systems because the *Lead Screening in Children* measure was not integrated into their existing electronic health record (EHR) and data systems. Based on the providers' data system limitations, Anthem Blue Cross modified the intervention to focus on educating and coaching providers about assessing organizational workflow processes and ways to improve blood lead screening. The MCP will use results from these discussions in future provider education campaigns.
- Conducting multiple interventions in Alameda, Fresno, Santa Clara, and rural counties to improve the rate of members receiving their annual flu shot. Anthem Blue Cross targeted eligible members in communities most impacted by COVID-19 and wildfires or who were at risk for respiratory illness. The MCP promoted the flu shot campaign via social media, bilingual radio outlets, IVR, and flier distribution in the communities. Additionally, the MCP promoted the flu shot clinics through the Anthem Blue Cross blog. Anthem Blue Cross offered incentives to providers who conducted flu shot clinic days and sponsored pop-up flu shot clinics for community members ages 3 years and older. In partnership with a vaccine administration vendor, the MCP co-sponsored 190 pop-up flu shot clinic events at sites in Alameda, Fresno, Los Angeles, Sacramento, and Santa Clara counties. To help overcome vaccine hesitancy in at-risk communities, Anthem Blue Cross partnered with the National Hispanic Medical Association. The MCP reported providing incentives, informational materials, health supplies (thermometers, hand sanitizers, etc.), and supporting back-to-school programs and drive-through immunization clinics in partnership with an FQHC and county public health departments in Nevada, Yuba, and Sutter counties. Anthem Blue Cross reported that the MCP administered 6,159 shots, and the public health departments and contracted providers administered a non-tallied number of shots. The MCP reported learning that success can be achieved with multiple partners through robust planning and identification of partner capabilities and that there is a direct correlation between local partners holding marketing events on Anthem Blue Cross' behalf and high vaccination rates at events.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Anthem Blue Cross' 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.109 through Table 3.120 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.109—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Alameda County

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

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	70.91	30.77	Not Tested	34.63
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.93%	9.17%	2.76	10.12%

Table 3.110—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Contra Costa County

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

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

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

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

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

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

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

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	54.04	29.74	Not Tested	31.76
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	9.05%	Not Comparable	9.06%

Table 3.111—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Anthem Blue Cross—Fresno County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	53.29	31.13	Not Tested	32.68
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.19%	8.28%	2.91	9.08%

Table 3.112—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Kings County

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

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

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

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

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

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

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

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	59.57	32.83	Not Tested	34.41
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	5.99%	Not Comparable	9.24%

Table 3.113—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Madera County

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

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

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

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

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

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

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

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	50.97	30.07	Not Tested	31.02
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	6.80%	Not Comparable	7.48%

Table 3.114—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	57.63	30.36	Not Tested	32.53
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.28%	8.75%	3.53	9.80%

Table 3.115—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	64.37	38.79	Not Tested	40.74
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.65%	7.37%	5.28	8.91%

Table 3.116—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Anthem Blue Cross—Sacramento County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	67.92	36.60	Not Tested	39.57
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.82%	8.89%	3.93	10.25%

Table 3.117—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—San Benito County

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

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

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

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

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

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

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

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	49.33	44.48	Not Tested	44.57
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	NA	Not Comparable	NA

Table 3.118—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Anthem Blue Cross—San Francisco County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	64.59	27.15	Not Tested	33.40
*Plan All-Cause Readmissions—Observed Readmissions—Total***	15.23%	9.65%	5.58	12.40%

Table 3.119—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Santa Clara County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.05	29.58	Not Tested	30.62
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.04%	10.27%	0.77	10.39%

Table 3.120—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Tulare County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	52.40	23.92	Not Tested	25.53
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.47%	8.45%	4.02	9.45%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

For the following reporting units for which HSAG could compare measurement year 2020 SPD rates to measurement year 2020 non-SPD rates:

- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020:
  - Fresno County
  - Region 1
  - Region 2
  - Sacramento County
  - San Francisco County
  - Tulare County

  Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

- For Alameda and Santa Clara counties, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for this measure.

Strengths—Performance Measures

The HSAG auditor determined that Anthem Blue Cross followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for Anthem Blue Cross across all reporting units and domains:

- The following measures for which HSAG compared rates to benchmarks had rates above the high performance levels:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment—Total* for Contra Costa County
  - *Asthma Medication Ratio—Total* for Contra Costa and San Benito counties
  - *Immunizations for Adolescents—Combination 2* for Madera County
  - *Prenatal and Postpartum Care—Postpartum Care* for Kings, San Benito, and Tulare counties
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* for Sacramento County

  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* for Sacramento County
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 50 of 394 rates (13 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.
  - Twenty-three of these 50 rates (46 percent) were in the Behavioral Health domain, 18 (36 percent) were in the Women's Health domain, six (12 percent) were in the Acute and Chronic Disease Management domain, and three (6 percent) were in the Children's Health domain.

Opportunities for Improvement—Performance Measures

Anthem Blue Cross has the opportunity to improve its supplemental data processes for future performance measure reporting, including:

- Implementing additional quality control processes to ensure supplemental data are appropriately compiled and available for reporting.
- Developing a summary document for its supplemental data sources which identifies the 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.
- 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.

Anthem Blue Cross has opportunities for improvement across all measure domains and related to access to and quality and timeliness of health care services. Across all reporting units and domains, for measures for which HSAG compared measurement year 2020 rates to benchmarks, 110 of 186 rates (59 percent) were below the minimum performance levels. Additionally, for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, Anthem Blue Cross' performance declined significantly from measurement year 2019 to measurement year 2020 for 53 of 394 rates (13 percent).

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, Anthem Blue Cross should assess the factors, which may include COVID-19, that affected the MCP'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.

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

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

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results Anthem Blue Cross—Santa Clara County

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

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

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

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

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

NA = The MLTSSP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	88.49	48.32	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	NA	Not Tested
Plan All-Cause Readmissions—Expected Readmissions—Total	NA	NA	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	NA	NA	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

Anthem Blue Cross determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, Anthem Blue Cross identified cervical cancer screening among Vietnamese members as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated Module 1 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the module, HSAG determined that Anthem Blue Cross met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the narrowed focus baseline specifications and data collection methodology. After receiving technical assistance from HSAG, Anthem Blue Cross incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

Anthem Blue Cross' *Cervical Cancer Screening* Health Equity PIP SMART Aim measures the percentage of Vietnamese members ages 24 to 30 years residing in Santa Clara County who complete their cervical cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Anthem Blue Cross' 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Anthem Blue Cross determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—childhood immunizations.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunizations* PIP. Anthem Blue Cross met all validation criteria for modules 1 and 2 in its initial submissions.

Anthem Blue Cross' *Childhood Immunizations* PIP SMART Aim measures the percentage of African-American children residing in Sacramento County who complete their *Childhood Immunization Status—Combination 10* measure vaccination series. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Anthem Blue Cross' 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

Anthem Blue Cross successfully met all validation criteria for Module 1 for the *Cervical Cancer Screening* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Cervical Cancer Screening* Health Equity PIP. Anthem Blue Cross has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, Anthem Blue Cross successfully met all validation criteria for modules 1 and 2 for the *Childhood Immunizations* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Childhood Immunizations* PIP. Anthem Blue Cross has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Anthem Blue Cross' PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Anthem Blue Cross submitted the MCP's final PNA report to DHCS on August 23, 2021, and DHCS notified the MCP via email on August 24, 2021, that DHCS approved the report as submitted. While Anthem Blue Cross submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Anthem Blue Cross' 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Increase the number of completed mammograms to meet the *Breast Cancer Screening—Total* measure minimum performance level at one or more high-volume, low-performing FQHC clinic systems in Alameda County.	Yes	Unknown	Ended in 2020
2	Increase the number of completed mammograms to meet the *Breast Cancer Screening—Total* measure minimum performance level at one or more high-volume, low-performing FQHC clinic systems in Fresno County.	Yes	Unknown	Ended in 2020
3	Increase both *Prenatal and Postpartum Care* measure rates for Black and African-American members in Fresno county.	Yes	Unknown	Changing for 2021
4	To establish a baseline rate, deploy 300 iPad kiosks with video remote interpreting capability to FQHCs statewide to increase on-demand interpreter services.	Yes	Better	Changing for 2021
5	Increase the rate of successful case management member engagement in Fresno, Sacramento, and San Francisco counties.	No	Better	Changing for 2021

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	Improve the rates for both *Prenatal and Postpartum Care* measures for members participating in the doula pilot cohort.	No	Changed from 2020
2	Maintain a monthly average utilization rate of 700 visits for video interpretation during 2021.	No	Changed from 2020
3	In 2021, maintain a targeted range of total rate of successful case management member engagement for counties with an available community health worker.	No	Changed from 2020
4	By December 2022, improve the *Childhood Immunization Status—Combination 10* measure rate among Black/African-American children residing in Sacramento County.	Yes	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from Anthem Blue Cross' July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of Anthem Blue Cross' self-reported actions.

Table 7.1—Anthem Blue Cross' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Postpartum Care* PIP.	At the close of the 2017–19 *Postpartum Care* PIP, Anthem Blue Cross shared results with our provider partner and discussed that postpartum education during prenatal visits may be a factor in improving postpartum visit rates. As a result, the provider has considered process improvements for member education within its obstetric clinic settings. The provider is part of a hospital/clinic system and can schedule a woman for her postpartum visit before hospital discharge. The provider also initiates active outreach to members who recently delivered a baby to encourage them to keep their postpartum visit appointment. As a continuation of the PIP intervention, Anthem Blue Cross effectively gained the partnership of another large health system in Fresno County for improvement of the *Prenatal and Postpartum Care—Postpartum Care* measure rate. The purpose was to leverage the opportunity to engage members early

2019–20 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	through the Comprehensive Perinatal Services Program (CPSP) to inform them of the importance of timely postpartum care as well as preventive well-child care. In measurement years 2019 and 2020, measuring the impact of postpartum care interventions was confounded by the impact of changes to the *Prenatal and Postpartum Care—Postpartum Care* measure, which expanded the allowable time frame for postpartum visits. While this change will bring more women into compliance for postpartum care, the importance of postpartum exams still needs to be discussed and shared with women during their prenatal visits to ensure that the need for this important service is reinforced. The role of CPSP and provider education is critical to improving the completion of postpartum care.
2. Apply the lessons learned from the 2017–19 *Postpartum Care* DHCS-priority PIP and *Asthma Medication Ratio* Disparity PIP to facilitate improvement for future PIPs and to strengthen other quality improvement efforts.	These important lessons learned as a result of the referenced PIPs have been applied to future PIPs and other quality projects: ♦ Anticipate expansion of provider partner involvement to include local and higher-level administrative leadership on the part of the clinic, other partners, and Anthem Blue Cross. ♦ Use clinic incentives, when possible, to maintain focus on the PIP measure (or quality project) and SMART Aim. ♦ Determine sources of member data as early in the project as possible, including internal and external sources (provider EHR) that may be more current. While face-to-face collaborative meetings are most effective, virtual meetings can still be successful if well planned.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Anthem Blue Cross' self-reported actions in Table 7.1 and determined that Anthem Blue Cross adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. Anthem Blue Cross described how the MCP monitored the intervention from the 2017–19 *Postpartum Care* PIP and summarized additional improvement activities the MCP engaged in with providers to continue efforts to improve postpartum care rates. Additionally, Anthem Blue Cross listed lessons learned from the 2017–19 PIPs that the MCP is applying to other quality improvement projects.

2020–21 Recommendations

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

- Improve supplemental data processes for future performance measure reporting, including:
  - Implementing additional quality control processes to ensure supplemental data are appropriately compiled and available for reporting.
  - Developing a summary document for its supplemental data sources which identifies the 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.
  - 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.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate Anthem Blue Cross' continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix E:
Performance Evaluation Report
Blue Shield of California Promise Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Blue Shield of California Promise Health Plan ("Blue Shield Promise" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Blue Shield Promise provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Blue Shield Promise's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Blue Shield Promise is a full-scope MCP delivering services to its members under a Geographic Managed Care (GMC) model. Although the GMC model operates in both San Diego and Sacramento counties, Blue Shield Promise only operates in San Diego County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to Blue Shield Promise, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California
- UnitedHealthcare Community Plan

Blue Shield Promise became operational in San Diego County to provide MCMC services effective February 2006. As of June 2021, Blue Shield Promise had 107,702 members.[1] This represents 13 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Blue Shield Promise. HSAG's compliance review summaries are based on final audit reports issued on or before the end of the review period for this report (June 30, 2021).

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of Blue Shield Promise. A&I conducted the audits from February 22, 2021, through March 5, 2021. The Medical Audit portion was a reduced scope audit, evaluating five categories rather than six.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Blue Shield Promise
Audit Review Period: January 1, 2020, through December 31, 2020

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

Strengths—Compliance Reviews

A&I identified no findings in the Case Management and Coordination of Care and State Supported Services categories during the 2021 Medical and State Supported Services Audits of Blue Shield Promise.

Opportunities for Improvement—Compliance Reviews

During the 2021 Medical Audit, A&I identified findings in the Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management categories, including repeat findings in all but the Utilization Management category. Blue Shield Promise should work with DHCS to ensure that the MCP fully resolves all findings from the 2021 A&I Medical Audit, paying particular attention to the repeat findings.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of Blue Shield Promise, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Blue Shield of California Promise Health Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for Blue Shield Promise's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Oct 25, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	35.37%	Not Comparable
Childhood Immunization Status—Combination 10	40.39%	43.58%	3.19
Developmental Screening in the First Three Years of Life—Total	37.42%	37.10%	-0.32
Immunizations for Adolescents—Combination 2	39.17%	**36.09%**	-3.08
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	91.15%	88.32%	-2.83
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	74.45%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	72.51%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	25.30%	Not Comparable
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	—	53.88%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	53.80%	**51.79%**	-2.01
*Cervical Cancer Screening^*	57.95%	**60.05%**	2.10
Chlamydia Screening in Women—Ages 16–20 Years	65.26%	57.44%	-7.82
Chlamydia Screening in Women—Ages 21–24 Years	65.84%	60.75%	-5.09
Chlamydia Screening in Women—Total	65.59%	59.33%	-6.26
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.79%	3.70%	-0.09
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.31%	4.38%	0.07

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.09%	17.61%	-0.48
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.13%	23.69%	-0.44
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	1.83%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.54%	10.72%	1.18
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.20%	8.60%	-1.60
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	37.04%	36.00%	-1.04
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	34.38%	33.15%	-1.23
*Prenatal and Postpartum Care—Postpartum Care^*	77.86%	81.71%	3.85
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	94.89%	89.63%	-5.26

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	19	21.05%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	61.77%	68.52%	6.75
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	46.90%	52.27%	5.37
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**79.78%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	46.88%	43.16%	-3.72
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	59.32%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	40.68%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	40.68%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	17.99%	34.82%	16.83
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	14.10%	28.11%	14.01
Screening for Depression and Follow-Up Plan—Ages 65+ Years	14.97%	29.23%	14.26

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	6	83.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	43.73	36.27	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Asthma Medication Ratio—Total	51.52%	**60.28%**	8.76
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	35.52%	**45.00%**	9.48
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.69%	9.45%	-2.24
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.90%	S	S
Controlling High Blood Pressure—Total	—	59.37%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.80%	9.09%	1.29
Plan All-Cause Readmissions—Expected Readmissions—Total	10.13%	10.33%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.77	0.88	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.01%	5.75%	-1.26
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates

because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of Blue Shield Promise's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures

- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	36	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	6	16	37.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	36	13.89%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Blue Shield Promise's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

Blue Shield Promise conducted two PDSA cycles to improve the MCP's performance on the *Child and Adolescent Well-Care Visits—Total* measure.

For the first PDSA cycle, Blue Shield Promise partnered with a provider office to distribute a gift card incentive to eligible members who completed a well-child visit. While Blue Shield Promise and the provider partner experienced challenges due to the COVID-19 pandemic, the MCP reported that it was able to successfully deliver some gift cards and that it identified more than one method for delivering the gift cards to members. Blue Shield Promise also reported

that due to workflow process challenges, the MCP was unable to deliver gift cards to some of the eligible members. Blue Shield Promise identified a different provider for the second PDSA cycle and indicated that it will adapt the intervention to have a health navigator available at the provider office who will be a point of contact for members and be responsible for the gift card distribution.

For the second PDSA cycle, Blue Shield Promise piloted having a health navigator as a dedicated point of contact at the provider office to conduct member outreach and track the gift card distribution to eligible members who completed a well-child visit. Blue Shield Promise reported meeting the PDSA cycle SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective. While having the health navigator present at the provider office was successful, the MCP experienced challenges related to staff turnover at the provider office and provider office staff members not seeing medical chart flags denoting members eligible for a gift card. Blue Shield Promise stated that the MCP identified additional methods for distributing the gift cards and that it will adopt this intervention and expand it to other clinics within San Diego County.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Blue Shield Promise reported:

- Providing a federally qualified health center (FQHC) with Bluetooth-enabled blood pressure cuffs for members to use during telehealth visits. The target population comprised members with hypertension who were at high risk for COVID-19 infection. The FQHC was able to deliver most of the blood pressure cuffs and conducted outreach to members who had not received their cuffs. Blue Shield Promise reported the following challenges to members receiving and using the blood pressure cuffs:
  - Lack of transportation/inability to pick up the cuff during clinic hours
  - Lack of access to technology or limited Wi-Fi to use the blood pressure cuff
  - Being technologically challenged
- Partnering with an FQHC to pilot providing gift card incentives to members in need of select screenings and preventive services (e.g., well-care visits, cervical cancer screenings, breast cancer screenings) for completing an in-person visit. The MCP targeted members who were not at high risk of COVID-19 infection. Blue Shield Promise reported that the pilot was successful, resulting in the MCP expanding the intervention to all Blue Shield Promise provider partners in San Diego County. The MCP reported the greatest challenges as members being deterred from in-office visits during the holiday season due to the rising COVID-19 infection rates and participating providers reporting reduced staffing due to an increased number of staff testing positive for COVID-19.
- Partnering with a mobile phlebotomy vendor to perform in-home blood draws and take the specimen to a designated lab that will send the results to the member's provider. Blue Shield Promise targeted members with diabetes who were at high risk for COVID-19 infection. While contact was made with several members to complete the in-home blood

draws, only a small percentage of those contacted agreed to and received the service. Blue Shield Promise reported the following barriers to this intervention being successful:

- Members reported being concerned about having health care services performed in their home due to the rising COVID-19 infection rate.
- Some members declined the service, indicating they preferred attending an in-office visit.
- Some members voiced concerns about how many households the vendor visited prior to their appointments.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Blue Shield Promise's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Blue Shield Promise—San Diego County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	72.66	32.64	Not Tested	36.27
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.88%	8.37%	2.51	9.09%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for

the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

HSAG identified the following notable measurement year 2020 performance measure results for Blue Shield Promise:

- The rates for both *Antidepressant Medication Management* measures were above the high performance levels.
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the following six measures showed statistically significant improvement from measurement year 2019 to measurement year 2020, with five of the six measures (83 percent) being in the Behavioral Health domain:
  - Both *Antidepressant Medication Management* measures
  - *Asthma Medication Ratio—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Opportunities for Improvement—Performance Measures

Across all domains, six of 16 measures for which HSAG compared rates to benchmarks (38 percent) were below the minimum performance levels. For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the MCP's performance declined significantly for five of 36 measures (14 percent) from measurement year 2019 to measurement year 2020.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, Blue Shield Promise should assess the factors, which may include COVID-19, that affected the MCP'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.

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

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

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results Blue Shield Promise—San Diego County

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

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

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

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	82.82	71.41	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.96%	11.25%	0.29
Plan All-Cause Readmissions—Expected Readmissions—Total	13.51%	13.34%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.81	0.84	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

Blue Shield Promise determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—childhood immunizations among non-Hispanic members.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunizations* Health Equity PIP. Blue Shield Promise met all validation criteria for both modules in its initial submissions.

Blue Shield Promise's *Childhood Immunizations* Health Equity PIP SMART Aim measures the percentage of non-Hispanic members turning 2 years of age who receive the appropriate immunizations according to the *Childhood Immunization Status—Combination 10* measure requirements. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Blue Shield Promise's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Blue Shield Promise determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, Blue Shield Promise selected well-child visits in the first 15 months of life for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits* PIP. Upon initial review of the modules, HSAG determined that Blue Shield Promise met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Completing all required components of the key driver diagram.
- Ensuring that the key drivers and interventions in the key driver diagram are dated according to the results of the corresponding process map and Failure Modes and Effects Analysis Table, and that the interventions are culturally and linguistically appropriate and have the potential to impact the SMART Aim goal.

After receiving technical assistance from HSAG, Blue Shield Promise incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2.

Blue Shield Promise's *Well-Child Visits* PIP SMART Aim measures the percentage of members 15 months of age who complete their well-child visits. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Blue Shield Promise's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

Blue Shield Promise successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. Blue Shield Promise has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Blue Shield Promise's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Blue Shield Promise submitted the MCP's PNA report to DHCS on May 20, 2021, and DHCS notified the MCP via email on June 17, 2021, that DHCS approved the report as submitted.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Blue Shield Promise's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2021, increase the percentage of members who report that their doctor always communicates well.	No	Unknown	Continuing into 2021
2	By June 30, 2021, increase the percentage of members who receive timely prenatal care in the first trimester of their pregnancy at the pilot clinic.	No	Unknown	Continuing into 2021
3	By June 30, 2021, increase the percentage of members who receive an annual flu vaccine.	No	Unknown	Continuing into 2021
4	By June 30, 2021, increase the percentage of Black/African-American and Hispanic/Latino members who receive timely prenatal care in the first trimester.	Yes	Unknown	Continuing into 2021

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 30, 2022, increase the percentage of members who report that their doctor always communicates well.	No	Continued from 2020
2	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	Continued from 2020
3	By June 30, 2022, increase the percentage of members who receive an annual flu vaccine.	No	Continued from 2020
4	By June 30, 2022, increase the percentage of Hispanic/Latino members who receive timely prenatal care in the first trimester.	Yes	Continued from 2020
5	By June 30, 2022, increase the percentage of Black/African-American members who receive timely prenatal care in the first trimester.	Yes	Continued from 2020

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from Blue Shield Promise's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of Blue Shield Promise's self-reported actions.

Table 7.1—Blue Shield Promise's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP.	The adapted text messaging engagement intervention from the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP was put on hold due to the Telephone Consumer Protection Act guidelines. In lieu of this intervention beyond 2019, Blue Shield Promise implemented an alternate member-centric intervention, the Health Navigator program. This program is centered around one-on-one whole person engagement, with the health navigator acting as a health concierge for members at the clinic/provider level. Through this intervention, members receive tailored engagement, personalized to meet their needs, similar to the previous text messaging engagement intervention. However, this program takes the intervention one step further by connecting members to a health navigator who is associated with their primary care provider, available to answer their health care

2019–20 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	questions, and can assist with ensuring the member's health care needs are met. This program started in 2020 and is expanding in 2021 to additional providers and clinics across San Diego County. Currently, 20,000 members have access to the Health Navigator program in San Diego County. In addition to this member engagement program, Blue Shield Promise has an internal outreach team that conducts live outreach and education to all members to educate them about the need to complete outstanding preventive care exams. Support is provided to help members with appointment scheduling and transportation if needed. Although Blue Shield Promise is currently unable to pursue text messaging, the MCP believes that offering these two forms of live, one-on-one member engagement not only improves member experience but also enhances the support that members need around their health care.
2. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.	During the implementation of the text messaging engagement intervention from the 2017–19 PIPs, Blue Shield Promise learned that more time was needed to properly onboard and launch a new vendor, specifically for the Medi-Cal population. Through these lessons learned, Blue Shield Promise has been mindful of the time frames needed to successfully select and launch any new program that is member-facing. Blue Shield Promise can now better predict when an intervention will have the anticipated impact on the targeted measure(s). Additionally, the issue of delayed data has been addressed and improved for all interventions. In 2019, Blue

2019–20 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	Shield Promise reorganized the Medi-Cal data analytics team, not only through growth but also restructuring responsibilities and reporting requirements. Many new monthly reports are required as a result of the PIP outcomes and lessons learned. Timely, accurate data are now able to be provided to internal and external quality partners when needed.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Blue Shield Promise's self-reported actions in Table 7.1 and determined that Blue Shield Promise adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. Blue Shield Promise described in detail alternate strategies the MCP implemented when it was unable to continue the texting intervention from the 2017–19 PIPs. Blue Shield Promise also summarized how the MCP is applying lessons learned from the 2017–19 PIPs and how those lessons learned have affected the MCP's processes unrelated to PIPs.

2020–21 Recommendations

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

- Work with DHCS to ensure that the MCP fully resolves all findings from the 2021 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.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate Blue Shield Promise's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix F:
Performance Evaluation Report
California Health & Wellness Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, California Health & Wellness Plan ("CHW" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that CHW provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in CHW's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CHW is a full-scope MCP delivering services to its members under the Regional and Imperial models. In all counties, beneficiaries may enroll in CHW or the other commercial plan.

CHW became operational to provide MCMC services effective November 1, 2013. Table 1.1 shows the counties in which CHW provides MCMC services, the other commercial plans for each county, CHW's enrollment for each county, the MCP's total number of members, and the percentage of beneficiaries in the county who were enrolled in CHW as of June 2021.[1]

Table 1.1—CHW Enrollment as of June 2021

County	Other Commercial Plan	CHW Enrollment as of June 2021	Percentage of Beneficiaries in the County Enrolled in CHW
Alpine	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan (Anthem Blue Cross)	68	30%
Amador	Anthem Blue Cross Kaiser NorCal	1,373	20%
Butte	Anthem Blue Cross	44,033	65%
Calaveras	Anthem Blue Cross	5,393	50%
Colusa	Anthem Blue Cross	3,766	43%

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

County	Other Commercial Plan	CHW Enrollment as of June 2021	Percentage of Beneficiaries in the County Enrolled in CHW
El Dorado	Anthem Blue Cross Kaiser NorCal	18,731	56%
Glenn	Anthem Blue Cross	8,489	75%
Imperial	Molina Healthcare of California Partner Plan, Inc.	67,522	81%
Inyo	Anthem Blue Cross	1,964	43%
Mariposa	Anthem Blue Cross	928	20%
Mono	Anthem Blue Cross	942	33%
Nevada	Anthem Blue Cross	9,220	41%
Placer	Anthem Blue Cross Kaiser NorCal	11,128	20%
Plumas	Anthem Blue Cross	2,747	48%
Sierra	Anthem Blue Cross	226	37%
Sutter	Anthem Blue Cross	12,429	35%
Tehama	Anthem Blue Cross	13,455	57%
Tuolumne	Anthem Blue Cross	5,432	46%
Yuba	Anthem Blue Cross	10,400	37%
Total		218,246	

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

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

The Imperial model consists of one reporting unit with a single county, Imperial County.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for CHW in 2020 for the review period of December 1, 2018, through November 30, 2019. HSAG included a summary of these audits in CHW's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of CHW during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of CHW from July 19, 2021, through July 30, 2021, for the review period of December 1, 2019, through April 30, 2021. HSAG will include a summary of these audits in CHW's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of CHW, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for California Health & Wellness Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CHW followed the appropriate specifications to produce valid rates; however, HSAG determined that CHW's processes for identifying dual-eligible exclusions for the Medicaid population were incomplete, though the overall impact on reporting was minimal. To address the identified issue, the auditor recommended that CHW update its exclusion methodology to ensure this methodology meets NCQA requirements to exclude dual-eligible Medicaid members with either (1) both Medicare Part A and Part B or (2) Medicare Part C coverage.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.27 for CHW's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.27:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into

domains based on the health care areas each measure affects. Table 3.1 through Table 3.24 present the performance measure results and findings by domain, and Table 3.25 through Table 3.27 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.3 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 through Table 3.3:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 20, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	35.07%	Not Comparable
Childhood Immunization Status—Combination 10	30.41%	41.36%	10.95
Developmental Screening in the First Three Years of Life—Total	25.02%	30.47%	5.45
Immunizations for Adolescents—Combination 2	37.23%	40.39%	3.16
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	88.32%	86.37%	-1.95

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**63.02%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**61.31%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	49.20%	Not Comparable
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	—	73.57%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	40.28%	Not Comparable
Childhood Immunization Status—Combination 10	29.93%	**36.50%**	6.57
Developmental Screening in the First Three Years of Life—Total	30.14%	31.75%	1.61
Immunizations for Adolescents—Combination 2	30.66%	**28.95%**	-1.71
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	70.80%	**79.56%**	8.76
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**71.29%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	69.34%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	42.80%	Not Comparable
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	—	68.49%	Not Comparable

Table 3.3—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	33.15%	Not Comparable
Childhood Immunization Status—Combination 10	24.33%	**26.52%**	2.19
Developmental Screening in the First Three Years of Life—Total	17.96%	13.59%	-4.37
Immunizations for Adolescents—Combination 2	28.71%	**24.82%**	-3.89
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	75.67%	**76.89%**	1.22
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**63.26%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**62.53%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	56.50%	Not Comparable
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	—	61.89%	Not Comparable

Findings—Children's Health Domain

Table 3.4 through Table 3.6 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.4 through Table 3.6:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.4—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Imperial County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	4	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.5—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	4	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.6—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.7 through Table 3.9 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.7—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	65.84%	59.39%	-6.45
*Cervical Cancer Screening^*	69.83%	**61.02%**	-8.81
Chlamydia Screening in Women—Ages 16–20 Years	44.13%	44.84%	0.71
Chlamydia Screening in Women—Ages 21–24 Years	67.90%	58.73%	-9.17
Chlamydia Screening in Women—Total	55.76%	**51.88%**	-3.88
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.51%	1.86%	-0.65
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.63%	3.32%	-1.31

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.84%	14.67%	-1.17
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.17%	24.06%	-4.11
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	5.68%	8.56%	2.88
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.80%	12.84%	0.04
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	37.88%	37.50%	-0.38
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.51%	46.82%	4.31
*Prenatal and Postpartum Care—Postpartum Care^*	76.16%	82.24%	6.08
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	91.97%	**85.89%**	-6.08

Table 3.8—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	53.51%	**51.75%**	-1.76
*Cervical Cancer Screening^*	52.57%	**50.24%**	-2.33
Chlamydia Screening in Women—Ages 16–20 Years	49.59%	45.04%	-4.55
Chlamydia Screening in Women—Ages 21–24 Years	60.07%	55.02%	-5.05
Chlamydia Screening in Women—Total	54.78%	**49.98%**	-4.80
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.30%	3.35%	0.05
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.38%	4.88%	0.50

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	25.09%	23.98%	-1.11
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.00%	26.73%	-1.27
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	19.57%	15.48%	-4.09
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.35%	12.00%	2.65
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.85%	7.28%	-3.57
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	56.52%	38.10%	-18.42
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.38%	41.74%	-0.64
*Prenatal and Postpartum Care—Postpartum Care^*	79.32%	82.73%	3.41
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	91.24%	89.78%	-1.46

Table 3.9—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	50.34%	**47.83%**	-2.51
*Cervical Cancer Screening^*	61.07%	**53.32%**	-7.75
Chlamydia Screening in Women—Ages 16–20 Years	38.40%	39.42%	1.02
Chlamydia Screening in Women—Ages 21–24 Years	57.89%	54.92%	-2.97
Chlamydia Screening in Women—Total	46.79%	**45.91%**	-0.88
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.36%	3.29%	-0.07
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.63%	3.91%	-0.72

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	28.90%	26.60%	-2.30
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.10%	23.85%	-1.25
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.81%	9.41%	-2.40
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.42%	8.89%	-0.53
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	42.86%	44.12%	1.26
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	40.65%	36.41%	-4.24
*Prenatal and Postpartum Care—Postpartum Care^*	78.35%	81.02%	2.67
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	90.75%	**87.83%**	-2.92

Findings—Women's Health Domain

Table 3.10 through Table 3.12 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.10 through Table 3.12:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.10—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Imperial County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	19	36.84%

Table 3.11—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	19	31.58%

Table 3.12—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	19	10.53%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.13 through Table 3.15 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.13 through Table 3.15:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.13—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	53.49%	**52.59%**	-0.90
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.14%	**33.49%**	-2.65
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	88.64%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	28.33%	29.44%	1.11

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	S	25.58%	S
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	48.70%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	33.91%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**33.04%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	2.50%	1.35%	-1.15
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.57%	0.77%	0.20
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Table 3.14—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	52.21%	55.40%	3.19
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	35.31%	41.13%	5.82
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**80.00%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	54.73%	56.70%	1.97

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	66.00%	65.38%	-0.62
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	48.03%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	30.92%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**30.92%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	S	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.32%	1.06%	0.74
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Table 3.15—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.54%	57.32%	-0.22
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	44.02%	41.56%	-2.46
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**74.70%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.86%	36.49%	-3.37
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	48.48%	36.96%	-11.52
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	55.75%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	30.97%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**30.97%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	0.73%	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.06%	0.11%	0.05
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Findings—Behavioral Health Domain

Table 3.16 through Table 3.18 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.16 through Table 3.18:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.16—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Imperial County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Table 3.17—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.18—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.19 through Table 3.21 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.19 through Table 3.21:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.19—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	51.26	36.32	Not Tested
Asthma Medication Ratio—Total	69.17%	66.29%	-2.88

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	32.84%	32.79%	-0.05
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	7.66%	5.95%	-1.71
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	64.48%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.04%	7.58%	-1.46
Plan All-Cause Readmissions—Expected Readmissions—Total	9.21%	9.04%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.98	0.84	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	2.30%	1.84%	-0.46
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.20—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	48.12	36.50	Not Tested
Asthma Medication Ratio—Total	60.94%	**59.43%**	-1.51
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	37.32%	**40.46%**	3.14
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.79%	11.16%	-1.63
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	NA	Not Comparable
Controlling High Blood Pressure—Total	—	64.23%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.62%	9.48%	0.86
Plan All-Cause Readmissions—Expected Readmissions—Total	10.28%	10.24%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.84	0.93	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.35%	2.20%	-1.15
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.21—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	54.70	43.35	Not Tested
Asthma Medication Ratio—Total	58.42%	63.95%	5.53

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	36.98%	**42.71%**	5.73
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.67%	15.11%	-1.56
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	54.50%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.30%	8.82%	-0.48
Plan All-Cause Readmissions—Expected Readmissions—Total	9.84%	9.63%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.94	0.92	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	8.55%	8.05%	-0.50
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.22 through Table 3.24 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.22 through Table 3.24:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.

- HSAG did not include the following two measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates for all three reporting units:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.22—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
CHW—Imperial County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.23—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.24—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Performance Measure Findings—All Domains

Table 3.25 through Table 3.27 present a summary of CHW's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.25 through Table 3.27:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates for all three reporting units:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*

- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.25—Measurement Year 2020 Performance Measure Findings for All Domains CHW—Imperial County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	16	6.25%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	35	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	8	16	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	35	22.86%

Table 3.26—Measurement Year 2020 Performance Measure Findings for All Domains CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	35	17.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	11	16	68.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	35	17.14%

Table 3.27—Measurement Year 2020 Performance Measure Findings for All Domains CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	35	5.71%
Measurement Year 2020 Rates Below Minimum Performance Levels	12	16	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	35	8.57%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Note that during the review period for this report, CHW was one of the MCPs DHCS required to meet quarterly via telephone with its assigned DHCS nurse consultant to enable DHCS to continue monitoring the MCP's performance.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of CHW's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

CHW conducted two PDSA cycles to improve the MCP's performance in Region 1 for the *Adolescent Well-Care Visits* measure.

For the first PDSA cycle, CHW health educators conducted outreach calls to encourage members 18 to 21 years of age to complete their annual well-care visits through telehealth services or in person, as preferred. The purpose of this intervention was to provide these members with easy access to flexible, convenient, real-time health care services during the COVID-19 pandemic. Although the MCP did not reach its goal for the PDSA cycle, it reported some improvement in the number of well-care visits completed. CHW noted that the primary barrier to success was that providers were short-staffed due to COVID-19.

For the second PDSA cycle, CHW continued to conduct outreach calls to members 18 to 21 years of age and added sending provider outreach letters to members the MCP did not reach during the first PDSA cycle. Despite these efforts, which included making 1,342 member calls and sending 201 provider letters, CHW reported the MCP did not reach its goal number of well-care visits completed. CHW indicated that it learned the importance of preparing youth for the transition from pediatric care to adolescent care. Additionally, the MCP noted that members appreciated callers being flexible to follow up with them at different times to accommodate schedule constraints. CHW determined to end the intervention following the second PDSA cycle due to resource constraints.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, CHW reported implementing three strategies. The following are high-level summaries of each strategy.

HEDIS Pediatric Household Outreach

This strategy targeted member households across all three reporting units in which multiple pediatric care gaps existed, with a focus on improving performance measure rates related to children and adolescent immunizations and well-care visits. CHW conducted outreach to encourage members to establish and maintain strong relationships with their primary care providers (PCPs) and to take advantage of telehealth services offered by their PCPs. The MCP partnered with telehealth vendors to deliver virtual care so that members could receive needed services without being exposed to public spaces. Although CHW reported some delays with implementing this strategy due to stay-at-home orders and some providers not being ready to provide services during the pandemic, the MCP indicated some success with members scheduling telehealth appointments. CHW reported that by Quarter 4 of 2020, all members with care gaps had received an outreach call. Moving forward, CHW will use a provider readiness survey to identify providers who are available to provide telehealth services and will evaluate the program in 2021 to determine if any changes need to be made.

Telehealth Strategy Targeting Rural Areas

This strategy targeted members who needed preventive care, help with managing chronic conditions, and support for behavioral health needs, particularly in rural areas where access may be limited. CHW conducted outreach to encourage members to establish and maintain strong relationships with their PCPs and to take advantage of telehealth services they offered. The MCP partnered with telehealth vendors to deliver virtual acute and chronic care so that members could receive needed services without being exposed to public spaces. During the COVID-19 crisis, CHW provided financial and technical support to provider organizations to assist with developing and providing virtual primary care visits. The MCP reported that telehealth utilization data suggest that telehealth visit utilization has potentially made a positive impact on the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* and *Controlling High Blood Pressure* measure rates.

CHW indicated experiencing barriers related to providers' adoption of technical platforms for telehealth and members' comfort level for using telehealth as a method of receiving health care. The MCP also noted that it determined the need for targeted communication to members regarding telehealth visits based on specific identified gaps in care.

myStrength Program

The myStrength program is a digital support program CHW offers as a resource to all members. In response to COVID-19, in May 2020 myStrength added COVID-19 educational modules to support mental health for people directly or indirectly affected by the pandemic. Modules included educational and interactive activities and offered practical strategies for navigating challenges, including parenting, relationship stress, and grief, while sheltering in place. CHW informed members of the COVID-19 information being added to myStrength via weekly emails. CHW noted a steady increase in the number of members registering for myStrength between July 2020 and January 2021, with a steep incline between June 2020 and November 2020. While CHW is able to determine how many members register for myStrength, myStrength does not collect member information in a way that allows CHW to know which specific educational modules the members access.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In CHW's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.28 through Table 3.30 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.28—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CHW—Imperial County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	65.21	34.94	Not Tested	36.32
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.24%	6.77%	4.47	7.58%

Table 3.29—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	64.87	33.95	Not Tested	36.50
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.26%	8.55%	2.71	9.48%

Table 3.30—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	78.87	40.60	Not Tested	43.35
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.96%	7.90%	3.06	8.82%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

In measurement year 2020, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in all three reporting units. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that CHW followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for CHW:

- The rate for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was above the high performance level in Imperial County.
- Across all reporting units and domains, 13 of 105 measurement year 2020 rates that HSAG compared to measurement year 2019 rates (12 percent) improved significantly from measurement year 2019 to measurement year 2020:
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total* in Region 1
  - *Asthma Medication Ratio—Total* in Region 2
  - *Childhood Immunization Status—Combination 10* in Imperial County and Region 1

- *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years* in Imperial County
- *Developmental Screening in the First Three Years of Life—Total* in Imperial County
- *Prenatal and Postpartum Care—Postpartum Care* in Imperial County
- *Screening for Depression and Follow-Up Plan—Ages 12–17 Years* in Region 1 and Region 2
- *Screening for Depression and Follow-Up Plan—Ages 18–64 Years* in Imperial County and Region 1
- *Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years* in Region 1
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* in Region 1

Opportunities for Improvement—Performance Measures

CHW has the opportunity to ensure the MCP'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.

CHW has opportunities for improvement across all measure domains and related to access to and quality and timeliness of 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 should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

CHW determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, CHW identified breast cancer screening among members living with disabilities in Region 1 as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated modules 1 and 2 for the MCP's *Breast Cancer Screening* Health Equity PIP. Upon initial review of Module 1, HSAG determined that CHW met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CHW incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CHW met all Module 2 validation criteria in its initial submission.

CHW's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of women ages 50 to 64 living in Region 1 who have a Medi-Cal aid code that indicates a disability, are assigned to the PIP provider group partner, and complete a breast cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CHW's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

CHW determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, CHW selected childhood immunizations for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunizations* PIP. Upon initial review of Module 1, HSAG determined that CHW met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CHW incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CHW met all Module 2 validation criteria in its initial submission.

CHW's *Childhood Immunizations* PIP SMART Aim measures the percentage of members turning 8 months of age assigned to Colusa, Glenn, or Tehama counties who receive the following immunizations:

- Three doses of diphtheria, tetanus, and acellular pertussis (DTaP).
- Three doses of pneumococcal conjugate (PCV).
- Two or three doses of rotavirus (RV).

This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CHW's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

CHW successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. CHW has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on CHW's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

CHW submitted the MCP's PNA report to DHCS on August 13, 2021, and DHCS notified the MCP via email on the same date that DHCS approved the report as submitted. While CHW submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with CHW's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2021, the Health Education Department will increase member utilization of the myStrength program.	No	Better	Changing for 2021
2	By June 30, 2021, the Cultural and Linguistics Services Department will train 80 percent of all health plan staff members in provider-facing departments to increase awareness of available Language Assistance Program services and resources.	No	Better	Ended in 2020
3	By June 30, 2021, achieve a statistically significant increase in the cervical cancer screening rate among females ages 21 to 34 years in Region 2 assigned to a select provider.	Yes	Unknown	Ended in 2020

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 30, 2022, the Health Education Department will continue increasing annual utilization of the myStrength program.	No	Continued from 2020
2	By June 30, 2022, the Cultural and Linguistics Services Department will increase utilization of Video Remote Interpreting Services to support member language needs.	No	New
3	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	New

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from CHW's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of CHW's self-reported actions.

Table 6.1—CHW's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual-eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.	CHW is working with NCQA to determine any required actions to address the process used to remove Medicare prime members from the HEDIS warehouse for reporting to DHCS. The expected rate change is immaterial and only impacts the *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure.
2. Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Controlling High Blood Pressure* Disparity PIP.	In 2020, CHW implemented a value-based care operating system with priority high-volume providers. It identifies care gaps for CHW members assigned to the providers. *Controlling High Blood Pressure* measure care gaps are included in the data. The data are updated twice a month versus once a month for the regular care gap data shared with providers, improving on the provider profiles that were given to the providers for the *Controlling High Blood Pressure* Disparity PIP intervention.

2019–20 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
3. Apply lessons learned from the 2017–19 *Controlling High Blood Pressure* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP to strengthen future quality improvement efforts.	♦ Both 2017–19 PIPs had providers discontinue their PIP participation due to other responsibilities, indicating the PIPs are burdensome for provider offices. As a result, both PIPs started in 2020 are targeting the MCP's processes, thereby avoiding provider abrasion. This was especially important during the COVID-19 pandemic, when providers were overwhelmed more than usual. ♦ The *Controlling High Blood Pressure* Disparity PIP indicated that many members were seen by the clinic to monitor their blood pressure, but those data are not captured administratively. CHW is therefore training providers to use the proper Current Procedural Terminology (CPT) II codes for the appropriate blood pressure reading so that CHW has more accurate administrative *Controlling High Blood Pressure* measure data.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CHW's self-reported actions in Table 6.1 and determined that CHW adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. HSAG identified the following notable actions taken by the MCP in response to the 2019–20 EQRO recommendations:

- Working with NCQA to confirm what actions the MCP needs to take to ensure that it is appropriately including and excluding dual-eligible members for performance measure reporting.
- Implemented a new care gaps system and made improvements to the provider profiles it used for the 2017–19 *Controlling High Blood Pressure* Disparity PIP.
- Based on feedback it received from provider partners for the 2017–19 PIPs that participating in PIPs is burdensome, determined to have the 2020–22 PIPs target MCP processes rather than include provider partners.
- Conducting provider training on proper use of CPT II codes to ensure administrative data capture for the *Controlling High Blood Pressure* measure.

2020–21 Recommendations

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

- To ensure CHW's processes for identifying dual-eligible exclusions for the Medicaid population are complete, update the MCP's 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.
- 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 the MCP'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 the next annual review, HSAG will evaluate CHW's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix G:
Performance Evaluation Report
CalOptima
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, CalOptima (or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that CalOptima provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in CalOptima's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CalOptima is a full-scope MCP delivering services to its members in the County Organized Health System model.

CalOptima became operational to provide MCMC services in Orange County effective October 1995. As of June 2021, CalOptima had 825,336 members in Orange County.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Follow-Up on 2020 A&I Medical and State Supported Services Audits

A&I conducted the most recent audits for CalOptima in 2020 for the review period of February 1, 2019, through January 31, 2020. HSAG included a summary of these audits in CalOptima's 2019–20 MCP-specific evaluation report. At the time of the 2019–20 MCP-specific evaluation report publication, CalOptima's CAP was in process and under DHCS review. A letter from DHCS dated January 19, 2021, stated that CalOptima provided DHCS with additional information regarding the CAP and that DHCS had evaluated the information and closed the CAP. The letter indicated that DHCS would continue to assess the overall effectiveness of the CAP and during the subsequent audit would determine to what extent the MCP has operationalized the proposed corrective actions.

Compliance Reviews Conducted

Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of CalOptima during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of CalOptima from November 29, 2021, through December 10, 2021, for the review period of February 1, 2020, through October 31, 2021. HSAG will include a summary of these audits in CalOptima's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

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

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

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

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of CalOptima, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for CalOptima* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for CalOptima's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 3, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	50.58%	Not Comparable
Childhood Immunization Status—Combination 10	44.99%	45.50%	0.51
Developmental Screening in the First Three Years of Life—Total	16.35%	24.84%	8.49
Immunizations for Adolescents—Combination 2	55.61%	53.32%	-2.29
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	89.26%	92.08%	2.82
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	82.08%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	81.67%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	43.18%	Not Comparable
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	—	71.76%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CalOptima—Orange County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	63.43%	59.52%	-3.91
*Cervical Cancer Screening^*	66.67%	**57.60%**	-9.07
Chlamydia Screening in Women—Ages 16–20 Years	73.09%	73.07%	-0.02
Chlamydia Screening in Women—Ages 21–24 Years	74.36%	70.35%	-4.01
Chlamydia Screening in Women—Total	73.64%	71.86%	-1.78
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.37%	1.71%	-0.66
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.43%	3.59%	-0.84
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.82%	12.61%	-1.21
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.42%	22.73%	-2.69

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	2.21%	3.09%	0.88
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.67%	2.97%	1.30
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	12.44%	10.34%	-2.10
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.68%	9.33%	0.65
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.39%	3.27%	0.88
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.45%	7.99%	1.54
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	31.69%	34.12%	2.43
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	31.38%	31.45%	0.07
*Prenatal and Postpartum Care—Postpartum Care^*	83.21%	78.35%	-4.86
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	95.13%	89.78%	-5.35

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CalOptima—Orange County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	9	19	47.37%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.32%	62.18%	2.86
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.47%	45.61%	2.14
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**71.23%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.80%	41.40%	1.60
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	47.39%	46.38%	-1.01
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	55.91%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	38.82%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	36.25%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	34.47%	33.46%	-1.01
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	13.33%	10.32%	-3.01
Screening for Depression and Follow-Up Plan—Ages 65+ Years	21.71%	22.26%	0.55

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CalOptima—Orange County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

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

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

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

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

— Indicates that the rate is not available.

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

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	34.98	25.13	Not Tested
Asthma Medication Ratio—Total	67.28%	71.22%	3.94
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	27.08%	35.26%	8.18
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.64%	13.99%	-0.65
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.13%	12.19%	0.06
Controlling High Blood Pressure—Total	—	64.48%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.01%	8.81%	-0.20

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Plan All-Cause Readmissions—Expected Readmissions—Total	9.71%	9.93%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.93	0.89	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.68%	5.07%	-0.61
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	2.57%	2.14%	-0.43

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
CalOptima—Orange County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of CalOptima's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains CalOptima—Orange County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	4	16	25.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	37	16.22%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	12	37	32.43%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of CalOptima's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

CalOptima conducted two PDSA cycles to improve the MCP's performance on the *Cervical Cancer Screening* measure.

For the first PDSA cycle, the provider partner office staff sent reminder letters to members who were due for their cervical cancer screenings. The MCP implemented this intervention to address members' reluctance to accessing needed preventive care services due to fear of being exposed to the COVID-19 virus. CalOptima indicated that because the MCP changed the focus of the intervention, the provider partner had a very short time frame in which to conduct the outreach and therefore did not achieve the PDSA cycle SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective.

For the second PDSA cycle, the provider partner conducted follow-up calls to members who were mailed letters during the first PDSA cycle. During the follow-up calls, the provider educated members on the importance of completing their cervical cancer screenings and offered to answer any questions they had regarding COVID-19 safety protocols the provider was implementing. Although the MCP did not achieve the SMART objective, it reported that some women completed their cervical cancer screening as a result of the follow-up calls.

Based on the intervention results, CalOptima indicated that it adopted the tested intervention. The MCP plans to spread the intervention to high-volume, low-performing provider offices with high numbers of CalOptima members who are due for their cervical cancer screening. Additionally, CalOptima indicated that the provider with whom the MCP partnered for the first two PDSA cycles will test the sustainability of continuing the intervention by completing follow-up phone calls to those members who were sent reminder letters and making additional attempts to reach members with disconnected phone numbers or for whom the provider left a voice message and requested a call back.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, CalOptima reported:

- Implementing temporary revisions to the MCP's telehealth requirements to ensure applied behavioral analysis services were able to continue with minimal disruption during the public health emergency. The MCP's provider relations team communicated with the applied behavioral analysis providers to inform them of the policy revisions and answered their questions. Additionally, CalOptima engaged with all applied behavioral analysis providers during the prior authorization review process. Lastly, CalOptima held a webinar on November 18, 2020, with all applied behavioral analysis providers to review telehealth options and other updates. CalOptima indicated that many of the providers quickly adapted to the telehealth modality and that the MCP emphasized to these providers that they should only use the telehealth modality when it is consistent with the treatment plan goals. The MCP noted that after it allowed providers to use telehealth for all applied behavioral analysis services, utilization of these services steadily increased in the second half of 2020. CalOptima indicated that it currently plans to continue this intervention. The MCP will evaluate utilization of telehealth appointments and providers' and members' feedback to assess whether to end the intervention.
- Extending unused authorizations for members assigned to CalOptima's Community Network. CalOptima automatically extended current and unused authorizations through December 31, 2020, and planned to continue extending unused authorizations until the COVID-19 public health emergency ends. Preliminary data suggested that extending unused authorizations resulted in members eventually accessing authorized services. Although CalOptima reported an increase in manual work as a result of implementing this process, the MCP is committed to making necessary changes to the process to ensure that members' needs are met.
- Implementing a member incentive campaign to encourage members to complete preventive care appointments during the COVID-19 public health emergency. To receive the incentive, the provider or member was required to submit the Health Reward Form, which included information confirming the member received the preventive service. CalOptima reported that December 2020 rates for preventive services measures were lower than December 2019 rates; however, the MCP noted some improvement for child and adolescent immunizations. CalOptima indicated that the efforts involved for this member incentive campaign helped to establish a foundation for future outreach campaigns. Due to a limited budget, the extensive resources needed to process the volume of form submissions, and barriers related to the COVID-19 pandemic, the MCP discontinued the member rewards program in 2021. CalOptima is pursuing a contract with a vendor to help the MCP improve, expand, and execute the health rewards programs efficiently and in a timely manner.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In CalOptima's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CalOptima—Orange County

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

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	34.79	24.33	Not Tested	25.13
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.66%	8.18%	3.48	8.81%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

HSAG identified the following notable measurement year 2020 performance measure results for CalOptima:

- The MCP performed best within the Children's Health domain, with three rates in this domain being above the high performance levels in measurement year 2020 and the rate for one measure improving significantly from measurement year 2019 to measurement year 2020. Additionally, no rates within this domain were below the minimum performance levels

in measurement year 2020 or declined significantly from measurement year 2019 to measurement year 2020.

- Across all domains, the rates for the following measures were above the high performance levels:
  - *Chlamydia Screening in Women—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *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 Physical Activity—Total*
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates across all domains, the rates for the following measures improved significantly from measurement year 2019 to measurement year 2020:
  - Both *Antidepressant Medication Management* measures
  - *Asthma Medication Ratio—Total*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years*
  - *Developmental Screening in the First Three Years of Life—Total*

Opportunities for Improvement—Performance Measures

Across all domains, for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, CalOptima's performance declined significantly for 12 of 37 measures (32 percent). Two rates were below the minimum performance levels in measurement year 2020. CalOptima has the most opportunities for improvement in the Women's Health domain, with one measure in this domain having a rate below the minimum performance level and nine additional measures having rates that declined significantly from measurement year 2019 to measurement year 2020.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, CalOptima should assess the factors, which may include COVID-19, that affected the MCP'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.

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

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

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results CalOptima—Orange County

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

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

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

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	60.39	44.15	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	14.01%	14.82%	0.82
Plan All-Cause Readmissions—Expected Readmissions—Total	13.34%	13.86%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.05	1.07	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

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

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

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

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

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

CalOptima determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, CalOptima identified breast cancer screening among Chinese and Korean members as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated modules 1 and 2 for the MCP's *Breast Cancer Screening* Health Equity PIP. CalOptima met all validation criteria for modules 1 and 2 in its initial submission.

CalOptima's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of Chinese and Korean members ages 50 to 74 who complete their breast cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CalOptima's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

CalOptima determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—well-child visits in the first 15 months of life.

HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review of Module 1, HSAG determined that CalOptima met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CalOptima incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CalOptima met all validation criteria for Module 2 in its initial submission.

CalOptima's *Well-Child Visits in the First 15 Months of Life* PIP SMART Aim measures the percentage of members turning 15 months of age assigned to the PIP provider partner who complete their well-child visits. This PIP did not progress to intervention testing during the

review period for this report. HSAG will include intervention information in CalOptima's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

CalOptima successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. CalOptima has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on CalOptima's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

CalOptima submitted the MCP's PNA report to DHCS on July 9, 2021, and DHCS notified the MCP via email on July 12, 2021, that DHCS approved the report as submitted. While CalOptima submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with CalOptima's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Improve the member experience for measurement year 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] *Getting Needed Care* measure for the adult population.	No	Same	Changing for 2021
2	Improve the member experience for measurement year 2020 CAHPS *Getting Care Quickly* measure for the adult population.	No	Same	Changing for 2021
3	By June 30, 2021, increase the primary care provider visit rate for members 18 years and older experiencing homelessness.	Yes	Better	Ended in 2020
4	Improve statin therapy rates for members diagnosed with cardiovascular disease and members diagnosed with diabetes.	No	Better	Ended in 2020
5	Increase the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life* measure.	No	Worse	Ended in 2020
6	Increase the rate for the *Child and Adolescent Well-Care Visits—Total* measure.	No	Worse	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By December 31, 2023, improve the rates for the member experience measures (i.e., *Getting Needed Care* and *Getting Care Quickly*).	No	Changed from 2020
2	By December 31, 2023, increase HbA1c testing and diabetes retinal eye exams.	No	New in 2021
3	By December 31, 2023, improve the rates for the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measures.	No	New in 2021
4	By December 31, 2023, improve the *Lead Screening in Children* measure rate.	No	New in 2021
5	By December 31, 2022, achieve a targeted rate for COVID-19 vaccine adherence for eligible members.	No	New in 2021
6	By December 31, 2023, improve the *Breast Cancer Screening—Total* measure rate for Chinese and Korean members.	Yes	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from CalOptima's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of CalOptima's self-reported actions.

Table 7.1—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure the MCP fully resolves the findings from the 2020 A&I Medical Audit regarding the MCP:	
a. Analyzing each provider's compliance with the access wait time standards and implementing CAPs for the providers when applicable.	Based on the data collected from the 2019 timely access survey, the MCP sent education letters throughout the month of October 2020 to 1,106 providers not meeting timely access standards. CalOptima excluded providers who should not receive a letter, such as providers who had since termed or do not see patients directly, such as radiologists. The letters notified providers of their specific instances of noncompliance and re-educated them on the timely access standards. Providers were also informed that the MCP will continue to monitor their ability to comply with the established wait time standards and that providers with continued non-compliance of wait time standards will be escalated to our Member Experience Sub-Committee for further action. While delayed due to the national health emergency, the MCP began fielding the 2020 timely access survey in Quarter 4 of 2020. Data collected from this survey will be used to

2019–20 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	analyze each provider's compliance with the access wait time standards.
b. Properly classifying member grievances, immediately submitting all quality of care grievances to its medical director for action, and completing the quality of service and quality of care grievance investigation processes before sending resolution letters to members.	A new process was implemented in November 2020. This process submits all quality of care grievances for an initial clinical review by a registered nurse, then to a medical director for action. The quality of care grievances reviewed by a medical director have recommendations which are included in the resolution letters to members.
2. Improve its data reconciliation processes by documenting the file volume and count reconciliation at each step of data migration between the MCP's enterprise systems and the measure calculation tool, not just the initial and final volumes and counts.	Queries have been formulated to track volumes of data sources. Discrepancies between the data warehouse and the HEDIS repository are members who do not qualify for HEDIS reporting. Any other issues are addressed with the information systems department or the department that is responsible for that data source.
3. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Diabetes Poor HbA1c Control* Disparity PIP and *Adults' Access to Preventive and Ambulatory Health Services* PIP.	The HbA1c testing member health reward continues. Health reward submissions that indicate an HbA1c level above 8 percent are forwarded to diabetes management health coaches for outreach calls to members. Access to the Quest Diagnostics analytics webpage was obtained. Homeless members' access to outpatient care efforts continues, with provider incentive and mobile units deploying to provide preventive and well visits in homeless hotspots. The MCP conducted multiple member outreach messaging campaigns through text, social media, and targeted mailings during the COVID-19 pandemic to urge telehealth as well as safe preventive health services to combat increasing delays brought on by members' fear of COVID-19 risk of exposure at the points of in-person service.

2019–20 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
4. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.	The MCP continued to address poor HbA1c control, including efforts to improve access to more complete HbA1c data. Future quality improvement efforts are being planned to pilot and extrapolate lessons learned from the 2017–19 *Diabetes Poor HbA1c Control* Disparity PIP for CalOptima members in CalOptima's direct network, CalOptima Community Network, including ongoing provider engagement, provider incentives, additional member rewards for improving HbA1c control, and addressing social determinants of health such as food scarcity as a factor for poor HbA1c control. Preventive health and ambulatory health member engagement will be transitioned, in part, to a health rewards vendor.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CalOptima's self-reported actions in Table 7.1 and determined that CalOptima adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. CalOptima described in detail actions taken during the review period to resolve the findings from the 2020 A&I Medical Audit of the MCP, including how CalOptima is monitoring providers' compliance with wait time standards and ensuring that the MCP is properly classifying member grievances. The MCP also described steps it took to improve its data reconciliation processes. Finally, CalOptima described how the MCP continued to monitor interventions and apply lessons learned from the 2017–19 PIPs.

2020–21 Recommendations

Based on the overall assessment of CalOptima's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, CalOptima assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate CalOptima's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix H:
Performance Evaluation Report
CalViva Health
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, CalViva Health ("CalViva" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that CalViva provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in CalViva's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CalViva is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in CalViva, the Local Initiative MCP, or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, the alternative commercial plan.

CalViva became operational in Fresno, Kings, and Madera counties to provide MCMC services effective March 2011. As of June 2021, CalViva had 311,420 members in Fresno County, 32,645 in Kings County, and 41,402 in Madera County—for a total of 385,467 members.[1] This represents 72 percent of the beneficiaries enrolled in Fresno County, 60 percent in Kings County, and 64 percent in Madera County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for CalViva in 2020 for the review period of February 1, 2019, through January 31, 2020. HSAG included a summary of these audits in CalViva's 2019–20 MCP-specific evaluation report. When the 2019–20 MCP-specific evaluation report was published, the MCP's CAP in the Case Management and Coordination of Care and Access and Availability of Care categories was in process and under review. At the time of this MCP-specific evaluation report, the CAP is still in process and under review by DHCS. HSAG will include an update on the status of this CAP in CalViva's 2021–22 MCP-specific evaluation report.

Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of CalViva during the review period for this report; therefore, HSAG includes no new compliance review information for the MCP in this report.

As of the date HSAG was producing this MCP-specific evaluation report, A&I had not yet scheduled the next Medical and State Supported Services Audits of CalViva.

Opportunities for Improvement—Compliance Reviews

CalViva should continue to work with DHCS to ensure the MCP has taken all required actions to fully resolve the findings from the 2020 Medical Audit.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of CalViva, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for CalViva Health* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid rates; however, HSAG determined that CalViva's processes for identifying dual-eligible exclusions for the Medicaid population were incomplete, though the overall impact on reporting was minimal. To address the identified issue, the auditor recommended that CalViva update its exclusion methodology to ensure this methodology meets NCQA requirements to exclude dual-eligible Medicaid members with either (1) both Medicare Part A and Part B or (2) Medicare Part C coverage.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.27 for CalViva's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.27:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into

domains based on the health care areas each measure affects. Table 3.1 through Table 3.24 present the performance measure results and findings by domain, and Table 3.25 through Table 3.27 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.3 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 through Table 3.3:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Oct 6, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	42.67%	Not Comparable
Childhood Immunization Status—Combination 10	33.82%	**32.36%**	-1.46
Developmental Screening in the First Three Years of Life—Total	34.22%	20.00%	-14.22
Immunizations for Adolescents—Combination 2	38.69%	43.55%	4.86
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.73%	**79.32%**	-3.41

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**71.29%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	68.13%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	47.74%	Not Comparable
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	—	66.97%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a

measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	37.55%	Not Comparable
Childhood Immunization Status—Combination 10	33.09%	**29.93%**	-3.16
Developmental Screening in the First Three Years of Life—Total	25.12%	S	S
Immunizations for Adolescents—Combination 2	35.04%	**30.05%**	-4.99
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	91.73%	94.16%	2.43
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	76.16%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	73.48%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	50.11%	Not Comparable
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	—	59.97%	Not Comparable

Table 3.3—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	52.75%	Not Comparable
Childhood Immunization Status—Combination 10	46.96%	51.58%	4.62
Developmental Screening in the First Three Years of Life—Total	52.51%	13.96%	-38.55
Immunizations for Adolescents—Combination 2	54.88%	53.06%	-1.82
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	95.38%	96.11%	0.73
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	83.21%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	78.83%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	56.48%	Not Comparable
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	—	82.10%	Not Comparable

Findings—Children's Health Domain

Table 3.4 through Table 3.6 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.4 through Table 3.6:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.4—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Fresno County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.5—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Kings County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.6—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Madera County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.7 through Table 3.9 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.7—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	55.26%	**52.64%**	-2.62
*Cervical Cancer Screening^*	63.50%	**60.42%**	-3.08
Chlamydia Screening in Women—Ages 16–20 Years	54.00%	49.38%	-4.62
Chlamydia Screening in Women—Ages 21–24 Years	68.09%	65.53%	-2.56
Chlamydia Screening in Women—Total	61.26%	**57.81%**	-3.45
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.12%	1.82%	-0.30
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.56%	4.35%	-0.21

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.68%	15.31%	-1.37
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	29.21%	26.79%	-2.42
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.92%	2.41%	1.49
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	10.38%	9.66%	-0.72
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.01%	9.56%	2.55
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	4.18%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.84%	10.12%	2.28
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	40.76%	42.30%	1.54
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	38.68%	39.26%	0.58
*Prenatal and Postpartum Care—Postpartum Care^*	78.83%	78.59%	-0.24
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	92.21%	89.29%	-2.92

Table 3.8—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	57.30%	**58.24%**	0.94
*Cervical Cancer Screening^*	70.07%	68.39%	-1.68
Chlamydia Screening in Women—Ages 16–20 Years	55.38%	49.46%	-5.92
Chlamydia Screening in Women—Ages 21–24 Years	73.90%	70.58%	-3.32
Chlamydia Screening in Women—Total	64.48%	59.85%	-4.63
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.95%	3.83%	-0.12
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.39%	5.76%	0.37

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.69%	17.73%	-0.96
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.40%	26.19%	-2.21
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	13.19%	11.92%	-1.27
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.80%	8.83%	0.03
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	38.00%	44.90%	6.90
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	45.60%	43.49%	-2.11
*Prenatal and Postpartum Care—Postpartum Care^*	86.13%	84.67%	-1.46
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	95.38%	91.24%	-4.14

Table 3.9—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	62.44%	59.15%	-3.29
*Cervical Cancer Screening^*	65.21%	66.49%	1.28
Chlamydia Screening in Women—Ages 16–20 Years	47.81%	49.37%	1.56
Chlamydia Screening in Women—Ages 21–24 Years	65.04%	57.01%	-8.03
Chlamydia Screening in Women—Total	55.42%	**52.85%**	-2.57
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.08%	1.97%	-1.11
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.46%	4.63%	-0.83

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.97%	15.37%	-0.60
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	29.24%	26.12%	-3.12
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.35%	6.90%	-2.45
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.91%	8.84%	-0.07
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	36.84%	35.00%	-1.84
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.39%	36.42%	-5.97
*Prenatal and Postpartum Care—Postpartum Care^*	81.51%	80.78%	-0.73
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	91.48%	92.21%	0.73

Findings—Women's Health Domain

Table 3.10 through Table 3.12 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.10 through Table 3.12:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.10—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Fresno County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	19	15.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	19	31.58%

Table 3.11—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Kings County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Table 3.12—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Madera County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.13 through Table 3.15 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.13 through Table 3.15:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.13—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	48.20%	**49.00%**	0.80
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	31.84%	**31.28%**	-0.56
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	86.99%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	35.39%	35.99%	0.60
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	39.16%	39.16%	0.00
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	45.32%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	32.85%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**31.65%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.13%	1.71%	1.58

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.30%	1.40%	1.10
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	1.40%	S

Table 3.14—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	43.72%	**43.25%**	-0.47
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	29.55%	**29.07%**	-0.48
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**79.03%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	41.86%	54.39%	12.53
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.00%	3.62%	3.62
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S	3.37%	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Table 3.15—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	47.74%	**50.74%**	3.00
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	27.44%	**31.99%**	4.55
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	86.96%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	44.78%	59.09%	14.31
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	58.82%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	32.35%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**32.35%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	S	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S	0.23%	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Findings—Behavioral Health Domain

Table 3.16 through Table 3.18 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.16 through Table 3.18:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- For Kings and Madera counties, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures
- For Kings County, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.16—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Fresno County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.17—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Kings County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	6	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	3	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Table 3.18—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Madera County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	6	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.19 through Table 3.21 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.19 through Table 3.21:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.19—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	48.71	34.95	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Asthma Medication Ratio—Total	64.16%	66.82%	2.66
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	34.06%	**41.49%**	7.43
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.67%	11.05%	-2.62
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	7.41%	S	S
Controlling High Blood Pressure—Total	—	53.04%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.33%	8.33%	-2.00
Plan All-Cause Readmissions—Expected Readmissions—Total	9.41%	8.95%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.10	0.93	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.57%	2.87%	-0.70
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%	S	S

Table 3.20—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	51.34	38.39	Not Tested
Asthma Medication Ratio—Total	71.17%	70.40%	-0.77
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	35.77%	35.00%	-0.77
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	19.96%	19.19%	-0.77
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	63.99%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.78%	10.69%	-0.09
Plan All-Cause Readmissions—Expected Readmissions—Total	8.72%	9.01%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.24	1.19	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S	S	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.21—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.66	30.99	Not Tested
Asthma Medication Ratio—Total	69.75%	73.55%	3.80

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	36.25%	**40.63%**	4.38
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.12%	9.92%	-6.20
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	65.94%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.53%	7.94%	-0.59
Plan All-Cause Readmissions—Expected Readmissions—Total	9.30%	8.79%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.92	0.90	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.96%	3.21%	-0.75
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.22 through Table 3.24 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.22 through Table 3.24:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- For Kings and Madera counties, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.22—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CalViva—Fresno County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	7	57.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Table 3.23—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CalViva—Kings County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.24—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
CalViva—Madera County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Performance Measure Findings—All Domains

Table 3.25 through Table 3.27 present a summary of CalViva's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.25 through Table 3.27:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ For Kings and Madera counties, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:

- *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ For Kings County, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in

the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.25—Measurement Year 2020 Performance Measure Findings for All Domains CalViva—Fresno County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	10	37	27.03%
Measurement Year 2020 Rates Below Minimum Performance Levels	10	16	62.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	37	21.62%

Table 3.26—Measurement Year 2020 Performance Measure Findings for All Domains CalViva—Kings County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	15	13.33%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	34	8.82%
Measurement Year 2020 Rates Below Minimum Performance Levels	6	15	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	34	11.76%

Table 3.27—Measurement Year 2020 Performance Measure Findings for All Domains CalViva—Madera County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	3	16	18.75%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	34	5.88%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	16	31.25%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	34	11.76%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of CalViva's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

CalViva conducted two PDSA cycles to improve chlamydia screening rates in Madera County.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, CalViva collaborated with a provider to add an electronic health record alert for members ages 16 to 24 years in need of their chlamydia screening that would be reviewed by the provider's medical assistant via the provider's daily huddle list. The medical assistant facilitated completion of the chlamydia screening for members flagged with an alert. Because of consent and privacy issues with the younger population, CalViva initially focused its efforts on members ages 21 to 24 years. CalViva reported exceeding the PDSA cycle SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective.

CalViva noted that the primary barrier was being unable to contact a subset of members. Additionally, some members refused the chlamydia screening due to lack of knowledge about the test. To address this barrier, CalViva developed scripts to use for the outreach calls and supplied the provider with educational materials to give to members during their office visits. CalViva also mailed the educational materials to members. CalViva noted challenges due to the clinic being focused on COVID-19 vaccine administration and having patients who were unable to go into the clinic because of either testing positive for COVID-19 or being exposed to the virus.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, CalViva continued the same intervention from the first PDSA cycle but focused on members ages 17 to 20 years. CalViva also tested for sustainability and reproducibility of the intervention with this younger population. CalViva reported exceeding the PDSA cycle SMART objective. The MCP attributed the intervention's success to the provider integrating the intervention into its existing workflow for preparing for each patient's visit. CalViva reported experiencing the same barriers during the second PDSA cycle that it experienced during the first PDSA cycle.

CalViva indicated that it plans to continue monitoring provider chlamydia screening rates and to expand the tested intervention to other clinics in Madera and Fresno counties.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, CalViva reported:

- Having MCP pharmacy clinicians conduct telephonic outreach to members in Fresno County who were non-compliant with their chronic disease medication regimens or with unmanaged chronic disease conditions. The pharmacy clinicians used motivational interviewing techniques to identify and address member barriers to medication adherence and when needed, connected members with their pharmacies and providers. CalViva reported reaching a small percentage of the 1,676 members identified for outreach and attributed the low reach percentage to inaccurate member contact information, limited pharmacist staffing, member unresponsiveness due to comorbidities and behavioral health conditions, and members not answering their phones due to thinking the calls were spam. CalViva indicated that the MCP is assessing how to address member barriers and although the pharmacy outreach initiative is currently on hold, the MCP plans to restart the outreach calls in 2021.
- Conducting telephonic outreach to members in Madera and Kings counties, ages 18 years and older who were newly treated with an antidepressant medication, have a diagnosis of major depression, and demonstrate antidepressant medication refill gaps of 15 to 50 days. CalViva's behavioral health division collaborated with a vendor to conduct live calls to non-compliant members, employing motivational interviewing to identify reasons for non-adherence and facilitate access to behavioral health treatment. CalViva noted that the outreach call script was approved by DHCS in January 2021; therefore, the MCP did not begin conducting the outreach until February 2021. CalViva indicated the MCP will monitor the outreach to ensure it is being implemented as intended and will meet regularly with the vendor to ensure quick identification and resolution of implementation barriers.
- Conducting telephonic outreach to parents/guardians of children 0 to 2 years of age in Fresno County who were due for immunizations included in the *Childhood Immunization Status—Combination 10* measure and who had two or more siblings within their household who were also due for recommended child or adolescent immunizations. During the outreach calls, CalViva:
  - Scheduled needed preventive appointments.
  - Scheduled same-day appointments for households with multiple care gaps.
  - Addressed transportation barriers.
  - Addressed primary care provider identification concerns.
  - Reminded members of the importance of preventive services.
  - Helped members connect with the MCP's member services team.
  - Connected members with community resources and services to address social determinants of health barriers.

CalViva reported reaching more than half of the 132 individuals identified for outreach and that most parents/guardians stated they would contact their providers to schedule their child's needed appointment. No parents/guardians requested that the MCP help schedule the appointment, and CalViva noted that the hesitancy may have been related to fear of scheduling office visits during COVID-19. CalViva indicated it plans to continue this intervention and will look for opportunities to expand the intervention's impact in 2021.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In CalViva's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.28 through Table 3.30 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.28—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CalViva—Fresno County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	60.01	33.33	Not Tested	34.95
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.17%	7.27%	3.90	8.33%

Table 3.29—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CalViva—Kings County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	78.48	35.91	Not Tested	38.39
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.50%	10.00%	2.50	10.69%

Table 3.30—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CalViva—Madera County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be calculated because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	55.26	29.95	Not Tested	30.99
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	7.34%	Not Comparable	7.94%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

For reporting units for which HSAG could compare measurement year 2020 SPD rates to measurement year 2020 non-SPD rates:

- The SPD population in Fresno County had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.
- For Kings County, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for *Plan All-Cause Readmissions—Observed Readmissions—Total* measure.

Strengths—Performance Measures

The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for CalViva across all domains and reporting units:

- The rates for the following measures were above the high performance levels:
  - *Asthma Medication Ratio—Total* for Madera County
  - *Immunizations for Adolescents—Combination 2* for Madera County
  - *Prenatal and Postpartum Care—Postpartum Care* for Kings County
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* for Kings and Madera counties
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 15 showed statistically significant improvement from measurement year 2019 to measurement year 2020. Seven of these rates (47 percent) were in the Behavioral Health domain, five rates (33 percent) were in the Acute and Chronic Disease Management domain, and three rates (20 percent) were in the Women's Health domain.

Opportunities for Improvement—Performance Measures

CalViva has the opportunity to ensure the MCP'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.

Across all domains and reporting units, 21 rates that HSAG compared to benchmarks were below the minimum performance levels in measurement year 2020. For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, CalViva's performance declined significantly from measurement year 2019 to measurement year 2020 for 16 rates. CalViva has the greatest opportunities for improvement in the Women's Health domain, with five rates in this domain being below the minimum performance levels and the MCP's performance declining significantly from measurement year 2019 to measurement year 2020 for 12 rates in the domain.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, CalViva should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

CalViva determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—breast cancer screening among Hmong-speaking members.

HSAG validated Module 1 for the MCP's *Breast Cancer Screening* Health Equity PIP. Upon initial review of the module, HSAG determined that CalViva met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim run chart.

After receiving technical assistance from HSAG, CalViva incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

CalViva's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of breast cancer screening completion among members who speak Hmong, Laotian, Cambodian, and Khmer. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CalViva's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

CalViva determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—childhood immunizations.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunizations* PIP. Upon initial review of Module 1, HSAG determined that CalViva met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CalViva incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CalViva met all validation criteria for Module 2 in its initial submission.

CalViva's *Childhood Immunizations* PIP SMART Aim measures the percentage of members assigned to the PIP provider partner who complete the *Childhood Immunization Status—Combination 10* measure vaccination series. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CalViva's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

CalViva successfully met all validation criteria for Module 1 for the *Breast Cancer Screening* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Breast Cancer Screening* Health Equity PIP. CalViva has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, CalViva successfully met all validation criteria for modules 1 and 2 for the *Childhood Immunizations* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Childhood Immunizations* PIP. CalViva has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on CalViva's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

CalViva submitted the MCP's final PNA report to DHCS on August 12, 2021, and DHCS notified the MCP via email on the same date that DHCS approved the report as submitted. While CalViva submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with CalViva's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2021, the Health Education Department will increase member utilization of the myStrength Program.	No	Better	Changing for 2021
2	By June 30, 2021, significantly increase the breast cancer screening rate among the Hmong-speaking population assigned to the targeted clinic sites in Fresno County.	Yes	Unknown	Ended in 2020
3	By June 30, 2021, the Cultural and Linguistics Services Department will conduct trainings with 80 percent of all MCP staff members working in provider-facing departments to increase awareness of available Language Assistance Program services and resources.	No	Better	Ended in 2020

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 30, 2022, the Health Education Department will continue increasing annual utilization of the myStrength Program.	No	Changed from 2020
2	By December 31, 2022, increase the breast cancer screening rate among Hmong-, Laotian-, and Khmer-	Yes	New in 2021

#	Objective Summary	Health Disparity (Yes/No)	Status
	speaking females ages 50 to 74 years assigned to the targeted clinic in Fresno County.		
3	By June 30, 2022, the Cultural and Linguistics Services Department will increase the use of new video remote interpreting services to support member language needs.	No	New in 2021

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from CalViva's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of CalViva's self-reported actions.

Table 6.1—CalViva's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCMC plan fully resolves the findings from the 2020 Medical Audit of CalViva by:	
a. Developing and implementing effective follow-up procedures to ensure the MCP's compliance with ensuring providers complete Individual Health Education Behavior Assessments (IHEBAs) as part of the initial health assessments (IHAs).	During the 2020–21 intervention period, CalViva identified two providers (one high-performing and one low-performing) to partner with in order to complete focus group interviews to identify significant barriers and strategies for success in completing the Staying Healthy Assessment/IHEBA. Additionally, during its session, the low-performing clinic agreed to engage in a quality improvement project with CalViva in order to improve its IHA/IHEBA completion rates. ♦ An initial key driver diagram was developed (September 25, 2020) and reviewed with the low-performing clinic's IHA team at the first team meeting on October 14, 2020, to identify early the factors that would influence our ability to achieve our aim. A monthly meeting schedule was established. ♦ Two main barriers were prioritized: ■ Consistent access to the new member list (NML) for outreach. ■ Correct coding of IHA/IHEBA completion.

2019–20 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	♦ In November 2020, provider engagement staff educated designated staff members at the low-performing clinic on the process for accessing the NML. ♦ An initial process map was created by the IHA team on January 12, 2021, in order to create a visual representation of the current workflow. An initial provider profile was also agreed upon at this meeting in order to gather data to assess the clinic's ability to schedule a sample of members from the NML. The provider profile is a tool (Microsoft Excel workbook) that captures member demographic information, outreach attempts, and appointment outcomes. ♦ The clinic began to use the approved provider profile in March 2021 and captured data for April, May, and June 2021, submitting updated profiles to the MCP each month. ♦ On December 10, 2020, a code was identified by the high-performing provider and implemented successfully with the low-performing provider according to data validation completed May 26, 2021. ♦ Best practices including the process map, member outreach methodology, and use of specified Current Procedural Terminology (CPT) codes that have been approved and included in provider engagement training materials for rollout in Fresno, Kings, and Madera counties. ♦ CalViva is developing a provider performance report to monitor the progress and success of this best practice implementation. An information technology enhancement is being initiated to identify the five lowest-performing providers to target for education regarding IHA/IHEBA compliance going forward.
b. Developing and implementing policies and procedures to ensure the	On July 31, 2020, the MCP completed an update of its policy (PV-100) to describe prompt investigation and effective corrective actions to ensure timely access

2019–20 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
MCP's provider network provides timely access for members.	throughout the MCP's provider network in the following ways: ♦ Identified responsible parties for managing the corrective action process, areas wherein escalation will occur, and how escalation will occur within the MCP. ♦ Sets timelines for identifying non-compliant providers (i.e., 30 calendar days); obtaining confirmation receipt from non-compliant providers (i.e., 10 business days); receiving a completed Timely Access Improvement Plan back (i.e., 30 calendar days); and validating a provider's submitted Timely Access Improvement Plan (i.e., 10 business days). ♦ Describes the corrective action the MCP takes to bring providers back into compliance (trainings, in-person/phone follow-up, sending of CAP/educational packets, etc.). ♦ Updated to also include the analysis and review of the DHCS EQRO quarterly Timely Access Survey results. ♦ The MCP will also utilize results of DHCS' monitoring and upon receipt of DHCS' findings, take appropriate corrective action on a more frequent basis than annually. Non-compliant providers identified through the DHCS EQRO survey will also receive corrective action as described in the MCP's policy PV-100. In July and August 2020, the MCP completed development of a CalViva CAP tracking log to monitor the timeliness and progress of the CAP activity with participating physician groups (PPGs) and providers. ♦ The log includes the dates CAPs are distributed to each PPG/provider, the dates CAP responses and improvement plans are received, and the dates the improvement plans are validated. ♦ All communications with the PPGs/providers are also logged in the tracking log.

2019–20 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	♦ Staff performing CAP activities were trained on the new CAP escalation process. Although the 2020 DHCS Medical Audit CAP has not yet been closed by DHCS because the IHEBA finding referenced above is still open, DHCS advised CalViva on August 28, 2020, of the following: "Our management has reviewed the updated response and supporting documents, and finding 3.1.1 has been approved for closure."
2. Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual-eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.	CalViva Health is working with NCQA to determine any required actions to address the process used to remove Medicare primary members from the HEDIS warehouse for reporting to DHCS. The expected rate change is immaterial and only impacts the *Ambulatory Care* measure.
3. Continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Postpartum Care* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP.	♦ During the 2020–21 intervention period, CalViva updated our Postpartum Provider Tip Sheet (on November 24, 2020) that includes best practices that we learned from our PIP. These practices include: ■ Asking patients about cultural considerations such as quarantines after childbirth. ■ Sending frequent appointment reminders via telephone or texting. ■ Helping members with transportation needs. ♦ The Postpartum Provider Tip Sheet was made available on the provider portal and was also distributed or emailed by provider engagement staff to providers receiving HEDIS/health education training. ♦ The COVID-19 public health emergency impacted CalViva's ability to share our PIP adopted/adapted improvement strategies, such as the use of an obstetric alert for appointment scheduling or revising clinic obstetric forms to include questions regarding cultural practices, with our high-priority

2019–20 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	federally quality health centers (FQHCs) and clinics during this intervention period. This is because we were not able to complete our annual clinic visits. Each year in the fall, CalViva schedules annual clinic visits with our high-priority FQHCs and clinics to review HEDIS results and share what we learned over the previous year through our PIP and PDSA projects and activities. The clinics were unavailable to participate in these meetings in fall 2020. ♦ CalViva Health Pregnancy Program continues to serve our members to identify high-risk pregnant members who meet criteria for case management. ♦ Outcomes measured quarterly continue to demonstrate greater compliance with postpartum visits (higher for women in Case Management as measured for Quarter 4 of 2020) and fewer preterm deliveries (as measured for Quarter 4 of 2020) for members managed versus those not managed. Childhood Immunization Status included: ♦ Member newsletter distributed in Quarter 3 of 2020 to educate members about the importance of childhood immunizations. ♦ Providers were offered an incentive to encourage outreach to members and completion of their immunizations. ♦ Provider tip sheets developed in Quarter 3 of 2020 (approved October 27, 2020) and made available through the provider portal were also distributed or emailed by provider engagement staff to providers receiving HEDIS/health education training. Each tip sheet outlines HEDIS specifications, best practices, and recommended immunization guidelines. ♦ In Quarter 4 of 2020, we decided to expand from the *Childhood Immunization Status—Combination 3* PIP to a *Childhood Immunization Status—Combination 10* PIP with a different high-volume, low-performing provider in Fresno County. We

2019–20 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	shared what we learned from the *Childhood Immunization Status—Combination 3* PIP throughout planning sessions with the multidisciplinary team in Quarter 4 of 2020 through Quarter 1 of 2021. ♦ The COVID-19 public health emergency impacted CalViva's ability to share our PIP adopted/adapted improvement strategies, such as eliminating double-booking for providers or holding Friday/Saturday immunization clinics (nurse visit) with our high-priority FQHCs and clinics during this intervention period. This is because we were not able to complete our annual clinic visits. Each year in the fall, CalViva schedules annual clinic visits with our high-priority FQHCs and clinics to review HEDIS results and share what we learned over the previous year through our PIP and PDSA projects and activities. The clinics were unavailable to participate in these meetings in fall 2020.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CalViva's self-reported actions in Table 6.1 and determined that CalViva adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. CalViva provided detailed descriptions of the following in response to the 2019–20 EQRO recommendations:

- The follow-up procedures the MCP developed to ensure providers are compliant with completing IHEBAs as part of the IHAs.
- Steps the MCP took to develop and implement policies and procedures to ensure the MCP's provider network provides timely access for members.
- How the MCP continued to monitor the interventions and outcomes from the 2017–19 *Postpartum Care* Disparity and *Childhood Immunization Status—Combination 3* PIPs, including additional efforts the MCP engaged in to improve postpartum care and childhood immunization rates.

CalViva also stated that the MCP is working with NCQA to determine any required actions needed related to the process the MCP uses to determine inclusion of dual-eligible members in performance measure reporting.

2020–21 Recommendations

Based on the overall assessment of CalViva's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Continue to work with DHCS to ensure the MCP has taken all required actions to fully resolve the findings from the 2020 Medical Audit.
- Continue working with NCQA to ensure the MCP'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.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate CalViva's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix I:
Performance Evaluation Report
CenCal Health
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, CenCal Health ("CenCal" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that CenCal provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in CenCal's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CenCal is a full-scope MCP delivering services to its members in the County Organized Health System model.

CenCal became operational to provide MCMC services in Santa Barbara County effective September 1983 and San Luis Obispo County in March 2008. As of June 2021, CenCal had 142,600 members in Santa Barbara County and 60,374 in San Luis Obispo County—for a total of 202,974 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for CenCal in 2019 for the review period of November 1, 2018, through October 31, 2019. HSAG included a summary of these audits in CenCal's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of CenCal during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of CenCal from October 25, 2021, through November 5, 2021, for the review period of November 1, 2019, through September 30, 2021. HSAG will include a summary of these audits in CenCal's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of CenCal, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for CenCal Health* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CenCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.18 for CenCal's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.18:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.16 present the performance measure results and findings by domain, and Table 3.17 and Table 3.18 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 and Table 3.2 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 and Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 21, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	60.95%	Not Comparable
Childhood Immunization Status—Combination 10	50.61%	50.36%	-0.25
Developmental Screening in the First Three Years of Life—Total	19.00%	14.60%	-4.40
Immunizations for Adolescents—Combination 2	44.77%	45.26%	0.49
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	90.75%	91.97%	1.22

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	86.62%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	86.37%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	41.42%	Not Comparable
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	—	78.02%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	58.07%	Not Comparable
Childhood Immunization Status—Combination 10	50.61%	51.58%	0.97
Developmental Screening in the First Three Years of Life—Total	20.24%	33.36%	13.12
Immunizations for Adolescents—Combination 2	55.72%	60.93%	5.21
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	90.75%	80.54%	-10.21
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	79.81%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	77.13%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	48.22%	Not Comparable
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	—	84.59%	Not Comparable

Findings—Children's Health Domain

Table 3.3 and Table 3.4 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.3 and Table 3.4:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.3—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CenCal—San Luis Obispo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.4—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CenCal—Santa Barbara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.5 and Table 3.6 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.5—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	63.06%	59.61%	-3.45
*Cervical Cancer Screening^*	67.15%	66.39%	-0.76
Chlamydia Screening in Women—Ages 16–20 Years	55.22%	53.25%	-1.97
Chlamydia Screening in Women—Ages 21–24 Years	66.17%	59.31%	-6.86
Chlamydia Screening in Women—Total	60.40%	**55.99%**	-4.41
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.25%	3.78%	0.53
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.92%	5.61%	-1.31

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	26.61%	25.08%	-1.53
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	31.80%	28.01%	-3.79
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.24%	7.20%	-4.04
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.86%	7.01%	0.15
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	27.66%	39.13%	11.47
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.57%	33.58%	-2.99
*Prenatal and Postpartum Care—Postpartum Care^*	88.56%	87.59%	-0.97
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	97.32%	92.21%	-5.11

Table 3.6—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	61.79%	60.46%	-1.33
*Cervical Cancer Screening^*	66.84%	62.53%	-4.31
Chlamydia Screening in Women—Ages 16–20 Years	51.08%	52.89%	1.81
Chlamydia Screening in Women—Ages 21–24 Years	65.15%	64.57%	-0.58
Chlamydia Screening in Women—Total	57.59%	58.59%	1.00
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.40%	3.18%	-0.22
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.89%	5.87%	-1.02

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	17.64%	16.90%	-0.74
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.10%	28.32%	-1.78
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	15.38%	15.29%	-0.09
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.22%	11.44%	0.22
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.22%	6.55%	-0.67
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	40.51%	38.43%	-2.08
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.08%	36.40%	0.32
*Prenatal and Postpartum Care—Postpartum Care^*	91.48%	93.19%	1.71
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	97.81%	94.40%	-3.41

Findings—Women's Health Domain

Table 3.7 and Table 3.8 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.7 and Table 3.8:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.7—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CenCal—San Luis Obispo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	19	36.84%

Table 3.8—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CenCal—Santa Barbara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.9 and Table 3.10 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.9 and Table 3.10:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.9—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.15%	58.01%	-0.14
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	42.83%	41.64%	-1.19
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**78.93%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.86%	44.81%	4.95

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	36.36%	56.82%	20.46
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	62.65%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	44.58%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	44.58%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	31.88%	41.38%	9.50
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	32.73%	35.29%	2.56
Screening for Depression and Follow-Up Plan—Ages 65+ Years	23.97%	35.11%	11.14

Table 3.10—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.37%	**52.85%**	-1.52
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.45%	**37.37%**	-1.08
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	83.23%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	43.39%	54.82%	11.43
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	55.56%	50.91%	-4.65
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	54.17%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	27.08%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**26.04%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	35.65%	34.60%	-1.05
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	28.83%	30.58%	1.75
Screening for Depression and Follow-Up Plan—Ages 65+ Years	19.08%	25.69%	6.61

Findings—Behavioral Health Domain

Table 3.11 and Table 3.12 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.11 and Table 3.12:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.11—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CenCal—San Luis Obispo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.12—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CenCal—Santa Barbara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.13 and Table 3.14 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.13 and Table 3.14:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.13—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	48.82	34.18	Not Tested
Asthma Medication Ratio—Total	67.53%	68.07%	0.54
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	28.64%	34.80%	6.16
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.51%	12.53%	-3.98
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	62.53%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.05%	8.51%	-0.54
Plan All-Cause Readmissions—Expected Readmissions—Total	9.76%	9.06%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.93	0.94	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.45%	3.81%	-1.64
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.14—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	42.26	28.19	Not Tested
Asthma Medication Ratio—Total	64.72%	68.77%	4.05
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	23.94%	33.44%	9.50
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.63%	13.47%	-3.16
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	59.61%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.97%	8.89%	-0.08
Plan All-Cause Readmissions—Expected Readmissions—Total	9.54%	8.98%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.94	0.99	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.86%	2.98%	-0.88
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.15 and Table 3.16 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.15 and Table 3.16:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years* for San Luis Obispo County
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* for both reporting units
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.15—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CenCal—San Luis Obispo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.16—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CenCal—Santa Barbara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	6	33.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	6	16.67%

Performance Measure Findings—All Domains

Table 3.17 and Table 3.18 present a summary of CenCal's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.17 and Table 3.18:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years* for San Luis Obispo County
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* for both reporting units
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*

- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.17—Measurement Year 2020 Performance Measure Findings for All Domains CenCal—San Luis Obispo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	4	16	25.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	35	11.43%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	35	22.86%

Table 3.18—Measurement Year 2020 Performance Measure Findings for All Domains CenCal—Santa Barbara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	36	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	16	18.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	36	13.89%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of CenCal's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

CenCal conducted two PDSA cycles to improve the MCP's performance on the *Controlling High Blood Pressure—Total* measure.

For the first PDSA cycle, CenCal's population health staff conducted outreach calls to members with hypertension who were assigned to a specific provider site in Santa Barbara County to provide education about healthy lifestyle changes, self-monitoring their blood pressure readings, and managing their medications. Members who had further questions about their medications were transferred to CenCal's pharmacists who provided answers. During the outreach calls, the MCP assisted members with scheduling appointments with their providers. CenCal indicated that the intervention resulted in some members scheduling a blood pressure check appointment, most of whom attended the appointment. The MCP indicated learning that making the outreach calls in the afternoon rather than in the morning resulted in the MCP reaching more members.

For the second PDSA cycle, CenCal continued conducting outreach calls to members with hypertension who were assigned to a different provider site, a large federally qualified health center (FQHC) in Santa Barbara County. The MCP's population health staff outreached to members assigned to the FQHC to provide education about the importance of blood pressure management and maintenance, including offering to assist members with scheduling appointments with their providers. When needed, CenCal's pharmacists answered members' questions about their medications. CenCal reported success with members who received the three-way outreach based on most of these members attending their scheduled appointments. The outreach goal was not met due to some inaccurate contact information or members not having a voicemail option; however, most members who were successfully outreached scheduled and attended their appointments. CenCal indicated that the MCP will work with its providers to update member contact information.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, CenCal reported:

- Providing business cards to pediatric providers to disseminate to members during provider visits. A quick response (QR) code and quick access link were printed on the cards that provided members electronic access to health promotion resources via a handheld device while waiting to be seen for their appointments. The target populations for this strategy were parents or guardians of children ages 0 to 2 and 11 to 12 who were overdue for receiving recommended vaccines. CenCal indicated that while the business cards made the health promotion information easily accessible, providers were unable to make disseminating the cards a priority during the COVID-19 response efforts. The MCP indicated that it would continue to promote the QR code and quick access link via provider and member outreach efforts, social media, and CenCal's website.
- Having CenCal's promotoras conduct three virtual home visits with members ages 19 to 50 who are high-risk with clinically persistent asthma and reside in north Santa Barbara County. The promotoras assessed members' knowledge about asthma control and home triggers, developed an action plan in collaboration with the member, provided a gift basket of home-trigger remediation supplies, and offered a follow-up outreach contact by a case manager. The MCP also offered a gift card incentive to members who completed the program. CenCal reported low participation in the program, primarily due to inaccurate member contact information and members being fearful of COVID-19 even though the promotoras conducted the visits virtually. To improve the number of participants, CenCal indicated plans to expand the target population to all high-risk members in Santa Barbara County.
- Mailing reminder letters to members with hypertension who had not filled their hypertension control medication in the prior three months. The letters included information about preventive care strategies and how to access home blood pressure cuffs via a provider prescription benefit. CenCal reported sending letters to more than 1,200 members and that more than 100 responded to the mailing. CenCal indicated that due to the complexity of the process for accessing home blood pressure cuffs, the MCP will send a separate mailing to members in the future regarding how to access these cuffs.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In CenCal's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.19 and Table 3.20 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.19—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CenCal—San Luis Obispo County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	64.58	32.68	Not Tested	34.18
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.32%	8.10%	2.22	8.51%

Table 3.20—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CenCal—Santa Barbara County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	55.66	27.14	Not Tested	28.19

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.41%	8.53%	1.88	8.89%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only. HSAG identified no statistically significant difference between the measurement year 2020 SPD rates and measurement year 2020 non-SPD rates for this measure for either reporting unit.

Strengths—Performance Measures

The HSAG auditor determined that CenCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for CenCal:

- The rates for the following measures were above the high performance levels:
  - *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
- The MCP's performance improved significantly from measurement year 2019 to measurement year 2020 for the following measures:
  - *Asthma Medication Ratio—Total* for Santa Barbara County
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years* for both reporting units
  - *Developmental Screening in the First Three Years of Life—Total* for Santa Barbara County
  - *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase* for Santa Barbara County
  - *Screening for Depression and Follow-Up Plan—Ages 12–17 Years* for San Luis Obispo County
  - *Screening for Depression and Follow-Up Plan—Ages 18–64 Years* and *Ages 65+ Years* for both reporting units

Opportunities for Improvement—Performance Measures

Across all domains and both reporting units, CenCal has the most opportunities for improvement in the Women's Health domain, with one rate in this domain below the minimum performance level and 10 rates declining significantly from measurement year 2019 to measurement year 2020. For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, CenCal should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness. s
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

CenCal determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—postpartum care for members residing in San Luis Obispo County.

HSAG validated modules 1 and 2 for the MCP's *Postpartum Care* Health Equity PIP. Upon initial review of Module 1, HSAG determined that CenCal met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CenCal incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CenCal met all validation criteria for Module 2 in its initial submission.

CenCal's *Postpartum Care* Health Equity PIP SMART Aim measures the percentage of members residing in San Luis Obispo County who complete a postpartum visit on or between seven to 84 days after having a live birth. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CenCal's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

CenCal determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—well-child visits in the first 15 months of life.

HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits* PIP. Upon initial review of Module 1, HSAG determined that CenCal met most of the required validation criteria; however, HSAG identified opportunities for improvement related to completing all required components of the key driver diagram. After receiving technical assistance from HSAG, CenCal incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CenCal met all validation criteria for Module 2 in its initial submission.

CenCal's *Well-Child Visits* PIP SMART Aim measures the percentage of members residing in San Luis Obispo County who complete six or more well-child visits on or before 15 months of age. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CenCal's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

CenCal successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. CenCal has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on CenCal's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

CenCal submitted the MCP's PNA report to DHCS on June 30, 2021, and DHCS notified the MCP via email on July 14, 2021, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with CenCal's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 1, 2021, increase the percentage of members who have completed clinically recommended cervical cancer screening to at least above the DHCS minimum performance level.	No	Worse	Ended in 2020
2	By June 1, 2022, increase the proportion of Spanish-speaking members who access behavioral health care in both counties to more closely match the proportion of Spanish speakers in their respective counties.	Yes	Unknown	Ended in 2020
3	By June 1, 2021, increase the childhood lead screening rate in San Luis Obispo County to be at least equal to the San Barbara County rate.	No	Worse	Ended in 2020
4	By June 1, 2021, increase the rate of English-speaking members who receive their clinically recommended breast cancer screening to the Healthy People 2020 goal.	Yes	Worse	Changing for 2021

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 1, 2022, increase diabetic and pre-diabetic members' use of nutrition education services (e.g., registered dietician or certified diabetes educator).	No	New in 2021
2	By June 1, 2022, increase the breast cancer screening rate for English-speaking members in both counties.	Yes	Changed from 2020
3	By January 1, 2023, increase the childhood developmental screening rate for children age 1 in San Luis Obispo County.	Yes	New in 2021

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from CenCal's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of CenCal's self-reported actions.

Table 6.1—CenCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the continued and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Human Papillomavirus (HPV) Vaccination* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP.	The Know More: HPV patient education program developed and tested through the *HPV Vaccination* Disparity PIP was modified to accommodate limitations due to the COVID-19 pandemic. QR codes and quick access links were placed on small cards linking to the program for individual viewing on smart devices. These cards were distributed among CenCal's pediatric providers, who had previously shared one tablet amongst multiple patients who viewed the program in the clinic. CenCal's HPV vaccination rates have continued to increase since the program launch. The rate surpassed NCQA's established 95th percentile benchmark for 2021, and the health disparity has remained closed. Ongoing implementation of the *Childhood Immunization Status—Combination 3* PIP has continued as well. Vaccination reports for all pediatric members due for one or more vaccinations were developed and

2019–20 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	disseminated monthly through CenCal's secure provider portal. Additionally, ongoing monitoring of childhood immunization rates continued. CenCal's overall vaccination rate during the time frame has remained commensurate with previous years, with only minor decreases during COVID-19 surges.
2. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the continued and adapted interventions and to strengthen future quality improvement efforts.	The primary lesson learned from the 2017–19 PIPs that will facilitate improvement is the importance of developing sustainable and non-labor-intensive interventions for providers. To address this, the interventions developed through the two PIPs were adapted to be user-friendly and easily accessible. CenCal has also used this lesson learned to inform development of current quality improvement interventions. Many interventions underway are simple and/or focused on internal system changes instead of placing the burden on a provider's ability to pilot the intervention.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CenCal 's self-reported actions in Table 6.1 and determined that CenCal adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. CenCal described how the MCP has monitored and adapted the interventions from the 2017–19 *HPV Vaccination* Disparity and *Childhood Immunization Status—Combination 3* PIPs and reported overall improvement in immunization rates. Additionally, CenCal indicated that based on lessons learned from the 2017–19 PIPs, the MCP changed interventions to make them easier to implement and to lessen the burden on provider partners.

2020–21 Recommendations

Based on the overall assessment of CenCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that CenCal assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate CenCal's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix J:
Performance Evaluation Report
Central California Alliance for Health
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Central California Alliance for Health ("CCAH" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that CCAH provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in CCAH's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CCAH is a full-scope MCP delivering services to its members in the County Organized Health System model.

CCAH became operational to provide MCMC services in Santa Cruz County effective January 1996, in Monterey County effective October 1999, and Merced County effective October 2009. As of June 2021, CCAH had 135,542 members in Merced County, 168,413 in Monterey County, and 73,682 in Santa Cruz County—for a total of 377,637 members.[1]

DHCS allows CCAH to combine data for Monterey and Santa Cruz counties for reporting purposes. For this report, Monterey and Santa Cruz counties represent one single reporting unit, and Merced County represents another single reporting unit.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for CCAH in 2019 for the review period of November 1, 2018, through October 31, 2019. HSAG included a summary of these audits in CCAH's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of CCAH during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is tentatively scheduled to conduct Medical and State Supported Services Audits of CCAH in February 2022. HSAG will include a summary of these audits in CCAH's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of CCAH, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Central California Alliance for Health* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CCAH followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.18 for CCAH's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.18:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.16 present the performance measure results and findings by domain, and Table 3.17 and Table 3.18 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 and Table 3.2 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 and Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 22, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	37.76%	Not Comparable
Childhood Immunization Status—Combination 10	19.71%	**21.65%**	1.94
Developmental Screening in the First Three Years of Life—Total	10.38%	15.66%	5.28
Immunizations for Adolescents—Combination 2	37.47%	38.33%	0.86
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	90.51%	88.56%	-1.95

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	72.02%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	70.56%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	34.76%	Not Comparable
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	—	62.39%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	50.14%	Not Comparable
Childhood Immunization Status—Combination 10	52.07%	53.66%	1.59
Developmental Screening in the First Three Years of Life—Total	17.00%	24.39%	7.39
Immunizations for Adolescents—Combination 2	60.73%	59.49%	-1.24
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	90.51%	87.10%	-3.41
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	82.48%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	79.81%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	44.21%	Not Comparable
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	—	83.18%	Not Comparable

Findings—Children's Health Domain

Table 3.3 and Table 3.4 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.3 and Table 3.4:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.3—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CCAH—Merced County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.4—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CCAH—Monterey/Santa Cruz Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.5 and Table 3.6 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.5—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	57.09%	**54.13%**	-2.96
*Cervical Cancer Screening^*	62.77%	63.66%	0.89
Chlamydia Screening in Women—Ages 16–20 Years	44.96%	44.26%	-0.70
Chlamydia Screening in Women—Ages 21–24 Years	63.22%	60.09%	-3.13
Chlamydia Screening in Women—Total	53.78%	**52.04%**	-1.74
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.36%	2.80%	-0.56
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.52%	4.92%	0.40

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.81%	16.82%	-1.99
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.78%	26.62%	-1.16
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	10.67%	13.30%	2.63
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.86%	8.79%	1.93
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.04%	8.86%	-1.18
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	41.01%	36.70%	-4.31
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.27%	38.99%	-2.28
*Prenatal and Postpartum Care—Postpartum Care^*	79.56%	81.61%	2.05
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	90.27%	91.67%	1.40

Table 3.6—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	60.88%	**56.38%**	-4.50
*Cervical Cancer Screening^*	73.72%	65.55%	-8.17
Chlamydia Screening in Women—Ages 16–20 Years	59.13%	53.44%	-5.69
Chlamydia Screening in Women—Ages 21–24 Years	67.22%	61.19%	-6.03
Chlamydia Screening in Women—Total	62.53%	**57.04%**	-5.49
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.84%	3.60%	-0.24
Contraceptive Care—All Women—LARC—Ages 21–44 Years	7.13%	6.55%	-0.58
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.01%	16.97%	-1.04
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.50%	29.10%	-1.40

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	8.18%	10.75%	2.57
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	5.02%	5.69%	0.67
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	26.77%	24.10%	-2.67
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.50%	18.24%	-1.26
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	9.29%	11.40%	2.11
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.29%	13.28%	0.99
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	46.84%	43.65%	-3.19
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	46.75%	45.38%	-1.37
*Prenatal and Postpartum Care—Postpartum Care^*	88.56%	84.93%	-3.63
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	91.73%	93.15%	1.42

Findings—Women's Health Domain

Table 3.7 and Table 3.8 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.7 and Table 3.8:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.7—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CCAH—Merced County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	19	21.05%

Table 3.8—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CCAH—Monterey/Santa Cruz Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	19	42.11%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.9 and Table 3.10 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.9 and Table 3.10:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.9—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.66%	58.10%	6.44
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	33.20%	38.98%	5.78

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	48.07%	47.21%	-0.86
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	46.15%	52.00%	5.85
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	2.93%	4.10%	1.17
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	3.57%	3.07%	-0.50
Screening for Depression and Follow-Up Plan—Ages 65+ Years	3.17%	S	S

Table 3.10—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	56.05%	61.86%	5.81
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.52%	43.71%	4.19
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	100.00%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	42.28%	48.41%	6.13

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	42.19%	56.06%	13.87
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	16.54%	16.85%	0.31
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	5.55%	4.13%	-1.42
Screening for Depression and Follow-Up Plan—Ages 65+ Years	4.17%	2.67%	-1.50

Findings—Behavioral Health Domain

Table 3.11 and Table 3.12 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.11 and Table 3.12:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures;

therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

♦ HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* for Merced County
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* for both reporting units

Table 3.11—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CCAH—Merced County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Table 3.12—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CCAH—Monterey/Santa Cruz Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.13 and Table 3.14 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.13 and Table 3.14:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.13—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	49.48	35.37	Not Tested
Asthma Medication Ratio—Total	66.34%	73.15%	6.81
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	37.23%	**43.30%**	6.07
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	10.55%	8.79%	-1.76
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	53.28%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	15.94%	14.22%	-1.72
Plan All-Cause Readmissions—Expected Readmissions—Total	9.06%	9.18%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.76	1.55	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.50%	2.61%	-0.89
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.14—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.77	32.15	Not Tested
Asthma Medication Ratio—Total	69.56%	75.32%	5.76
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	36.92%	37.24%	0.32
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.11%	12.51%	0.40
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	54.01%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	18.58%	17.57%	-1.01
Plan All-Cause Readmissions—Expected Readmissions—Total	9.26%	9.59%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	2.01	1.83	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.04%	3.21%	-0.83
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.15 and Table 3.16 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.15 and Table 3.16:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- For Merced County, HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.15—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CCAH—Merced County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	6	33.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Table 3.16—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings CCAH—Monterey/Santa Cruz Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Performance Measure Findings—All Domains

Table 3.17 and Table 3.18 present a summary of CCAH's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.17 and Table 3.18:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- For Merced County, HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures

- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* for Merced County
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* for both reporting units

Table 3.17—Measurement Year 2020 Performance Measure Findings for All Domains CCAH—Merced County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	14	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	36	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	14	28.57%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	36	13.89%

Table 3.18—Measurement Year 2020 Performance Measure Findings for All Domains CCAH—Monterey/Santa Cruz Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	5	15	33.33%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	37	10.81%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	15	13.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	37	27.03%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of CCAH's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

CCAH conducted two PDSA cycles to improve the MCP's performance on the *Breast Cancer Screening—Total* measure in Merced County.

For both PDSA cycles, CCAH tested whether issuing a standing mammogram order, coupled with a retrospective referral process for eligible members who had an office visit within the prior 12 months, would result in an increase in the percentage of members completing their breast cancer screenings. The MCP reported exceeding its PDSA SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective for both PDSA cycles. CCAH reported that eligible members who had been seen by their primary care provider (PCP) within the prior 12 months and were contacted by the imaging center regarding the standing mammogram order from their PCP were willing to complete the screening. CCAH also indicated that the intervention was successful in part due to in-house mammography and scheduling services. Finally, the MCP noted that ongoing provider participation in the intervention is essential for sustainability.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, CCAH reported:

- Conducting live outreach calls to members determined to be at highest risk for COVID-19 to educate them about available preventive and behavioral health resources, address their physical and mental health concerns, and help with barriers to health care access. CCAH reported that 1,059 of the 1,479 members outreached (72 percent) completed the call with an MCP staff member and that the live calls had a larger percentage of member participation than robocalls. CCAH noted that while live calls are more personal and allow MCP staff members to immediately address member needs, resource constraints result in some challenges with the live call strategy. CCAH indicated that the MCP created standardized templates to collect future public health emergency outreach data.
- Contracting with a vendor to conduct outreach robocalls to members determined to be at risk for COVID-19 based on a scoring methodology that considered a member's known risk factors, age, gender, disability status, and diagnoses. Of the 39,265 members who received a robocall, 19,278 members (49 percent) engaged with the vendor. The vendor

addressed member safety issues, provided access to the MCP's nurse advice line, discussed prescription medication concerns, addressed physical and mental health concerns, and assisted with accessing social services and MCP member services. CCAH indicated that using robocalls allows the MCP to reach more members and has fewer constraints when compared to live outreach calls.

- Sending monthly letters to parents and guardians of members due for their four-month or 15-month well-child visit. The letters highlighted the importance of early and periodic screening, diagnosis, and treatment for optimal child health and development, and included guidance during the COVID-19 pandemic. The MCP included educational handouts in the mailing on topics such as immunization schedules, health programs, and the MCP's nurse advice line. CCAH reported mailing 1,137 letters. CCAH indicated that in the future, the MCP may establish a mechanism to measure how many letters were received and reviewed.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In CCAH's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.19 and Table 3.20 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.19—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CCAH—Merced County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	71.07	33.22	Not Tested	35.37
*Plan All-Cause Readmissions—Observed Readmissions—Total***	17.75%	12.88%	4.87	14.22%

Table 3.20—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CCAH—Monterey/Santa Cruz Counties

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	57.56	30.96	Not Tested	32.15
*Plan All-Cause Readmissions—Observed Readmissions—Total***	21.18%	16.62%	4.56	17.57%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

In measurement year 2020, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population for both reporting units. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that CCAH followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for CCAH:

- Across all domains, the following measures for Monterey/Santa Cruz counties had rates above the high performance levels:
  - *Asthma Medication Ratio—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- Across all domains and both reporting units for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 10 rates improved significantly from measurement year 2019 to measurement year 2020

Opportunities for Improvement—Performance Measures

Across all domains, CCAH has the most opportunities for improvement in the Women's Health domain. For both reporting units in measurement year 2020, the rates for the *Breast Cancer Screening—Total* and *Chlamydia Screening in Women—Total* measures were below the minimum performance levels. Additionally, CCAH's performance declined significantly from measurement year 2019 to measurement year 2020 for four measures in Merced County and eight measures in Monterey/Santa Cruz counties in this domain.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, CCAH should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

CCAH determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, CCAH identified child and adolescent well-care visits among members residing in Merced County as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated Module 1 for the MCP's *Child and Adolescent Well-Care Visits* Health Equity PIP. Upon initial review of the module, HSAG determined that CCAH met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CCAH incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

CCAH's *Child and Adolescent Well-Care Visits* Health Equity PIP SMART Aim measures the percentage of members ages 3 to 17 assigned to the PIP health center partner who complete their well-care visits. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CCAH's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

CCAH determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—childhood immunizations.

HSAG validated modules 1 through 3 for the MCP's *Childhood Immunizations* PIP. Upon initial review of the modules, HSAG determined that CCAH met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.

- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CCAH incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CCAH met all validation criteria for modules 2 and 3 in its initial submissions.

CCAH's *Childhood Immunizations* PIP SMART Aim measures the percentage of members assigned to the PIP health center partner who meet the *Childhood Immunization Status—Combination 10* measure criteria.

Table 4.1 presents a description of the intervention that CCAH selected to test for its *Childhood Immunizations* PIP. The table also indicates the key driver and failure mode that the intervention aims to address. Key drivers are factors identified in the key driver diagram that are thought to influence the achievement of the SMART Aim. Failure modes, which are identified as a result of a failure modes and effects analysis, are ways or modes in which something might fail. They include any errors, defects, gaps, or flaws that may occur now or could occur in the future.

Table 4.1—CCAH *Childhood Immunizations* PIP Intervention Testing

Intervention	Key Driver Addressed	Failure Mode Addressed
Work with the local immunization registry to correct data exchange issues	Efficient medical assistant and clinician workflows	Vaccination information is not uploading to the local immunization registry

During the review period, CCAH began intervention testing. The MCP will continue intervention testing through the SMART Aim end date of December 31, 2022. In CCAH's 2021–22 MCP-specific evaluation report, HSAG will include information regarding CCAH's intervention testing and any technical assistance HSAG provides to the MCP. HSAG will include a summary of the PIP outcomes in CCAH's 2022–23 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

CCAH successfully met all validation criteria for Module 1 for the *Child and Adolescent Well-Care Visits* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Child and Adolescent Well-Care Visits* Health Equity PIP. CCAH has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, CCAH successfully met all validation criteria for modules 1, 2, and 3 for the *Childhood Immunizations* PIP. The validation findings show that the MCP built a strong foundational framework, used quality improvement tools to define quality improvement

activities that have the potential to impact the SMART Aim, established an intervention plan for the intervention to be tested, and progressed to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on CCAH's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

CCAH submitted the MCP's final PNA report to DHCS on August 13, 2021, and DHCS notified the MCP via email on August 17, 2021, that DHCS approved the report as submitted. While CCAH submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with CCAH's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By December 31, 2022, increase the percentage of members reporting timely access to care via the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] survey in all three service counties.	No	Better	Continuing into 2021
2	By December 31, 2021, increase the percentage of members utilizing care for behavioral health services across all members living in Merced and Monterey counties to address current geographical disparities.	Yes	Better	Ended in 2020
3	By December 31, 2021, identify one essential health plan tool to field-test to assess a member's ability to access and utilize health plan information to make informed decisions.	No	Unknown	Ended in 2020
4	By June 30, 2022, identify specific educational programming resources aimed at preventing health complications among members with diabetes as measured through measurement year 2021 HEDIS performance measure results and as demonstrated by maintaining historic levels of performance or achieving the 50th percentiles, whichever is highest.	No	Unknown	Ended in 2020
5	By June 30, 2022, increase the *Well-Child Visits in the First 30 Months of Life* and *Childhood Immunization Status—Combination* 10 measure rates as demonstrated by maintaining historic levels of performance or achieving the 50th percentiles, whichever is highest.	No	Unknown	Changing for 2021

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

High-level summaries of the MCP's 2021 PNA Action Plan objectives

- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	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	Continued from 2020
2	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 limited English proficiency or who are deaf and/or hard of hearing.	No	New in 2021
3	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	New in 2021
4	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	Changed from 2020

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from CCAH's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of CCAH's self-reported actions.

Table 6.1—CCAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Continue testing the academic detailing intervention to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Opioid Overdose Deaths* Disparity PIP.	Due to a shift in organizational priorities and resources, the MCP did not continue testing the academic detailing intervention beyond the life of the 2017–19 *Opioid Overdose Deaths* Disparity PIP during the period of July 1, 2020, through June 30, 2021. Academic detailing has continued; however, it is mainly provided on an ad hoc basis for those providers who request it or if opioid trends are identified, necessitating provider intervention.
2. Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* PIP.	CCAH continues to work with the clinic partner to improve immunization rates for infants 0 to 2 years of age. Lists and dashboards of members who are compliant and non-compliant are available and accessible to the clinic staff members through the CCAH provider portal and via ad hoc request to the PIP team. CCAH has moved from tracking the *Childhood Immunization Status—Combination 3* measure to tracking the *Childhood Immunization Status—Combination 10* measure. We are working with the clinic to improve its rate for this measure and have

2019–20 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	started a new PIP for 2020–22. From July 1, 2020, through June 30, 2021, we have worked with the clinic to look at other possible interventions to help increase the rate and have completed one intervention to assist the clinic in fixing a data submission issue it had with a community program. The intervention was successful, and the clinic PIP team is working together to explore the next intervention it wants to test.
3. Apply lessons learned from the 2017–19 PIPs to future quality improvement efforts.	***Opioid Overdose Deaths* Disparity PIP**: Data-driven interventions are not only essential for identifying, targeting, and completing a program or project, they are essential components of effective provider education. Each of the providers and leaders we outreached during our *Opioid Overdose Deaths* Disparity PIP not only commented on the value of receiving individualized data, each continued to request the data after the intervention to deliver more effective, safer, quality-aligned care. With this in mind, we have been diligent to maintain the accuracy and value of the opioid registry. When intervening in any way with a provider or clinical group specific to opioid safety, we anchor it in data and come to the provider table transparent in our findings and goals. Further, especially given the complex nature of opioid safety, we learned the importance of prioritizing internal, cross-departmental communication to better target provider issues, needs, and interventions for improved outcomes. Finally, although academic detailing was not formally continued past the intervention period, great value has been identified using this

2019–20 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	model of provider education and will be utilized again in future interventions for engaged and effective prescribing behavior change. The MCP has continued the development and use of the opioid registry to: ♦ Identify high-risk members receiving opioid regimens of 90 mg morphine equivalent dosing or more or who are on concurrent opioids and benzodiazepines. Notification/outreach was provided to each member's PCP with the option to enroll these members in the Pharmacy Home Program, wherein the member is locked into one pharmacy. Mailers also included reminders about co-prescribing naloxone and advised educating members about opioid overdose. A total of 455 members were identified and letters were sent as described. Sixty-six members were successfully enrolled in the Pharmacy Home Program through third quarter 2020 when the intervention stopped due to the planned Medi-Cal prescription carve-out in January 2021. ♦ Create an opioid-benzodiazepine dashboard to monitor patient safety events and trending, identify and outreach to high-risk prescribers for education, and provide individualized data to provider group leadership during clinical joint operations meetings. This work has been maintained through the identified time period. ♦ Track, monitor, flag, and analyze member- and provider-level opioid safety practices across all counties for intervention as appropriate. This work has been maintained through the identified time period.

2019–20 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	***Childhood Immunization Status—Combination 3* PIP:** Providing access to quality care for our members has always been a priority for CCAH, and even more so during events such as the COVID-19 pandemic. CCAH wants to make sure its members do not fall behind in their preventive care and immunizations. Working on these previous PIPs has highlighted our continuous need to work with our provider network. CCAH continues to provide support and resources and share best practices with our provider network, in part through partnership with the California Department of Public Health. Some of the activities include the launch of our immunization resources webpage on our provider website, media campaigns for resuming care (member newsletters, Facebook posts), member outreach campaigns, and provider immunization trainings (our most recent focused on how to address vaccine hesitancy). CCAH's quality improvement department also has a practice coaching team that is available to providers who want to make improvements in their clinics.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CCAH's self-reported actions in Table 6.1 and determined that CCAH adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. CCAH described in detail how the MCP has continued and expanded efforts from both 2017–19 PIPs to prevent opioid overdose deaths and improve immunization completion rates, including how CCAH applied lessons learned from both PIPs.

2020–21 Recommendations

Based on the overall assessment of CCAH's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that CCAH assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate CCAH's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix K:
Performance Evaluation Report
Community Health Group
Partnership Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Community Health Group Partnership Plan ("CHG" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that CHG provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in CHG's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CHG is a full-scope MCP delivering services to its members under a Geographic Managed Care (GMC) model. Although the GMC model operates in both San Diego and Sacramento counties, CHG only operates in San Diego County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to CHG, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California
- UnitedHealthcare Community Plan

CHG became operational in San Diego County to provide MCMC services effective August 1998. As of June 2021, CHG had 292,021 members.[1] This represents 36 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for CHG from June 21, 2021, through July 2, 2021, for the review period of June 1, 2019, through May 31, 2021. At the time this 2020–21 MCP-specific evaluation report was published, the final audit reports were not available. HSAG will include a summary of the 2021 audits in CHG's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of CHG, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Community Health Group Partnership Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CHG followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for CHG's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Oct 19, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	43.61%	Not Comparable
Childhood Immunization Status—Combination 10	50.12%	48.42%	-1.70
Developmental Screening in the First Three Years of Life—Total	41.56%	43.47%	1.91
Immunizations for Adolescents—Combination 2	48.66%	45.50%	-3.16
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	93.43%	85.40%	-8.03
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	72.26%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	70.80%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	39.50%	Not Comparable
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	—	71.47%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CHG—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	69.36%	63.28%	-6.08
*Cervical Cancer Screening^*	70.32%	62.04%	-8.28
Chlamydia Screening in Women—Ages 16–20 Years	66.06%	57.80%	-8.26
Chlamydia Screening in Women—Ages 21–24 Years	71.76%	63.98%	-7.78
Chlamydia Screening in Women—Total	68.64%	60.70%	-7.94
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.04%	2.61%	-0.43
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.51%	5.19%	-1.32

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.42%	15.84%	-0.58
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.83%	25.78%	-2.05
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.96%	0.55%	-0.41
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	20.38%	12.77%	-7.61
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	12.49%	10.22%	-2.27
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.82%	8.81%	-0.01
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	36.49%	29.79%	-6.70
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.98%	37.04%	0.06
*Prenatal and Postpartum Care—Postpartum Care^*	78.27%	83.70%	5.43
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	86.80%	90.51%	3.71

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CHG—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	19	52.63%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.07%	64.31%	9.24
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.71%	49.54%	9.83
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	82.19%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	56.48%	61.43%	4.95
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	79.31%	72.82%	-6.49
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	51.35%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	38.51%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	37.16%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	30.85%	38.58%	7.73
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	23.60%	29.68%	6.08
Screening for Depression and Follow-Up Plan—Ages 65+ Years	20.22%	18.24%	-1.98

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CHG—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	7	57.14%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	42.51	31.15	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Asthma Medication Ratio—Total	65.45%	71.79%	6.34
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	25.30%	35.52%	10.22
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	10.28%	9.63%	-0.65
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	4.80%	5.27%	0.47
Controlling High Blood Pressure—Total	—	62.77%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.73%	8.79%	1.06
Plan All-Cause Readmissions—Expected Readmissions—Total	9.30%	9.44%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.83	0.93	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	18.20%	4.65%	-13.55
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	6.97%	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates

because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
CHG—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of CHG's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*

- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains CHG—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	10	37	27.03%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	14	37	37.84%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of CHG's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

CHG conducted two PDSA cycles to improve the MCP's performance on the *Childhood Immunization Status—Combination 10* measure.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, CHG used a script to conduct outreach calls to parents/guardians of members in need of their influenza vaccinations to discuss the importance of the vaccine and assist the parents/guardians with scheduling appointments with their child's primary care providers (PCPs). The MCP used the three-way calling feature to connect to members' PCP offices when parents/guardians consented to receiving help with scheduling appointments. CHG reported an increase in the influenza vaccination rate and correlated this increase with the intervention based on the following:

- CHG left voice mail reminders about the influenza vaccine for many members.
- During some of the outreach calls, parents/guardians indicated plans to contact their child's PCP to schedule an appointment for the vaccine.
- During some of the outreach calls, CHG scheduled appointments for vaccinations via three-way calls with the PCPs.

CHG indicated the following challenges during intervention testing:

- Inaccurate member phone numbers and not enough time to research alternative contact information.
- Long wait times when contacting PCP offices to help schedule appointments.
- Parents/guardians being fearful of attending a face-to-face appointment during the pandemic.
- Some parents/guardians refusing to have their child vaccinated.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, CHG conducted outreach calls to parents/guardians of children eligible for an influenza vaccination but who had not yet received the vaccination. CHG performed data mining to identify updated contact information and reported exceeding the PDSA goal. While CHG reported that the intervention was successful, the MCP determined to abandon this intervention because the data mining process was labor-intensive and unsustainable. CHG noted that the MCP implemented an alternative method for capturing and updating member information by adding a flagging mechanism to the member eligibility screen window to denote when a phone number is missing or the member's contact information is not current.

COVID-19 Quality Improvement Plan Summary

For its COVID-19 QIP, CHG reported:

- Conducting a telehealth visits campaign. CHG reminded PCPs and specialists via the MCP's provider alert mechanism, newsletters, and website provider portal about using telehealth visits as an option for providing preventive care services. CHG's member services department and case managers informed members about telehealth visits and how to seek health care during the pandemic, and the MCP also communicated this information to members via member newsletters. CHG noted a large increase in telehealth visits in 2020 when compared to 2019 and that telehealth visits helped to bridge care gaps, enabled members to receive needed health care services, and helped to reduce no-show rates. CHG indicated that the MCP received mixed feedback from members and providers about telehealth visits, but that overall, offering telehealth visits helped to address member barriers to access to care. CHG stated that the MCP will continue to promote telehealth visits as an option throughout and beyond the pandemic to improve member access to care.
- Developing the Feels Lonely project to provide members with information about COVID-19, how to access services, and available behavioral health resources. The MCP conducted outreach calls to members who had indicated feeling lonely on their health risk assessment during 2020 to mitigate these members' loneliness and social isolation, answer questions, and address concerns. CHG reported that most of the members reached were either already engaged in behavioral health services or declined the need for these services, and a small number of members reached requested to be warm transferred to the MCP's

Behavioral Health Department for referrals to behavioral health services. CHG reported having difficulty reaching members via phone either due to incorrect or incomplete contact information or because the members did not answer the calls. CHG indicated plans to continue the Feels Lonely project and that the MCP would be making changes to the data collection tool to help the MCP better analyze the intervention outcomes.

- Collaborating with several community organizations to improve the percentage of members completing all vaccines for the *Childhood Immunization Status—Combination 10* measure. CHG distributed the "Caring for Children During the COVID-19 Public Health Emergency" toolkit to pediatric providers, collaborated with the MCP's contracted PCPs to identify gaps in care, and disseminated provider educational materials to assist with practice redesign. CHG also implemented a member incentive program ($50 e-card) for members who completed all required vaccines. CHG reported that some members submitted completed immunization cards; however, PCPs indicated that members were hesitant to attend immunization appointments due to fear of COVID-19 exposure or were unable to attend the appointments due to lack of childcare for children in the household not needing any immunizations. CHG noted that additional messaging regarding the importance of obtaining all vaccines in the series may improve vaccination completion rates and that the MCP learned the importance of coordinating transportation scheduling with the appointment times because many provider offices do not allow patients in their offices more than 15 minutes in advance of the appointment time. CHG stated that the MCP will continue offering the member incentive, will expand the target population to include infants and toddlers ages 6 to 35 months, and will encourage PCPs to complete well-child visits during immunization appointments.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In CHG's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHG—San Diego County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	53.90	29.56	Not Tested	31.15
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.52%	8.21%	2.31	8.79%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that CHG followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for CHG:

- No measures had rates below the minimum performance levels.
- The rates for both *Antidepressant Medication Management* measures were above the high performance levels.
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 10 of 37 rates (27 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.

Opportunities for Improvement—Performance Measures

Across all domains, for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, CHG's performance declined significantly from measurement year 2019 to measurement year 2020 for 14 of 37 measures (38 percent). Ten of these 14 measures (71 percent) were in the Women's Health domain, demonstrating that the MCP has the most opportunities for improvement in this domain.

For all measures for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, CHG should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to CHG's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in San Diego County, DHCS required that CHG report rates for four HEDIS measures that HSAG validated as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results CHG—San Diego County

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.06	37.46	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.38%	7.88%	0.50
Plan All-Cause Readmissions—Expected Readmissions—Total	9.12%	9.22%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.81	0.85	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

CHG determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—cervical cancer screening among Black/African-American members.

HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Logically linking the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.

After receiving technical assistance from HSAG, CHG incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. At the end of this review period for this report, CHG was in the process of meeting all validation criteria for Module 2; therefore, HSAG includes no final validation results for the module in this report.

CHG's *Cervical Cancer Screening* Health Equity PIP SMART Aim measures the percentage of Black/African-American members living in the targeted ZIP Codes who complete their cervical cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CHG's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

CHG determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—adolescent well-care visits.

HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of Module 1, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CHG incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CHG met all validation criteria for Module 2 in its initial submission.

CHG's *Adolescent Well-Care Visits* PIP SMART Aim measures the percentage of members ages 12 to 17 years assigned to the PIP provider partner who complete their well-care visits. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CHG's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

CHG successfully met all validation criteria for Module 1 for the *Cervical Cancer Screening* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Cervical Cancer Screening* Health Equity PIP. CHG has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, CHG successfully met all validation criteria for modules 1 and 2 for the *Adolescent Well-Care Visits* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Adolescent Well-Care Visits* PIP. CHG has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on CHG's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

CHG submitted the MCP's final PNA report to DHCS on July 28, 2021, and DHCS notified the MCP via email on July 29, 2021, that DHCS approved the report as submitted. While CHG submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with CHG's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By July 1, 2021, increase the proportion of members who get needed care quickly.	No	Better	Changing for 2021
2	By July 1, 2021, increase the proportion of adult and child members who get needed care with a specialist.	No	Worse	Continuing into 2021
3	By July 1, 2021, increase the proportion of adult and child members who discuss health education and promotion topics with their physicians.	No	Unknown	Ended in 2020
4	By July 1, 2021, increase the proportion of members with good or excellent overall physical health.	No	Better	Continuing into 2021
5	By July 1, 2021, increase the *Cervical Cancer Screening* measure rate for all racial/ethnic groups.	Yes	Better	Continuing into 2021
6	By July 1, 2021, increase the *Breast Cancer Screening—Total* measure rate for all racial/ethnic groups.	Yes	Worse	Continuing into 2021
7	By July 1, 2021, reduce the *Plan All-Cause Readmissions* measure rates among racial/ethnic groups.	Yes	Better	Continuing into 2021

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By July 1, 2023, increase the proportion of adult members who get needed care quickly.	No	Changed from 2020
2	By July 1, 2023, increase the proportion of child members who get needed care with a specialist.	No	Continued from 2020
3	By July 1, 2023, increase the proportion of adult members who get needed care with a specialist.	No	Continued from 2020
4	By July 1, 2023, increase the proportion of members with good or excellent overall physical health.	No	Continued from 2020
5	By July 1, 2023, increase the *Cervical Cancer Screening* measure rate for the White racial/ethnic group.	Yes	Continued from 2020
6	By July 1, 2023, increase the *Cervical Cancer Screening* measure rate for the Asian racial/ethnic group.	Yes	Continued from 2020
7	By July 1, 2023, increase the *Cervical Cancer Screening* measure rate for the Black racial/ethnic group.	Yes	Continued from 2020
8	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the White racial/ethnic group.	Yes	Continued from 2020
9	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the American Indian/Alaska Native racial/ethnic group.	Yes	Continued from 2020
10	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the Black racial/ethnic group.	Yes	Continued from 2020
11	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the Native Hawaiian/Other Pacific Islander racial/ethnic group.	Yes	Continued from 2020
12	By July 1, 2023, reduce the *Plan All-Cause Readmissions* measure rate for the White racial/ethnic group.	Yes	Continued from 2020

#	Objective Summary	Health Disparity (Yes/No)	Status
13	By July 1, 2023, reduce the *Plan All-Cause Readmissions* measure rate for the American Indian/Alaska Native racial/ethnic group.	Yes	Continued from 2020
14	By July 1, 2023, reduce the *Plan All-Cause Readmissions* measure rate for the Black racial/ethnic group.	Yes	Continued from 2020

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from CHG's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of CHG's self-reported actions.

Table 7.1—CHG's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Annual Provider Visits* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP.	CHG has implemented various internal processes to capture and update member demographic information. Most recently, in cases where a phone number is missing or there is an indication that member contact information is not current, a flag appears as a "pop-up" window in the member's eligibility screen. This allows CHG's call centers to be made aware when a member calls in that the member's contact information should be obtained/validated and documented. The information collected is used to populate member demographic information made available to providers through the provider portal on gap reports to facilitate member outreach attempts to new members.
2. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adopted intervention and to strengthen future quality improvement efforts.	With every PIP, CHG's PIP team has built on lessons learned from its experiences to strengthen the methodology to be able to link the outcomes to the interventions that are being tested. The discussions on project design take into consideration a more realistic expectation of the role played by provider

2019–20 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	partners and MCP staff and what can reasonably be executed successfully given competing priorities. Additionally, challenges on the part of members, providers, and CHG staff related to the COVID-19 public health crisis have been a consideration in the planning of the 2020–22 PIPs.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CHG's self-reported actions in Table 7.1 and determined that CHG adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. CHG described how the MCP has developed and implemented internal processes to improve the accuracy of member contact and demographic information. Additionally, CHG summarized how the MCP applied lessons learned from both 2017–19 PIPs.

2020–21 Recommendations

Based on the overall assessment of CHG's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020 that CHG assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate CHG's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix L:
Performance Evaluation Report
Contra Costa Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Contra Costa Health Plan ("CCHP" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that CCHP provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in CCHP's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CCHP is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in CCHP, the Local Initiative MCP, or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, the alternative commercial plan.

CCHP became operational in Contra Costa County to provide MCMC services effective February 1997. As of June 2021, CCHP had 206,625 members.[1] This represents 87 percent of the beneficiaries enrolled in Contra Costa County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Follow-Up on 2019 A&I Medical Audit

A&I conducted a Medical Audit of CCHP from April 8, 2019, through April 19, 2019, covering the review period of June 1, 2018, through March 31, 2019. HSAG provided a summary of the audit results and status in CCHP's 2019–20 MCP-specific evaluation report. At the time the 2019–20 MCP-specific evaluation report was published, CCHP's CAP was in progress and under DHCS' review. A letter from DHCS dated May 19, 2021, stated that CCHP provided DHCS with additional information regarding the CAP, and that DHCS had evaluated the information and closed the CAP. The letter indicated that DHCS would continue to assess the overall effectiveness of the CAP and determine the extent to which the MCP has operationalized the proposed corrective actions during the subsequent audit.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CCHP. HSAG's compliance review summaries are based on final audit reports issued and CAP closeout letters dated on or before the end of the review period for this report (June 30, 2021).

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of CCHP. A&I conducted the audits from August 17, 2020, through August 28, 2020. A&I assessed CCHP's compliance documentation and determined to what extent the MCP had implemented its CAP from the 2019 Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CCHP
Audit Review Period: May 1, 2019, through April 30, 2020

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	Yes	CAP in process and under review.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

CCHP provided documentation to DHCS that resulted in DHCS closing the CAP from the 2019 Medical Audit. Additionally, A&I identified no findings in the State Supported Services category during the 2020 State Supported Services Audit.

Opportunities for Improvement—Compliance Reviews

CCHP should work with DHCS to ensure the MCP satisfactorily resolves the findings from the 2020 A&I Medical Audit. During the 2020 Medical Audit, A&I identified 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 should thoroughly review all findings and implement the actions recommended by A&I.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of CCHP, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Contra Costa Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid rates. The auditor noted that based on the prior year's recommendation, CCHP made incremental improvements to its enrollment span determination to ensure that dual eligible members remain in Medi-Cal reporting during the months in which they are not covered by primary insurance through Medicare or commercial insurers. While CCHP revised its process, during primary source verification on members who were excluded from reporting, the auditor determined that the MCP improperly excluded some members. To ensure the MCP accurately excludes enrollment spans, CCHP should update its 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. This process change will require CCHP to populate key data elements associated with the member's date of death and non-Medicaid enrollment spans.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for CCHP's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.
- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Nov 2, 2021.

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:

- *Child and Adolescent Well-Care Visits—Total*
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	42.09%	Not Comparable
Childhood Immunization Status—Combination 10	51.34%	51.34%	0.00

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Developmental Screening in the First Three Years of Life—Total	24.38%	21.68%	-2.70
Immunizations for Adolescents—Combination 2	50.85%	43.80%	-7.05
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	91.11%	84.18%	-6.93
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	75.91%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	76.64%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	56.69%	Not Comparable
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	—	69.85%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
CCHP—Contra Costa County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	4	75.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	68.86%	**58.33%**	-10.53
*Cervical Cancer Screening^*	68.37%	68.06%	-0.31
Chlamydia Screening in Women—Ages 16–20 Years	61.73%	57.55%	-4.18
Chlamydia Screening in Women—Ages 21–24 Years	76.63%	68.99%	-7.64
Chlamydia Screening in Women—Total	68.36%	62.81%	-5.55
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.76%	2.79%	-0.97
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.09%	4.70%	-1.39
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	20.09%	18.34%	-1.75
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.98%	25.52%	-2.46
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	15.56%	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	4.65%	10.12%	5.47
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	33.68%	31.11%	-2.57
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.34%	20.62%	1.28
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	15.79%	25.56%	9.77
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	18.01%	21.99%	3.98

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	57.89%	57.78%	-0.11
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	46.56%	46.19%	-0.37
*Prenatal and Postpartum Care—Postpartum Care^*	88.08%	90.97%	2.89
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	93.43%	93.40%	-0.03

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
CCHP—Contra Costa County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	19	42.11%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	62.59%	63.07%	0.48
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	41.17%	41.01%	-0.16
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**79.41%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	47.23%	51.63%	4.40

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	53.03%	62.50%	9.47
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	66.67%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	42.22%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	42.22%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	18.49%	16.35%	-2.14
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	39.72%	20.07%	-19.65
Screening for Depression and Follow-Up Plan—Ages 65+ Years	38.80%	18.32%	-20.48

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
CCHP—Contra Costa County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	7	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	7	42.86%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	52.90	36.45	Not Tested
Asthma Medication Ratio—Total	60.48%	63.93%	3.45
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	37.71%	**38.93%**	1.22
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.15%	8.48%	-0.67
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	64.96%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.26%	8.16%	-2.10
Plan All-Cause Readmissions—Expected Readmissions—Total	10.22%	9.89%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.00	0.83	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.25%	3.37%	-0.88
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
CCHP—Contra Costa County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of CCHP's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains CCHP—Contra Costa County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	16	6.25%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	37	10.81%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	16	18.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	14	37	37.84%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of CCHP's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

CCHP conducted two PDSA cycles to improve the MCP's performance on the *Asthma Medication Ratio—Total* measure.

For the first PDSA cycle, CCHP planned to test whether conducting phone outreach to members with recent asthma-related acute visits to enroll them into the asthma home visiting program would improve the *Asthma Medication Ratio—Total* measure rate. The MCP indicated that the county experienced drastic changes in staffing resources due to COVID-19. These staffing changes resulted in the registered nurse who was originally slated to conduct the intervention being pulled from the project to support vaccine clinic needs. CCHP indicated that the MCP began onboarding and training a newly hired community health worker; however, limited staffing resources impacted the MCP's ability to launch the intervention.

For the second PDSA cycle, CCHP tested whether member outreach by either text messages, emails, or phone calls would improve the *Asthma Medication Ratio—Total* measure rate. The purpose of the outreach was to encourage members to contact their providers to schedule a visit to discuss their asthma, including medications. CCHP reported that the intervention did not lead to improvement in the overall SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim; however, the MCP revealed that after looking at different measures to evaluate early indicators of progress, it noted some improvement in the controller medications filled by the intervention population. CCHP indicated learning that the scope for this PDSA cycle was too wide, resulting in the MCP being unable to develop measures and collect data in a way that allowed the MCP to quickly see results and adapt the intervention based on those results. CCHP indicated that for the next PDSA cycle, the MCP will focus on working with a limited number of high-volume providers to test data reports that identify patients with an asthma medication ratio of less than .50 (using HEDIS criteria), and CCHP will work more closely with these providers on best practices for improving members' medication regimens.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, CCHP reported:

- Collaborating with clinics to conduct targeted outreach to members due for a well-child visit to encourage them to complete their well-child visit appointments and any needed immunizations and provide them a gift card incentive for attending a well-child visit or immunization appointment. Of 1,296 outreach calls made, the MCP and clinics reached 1,048 members, and 391 members attended their scheduled appointments. CCHP indicated that it experienced staffing resource challenges due to staff being assigned to COVID-19 activities. The MCP reported that it continues to discuss next steps for improving well-child visit attendance. CCHP also noted the importance of using multiple forms of outreach, including mailings, phone calls, and text messages amid the continuing COVID-19 pandemic to prevent decreased well-child visit attendance and increase preventive care appointment utilization.
- Sending 4,984 letters to parents of pediatric members to address concerns about attending well-child visits during COVID-19. The letter contained information about how to request help for setting up the online scheduling application, how to reach the CCHP Advice Nurse Line, and where to go for more updates. CCHP noted that while this intervention required less staff, the MCP had challenges assessing the intervention's effectiveness. CCHP determined that partnering with the provider delivery system and conducting other interventions in tandem with the letter (e.g., making outreach calls, sending texts, and offering incentives) would result in more successful outcomes.
- Planning to pilot providing in-home, cellular-enabled glucose monitors to members whose most recent HbA1c reading was 9.0 or greater to allow these members to manage their diabetes at home. The MCP indicated that the program experienced delays due to pending changes to the Medi-Cal pharmacy benefit. CCHP reported learning that provider buy-in is important for program success and that it should make integrating interventions into providers' already-existing frameworks an easy process. CCHP plans to offer the in-home, cellular-enabled glucose monitors to eligible members assigned to select provider partners, and the MCP will also review the most recent HEDIS data to identify members eligible for the monitors.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In CCHP's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
CCHP—Contra Costa County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	58.17	34.01	Not Tested	36.45
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.35%	7.68%	1.67	8.16%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only. For CCHP, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for this measure.

Strengths—Performance Measures

The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for CCHP:

- The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was above the high performance level.
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the following measures showed statistically significant improvement from measurement year 2019 to measurement year 2020:
  - *Asthma Medication Ratio—Total*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years*
  - *Plan All-Cause Readmissions—Observed Readmissions—Total*

Opportunities for Improvement—Performance Measures

To ensure the MCP accurately excludes enrollment spans, CCHP should update its 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. This process change will require CCHP to populate key data elements associated with the member's date of death and non-Medicaid enrollment spans.

Across all domains, three of 16 measures for which HSAG compared rates to benchmarks (19 percent) were below the minimum performance levels. For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, CCHP's performance declined significantly for 14 of 37 measures (38 percent). The MCP has the most opportunities for improvement in the Women's Health domain, with one measure in this domain having a rate below the minimum performance level and the MCP's performance declining significantly for eight measures.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, CCHP should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

CCHP determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—diabetes control among members who reside in specific regions of Contra Costa County.

HSAG validated modules 1 and 2 for the MCP's *Diabetes Control* Health Equity PIP. Upon initial review of Module 1, HSAG determined that CCHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CCHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CCHP met all validation criteria for Module 2 in its initial submission.

CCHP's *Diabetes Control* Health Equity PIP SMART Aim measures the percentage of members living in specific regions of Contra Costa County who have an HbA1c level greater than 9.0 percent. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CCHP's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

CCHP determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, CCHP selected well-child visits for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits* PIP. Upon initial review of Module 1, HSAG determined that CCHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim run chart.

- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, CCHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. CCHP met all validation criteria for Module 2 in its initial submission.

CCHP's *Well-Child Visits* PIP SMART Aim measures the percentage of African-American members ages 3 to 6 years who complete their annual well-child visit. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in CCHP's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

CCHP successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. CCHP has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on CCHP's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

CCHP submitted the MCP's PNA report to DHCS on August 12, 2021, and DHCS notified the MCP via email on August 16, 2021, that DHCS approved the report as submitted. While CCHP submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with CCHP's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By 2022, increase the number of providers who talk to members regarding ways to prevent illnesses.	No	Unknown	Continuing into 2021
2	Increase the number of providers who ask members about tobacco use.	No	Unknown	Ended in 2020
3	By 2022, reduce emergency room visits for anxiety.	No	Better	Continuing into 2021
4	By 2022, increase providers' knowledge about how to access interpreter services and increase the provider access survey rating.	No	Better	Continuing into 2021
5	By 2021, increase Kaiser Spanish-speaking members' knowledge about available interpreter services.	No	Better	Ended in 2020
6	By 2022, reduce the Cesarean deliveries rate for African-American members assigned to a specific regional medical center.	Yes	Better	Ended in 2020
7	By 2022, decrease the number of members who are not aware of the Advice Nurse Line.	No	Unknown	Changing for 2021
8	By 2022, increase the percentage of health education services and materials that meet members' needs.	No	Better	Continuing into 2021

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	Decrease the percentage of obese members with an HbA1c level greater than 9.0 who reside in specific regions of Contra Costa County.	Yes	New in 2021
2	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	New in 2021
3	In 2022, improve the percentage of members screened for depression and follow-up.	No	New in 2021
4	By 2022, increase the number of providers who talk to members regarding ways to prevent illnesses.	No	Continued from 2020
5	By 2022, reduce emergency room visits for anxiety.	No	Continued from 2020
6	By 2022, increase providers' knowledge about how to access interpreter services and increase the provider access survey rating.	No	Continued from 2020
7	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	Changed from 2020
8	By 2022, increase the percentage of health education services and materials that meet members' needs.	No	Continued from 2020

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from CCHP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of CCHP's self-reported actions.

Table 6.1—CCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve all findings from the 2019 A&I Medical Audit, paying particular attention to the repeat findings in the Member's Rights category.	CCHP has been actively recruiting and training program managers to assist CCHP operational units with performing internal monitoring of key compliance areas. CCHP completed self-audits for July 2020 through December 2020. For 2021, the MCP has initiated quarterly self-monitoring to ensure that repeated findings are addressed along with other contractual requirements. CCHP has been actively working with the DHCS Compliance Unit to refine and amend proposed corrective actions to avoid repeat findings.
2. Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.	CCHP will calculate monthly determinations of eligibility to minimize the discrepancies encountered for measurement year 2020. The MCP's information technology/business intelligence units and the quality improvement team meet regularly. CCHP is awaiting final measure specifications from its vendor, Cotiviti, and once received, the MCP will work with the vendor to implement the monthly eligibility determination and understand how

2019–20 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	the vendor will process the exclusions desired by the MCP.
3. Monitor the continued and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Controlling Blood Pressure* Disparity PIP and *Diabetes Nephropathy Screening* PIP.	The interventions tried have not been continued. CCHP conducted a deep dive into the data, realized that there was a greater disparity by region, and has focused the next PIP on that. CCHP also learned that the coaching/care management strategies worked well in the last PIP, so the MCP has a dedicated diabetes care manager working with members with diabetes and has partnered with a technology vendor to support patients in checking their blood glucose levels. CCHP is currently working with a small number of patients and collecting data on how often patients are checking their blood glucose and changes in HbA1c levels, and the MCP is identifying qualitative measures to understand improvements in quality of life among members enrolled in the program. If successful, CCHP will scale up this intervention.
4. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the continued and adapted interventions and to strengthen future quality improvement efforts.	CCHP has made several improvements to its PIP process. A summary is below: ♦ Established PIP improvement teams that meet weekly and that include quality and analytics staff; created a charter for the new PIPs; started using PDSA forms to track effectiveness of the smaller changes. ♦ In process—obtaining feedback directly from members to understand barriers/drivers to inform which changes to test; working on new reports to help the MCP track PIP performance on a monthly basis.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CCHP's self-reported actions in Table 6.1 and determined that CCHP adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. CCHP provided information regarding the following:

- Steps CCHP took to ensure full resolution of all findings from the 2019 A&I Medical Audit and monitoring processes the MCP has implemented to ensure compliance moving forward.
- A summary of what the MCP is doing to ensure dual eligible members are appropriately included and excluded in performance measure reporting.
- A description of the status of the interventions from the 2017–19 PIPs and a new intervention the MCP is testing.
- A list of the ways the MCP is applying lessons learned from the 2017–19 PIPs.

2020–21 Recommendations

Based on the overall assessment of CCHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- 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.
- To ensure the MCP accurately excludes enrollment spans, update its 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.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate CCHP's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix M:
Performance Evaluation Report
Family Mosaic Project
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted SHP, Family Mosaic Project ("FMP" or "the SHP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that FMP provides to its members. HSAG provides a summary of the SHP-specific results and findings for each activity and an assessment of the SHP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this SHP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in FMP's 2021–22 SHP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Specialty Health Plan Overview

FMP is an SHP which provides intensive case management and wraparound services for MCMC children and adolescents at risk of out-of-home placement in San Francisco County. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health Community Behavioral Health Services. To receive services from FMP, a beneficiary must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. FMP submits qualifying clients to DHCS for approval to be enrolled in FMP's MCMC. Once a client is approved and included under FMP's contract with DHCS, The SHP receives a per-member, per-month capitated rate to provide mental health and related wraparound services. Due to FMP's unique membership, some SHP contract requirements differ from the MCP contract requirements.

FMP became operational in San Francisco County to provide MCMC services effective December 1992. As of June 2021, FMP had 13 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

DHCS' Audits & Investigation Division (A&I) conducts triennial oversight reviews of specialty mental health services provided by each county mental health plan (MHP) to determine compliance with federal and State regulations as well as with the terms of the MHP contract. DHCS works closely with each MHP to ensure compliance and to identify opportunities for improvement. Using a collaborative and educational approach, DHCS provides guidance and technical assistance when it determines that the MHP is out of compliance. After the review, DHCS provides feedback related to areas of non-compliance. DHCS provides the MHP with a written report of findings which includes a description of each finding and a description of any corrective actions needed. Within 60 days of receiving the final report of findings, MHPs are required to submit to DHCS a corrective action plan (CAP) for all items that DHCS determined to be out of compliance. If an urgent issue is identified, the issue is addressed immediately.

DHCS did not conduct an oversight review of FMP directly during the review period for this report. The most recent review conducted by DHCS was a triennial on-site review of the San Francisco County MHP in April 2017. FMP is part of the Children, Youth, & Family System of Care operated by the San Francisco Department of Public Health Community Behavioral Health Services; therefore, FMP was included in the April 2017 review. HSAG included a summary of the April 2017 review in FMP's 2016–17 SHP-specific evaluation report.

3. Specialty Health Plan Performance Measures

Performance Measures Overview

Due to FMP's specialized population, DHCS determined that no CMS Core Set or Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures were appropriate for the SHP to report; therefore, for measurement year 2020, DHCS required FMP to continue reporting the same two measures the SHP reported for previous measurement years. In collaboration with DHCS and HSAG, the SHP designed the two measures to evaluate performance elements specific to FMP's specialized population.

DHCS-Established Performance Levels

No national benchmarks exist for the SHP-developed measures; therefore, DHCS did not establish performance levels for FMP.

Measurement Year 2020 Quality Monitoring

While for measurement year 2020 DHCS will require that all MCPs and PSPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019, based on FMP's limited number of members and its work with a specialized population, DHCS will not require the SHP to submit a COVID-19 QIP. Additionally, DHCS will not require the SHP to conduct any quality improvement projects related to performance measure results.

Performance Measure Validation Results

For measurement year 2020, DHCS required FMP to report two performance measures—*Promotion of Positive Pro-Social Activity* and *School Attendance*. Because neither measure is a HEDIS measure, HSAG conducted performance measure validation (PMV) for the two performance measures selected, calculated, and reported by the SHP. HSAG conducted the validation activities as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019.[3]

[2] HEDIS® is a registered trademark of NCQA.

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 27, 2020.

The *2021 Validation of Performance Measures Final Report of Findings for Family Mosaic Project* contains the detailed findings and recommendations from HSAG's PMV of the two measures that FMP reported. The HSAG auditor determined that FMP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating FMP's performance measure rates, HSAG assessed the results. See Table 3.1 for FMP's performance measure results for measurement years 2017, 2018, 2019, and 2020. Note that FMP had less than 30 beneficiaries during all four measurement years as depicted in Table 3.1, resulting in an "NA" audit designation for each performance measure.

Table 3.1—Multi-Year Performance Measure Results
FMP—San Francisco County

Measurement year 2017 rates reflect data from January 1, 2017, through December 31, 2017

Measurement year 2018 rates reflect data from January 1, 2018, through December 31, 2018.

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.

NA = The SHP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 2017 Rate	Measurement Year 2018 Rate	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
School Attendance	NA	NA	NA	NA	Not Comparable
Promotion of Positive Pro-Social Activity	NA	NA	NA	NA	Not Comparable

Measurement Year 2019 Quality Monitoring

While for measurement year 2019 DHCS required that all MCPs and PSPs, regardless of performance, conduct a Plan-Do-Study-Act (PDSA) cycle and submit a COVID-19 QIP, based on FMP's limited number of members and its work with the specialized population, DHCS did not require the SHP to submit a COVID-19 QIP.

Strengths—Performance Measures

The HSAG auditor determined that FMP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on performance measure results, HSAG identified no opportunities for improvement for FMP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.

    - Final key driver diagram.
- MCMC plans provide narrative summaries to address the following:
    - Project conclusions.
    - Intervention testing conclusions.
    - Plans for spreading successful intervention(s), as applicable.
    - Challenges encountered.
    - Lessons learned and information gained.
    - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Note that based on FMP's limited number of members and its specialized population, DHCS approved FMP to select the 2020–22 PIP topics based on SHP-specific data rather than requiring FMP to identify topics related to the two required topic categories.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the SHP's module submissions for the 2020–22 PIPs, as well as HSAG's validation findings from the review period.

Reducing Anxiety Symptoms Performance Improvement Project

FMP determined to resume the SHP's 2019–21 PIP topic for its 2020–22 PIP—reducing anxiety symptoms.

HSAG validated Module 1 for the SHP's *Reducing Anxiety Symptoms* PIP. FMP met all validation criteria for Module 1 in its initial submission.

FMP's *Reducing Anxiety Symptoms* PIP SMART Aim measures the percentage of members with initial Child and Adolescent Needs and Strengths (CANS) scores of 2 or 3 on the Anxiety item whose scores decrease by at least one point by the subsequent CANS assessment. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in FMP's 2021–22 SHP plan-specific evaluation report.

Improving Family Functioning Performance Improvement Project

FMP determined to resume the SHP's 2019–21 PIP topic for its 2020–22 PIP—improving family functioning.

HSAG validated Module 1 for the SHP's *Improving Family Functioning* PIP. Upon initial review of the module, HSAG determined that FMP met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the SMART Aim. After receiving technical assistance from HSAG, FMP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the SHP met all validation criteria for Module 1.

FMP's *Improving Family Functioning* PIP SMART Aim measures the percentage of members with initial CANS scores of 2 or 3 on the Family Functioning item whose scores decrease by at least one point by the subsequent CANS assessment. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in FMP's 2021–22 SHP plan-specific evaluation report.

Strengths—Performance Improvement Projects

FMP successfully met all validation criteria for Module 1 for both PIPs. The validation findings show that the SHP built a strong foundational framework for both PIPs. FMP has progressed to Module 2 for both PIPs, in which the SHP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Opportunities for Improvement—Performance Improvement Projects

Based on FMP's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Due to the size and type of population that FMP serves, DHCS does not require the SHP to conduct a PNA.

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from FMP's July 1, 2019, through June 30, 2020, SHP-specific evaluation report, along with the SHP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of FMP's self-reported actions.

Table 6.1—FMP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, SHP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to FMP	Self-Reported Actions Taken by FMP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Apply the lessons learned from the 2017–19 *Reducing Physical Health Issues* PIP and *Improving Client Access and Use of Recreational Activities* PIP to facilitate improvement for future PIPs.	One of the key lessons learned was to develop ways to identify physical health needs/concerns at the time of intake. A member is assigned behavioral support services in the beginning of treatment. Members complete an assessment which targets areas of physical health and recreational activities. The support person then discusses these action items with the family and clinical team which leads to goal development related to the identified needs/concerns.

Assessment of SHP's Self-Reported Actions

HSAG reviewed FMP's self-reported actions in Table 6.1 and determined that FMP adequately addressed HSAG's recommendation from the SHP's July 1, 2019, through June 30, 2020, SHP-specific evaluation report. Specifically, FMP described a key lesson learned from the 2017–19 PIPs and how the SHP is applying the lesson learned.

2020–21 Recommendations

Based on the overall assessment of FMP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the SHP.

In the next annual review, HSAG will evaluate FMP's continued successes.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix N:
Performance Evaluation Report
Gold Coast Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Gold Coast Health Plan ("GCHP" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that GCHP provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in GCHP's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

GCHP is a full-scope MCP delivering services to its members in the County Organized Health System model.

GCHP became operational to provide MCMC services in Ventura County effective July 2011. As of June 2021, GCHP had 222,219 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for GCHP in 2019 for the review period of April 1, 2018, through March 31, 2019. HSAG included a summary of these audits in GCHP's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of GCHP during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of GCHP from August 2, 2021, through August 6, 2021, for the review period of April 1, 2019, through May 31, 2021. HSAG will include a summary of these audits in GCHP's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of GCHP, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Gold Coast Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that GCHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for GCHP's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both Well-Child Visits in the First 30 Months of Life measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 25, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
GCHP—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	30.89%	Not Comparable
Childhood Immunization Status—Combination 10	42.09%	39.66%	-2.43
Developmental Screening in the First Three Years of Life—Total	32.43%	36.03%	3.60
Immunizations for Adolescents—Combination 2	37.96%	41.85%	3.89
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	94.89%	88.32%	-6.57
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	72.26%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	69.10%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	21.28%	Not Comparable
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	—	67.83%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
GCHP—Ventura County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
GCHP—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	61.84%	**57.29%**	-4.55
*Cervical Cancer Screening^*	64.23%	**56.69%**	-7.54
Chlamydia Screening in Women—Ages 16–20 Years	48.84%	46.88%	-1.96
Chlamydia Screening in Women—Ages 21–24 Years	64.87%	59.37%	-5.50
Chlamydia Screening in Women—Total	56.02%	**52.72%**	-3.30
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.01%	2.94%	-1.07
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.94%	5.92%	-1.02
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.55%	16.41%	-2.14
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	29.65%	25.80%	-3.85
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.55%	2.92%	1.37
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	25.75%	28.04%	2.29
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	17.90%	18.05%	0.15
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.02%	8.69%	-0.33
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	45.51%	50.47%	4.96
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	43.34%	41.03%	-2.31
*Prenatal and Postpartum Care—Postpartum Care^*	86.86%	88.81%	1.95
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	97.32%	90.02%	-7.30

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
GCHP—Ventura County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	19	5.26%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	9	19	47.37%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
GCHP—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	63.18%	57.94%	-5.24
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	46.78%	42.56%	-4.22
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	32.73%	28.78%	-3.95
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	33.75%	29.58%	-4.17
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.64%	8.70%	7.06

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	1.00%	8.68%	7.68
Screening for Depression and Follow-Up Plan—Ages 65+ Years	1.65%	4.55%	2.90

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures
- HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
GCHP—Ventura County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results GCHP—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	43.85	29.74	Not Tested
Asthma Medication Ratio—Total	50.09%	**48.52%**	-1.57
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	32.85%	**40.88%**	8.03
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.29%	14.37%	-1.92
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	54.26%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.43%	8.28%	-0.15
Plan All-Cause Readmissions—Expected Readmissions—Total	9.03%	9.61%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.93	0.86	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.70%	3.66%	-1.04
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.

- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings GCHP—Ventura County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	6	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	6	16.67%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of GCHP's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures

- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains GCHP—Ventura County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	14	7.14%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	36	16.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	14	35.71%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	13	36	36.11%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of GCHP's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

GCHP conducted two PDSA cycles to improve the MCP's performance for the *Asthma Medication Ratio—Total* measure.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, using an asthma-specific script, GCHP's bilingual health navigators conducted telephonic member outreach to a target population to assess members' asthma medication use, promote the importance of attending routine appointments for medication

review, and link members with the care management team, if needed. The *Asthma Medication Ratio—Total* measure rate for the target population improved, and the intervention helped the MCP identify targeted areas for future interventions. GCHP reported receiving positive feedback from members and seeing an increase in the number of members receiving coordination of care from the MCP's care management team.

The MCP indicated that the timing of the intervention was such that changes the members made would likely not be reflected in the *Asthma Medication Ratio—Total* measure rate until measurement year 2021. Additionally, GCHP indicated that the MCP had challenges reaching members due to incorrect phone numbers or mailing addresses and members not returning calls. GCHP determined to modify the intervention to be led by providers rather than the MCP.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, GCHP conducted secondary outreach to the 126 members who were successfully contacted in the first PDSA cycle to determine whether the initial outreach led to improvement in these members' medication regimens and asthma management. The MCP successfully reached 59 of these members. Although the MCP did not reach its goal for the PDSA cycle, it reported some improvement in the *Asthma Medication Ratio—Total* measure rate.

GCHP indicated that the MCP continued to have challenges reaching members due to incorrect phone numbers or members not answering their phones or returning calls. Additionally, the MCP noted that members did not use the asthma educational materials made available in the clinic setting, and some members indicated they did not think a provider visit was required because their asthma was under control. GCHP determined to abandon this intervention and move forward with new projects, including offering asthma exam member incentives and collaborating with the MCP's Health Education Department health navigators to evaluate members with asthma for participation in the Chronic Disease Self-Management Program.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, GCHP reported:

- Collaborating with local health departments, school districts, and community partners to conduct member outreach via a mailing to parents and guardians of children 0 to 6 years of age regarding the importance of immunizations and lead screening. The outreach information also included GCHP's well-child visit member incentive flyer. GCHP reported sending out 15,624 screening letters, inviting a provider group to present about child lead screening at a Quality Improvement Collaborative meeting, and partnering with Ventura County Public Health to distribute provider education packets on blood lead screening during Lead Poisoning Prevention Week. GCHP noted that members postponed scheduling routine preventive screening appointments due to fear of COVID-19 infection and that the MCP distributed several publications to members throughout 2020 which provided

information about preventive screenings, telehealth visits, and the importance of preventive care during COVID-19.

- Having bilingual health navigators conduct telephonic outreach to children and adults ages 5 to 64 years with a less than 50 percent ratio of controller medications to total asthma medications. The outreach focused on two groups—members living in Oxnard City with a health disparity who were non-compliant with their asthma medications, and members not living in Oxnard City who were non-compliant with their asthma medications. GCHP started the outreach in Quarter 4 of 2020, which may not have allowed enough time for the intervention to positively affect the measurement year 2020 *Asthma Medication Ratio—Total* measure rate. The MCP noted that members were in denial of their asthma diagnosis or symptoms, lacked interest in receiving education, or were difficult to reach due to inaccurate or inactive phone numbers.
- Partnering with a behavioral health and substance use disorder organization that allowed GCHP members free access to the organization's myStrength and mental wellness resources, which offer a variety of topics to support members and their families in coping with stress, isolation, and parental challenges exacerbated by COVID-19. The MCP promoted these resources to members via GCHP's member website, GCHP's quarterly member newsletter, the local newspaper, and radio advertisements that were broadcast in both English and Spanish. The MCP indicated that it could not inform members via email of the available resources due to the data the MCP receives from the State not including members' email addresses. GCHP also noted that the behavioral health and substance use disorder organization only made the resources available to the MCP's members for a limited time.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In GCHP's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations GCHP—Ventura County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	56.77	28.41	Not Tested	29.74
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.50%	7.58%	3.92	8.28%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only. The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that GCHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for GCHP:

- The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was above the high performance level.
- The rates for the following measures improved significantly from measurement year 2019 to measurement year 2020:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years*
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years*
  - *Developmental Screening in the First Three Years of Life—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Opportunities for Improvement—Performance Measures

GCHP has the greatest opportunity for improvement in the Women's Health domain, with the MCP performing below the minimum performance level for three measures in this domain and nine measures with rates that declined significantly from measurement year 2019 to measurement year 2020.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, GCHP should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

GCHP determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—cervical cancer screening in Area 5 (which includes Oxnard and Port Hueneme).

HSAG validated Module 1 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the module, HSAG determined that GCHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.

After receiving technical assistance from HSAG, GCHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

GCHP's *Cervical Cancer Screening* Health Equity PIP SMART Aim measures the percentage of female members, ages 24 to 29 years, who were assigned to the PIP clinic partner and completed cervical cancer screenings. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in GCHP's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

GCHP determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—adolescent well-care visits.

HSAG validated modules 1 through 3 for the MCP's *Adolescent Well-Care Visits* PIP. GCHP met all validation criteria for modules 1 through 3 in its initial submission. The PIP SMART Aim measures the percentage of members ages 12 to 17 years who are assigned to the PIP clinic partner and receive well-care visits.

Table 4.1 presents a description of the intervention that GCHP selected to test for its *Adolescent Well-Care Visits* PIP. The table also indicates the key driver and failure modes that the intervention aims to address. Key drivers are factors identified in the key driver diagram that are thought to influence the achievement of the SMART Aim. Failure modes, which are identified as a result of a failure modes and effects analysis, are ways or modes in which something might fail. They include any errors, defects, gaps, or flaws that may occur now or could occur in the future.

Table 4.1—GCHP *Adolescent Well-Care Visits* PIP Intervention Testing

Intervention	Key Driver Addressed	Failure Modes Addressed
A comprehensive outreach program that includes calling members to promote the well-care visit member incentive program to engage adolescent members ages 12 to 17 years who are assigned to the PIP clinic partner to schedule their well-care visits	♦ Member education, awareness, and engagement	♦ Parents/guardians forget to schedule members' well-care visits ♦ Parents/guardians are not assessed for barriers that prevent access to primary care providers (PCPs) (e.g., child care, work, transportation) ♦ Members go to their PCPs only for acute and/or chronic conditions (e.g., cold/flu, injury, asthma) ♦ Members never see their PCPs

During the review period, GCHP began intervention testing and will continue intervention testing through the SMART Aim end date of December 31, 2022. In GCHP's 2021–22 MCP-specific evaluation report, HSAG will include information regarding GCHP's intervention testing and any technical assistance HSAG provides to the MCP. HSAG will include a summary of the PIP outcomes in GCHP's 2022–23 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

GCHP successfully met all validation criteria for Module 1 for the *Cervical Cancer Screening* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Cervical Cancer Screening* Health Equity PIP. GCHP has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

GCHP successfully met all validation criteria for modules 1, 2, and 3 for the *Adolescent Well-Care Visits* PIP. The validation findings show that the MCP built a strong foundational framework, used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim, established an intervention plan for the intervention to be tested for the *Adolescent Well-Care Visits* PIP, and progressed to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on GCHP's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

GCHP submitted the MCP's PNA report to DHCS on June 28, 2021, and DHCS notified the MCP via email on June 30, 2021, that DHCS approved the report as submitted.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with GCHP's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By December 31, 2020, increase awareness about the Chronic Disease Self-Management Program among members diagnosed with diabetes, hypertension, heart disease, and asthma.	No	Better	Continuing into 2021
2	By December 31, 2020, 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	Worse	Continuing into 2021
3	By December 31, 2020, increase the rate for the *Chlamydia Screening in Women—Total* measure to meet or exceed the DHCS minimum performance level.	No	Worse	Continuing into 2021
4	By December 31, 2020, increase the percentage of children who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	No	Worse	Ended in 2020
5	By December 31, 2020, implement a health education campaign to promote well-child visits and immunizations among children ages 0 to 24 months.	No	Worse	Continuing into 2021
6	By December 31, 2020, implement a diabetes education program for Latinos living in the Ventura/Santa Paula area and decrease the percentage of members diagnosed with diabetes.	Yes	Worse	Changing for 2021

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
7	By December 31, 2020, implement an awareness campaign of language access services among providers and members to increase the percentage of providers who are able to address health literacy for shared decision making and improve communication with members.	No	Unknown	Continuing into 2021
8	By December 31, 2020, implement a childhood obesity and health education campaign on reducing sugary drinks among children living in the Port Hueneme and Oxnard areas.	Yes	Unknown	Ended in 2020
9	By December 31, 2020, increase awareness of access to care among members seeking routine medical services with PCPs and specialists.	No	Unknown	Ended in 2020

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	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	Continued from 2020
2	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	Continued from 2020
3	By December 31, 2021, increase the percentage of cervical cancer screenings among women 21 to 64 years of age.	No	New in 2021
4	By December 31, 2021, increase the percentage of breast cancer screenings among women 50 to 74 years of age.	No	New in 2021
5	By December 31, 2021, implement a hypertension education program for members with hypertension to increase the percentage of members 18 to 85 years of age with controlled blood pressure (<140/90 mm Hg).	No	New in 2021
6	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).	Yes	Changed from 2020
7	Implement a provider cultural competency training and increase awareness among providers.	No	Continued from 2020
8	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	Continued from 2020

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from GCHP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of GCHP's self-reported actions.

Table 6.1—GCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the adopted and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Diabetes Poor HbA1c Control* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP.	**Monitor the adopted and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs:** At the conclusion of both 2017–19 PIPs in June 2019, the Quality Improvement Department continued to monitor performance for both measures. For measurement year 2019, the MCAS updates replaced the *Childhood Immunization Status—Combination 3* measure with *Childhood Immunization Status—Combination 10*, which expanded the monitoring and reporting of all childhood immunizations. **Impact of the COVID-19 Pandemic** The measurement years 2019 and 2020 rates and percentile comparisons show that both rates declined in measurement year 2020, and this was primarily due to the COVID-19 pandemic. It was challenging for both the MCP and health care providers to sustain the improvements achieved for both measures, as clinics restructured their workflows to maintain patient safety during the public health crisis, and members chose to defer routine care due to the statewide social

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	distancing and stay-at-home mandates, or from fear of catching the COVID-19 virus. Actions taken during the period of July 1, 2020, through June 30, 2021, that addressed both the EQR recommendations and the decline in care during the COVID-19 pandemic are listed below. **Both measures: *Childhood Immunization Status—Combination 10* and *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*** Provider Rate and Gap Reports ♦ Annual provider report cards ■ The Quality Improvement Department distributed annual MCAS provider report cards, which summarize clinic-level rates for each MCAS measure, with benchmarks on applicable measures, to compare performance against established standards and help providers identify opportunities for improvement. ♦ Monthly provider MCAS rate reports, including dashboards and member-level gap reports. ■ In 2020, the Quality Improvement Department transitioned to a new prospective provider reporting system. The previous reports were delivered three times per year and included only a current rate and gap report. In June 2020, a new advanced analytics reporting system was launched using Inovalon INDICES Provider Insights Dashboards, a portal where providers can view monthly performance of their MCAS measures, including member- and clinic-level data for monitoring current and projected measure performance against trends and benchmarks, and manage care gaps. The new system improves access to reports and enables performance monitoring and identification of

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	care gaps to help improve performance rates and outcomes. Provider MCAS Reference Documents ♦ To promote provider awareness on the specific MCAS measures used to evaluate performance, the Quality Improvement Department continued to update the MCAS reference documents annually. The reference documents include: ■ MCAS measure tips sheets. ■ MCAS frequently asked questions. ■ MCAS reference guides. ***Childhood Immunization Status—Combination 10*** Health Education Material ♦ The Quality Improvement and Health Education/Cultural Linguistics Departments collaborated on the development of a "0–3-Year-Old Well-Care Visits: What to Expect" flyer to increase parent/guardian awareness on the importance of annual well-care exams and promote the American Academy of Pediatrics Bright Futures periodicity schedule for well-care exams, immunizations, blood lead screenings, and developmental screenings. The development of the health education flyer included field testing with community partners to receive feedback and recommendations on the design and messaging of the health education materials. ♦ The GCHP Health Education Resources webpage was updated to add the new "0–3-Year-Old Well-Care Visits: What to Expect" flyer. Gap Closure Outreach Campaigns in 2020 and 2021 ♦ 2020 Preventive Care Mail Campaign (Ages 0 to 6) ■ Member outreach via direct mail. ■ Preventive care letter to parents/guardians focused on the importance of completing

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	immunizations, lead screening, and well-care exams for children 0 to 6 years of age. ■ Preventive care outreach letters were mailed November 2, 2020. ♦ 2021 Preventive Care Live Agent Telephone Campaign (Ages 0 to 4) ■ Member outreach via telephone. ■ Preventive care outreach to parents/guardians focused on the importance of completing immunizations, lead screening, and well-care exams in children 0 to 4 years of age. Three-way calls were conducted to facilitate appointment scheduling. ■ Outreach period: April 2021 to July 2021. Provider Education/Awareness Campaigns ♦ "DHCS Resources for Addressing Childhood Immunizations During COVID-19" Provider Operations Bulletin, July 2020. ♦ "Prioritizing Immunizations and Well-Child Visits When Reopening Your Pediatric Medical Practice During the COVID-19 Pandemic" Provider Operations Bulletin, July 2020. ♦ "Guidance on Telehealth for Well-Child Visits During COVID-19" Provider Operations Bulletin, July 2020. ♦ "Well-Child and Immunization Visits" Provider Operations Bulletin, October 2020. ♦ "New California Immunization Registry Provider Immunization Report" provider email, November 17, 2020. ♦ "Return to Care" promoting the 2021 outreach campaign to the parents/guardians of children 0 to 3 years of age to complete well-care visits, immunizations, and blood lead screenings, Provider Operations Bulletin, June 2021.

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	Health-Theme Gap Reports ♦ In addition to the monthly provider reporting available in INDICES, in 2021, the Quality Improvement Department scheduled the distribution of several health-themed provider rate/gap reports that coincide with national health awareness months. The focused care gap reports target measures that were most impacted by the COVID-19 pandemic and assist providers with identifying members who may have one or more care gaps in a focus area such as child health and women's health. In the summer of 2021, the Quality Improvement Department distributed a well-child-themed gap report which identified children and adolescents tied to the two *Well-Child Visits in the First 30 Months of Life* measures and *Child and Adolescent Well-Care Visits—Total* measure. ***Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*** Lab Data Improvement Initiative ♦ The Quality Improvement Department collaborated with internal departments and external lab vendors to evaluate solutions for improving the reporting of lab services by transitioning to a member-centric reporting process. Member-centric data capture was achieved for Quest Diagnostics. Member-centric data capture is currently being pursued with LabCorp. Health Education Material ♦ The Quality Improvement and Health Education/Cultural Linguistics Departments collaborated on the development of a "My Diabetes Exam Record" form for members to record and schedule annual diabetes screenings. This was mailed to all members identified as having a diagnosis of diabetes.

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	Provider Education/Awareness Campaigns ♦ "Managing Diabetes during COVID-19" provider email, June 2020. ♦ "Managing Diabetes during COVID-19" Provider Operations Bulletin, July 2020. ♦ "Diabetes Awareness Month" Provider Operations Bulletin, November 2020. ♦ "Diabetes Awareness Month" Provider email, November 2020. ♦ "Diabetes Awareness Month" Building Community newsletter, December 2020. Member Education/Awareness Campaigns ♦ The GCHP Health Education Resources webpage was updated to include the following diabetic resources for members to manage their diabetes: ■ The GCHP "My Diabetes Exam Record" ■ Diabetes Health Library ■ American Diabetes Association ■ Centers for Disease Control and Prevention Member Outreach During Diabetes Awareness Month 2020 ♦ In November 2020, the Health Education Department mailed the "My Diabetes Exam Record" to 6,094 members diagnosed with diabetes. ♦ In November 2020, the Health Education Department conducted telephonic outreach to recruit diabetic members into the Chronic Disease Self-Management Program. ***Member Outreach During COVID-19*** ♦ GCHP's Chronic Disease Self-Management Program ■ This program is managed by the Health Education Department and focuses on helping members with chronic diseases, such as

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	diabetes, gain self-confidence in taking charge of their health and managing their chronic conditions by attending workshops aimed at teaching long-term health management skills that include making action plans, healthy eating, physical activity and exercise, and medication usage. ■ During COVID-19, the workshops continued to be offered online and telephonically. ♦ Vulnerable Population Outreach Program ■ Due to the COVID-19 pandemic, many community organizations that supported vulnerable populations, such as home health services, Community-Based Adult Services centers, and food pantries were temporarily closed and could not provide the services on which the vulnerable populations relied. The pandemic also increased the risk of the disruption of care for vulnerable populations receiving outpatient and/or long-term care services, such as home health, skilled nursing facilities/long-term care, local regional centers, dialysis centers, and California Children's Services children receiving specialty care. This created the immediate need to create an outreach program to assist GCHP's vulnerable population to transition to alternative resources and services and ensure continuity of care. ■ GCHP developed the Vulnerable Population Outreach program that was conducted telephonically by bilingual GCHP health navigators and care managers. The outreach calls by health navigators included providing information about alternative resources for members such as food pantries, meal delivery services, durable medical equipment, referral to GCHP's care management clinicians, GCHP's 24-Hour Nurse Advice Line, linking to county resources, and assisting with appointment scheduling. Outreach calls by care managers included ensuring clinical care needs were being

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	met and not disrupted due to the COVID-19 pandemic.
2. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the interventions and to strengthen future quality improvement efforts.	**Stakeholder Collaborations with Clinic Systems and Community Agencies** An important takeaway from both 2017–19 PIPs was that performance improvements often require multi-pronged approaches and ongoing assessments of interventions to evaluate their effectiveness with improving performance. The responses to Recommendation 1 summarized the multiple interventions that were utilized to facilitate improvement. Additionally, working with clinic partners on these focused projects has underscored the importance of collaborating on shared objectives to improve outcomes. Collaborations with internal and external stakeholders, clinic systems, and community partners has become an integral part of facilitating improvement of interventions and strengthening quality improvement efforts. **Quarterly Quality Improvement Collaborations** In 2020, the Quality Improvement Department began organizing Quality Improvement Collaboration meetings three times per year to create a forum for GCHP's Quality Improvement Department to meet with affiliates from GCHP's provider network (e.g., medical directors, quality improvement managers, clinic managers, and administrators) to achieve the following objectives: ♦ Establish a positive forum to facilitate information sharing and feedback exchange for the mutual benefit of GCHP and clinical plan partners. ♦ Build partnerships and support to improve quality metrics and member health outcomes for GCHP members. ♦ Work collaboratively to develop strategies to solution challenges and achieve improved quality of care and services for GCHP members.

2019–20 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	♦ Facilitate best practice sharing across the clinic systems to support efficiency, innovation, and performance improvement. ♦ Provide a forum to disseminate legislative updates related to quality improvement and discuss implementation strategies. ♦ Identity opportunities to partner with external stakeholders to improve member outcomes. **Collaborations with Community Partners and Agencies** GCHP continued virtual collaborations with community partners to focus on shared objectives. ♦ Ventura County Public Health ♦ Child Health and Disability Prevention Program ♦ First 5/Help Me Grow Ventura **Forum to Address the Impact of COVID-19 on Health Care** The COVID-19 pandemic made it challenging for both the MCP and health care providers to sustain the improvements achieved for both measures, as clinics restructured their workflows to maintain patient safety and redirect care to COVID-19 needs during the public health crisis, and members chose to defer routine care due to the statewide social distancing and stay-at-home mandates, or from fear of catching the COVID-19 virus. The collaborative meetings became a valuable forum for the MCP and provider networks to continue to focus on current shared objectives in the health care realm while addressing the COVID-19 pandemic and sharing strategies, challenges, barriers, and successes with maintaining clinical care during the public health crisis.

Assessment of MCP's Self-Reported Actions

HSAG reviewed GCHP's self-reported actions in Table 6.1 and determined that GCHP adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. GCHP described in detail member- and provider-focused strategies and what the MCP aimed to achieve by implementing the various strategies. GCHP also provided its assessment of the impact of COVID-19 on the *Childhood Immunization Status—Combination 10* and *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure rates, including interventions the MCP implemented to address the impact.

2020–21 Recommendations

Based on the overall assessment of GCHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that GCHP assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate GCHP's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix O:
Performance Evaluation Report
Health Net Community Solutions, Inc.
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Health Net Community Solutions, Inc. ("Health Net" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Health Net provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Health Net's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Health Net is a full-scope MCP delivering services to its members as a commercial MCP under the Two-Plan Model and also under a Geographic Managed Care (GMC) model.

Health Net became operational in Sacramento County to provide MCMC services in 1994 and then expanded to additional contracted counties, the most recent being San Joaquin County, effective January 2013.

Health Net's Two-Plan Model

Table 1.1 shows the counties in which Health Net provided services to its members under the Two-Plan Model and denotes which MCP is the "Local Initiative." Beneficiaries may enroll in Health Net, the commercial MCP, or in the alternative Local Initiative.

Table 1.1—Local Initiative Plans under the Two-Plan Model in Counties in which Health Net Serves as the Commercial Managed Care Health Plan

County	Local Initiative Plan
Kern	Kern Health Systems, DBA Kern Family Health Care (KHS)
Los Angeles	L.A. Care Health Plan
San Joaquin	Health Plan of San Joaquin
Stanislaus	Health Plan of San Joaquin
Tulare	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan

Health Net's Geographic Managed Care Model

The GMC model currently operates in San Diego and Sacramento counties. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Health Net, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- Kaiser NorCal
- Molina Healthcare of California

In addition to Health Net, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan
- Community Health Group Partnership Plan
- Kaiser SoCal
- Molina Healthcare of California
- UnitedHealthcare Community Plan

Health Net's Enrollment

Table 1.2 shows the counties in which Health Net provides MCMC services, Health Net's enrollment for each county, the MCP's total number of members, and the percentage of beneficiaries in the county enrolled in Health Net as of June 2021.[1]

Table 1.2—Health Net Enrollment as of June 2021

County	Enrollment as of June 2021	Percentage of Beneficiaries in the County Enrolled in Health Net
Kern	71,977	19%
Los Angeles	988,714	30%
Sacramento	120,092	25%

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

County	Enrollment as of June 2021	Percentage of Beneficiaries in the County Enrolled in Health Net
San Diego	78,307	10%
San Joaquin	22,080	9%
Stanislaus	63,045	30%
Tulare	116,346	52%
Total	**1,460,561**	

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Health Net.

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of Health Net. A&I conducted the audits from April 26, 2021, through May 7, 2021. The Medical Audit was a limited-scope audit and did not include A&I review of the Administrative and Organizational Capacity category. Additionally, A&I examined the MCP's compliance with its DHCS contract and assessed Health Net's implementation of its closed CAP from the 2019 Medical Audit. DHCS issued the final audit reports on September 3, 2021, which is outside the review period for this report; however, HSAG includes the information from the reports because A&I conducted the on-site audits during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Health Net
Audit Review Period: May 1, 2019, through March 31, 2021

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Utilization Management, Case Management and Coordination of Care, Quality Management, and State Supported Services categories during the 2021 Medical and State Supported Services Audits of Health Net.

Opportunities for Improvement—Compliance Reviews

Health Net should work with DHCS to ensure that the MCP fully resolves the findings from the 2021 Medical Audit in the Access and Availability of Care and Member's Rights categories. The MCP should review A&I's recommendations and develop and implement policies and procedures that address the identified findings.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of Health Net, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Health Net Community Solutions, Inc.* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid rates; however, HSAG determined that Health Net's processes for identifying dual-eligible exclusions for the Medicaid population were incomplete, though the overall impact on reporting was minimal. To address the identified issue, the auditor recommended that Health Net update its exclusion methodology to ensure this methodology meets NCQA requirements to exclude dual-eligible Medicaid members with either (1) both Medicare Part A and Part B or (2) Medicare Part C coverage.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.63 for Health Net's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.63:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into

domains based on the health care areas each measure affects. Table 3.1 through Table 3.56 present the performance measure results and findings by domain, and Table 3.57 through Table 3.63 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.7 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 through Table 3.7:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Nov 4, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	32.93%	Not Comparable
Childhood Immunization Status—Combination 10	26.03%	**27.01%**	0.98
Developmental Screening in the First Three Years of Life—Total	55.09%	12.34%	-42.75
Immunizations for Adolescents—Combination 2	35.52%	**33.11%**	-2.41
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	72.99%	**72.26%**	-0.73
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**53.28%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**50.36%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	28.66%	Not Comparable
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	—	51.01%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	40.60%	Not Comparable
Childhood Immunization Status—Combination 10	27.98%	**34.31%**	6.33
Developmental Screening in the First Three Years of Life—Total	45.01%	18.71%	-26.30
Immunizations for Adolescents—Combination 2	41.36%	38.93%	-2.43
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	87.10%	82.73%	-4.37
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	74.70%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	72.51%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	40.41%	Not Comparable
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	—	64.77%	Not Comparable

Table 3.3—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	49.70%	Not Comparable
Childhood Immunization Status—Combination 10	32.36%	**34.31%**	1.95
Developmental Screening in the First Three Years of Life—Total	54.50%	36.61%	-17.89
Immunizations for Adolescents—Combination 2	41.61%	42.86%	1.25
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	86.86%	85.64%	-1.22
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	85.64%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	82.00%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	41.92%	Not Comparable
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	—	71.19%	Not Comparable

Table 3.4—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	43.98%	Not Comparable
Childhood Immunization Status—Combination 10	38.93%	42.34%	3.41
Developmental Screening in the First Three Years of Life—Total	58.60%	48.72%	-9.88
Immunizations for Adolescents—Combination 2	36.50%	**33.82%**	-2.68
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	86.37%	85.40%	-0.97
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	74.45%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	73.97%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	41.33%	Not Comparable
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	—	69.16%	Not Comparable

Table 3.5—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	28.51%	Not Comparable
Childhood Immunization Status—Combination 10	36.23%	**35.21%**	-1.02
Developmental Screening in the First Three Years of Life—Total	12.76%	23.16%	10.40
Immunizations for Adolescents—Combination 2	31.28%	**23.88%**	-7.40
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	85.89%	81.27%	-4.62
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**62.04%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**62.29%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	29.77%	Not Comparable
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	—	56.97%	Not Comparable

Table 3.6—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	28.44%	Not Comparable
Childhood Immunization Status—Combination 10	27.98%	**27.25%**	-0.73
Developmental Screening in the First Three Years of Life—Total	35.09%	17.48%	-17.61
Immunizations for Adolescents—Combination 2	27.74%	**34.31%**	6.57
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	82.97%	82.48%	-0.49
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**64.48%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**59.12%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	39.45%	Not Comparable
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	—	53.77%	Not Comparable

Table 3.7—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	43.89%	Not Comparable
Childhood Immunization Status—Combination 10	40.88%	45.50%	4.62
Developmental Screening in the First Three Years of Life—Total	27.43%	4.46%	-22.97
Immunizations for Adolescents—Combination 2	43.55%	44.28%	0.73
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	87.59%	89.54%	1.95
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	81.27%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	81.02%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	52.64%	Not Comparable
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	—	70.53%	Not Comparable

Findings—Children's Health Domain

Table 3.8 through Table 3.14 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.8 through Table 3.14:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.8—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.9—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.10—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.11—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.12—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.13—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.14—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Tulare County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.15 through Table 3.21 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.15—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	53.25%	**47.96%**	-5.29
*Cervical Cancer Screening^*	54.01%	**50.86%**	-3.15
Chlamydia Screening in Women—Ages 16–20 Years	42.11%	41.77%	-0.34
Chlamydia Screening in Women—Ages 21–24 Years	56.48%	54.48%	-2.00
Chlamydia Screening in Women—Total	49.36%	**48.09%**	-1.27
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.21%	2.04%	-0.17
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.62%	3.39%	-0.23

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.18%	12.79%	-1.39
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	22.09%	19.87%	-2.22
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	13.48%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.13%	8.29%	0.16
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.91%	6.00%	0.09
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.83%	40.63%	5.80
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	32.72%	36.51%	3.79
*Prenatal and Postpartum Care—Postpartum Care^*	67.64%	**73.48%**	5.84
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	88.56%	**82.97%**	-5.59

Table 3.16—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	62.13%	**57.29%**	-4.84
*Cervical Cancer Screening^*	61.06%	**53.40%**	-7.66
Chlamydia Screening in Women—Ages 16–20 Years	66.10%	65.52%	-0.58
Chlamydia Screening in Women—Ages 21–24 Years	71.78%	69.60%	-2.18
Chlamydia Screening in Women—Total	68.86%	67.52%	-1.34
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	1.59%	1.35%	-0.24
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.58%	3.30%	-0.28
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	11.30%	10.60%	-0.70
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.10%	19.12%	-1.98

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	1.59%	1.75%	0.16
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	2.02%	2.07%	0.05
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	7.37%	8.93%	1.56
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.58%	7.71%	0.13
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.46%	3.83%	1.37
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.10%	9.40%	-0.70
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	26.88%	26.63%	-0.25
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	29.89%	29.55%	-0.34
*Prenatal and Postpartum Care—Postpartum Care^*	66.91%	**74.70%**	7.79
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	86.13%	**84.67%**	-1.46

Table 3.17—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	56.04%	**49.48%**	-6.56
*Cervical Cancer Screening^*	51.09%	**58.15%**	7.06
Chlamydia Screening in Women—Ages 16–20 Years	69.97%	67.12%	-2.85
Chlamydia Screening in Women—Ages 21–24 Years	67.73%	62.44%	-5.29
Chlamydia Screening in Women—Total	68.97%	65.07%	-3.90
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.51%	2.54%	0.03
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.88%	4.41%	0.53

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.66%	14.11%	-0.55
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.68%	20.06%	-0.62
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	1.37%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	13.46%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.86%	11.04%	3.18
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.43%	5.76%	0.33
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	35.06%	32.69%	-2.37
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	28.32%	29.79%	1.47
*Prenatal and Postpartum Care—Postpartum Care^*	77.86%	**73.97%**	-3.89
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	91.48%	**86.37%**	-5.11

Table 3.18—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	55.08%	**49.83%**	-5.25
*Cervical Cancer Screening^*	51.82%	**50.12%**	-1.70
Chlamydia Screening in Women—Ages 16–20 Years	58.23%	49.07%	-9.16
Chlamydia Screening in Women—Ages 21–24 Years	64.50%	61.27%	-3.23
Chlamydia Screening in Women—Total	60.42%	**53.65%**	-6.77
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.31%	2.12%	-0.19
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.88%	3.29%	-0.59

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	17.34%	16.91%	-0.43
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	22.26%	19.87%	-2.39
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.43%	11.11%	0.68
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.52%	6.06%	-0.46
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	33.48%	32.32%	-1.16
*Prenatal and Postpartum Care—Postpartum Care^*	75.72%	**75.96%**	0.24
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	86.59%	**84.67%**	-1.92

Table 3.19—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	47.77%	**41.17%**	-6.60
*Cervical Cancer Screening^*	49.39%	**45.26%**	-4.13
Chlamydia Screening in Women—Ages 16–20 Years	60.19%	54.25%	-5.94
Chlamydia Screening in Women—Ages 21–24 Years	66.95%	57.07%	-9.88
Chlamydia Screening in Women—Total	63.74%	**55.51%**	-8.23

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	S	2.33%	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.92%	2.76%	-1.16
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.72%	12.88%	-1.84
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.45%	16.98%	-4.47
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S	7.48%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	25.45%	32.65%	7.20

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Prenatal and Postpartum Care—Postpartum Care^*	67.98%	**75.13%**	7.15
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	84.83%	**86.77%**	1.94

Table 3.20—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	58.82%	**51.91%**	-6.91
*Cervical Cancer Screening^*	54.26%	**55.75%**	1.49
Chlamydia Screening in Women—Ages 16–20 Years	47.92%	44.67%	-3.25

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Chlamydia Screening in Women—Ages 21–24 Years	67.86%	55.99%	-11.87
Chlamydia Screening in Women—Total	56.29%	**49.70%**	-6.59
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.17%	1.54%	-0.63
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.00%	2.93%	-1.07
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.22%	15.46%	-2.76
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.60%	21.85%	-3.75
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	19.35%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.98%	4.85%	-3.13
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	11.67%	8.89%	-2.78
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	41.94%	27.63%	-14.31

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.80%	37.37%	-5.43
*Prenatal and Postpartum Care—Postpartum Care^*	80.54%	80.29%	-0.25
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	85.89%	89.29%	3.40

Table 3.21—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	56.70%	**58.32%**	1.62
*Cervical Cancer Screening^*	68.04%	66.94%	-1.10
Chlamydia Screening in Women—Ages 16–20 Years	52.06%	55.25%	3.19
Chlamydia Screening in Women—Ages 21–24 Years	65.47%	67.44%	1.97
Chlamydia Screening in Women—Total	58.48%	61.09%	2.61
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.15%	2.56%	-0.59
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.34%	5.23%	-0.11
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.41%	17.28%	-1.13
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	31.39%	28.95%	-2.44
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	17.26%	12.28%	-4.98
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	12.14%	10.14%	-2.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.41%	8.04%	-0.37

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	49.40%	42.11%	-7.29
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	48.34%	44.57%	-3.77
*Prenatal and Postpartum Care—Postpartum Care^*	88.08%	86.37%	-1.71
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	94.40%	93.19%	-1.21

Findings—Women's Health Domain

Table 3.22 through Table 3.28 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.22 through Table 3.28:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- For San Diego and San Joaquin counties, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*

Table 3.22—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Table 3.23—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	19	5.26%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	19	42.11%

Table 3.24—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	19	15.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	19	21.05%

Table 3.25—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	15	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	15	26.67%

Table 3.26—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	15	6.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	15	33.33%

Table 3.27—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	9	19	47.37%

Table 3.28—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Tulare County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.29 through Table 3.35 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.29 through Table 3.35:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.29—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.56%	54.97%	4.41
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	34.64%	**37.82%**	3.18

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**73.60%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	21.70%	29.36%	7.66
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	52.56%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	34.62%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**33.33%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	0.22%	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.60%	0.45%	-0.15
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	S	S

Table 3.30—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.74%	**52.97%**	1.23
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.55%	**36.23%**	-0.32
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**81.84%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	26.85%	32.31%	5.46
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	29.35%	24.62%	-4.73

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	53.93%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	34.82%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**33.21%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.64%	10.70%	0.06
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	6.90%	5.48%	-1.42
Screening for Depression and Follow-Up Plan—Ages 65+ Years	7.56%	7.98%	0.42

Table 3.31—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG

suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	52.21%	**52.67%**	0.46
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.92%	**37.20%**	0.28
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	82.52%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	26.87%	28.78%	1.91
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	33.33%	42.42%	9.09
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	55.86%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	45.05%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	39.64%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.26%	1.32%	1.06

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.70%	2.25%	1.55
Screening for Depression and Follow-Up Plan—Ages 65+ Years	1.78%	S	S

Table 3.32—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.49%	57.65%	0.16
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	41.71%	41.07%	-0.64
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	82.62%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	33.77%	27.71%	-6.06
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	S	39.47%	S
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	53.25%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	45.45%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	38.96%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.84%	37.11%	26.27
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	13.20%	12.48%	-0.72
Screening for Depression and Follow-Up Plan—Ages 65+ Years	12.38%	12.85%	0.47

Table 3.33—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.86%	53.59%	-1.27
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.19%	**37.25%**	-0.94
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	89.47%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	S	NA	Not Comparable
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.00%	S	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.26%	0.92%	0.66
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	0.00%	0.00

Table 3.34—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	52.38%	53.78%	1.40
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	32.38%	**34.99%**	2.61
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**77.82%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	35.71%	34.53%	-1.18

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	35.56%	36.36%	0.80
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	59.02%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	42.62%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	39.34%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	1.05%	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S	0.15%	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	0.00%	S

Table 3.35—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	43.18%	**47.91%**	4.73
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	27.48%	**31.76%**	4.28
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**78.83%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	41.38%	42.86%	1.48

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	51.47%	50.98%	-0.49
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	58.39%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	43.62%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	42.28%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.79%	9.13%	8.34
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.32%	11.35%	11.03
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	13.96%	S

Findings—Behavioral Health Domain

Table 3.36 through Table 3.42 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.36 through Table 3.42:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- For San Joaquin County, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure in the calculations comparing measurement

year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

- For Kern and San Joaquin counties, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures
- For San Joaquin County, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.36—Behavioral Health Domain Measurement Year 2020 Performance Measure Findings Health Net—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	6	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	6	16.67%

Table 3.37—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	4	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Table 3.38—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Table 3.39—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.40—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	5	40.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.41—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.42—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Tulare County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	7	71.43%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	4	75.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.43 through Table 3.49 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.43 through Table 3.49:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.43—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.03	35.02	Not Tested
Asthma Medication Ratio—Total	50.64%	**52.88%**	2.24

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	35.77%	**41.32%**	5.55
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	20.64%	19.11%	-1.53
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	50.61%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.32%	8.03%	-1.29
Plan All-Cause Readmissions—Expected Readmissions—Total	9.24%	9.36%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.01	0.86	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.61%	3.67%	0.06
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.44—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	41.11	28.63	Not Tested
Asthma Medication Ratio—Total	59.07%	**60.72%**	1.65
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	33.58%	**45.55%**	11.97
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.90%	13.29%	-0.61
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	13.91%	14.45%	0.54
Controlling High Blood Pressure—Total	—	63.02%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.36%	9.43%	0.07

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Plan All-Cause Readmissions—Expected Readmissions—Total	9.20%	9.34%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.02	1.01	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.61%	3.52%	-0.09
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Table 3.45—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's

de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	50.52	37.62	Not Tested
Asthma Medication Ratio—Total	62.10%	63.28%	1.18
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	36.50%	**45.05%**	8.55
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.77%	8.54%	-1.23
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	NA	Not Comparable
Controlling High Blood Pressure—Total	—	49.88%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.59%	9.74%	-1.85
Plan All-Cause Readmissions—Expected Readmissions—Total	9.89%	9.76%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.17	1.00	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	8.75%	7.82%	-0.93
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.46—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	37.23	27.71	Not Tested
Asthma Medication Ratio—Total	68.45%	66.47%	-1.98
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	32.03%	**41.26%**	9.23
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.66%	11.35%	-0.31
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	20.00%	S	S
Controlling High Blood Pressure—Total	—	62.53%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.55%	7.65%	-2.90
Plan All-Cause Readmissions—Expected Readmissions—Total	9.46%	9.25%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.12	0.83	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	9.88%	9.93%	0.05
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Table 3.47—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.76	36.56	Not Tested
Asthma Medication Ratio—Total	61.29%	64.71%	3.42
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	38.20%	**41.33%**	3.13
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	10.50%	S	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Controlling High Blood Pressure—Total	—	56.69%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.76%	10.15%	0.39
Plan All-Cause Readmissions—Expected Readmissions—Total	9.51%	9.17%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.03	1.11	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.64%	S	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.48—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	50.98	39.16	Not Tested
Asthma Medication Ratio—Total	62.45%	**62.40%**	-0.05
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	37.23%	**42.27%**	5.04
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.15%	9.84%	-1.31
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	58.15%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.20%	8.93%	-1.27
Plan All-Cause Readmissions—Expected Readmissions—Total	9.49%	9.13%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.08	0.98	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.57%	5.13%	-0.44
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.49—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	36.43	26.77	Not Tested
Asthma Medication Ratio—Total	69.55%	71.70%	2.15
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	36.01%	36.72%	0.71
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.22%	12.49%	-1.73
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	63.50%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.12%	8.77%	0.65
Plan All-Cause Readmissions—Expected Readmissions—Total	8.89%	8.93%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.91	0.98	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	1.97%	1.75%	-0.22
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	0.00%	Not Comparable

Findings—Acute and Chronic Disease Management Domain

Table 3.50 through Table 3.56 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.50 through Table 3.56:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- For the following reporting units, HSAG did not include the *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Kern County
  - Sacramento County
  - San Joaquin County
  - Stanislaus County
- For the following reporting units, HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Kern County
  - Sacramento County
  - San Joaquin County
  - Stanislaus County
  - Tulare County
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*

- All three *Plan All-Cause Readmissions* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.50—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Health Net—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.51—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Health Net—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Table 3.52—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Health Net—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	5	20.00%

Table 3.53—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Health Net—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Table 3.54—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Health Net—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.55—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Health Net—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.56—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
Health Net—Tulare County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	6	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Performance Measure Findings—All Domains

Table 3.57 through Table 3.63 present a summary of Health Net's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.57 through Table 3.63:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

- For the following reporting units, HSAG did not include the *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Kern County
  - Sacramento County
  - San Joaquin County
  - Stanislaus County
- For San Diego and San Joaquin counties, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*
- For San Joaquin County, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- For Kern and San Joaquin counties, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.
- For the following reporting units, HSAG did not include the *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure were too small (less than 30) for the MCP to report valid rates:
  - Kern County

- Sacramento County
- San Joaquin County
- Stanislaus County
- Tulare County

- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Plan All-Cause Readmissions* measures
  - All three *Screening for Depression and Follow-Up Plan* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- For San Joaquin County, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.57—Measurement Year 2020 Performance Measure Findings for All Domains Health Net—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	34	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	15	16	93.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	34	14.71%

Table 3.58—Measurement Year 2020 Performance Measure Findings for All Domains Health Net—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	37	8.11%
Measurement Year 2020 Rates Below Minimum Performance Levels	11	16	68.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	11	37	29.73%

Table 3.59—Measurement Year 2020 Performance Measure Findings for All Domains Health Net—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	35	17.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	8	16	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	35	20.00%

Table 3.60—Measurement Year 2020 Performance Measure Findings for All Domains Health Net—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	33	6.06%
Measurement Year 2020 Rates Below Minimum Performance Levels	7	16	43.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	33	18.18%

Table 3.61—Measurement Year 2020 Performance Measure Findings for All Domains Health Net—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	15	6.67%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	29	13.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	11	15	73.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	29	20.69%

Table 3.62—Measurement Year 2020 Performance Measure Findings for All Domains Health Net—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	35	8.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	11	16	68.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	35	28.57%

Table 3.63—Measurement Year 2020 Performance Measure Findings for All Domains Health Net—Tulare County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	7	36	19.44%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	16	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	36	11.11%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Note that during the review period for this report, Health Net was one of the MCPs DHCS required to meet quarterly via telephone with its assigned DHCS nurse consultant to enable DHCS to continue monitoring the MCP's performance.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were

required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Health Net's SWOT analysis and COVID-19 QIP. Note that while MCPs and PSPs submitted their final SWOT analysis information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Strengths, Weaknesses, Opportunities, Threats Analysis Summary

Health Net reported that it implemented the following quality improvement strategies related to its SWOT analysis, which targeted all measures in Kern County with rates below the minimum performance levels:

- Using a systems barrier identification tool with high-volume providers in Kern County to identify root causes of poor HEDIS performance, identifying interventions based on a root cause analysis, and implementing the interventions. Health Net conducted training about HEDIS and the MCAS measures for all provider office staff, as well as an office manager training about how to succeed in quality, HEDIS, and performance improvement. Health Net indicated that the primary barriers it encountered were providers being unable to schedule training before or after the holidays and providers being challenged with transitioning staff responsibilities. Health Net reported that the intervention implementation is still in progress.
- Collaborating with the highest-volume participating physician group (PPG) in Kern County to conduct provider training about HEDIS and the MCAS measures. Health Net conducted the training during the PPG's monthly provider forum and during joint provider visits. The MCP indicated that the PPG was unable to schedule any joint provider visits at the end of 2020. Additionally, Health Net reported that providers were hesitant to schedule trainings around the holidays. Health Net stated that it is unclear whether the PPG will include the joint provider visits in its 2021 strategy, although Health Net indicated plans to move forward with MCAS training for providers in 2021.
- To improve encounter submissions from the highest-volume PPG in Kern County, identifying the root cause of the problem and implementing a CAP with the PPG to monitor the timeliness and volume of encounter submissions. Health Net indicated that the PPG initially had technical issues with encounter submissions in addition to staffing challenges while the lead staff member was on leave. Health Net stated that the MCP continues to monitor the timeliness and volume of encounter submissions via the PPG's CAP.

- Partnering with the Local Initiative plan in Kern County, KHS, to identify common barriers and develop a plan to collaboratively address the barriers. The two MCPs focused on the *Child and Adolescent Well-Care Visits—Total* measure and telehealth for preventive care visits. Health Net and KHS developed a co-branded telehealth and well-care visit provider flyer and formed a plan to jointly train providers on well-care visits and telehealth using the flyer as a resource. Additionally, the two MCPs met biweekly to identify other measures and common barriers and to develop interventions as needed. Finally, Health Net and KHS began developing a strategic plan to improve HEDIS rates for each federally qualified health center in Kern County, which are the highest-volume providers. Although the collaboration with KHS was progressing, due to its organizational reprioritization, KHS determined to postpone further collaboration with Health Net. This collaboration may proceed in the future.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Health Net reported conducting multiple interventions.

Outreach Interventions to Improve Performance on Multiple Child and Adolescent Measures

Health Net conducted two interventions:

- 2020 HEDIS Household Live Call Outreach: From July 14, 2020, through December 23, 2020, Health Net conducted outreach calls to households with two to four pediatric members due for immunizations included in the *Childhood Immunization Status—Combination 10* measure and/or due for a well-care visit. Health Net reported success with reaching members and that most members reached either already had an appointment scheduled or indicated intentions to schedule an appointment. The MCP noted that a very small percentage of members reached needed help with scheduling an appointment.
- Member Connections Health Net Household Outreach: From April 2020 through January 2021, the MCP conducted outreach calls to households in Kern, San Joaquin, and Stanislaus counties with two or more members ages 3 to 18 years who had not completed their annual well-care visit. Health Net reported success with reaching members and that most members reached indicated they planned to schedule their child's well-care visit or that their child had already completed the visit. The MCP reported assisting some parents/guardians with scheduling the appointments and that the percentage needing assistance was higher than for similar outreach efforts conducted earlier in 2020.

Health Net reported delays in implementing the outreach interventions due to COVID-19 stay-at-home orders and the effects of COVID-19 on providers' ability to schedule appointments. For the 2020 HEDIS Household Live Call Outreach intervention, the MCP indicated plans to use a provider readiness survey to identify providers' ability to schedule well-care visit appointments and to assign members to new providers when needed. The MCP also will evaluate this intervention to determine if changes are needed. For the Member Connections Health Net Household Outreach intervention, Health Net indicated it will make no changes to

the intervention and will continue working to develop a process to track identified member barriers and shared community resources to better understand and address the needs of the target population.

Promotion of Telehealth Visits

Health Net encouraged members to establish and maintain strong relationships with their primary care providers (PCPs) and take advantage of telehealth services offered by their PCPs. Health Net partnered with telehealth vendors to deliver virtual acute and chronic care to members so they could receive needed care without having to go into public spaces during COVID-19. Health Net targeted members in all counties who were due for a preventive care appointment, who needed help managing a chronic condition, or who had a behavioral health care need that could be met via a telehealth visit. Health Net also provided financial and technical support to provider organizations to assist with development of clinic-based, virtual primary care visits. The MCP reported that telehealth utilization data suggest a potential positive impact on *Comprehensive Diabetes Care* and *Controlling High Blood Pressure—Total* measure rates.

Health Net reported that some providers were delayed in adopting technical platforms for telehealth visits and that some members were uncomfortable using telehealth as a method of health care. The MCP noted a need for a telehealth member communication strategy that promotes completion of services specific to identified care gaps rather than general telehealth visit promotion.

Health Net indicated that the MCP offered on-demand, virtual language interpretation at a number of clinic sites and that in February and March 2021, the MCP launched a member text messaging campaign in English and Spanish as well as a marketing campaign via email and flyers to promote telehealth visits. Health Net also noted that the MCP is working on strategies to improve accessibility to specialty care visits that address member barriers to seeking care.

COVID-19 Education

Via the myStrength digital support program, Health Net launched a set of COVID-19-specific cognitive and behavioral modules to help members process uncertainty, maintain connection while social distancing, and keep perspective during the COVID-19 crisis. Between March 2020 and January 2021, Health Net reported a steady increase in the number of members accessing myStrength; however, few members chose the COVID-19 modules to view. Instead, members more often chose modules focused on anxiety and depression. Through weekly email newsletters, Health Net encouraged myStrength participants to use the COVID-19 modules.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Health Net's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.64 through Table 3.70 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.64—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Health Net—Kern County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	68.32	32.17	Not Tested	35.02
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.75%	7.19%	2.56	8.03%

Table 3.65—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Health Net—Los Angeles County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	49.09	27.14	Not Tested	28.63
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.99%	8.45%	4.54	9.43%

Table 3.66—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Health Net—Sacramento County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	70.17	34.30	Not Tested	37.62
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.28%	8.75%	2.53	9.74%

Table 3.67—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Health Net—San Diego County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	53.84	26.06	Not Tested	27.71
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.30%	6.31%	5.99	7.65%

Table 3.68—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Health Net—San Joaquin County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be calculated because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	73.19	34.05	Not Tested	36.56
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	9.68%	Not Comparable	10.15%

Table 3.69—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Health Net—Stanislaus County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	67.29	37.03	Not Tested	39.16
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.67%	7.38%	5.29	8.93%

Table 3.70—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Health Net—Tulare County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	52.91	25.22	Not Tested	26.77
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.53%	7.88%	3.65	8.77%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

For reporting units for which HSAG could compare measurement year 2020 SPD rates to measurement year 2020 non-SPD rates:

- For Kern County, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020 for Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for Health Net across all domains and reporting units:

- The following measures for which HSAG compared rates to benchmarks had rates above the high performance levels:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* in San Joaquin County
  - *Prenatal and Postpartum Care—Postpartum Care* in Tulare County
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* in Sacramento County
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* in Sacramento and Tulare counties
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 25 rates showed statistically significant improvement from measurement year 2019 to measurement year 2020.

Opportunities for Improvement—Performance Measures

Health Net has the opportunity to ensure the MCP'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.

Across all domains and reporting units, 67 of 111 rates for which HSAG compared rates to benchmarks (60 percent) had rates below the minimum performance levels. Additionally, for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, Health Net's performance declined significantly from measurement year 2019 to measurement year 2020 for 49 of 239 rates (21 percent). Health Net has the greatest opportunities for improvement in the Women's Health domain, with 27 of 67 rates below the minimum performance levels (40 percent) and 36 of the 49 rates for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020 (73 percent) being in this domain.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, Health Net should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Health Net's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in Los Angeles and San Diego counties, DHCS required that Health Net report rates for four HEDIS measures that HSAG validated as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 and Table 4.2 present the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results Health Net—Los Angeles County

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	78.68	60.04	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	13.91%	14.82%	0.91
Plan All-Cause Readmissions—Expected Readmissions—Total	11.46%	12.04%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.21	1.23	Not Tested

Table 4.2—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results Health Net—San Diego County

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MLTSSP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	56.19	54.09	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	NA	Not Tested
Plan All-Cause Readmissions—Expected Readmissions—Total	NA	NA	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	NA	NA	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

Health Net determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, Health Net identified breast cancer screening among Russian members in Sacramento County as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated modules 1 and 2 for the MCP's *Breast Cancer Screening* Health Equity PIP. Upon initial review of Module 1, HSAG determined that Health Net met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the narrowed focus baseline specifications and data collection methodology. After receiving technical assistance from HSAG, Health Net incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Health Net met all validation criteria for Module 2 in its initial submission.

Health Net's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of Russian members living in Sacramento County who complete their breast cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Health Net's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Health Net determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—childhood immunizations.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunizations* PIP. Upon initial review of Module 1, HSAG determined that Health Net met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.

After receiving technical assistance from HSAG, Health Net incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Health Net met all validation criteria for Module 2 in its initial submission.

Health Net's *Childhood Immunizations* PIP SMART Aim measures the percentage of members turning 18 months of age assigned to the PIP provider partner who complete the following immunizations:

- Three doses of hepatitis B (HepB)
- Two or three doses of rotavirus (RV)
- Two doses of influenza (flu)

This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Health Net's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

Health Net successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. Health Net has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Health Net's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Health Net submitted the MCP's final PNA report to DHCS on August 10, 2021, and DHCS notified the MCP via email on August 11, 2021, that DHCS approved the report as submitted. While Health Net submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Health Net's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2021, the Health Education Department will increase utilization of the myStrength program.	No	Better	Changing for 2021
2	By June 30, 2021, the Cultural and Linguistic Services Department will train 80 percent of all health plan staff in provider-facing departments to increase awareness of available language assistance program services and resources.	No	Better	Ended in 2020
3	By June 30, 2021, see a statistically significant increase in the percentage of cervical cancer screenings among females ages 51 to 64 years in Sacramento County who are assigned to the targeted high-volume provider.	Yes	Unknown	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 30, 2022, the Health Education Department will increase annual utilization of the myStrength program.	No	Changed from 2020
2	By June 30, 2022, the Cultural and Linguistics Services Department will increase utilization of video remote	No	New in 2021

#	Objective Summary	Health Disparity (Yes/No)	Status
	interpreting services to support member language needs.		
3	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	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from Health Net's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of Health Net's self-reported actions.

Table 7.1—Health Net's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual-eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.	Health Net is working with NCQA to determine any required actions to address the process used to remove Medicare prime members from the HEDIS warehouse for reporting to DHCS. The expected rate change is immaterial and only impacts the *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure.
2. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Cervical Cancer Screening* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP.	Three primary interventions that were implemented throughout 2020 after the PIP concluded included: ♦ The HEDIS Live Call Multi-Care Gap Outreach intervention was deployed to target members who were non-compliant for at least two measures, including *Cervical Cancer Screening*, *Breast Cancer Screening—Total*, *Comprehensive Diabetes Care—HbA1c Testing*, *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total*, and *Controlling High Blood Pressure—Total*.

2019–20 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	♦ The Medi-Cal Member Reward Cards Program was launched for non-compliant members and included educational interactive voice response/email outreach to members non-compliant for their cervical cancer screening who had not activated their Member Rewards account. ♦ The One Stop Clinics Program was designed to address multiple gaps in care by partnering with providers and clinics to hold clinic days during extended hours. Childhood immunizations combination status interventions included: ♦ Multimodal Member Incentive Program: The program informs members' parents about gift cards they can earn for completing their child's well-care visits. ♦ Reactive Immunization HEDIS Calls: Live calls to households that include a member who has not completed the recommended immunizations by 18 months. Any open pediatric care gaps of other family members are also addressed during the call. ♦ Pfizer Monthly Mailing: 12-month reminder/birthday postcard to remind parents of their child's 12-month check-up and vaccinations.
3. Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.	*Cervical Cancer Screening* Disparity PIP Status: For this PIP, Health Net implemented a prescription form for a cervical cancer screening that was given to members to encourage them to schedule an appointment with their cervical cancer screening provider. The clinic partner did not have the bandwidth to continue the program due to the effects of the COVID-19 pandemic. The clinic reported that it felt the largest impact from the PIP intervention was health education for its staff.

2019–20 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	Previously, before the PIP interventions, clinic staff did not feel comfortable discussing the importance of cervical cancer screenings with members. Now that their comfort level has increased, the clinic staff is an integral part of making the member feel comfortable through health education to schedule their cervical cancer screening appointment. In 2020, using the best practices gained from the PIP interventions, the Health Net provider engagement team expanded their interactions with providers to include cervical cancer screening health education and best practices to help provider staff encourage members to schedule their cervical cancer screening appointment. The *Childhood Immunization Status—Combination 3* PIP tested a two-part immunization incentive, providing members with a point-of-care gift card for being up to date with their vaccinations at 12 months and by 24 months. Health Net found that the clinic partner did not have the capacity to effectively manage the two-part incentive program, leading to inconclusive results. In 2020, using lessons learned, Health Net simplified and expanded the member incentive program by implementing a multimodal member incentive program.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Health Net's self-reported actions in Table 7.1 and determined that Health Net adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. HSAG identified the following notable actions taken by the MCP in response to the 2019–20 EQRO recommendations:

- Working with NCQA to confirm what actions the MCP needs to take to ensure that it is appropriately including and excluding dual-eligible members for performance measure reporting.
- Developed and implemented interventions following the conclusion of the 2017–19 PIPs to continue building on successful outcomes achieved during PIP implementation.
- Worked with provider partners to apply the lessons learned from the 2017–19 PIPs.

2020–21 Recommendations

Based on the overall assessment of Health Net's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves the findings from the 2021 Medical Audit in the Access and Availability of Care and Member's Rights categories. The MCP should review A&I's recommendations and develop and implement policies and procedures that address the identified findings.
- To ensure Health Net's processes for identifying dual-eligible exclusions for the Medicaid population are complete, update 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.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate Health Net's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix P:
Performance Evaluation Report
Health Plan of San Joaquin
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Health Plan of San Joaquin ("HPSJ" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that HPSJ provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in HPSJ's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

HPSJ is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in HPSJ, the Local Initiative MCP, or in Health Net Community Solutions, Inc., the alternative commercial plan.

HPSJ became operational in San Joaquin County to provide MCMC services effective February 1996 and in Stanislaus County effective January 2013. As of June 2021, HPSJ had 233,330 members in San Joaquin County and 145,429 in Stanislaus County—for a total of 378,759 members.[1] This represents 91 percent of the beneficiaries enrolled in San Joaquin County and 70 percent in Stanislaus County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for HPSJ in 2019 for the review period of July 1, 2018, through June 30, 2019. HSAG included a summary of these audits in HPSJ's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of HPSJ during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of HPSJ from December 6, 2021, through December 17, 2021, for the review period of July 1, 2019, through June 30, 2021. HSAG will include a summary of these audits in HPSJ's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of HPSJ, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Health Plan of San Joaquin* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that HPSJ followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.18 for HPSJ's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.18:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.16 present the performance measure results and findings by domain, and Table 3.17 and Table 3.18 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 and Table 3.2 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 and Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 31, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	40.68%	Not Comparable
Childhood Immunization Status—Combination 10	41.61%	**36.01%**	-5.60
Developmental Screening in the First Three Years of Life—Total	17.43%	25.66%	8.23
Immunizations for Adolescents—Combination 2	46.47%	44.04%	-2.43
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	86.37%	**76.89%**	-9.48

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**65.21%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**62.77%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	45.82%	Not Comparable
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	—	65.96%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	34.87%	Not Comparable
Childhood Immunization Status—Combination 10	30.66%	**32.60%**	1.94
Developmental Screening in the First Three Years of Life—Total	12.49%	25.25%	12.76
Immunizations for Adolescents—Combination 2	33.82%	**35.52%**	1.70
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	86.37%	**78.10%**	-8.27
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**56.20%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**47.20%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	39.93%	Not Comparable
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	—	63.35%	Not Comparable

Findings—Children's Health Domain

Table 3.3 and Table 3.4 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.3 and Table 3.4:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.3—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
HPSJ—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.4—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
HPSJ—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.5 and Table 3.6 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.5—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	55.89%	**51.71%**	-4.18
*Cervical Cancer Screening^*	63.99%	**58.64%**	-5.35
Chlamydia Screening in Women—Ages 16–20 Years	60.57%	55.34%	-5.23
Chlamydia Screening in Women—Ages 21–24 Years	70.83%	63.65%	-7.18
Chlamydia Screening in Women—Total	65.28%	59.27%	-6.01
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.26%	1.90%	-0.36
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.72%	4.41%	-0.31

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.58%	14.61%	-1.97
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.25%	28.42%	-1.83
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	0.87%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	7.65%	10.75%	3.10
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.63%	6.77%	0.14
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.72%	8.89%	1.17
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.97%	38.81%	3.84
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.83%	36.60%	-1.23
*Prenatal and Postpartum Care—Postpartum Care^*	79.56%	**75.43%**	-4.13
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	87.10%	**86.62%**	-0.48

Table 3.6—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	61.26%	**57.08%**	-4.18
*Cervical Cancer Screening^*	54.74%	**58.39%**	3.65
Chlamydia Screening in Women—Ages 16–20 Years	51.23%	47.87%	-3.36
Chlamydia Screening in Women—Ages 21–24 Years	68.53%	60.93%	-7.60
Chlamydia Screening in Women—Total	59.97%	**54.57%**	-5.40
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.26%	2.03%	-0.23
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.88%	4.04%	-0.84

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.20%	16.49%	-1.71
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.97%	26.06%	-2.91
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	11.79%	8.46%	-3.33
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.90%	8.89%	-1.01
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.06%	7.06%	-2.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	43.40%	41.79%	-1.61
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.67%	38.63%	-4.04
*Prenatal and Postpartum Care—Postpartum Care^*	79.81%	**75.43%**	-4.38
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	90.75%	**86.37%**	-4.38

Findings—Women's Health Domain

Table 3.7 and Table 3.8 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.7 and Table 3.8:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.7—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
HPSJ—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	19	31.58%

Table 3.8—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
HPSJ—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	19	52.63%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.9 and Table 3.10 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.9 and Table 3.10:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.9—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.97%	**50.17%**	-0.80
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	33.18%	**34.10%**	0.92

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**81.44%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	42.95%	42.71%	-0.24
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	56.98%	53.54%	-3.44
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	1.02%	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.24%	0.46%	0.22
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	S	S

Table 3.10—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.35%	54.31%	2.96
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	35.09%	39.69%	4.60
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**78.38%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	25.00%	39.22%	14.22

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	37.78%	58.93%	21.15
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.00%	1.89%	1.89
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.05%	0.06%	0.01
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	0.00%	0.00

Findings—Behavioral Health Domain

Table 3.11 and Table 3.12 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.11 and Table 3.12:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures;

therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

♦ For both reporting units, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.

Table 3.11—Behavioral Health Domain Measurement Year 2020 Performance Measure Findings HPSJ—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	3	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.12—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
HPSJ—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	7	57.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.13 and Table 3.14 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.13 and Table 3.14:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.13—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.82	35.66	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Asthma Medication Ratio—Total	59.49%	**55.58%**	-3.91
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	32.85%	**44.77%**	11.92
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	17.10%	13.28%	-3.82
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	55.23%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.76%	9.74%	1.98
Plan All-Cause Readmissions—Expected Readmissions—Total	9.77%	9.88%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.79	0.99	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.43%	1.92%	-1.51
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	0.00%	S

Table 3.14—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	52.19	39.59	Not Tested
Asthma Medication Ratio—Total	63.12%	**60.86%**	-2.26
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	35.77%	**47.45%**	11.68
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	21.13%	18.76%	-2.37
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	51.82%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.15%	9.13%	0.98

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Plan All-Cause Readmissions—Expected Readmissions—Total	9.52%	9.90%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.86	0.92	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.24%	2.99%	-1.25
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	0.00%	S

Findings—Acute and Chronic Disease Management Domain

Table 3.15 and Table 3.16 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.15 and Table 3.16:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.15—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings HPSJ—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	7	42.86%

Table 3.16—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings HPSJ—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.17 and Table 3.18 present a summary of HPSJ's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.17 and Table 3.18:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*

- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ For both reporting units, HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for this measure were too small (less than 30) for the MCP to report valid rates.

Table 3.17—Measurement Year 2020 Performance Measure Findings for All Domains HPSJ—San Joaquin County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	15	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	7	37	18.92%
Measurement Year 2020 Rates Below Minimum Performance Levels	13	15	86.67%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	37	27.03%

Table 3.18—Measurement Year 2020 Performance Measure Findings for All Domains HPSJ—Stanislaus County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	15	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	7	37	18.92%
Measurement Year 2020 Rates Below Minimum Performance Levels	13	15	86.67%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	12	37	32.43%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Note that during the review period for this report, HPSJ was one of the MCPs DHCS required to meet quarterly via telephone with its assigned DHCS nurse consultant to enable DHCS to continue monitoring the MCP's performance.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were

required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of HPSJ's SWOT analysis and COVID-19 QIP. Note that while DHCS required plans to submit their SWOT analysis and COVID-19 QIP information in August 2021, HPSJ submitted its information early. While the review period for this MCP-specific evaluation report ended June 30, 2021, HSAG includes the SWOT analysis and COVID-19 QIP information because it was available at the time this report was produced.

Strengths, Weaknesses, Opportunities, Threats Analysis Summary

HPSJ reported that it implemented the following quality improvement strategies related to its SWOT analysis, which focused on all performance measures in the Children's Health domain:

- Conducted the following trainings to targeted providers, with most being conducted virtually due to COVID-19 restrictions:
  - Navigation of the MCP's new integrated report system, which provides multi-level report functionality and identifies member gaps in care for targeted member outreach follow-up. HPSJ was able to create training videos, presentations, and reference materials about the use of this reporting system, including establishing trends and prioritizing outreach groups.
  - Webinars on clinical practices, technical specifications, and updates on standards related to improving children's preventive health. In March 2021, 103 providers participated in a lunch and learn session.
  - Developing processes and a clinic systems workflow related to member outreach, follow-up, and evaluation. HPSJ reported that the MCP facilitated 152 data reporting and 33 care gap finder trainings.
- Conducted the following outreach activities:
  - Developed and distributed children's preventive and health promotion materials and information about member incentives to providers and members.
  - Assisted providers with calling members about health care services related to children's health measures. HPSJ successfully reached 676 and 56 members during immunization and well-child visit outreach call initiatives, respectively. In addition, HPSJ used a member outreach and engagement vendor to conduct calls and other forms of member outreach for the well-child visit measures.

  - Established an audio library through HPSJ's website and added the library to the member portal so members can access information regarding children's health. HPSJ's health educators promoted this educational feature through newsletters and Web update alerts.
- Collaborated with community organizations to disseminate information and conduct trainings about children's preventive health services. Activities included the following:
  - During Community Advisory Committee meetings, conducted educational sessions about various children's health preventive topics.
  - Created a "Monday Kid's Day" social media campaign and posted weekly about children's health and preventive services via social media platforms.
  - Provided informational materials to local school districts to disseminate to parents on their digital platforms, during parent forums, and via blast emails.
  - Produced a radio spot about the importance of children's preventive care visits that aired on Radio Catolica. HPSJ plans to produce more radio spots on other topics, including children's immunizations and mental health.
- Collaborated with provider offices on efforts to increase the number of members accessing children's preventive health services, which included:
  - Supporting drive-up immunization and other care gap clinics.
  - Providing electronic downloadable member incentives for members completing preventive services.
  - Participating in clinic workflow strategy sessions with providers.
  - Coordinating Thursday preventive care clinics, resulting in the MCP closing 112 well-child visit care gaps from March 2021 to May 2021.
  - Working on a grant sponsorship for eligible providers to improve vaccination rates for high-risk members.
  - Partnering with local promotoras to improve member vaccination rates and to increase confidence in preventive office visits.
- Conducted assessments of provider workflow processes and provided feedback to the providers.
- Worked with individual providers to co-brand member outreach materials describing safe practices at clinic offices upon members' return to face-to-face preventive care appointments.

HPSJ reported that because of challenges related to COVID-19, the MCP learned to prioritize activities based on members' needs and risk factors.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, HPSJ reported:

- Conducting targeted outreach via phone using support from an outreach vendor and sending mailings to remind members in both San Joaquin and Stanislaus counties to schedule appointments for needed preventive services. The MCP reported that the success of the outreach efforts was affected by the increase in COVID-19 cases and the stay-at-home orders. HPSJ also noted that providers indicated that members were not attending preventive services appointments as consistently as they were prior to the COVID-19 pandemic.
- Implementing multiple interventions to improve access to telehealth appointments and preventive health screenings, including educating providers on telehealth and how to code/bill for the services, scheduling care gap clinics for members, offering mobile mammography clinics, offering diabetes screenings during a diabetes management clinic at a federally qualified health center (FQHC) in Stanislaus County, and scheduling women's health day screenings.
- Conducting provider education on various topics, including HEDIS updates and MCAS measures, telehealth, documentation and coding tips, best practices during COVID-19, and behavioral health resources. HPSJ reported conducting a virtual town hall meeting in collaboration with county public officers from both San Joaquin and Stanislaus counties. Additionally, the MCP continues to conduct provider education on topics related to MCAS measures and helpful resources via webinars, provider partnership meetings, and alerts through HPSJ's provider portal. Although providers have had to divert their resources to COVID-19 response efforts, HPSJ indicated that the MCP continues to advocate for improvement on MCAS measures by supporting providers' efforts to make preventive health services accessible to members.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In HPSJ's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.19 and Table 3.20 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.19—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
HPSJ—San Joaquin County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	63.32	33.44	Not Tested	35.66
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.32%	8.55%	3.77	9.74%

Table 3.20—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
HPSJ—Stanislaus County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	74.22	37.49	Not Tested	39.59
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.54%	8.98%	0.56	9.13%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

In measurement year 2020, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in San Joaquin County. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that HPSJ followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for HPSJ:

- Across all domains for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, both reporting units had seven of 37 rates (19 percent) that improved significantly from measurement year 2019 to measurement year 2020:
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total* in Stanislaus County
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years* in both reporting units
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years* in San Joaquin County
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years* in San Joaquin County
  - *Developmental Screening in the First Three Years of Life—Total* in both reporting units

- Both *Follow-Up Care for Children Prescribed ADHD Medication* measures in Stanislaus County
- *Screening for Depression and Follow-Up Plan—Ages 12–17 Years* in both reporting units
- *Screening for Depression and Follow-Up Plan—Ages 18–64 Years* in San Joaquin County
- *Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years* in both reporting units

Opportunities for Improvement—Performance Measures

HPSJ had many opportunities for improvement. Across all domains for rates that HSAG compared to minimum performance levels, both reporting units had 13 of 15 rates (87 percent) that were below the minimum performance levels in measurement year 2020. Additionally, across all domains for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the MCP's performance declined significantly from measurement year 2019 to measurement year 2020 for 10 of 37 measures in San Joaquin County (27 percent) and 12 of 37 measures in Stanislaus County (32 percent).

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, HPSJ should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

HPSJ determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—cervical cancer screening among White women, ages 24 to 64 years, residing in Stanislaus County.

HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of Module 1, HSAG determined that HPSJ met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, HPSJ incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. HPSJ met all validation criteria for Module 2 in its initial submission.

HPSJ's *Cervical Cancer Screening* Health Equity PIP SMART Aim measures the percentage of White women ages 24 to 64 years residing in Stanislaus County who were assigned to the PIP clinic partner and complete a cervical cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in HPSJ's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

HPSJ determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—adolescent well-care visits.

HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of Module 1, HSAG determined that HPSJ met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.

- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, HPSJ incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. HPSJ met all validation criteria for Module 2 in its initial submission.

HPSJ's *Adolescent Well-Care Visits* PIP SMART Aim measures the percentage of members ages 12 to 21 years residing in Stanislaus County who complete their well-care visits. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in HPSJ's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

HPSJ successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. HPSJ has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing it through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on HPSJ's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

HPSJ submitted the MCP's final PNA report to DHCS on August 27, 2021, and DHCS notified the MCP via email on September 28, 2021, that DHCS approved the report as submitted. While HPSJ submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with HPSJ's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2021, increase overall utilization of language assistance services by providers, members, and internal staff.	No	Worse	Continuing into 2021
2	By June 30, 2021, increase utilization of health education materials and resources as evidenced by visits to health education webpages, downloads of health education materials, and provision of health education materials through outreach teams.	No	Unknown	Changing for 2021
3	By June 30, 2021, expand population-level chronic disease management (e.g., asthma, diabetes, chronic obstructive pulmonary disease [COPD], and congestive heart failure) to include targeted engagement of low-risk members for health education messages. Low-risk member engagement will match current high-risk member engagement.	No	Unknown	Ended in 2020
4	By December 21, 2022, increase the cervical cancer screening compliance rate among White (Caucasian) members ages 24 to 64 years who reside in Stanislaus County to reduce or remove the statistical health disparity identified for this group.	Yes	Unknown	Continuing into 2021

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 30, 2023, increase overall utilization of language assistance by members, providers, and internal staff.	No	Changed from 2020
2	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	Changed from 2020
3	By June 30, 2022, implement a virtual diabetes prevention program with a vendor and have at least one complete cohort of members.	No	New in 2021
4	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	Changed from 2020

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from HPSJ's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of HPSJ's self-reported actions.

Table 6.1—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Cervical Cancer Screening* Disparity PIP.	The MCP has worked to shift its focus by engaging the larger of the two FQHCs in Stanislaus County in the subsequent 2020–22 *Cervical Cancer Screening* Health Equity PIP. We have identified that since this larger FQHC has most of the members who qualify for the *Cervical Cancer Screening* measure in its membership assignment, it is imperative that the FQHC work with the MCP to affect change. We had previously reached out to the FQHC for the 2017–19 PIP, and the FQHC was unable to assist at that time. As such, we continued our efforts in the interim to recruit the FQHC's aid in addressing this disparity. The FQHC has since been more amenable to the idea of working with the MCP on this project; however, COVID-19 created a staffing issue that has become a major setback in the planning. We are now working with the FQHC to see how the MCP can help reduce some of the operational barriers and get this project back on track.

2019–20 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
2. Apply lessons learned from the 2017–19 *Cervical Cancer Screening* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP to strengthen future quality improvement efforts.	*Childhood Immunization Status—Combination 3* PIP: The MCP has redoubled efforts regarding member outreach for various MCAS measures, including *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2*, in order to try to positively impact rates. This was especially important since it is more difficult to achieve compliance for the *Childhood Immunization Status—Combination 10* measure than the *Childhood Immunization Status—Combination 3* measure. This is mainly due to some barriers within our population, including general parental aversion to the influenza vaccine and also the tendency for members to miss important visits during the window for the rotavirus vaccine. Our providers have indicated some hardship when trying to educate members regarding the importance of vaccinations, as those who refuse often are adamantly against it until the child is school-aged, and then requires vaccines for entry into school. We have contracted with an engagement vendor and have had several MCAS-related campaigns. We also recently completed an Early and Periodic Screening, Diagnostic, and Treatment call and mailer campaign, which also reminded parents to talk to their doctors about any immunizations for which their children are due. The MCP also has continued Provider Partnership Program efforts and pushed the importance of using the Regional Immunization Data Exchange/California Immunization Registry and using billing/coding to capture vaccine data for HEDIS with the providers. Other education provided includes continuing to have meaningful discussions with the parents at each visit, and to ensure that any refusals are documented and a refusal form is signed by the parents.

2019–20 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	COVID-19 has presented some major setbacks statewide for vaccine efforts, and we have noted its impact in our two counties as well. We will continue our efforts to encourage members to care and encourage providers to educate and to improve their data. *Cervical Cancer Screening* PIP: The MCP has continued to work hard with other efforts, including our ongoing Provider Partnership Program, which has made some impact along the way. Efforts include provider education regarding best practice guidelines; provider data clean-up (e.g., providers submitting claims for services if rendered in-office, providers submitting exclusion codes if a member has a hysterectomy); and provider education regarding continued member education and reminders. Although we did not meet the SMART Aim for the 2017–19 *Cervical Cancer Screening* PIP, which ended June 30, 2019, we met the goal by December 2019. Because the cervical cancer screening rate improved for all other ethnicities, the disparity still exists for Caucasian women; therefore, we continued the topic for our 2020–22 Health Equity PIP. This has been detailed in the Module 1 submission of the 2020–22 PIP. The ongoing issue with how the State collects language and ethnicity data, especially in Stanislaus County, still remains. We highly recommend that DHCS reevaluate the optional reporting of language and ethnicity on its Medi-Cal eligibility forms, especially since the Department of Managed Health Care is now interested in health equity, replete with a CAP and sanction process, as well as DHCS' recent All Plan Letter 21-004 that addresses new cultural and linguistic requirements and

2019–20 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	nondiscrimination. In the interim, we are trying to explore options to see if we can find an alternative way to capture these data so we have this information, even if on an unofficial basis. Member incentives for this measure have continued, and we expanded the options for the incentives to different gift card types. We also have made it easier for members to request gift cards through the use of our website and online forms. The MCP still verifies the visit prior to the vendor sending the gift cards. On-site gift cards have been ended due to COVID-19.

Assessment of MCP's Self-Reported Actions

HSAG reviewed HPSJ's self-reported actions in Table 6.1 and determined that HPSJ adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. HPSJ described how the MCP is working to address barriers so that it can continue implementing interventions tested through the 2017–19 *Cervical Cancer Screening* Disparity PIP. Additionally, HPSJ described in detail steps the MCP has taken to apply lessons learned and continue efforts from both of the 2017–19 PIPs, including how COVID-19 has affected the strategies.

2020–21 Recommendations

Based on the overall assessment of HPSJ's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, HPSJ assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate HPSJ's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix Q:
Performance Evaluation Report
Health Plan of San Mateo
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Health Plan of San Mateo ("HPSM" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that HPSM provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in HPSM's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

HPSM is a full-scope MCP delivering services to its members in the County Organized Health System model.

HPSM became operational to provide MCMC services in San Mateo County effective December 1987. As of June 2021, HPSM had 119,204 members in San Mateo County.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Follow-Up on 2019 A&I Medical and State Supported Services Audits

A&I conducted the most recent audits for HPSM in 2019 for the review period of November 1, 2018, through October 31, 2019. HSAG included a summary of these audits in HPSM's 2019–20 MCP-specific evaluation report. At the time of the 2019–20 MCP-specific evaluation report publication, HPSM's CAP was in process and under DHCS review. A letter from DHCS dated September 21, 2021, stated that HPSM provided DHCS with additional information regarding the CAP and that DHCS had evaluated the information and closed the CAP. The letter indicated that DHCS will continue to assess the effectiveness of the CAP and during the subsequent audit will assess the extent to which HPSM has operationalized the proposed corrective actions. Note that while DHCS issued the closeout letter outside the review dates for this report, HSAG includes the information from the letter because it reflects full resolution of the findings from the 2019 audits.

Compliance Reviews Conducted

Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of HPSM during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of HPSM from August 30, 2021, through September 10, 2021, for the review period of November 1, 2019, through July 31, 2021. HSAG will include a summary of these audits in HPSM's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of HPSM, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Health Plan of San Mateo* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that HPSM followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for HPSM's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 20, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	48.80%	Not Comparable
Childhood Immunization Status—Combination 10	51.58%	61.56%	9.98
Developmental Screening in the First Three Years of Life—Total	45.28%	24.24%	-21.04
Immunizations for Adolescents—Combination 2	55.12%	50.61%	-4.51
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	73.97%	**75.18%**	1.21
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	74.70%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**65.94%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	20.03%	Not Comparable
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	—	76.94%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
HPSM—San Mateo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	65.86%	59.20%	-6.66
*Cervical Cancer Screening^*	70.10%	**58.91%**	-11.19
Chlamydia Screening in Women—Ages 16–20 Years	64.49%	60.43%	-4.06
Chlamydia Screening in Women—Ages 21–24 Years	72.37%	68.66%	-3.71
Chlamydia Screening in Women—Total	67.49%	63.98%	-3.51
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	3.58%	3.07%	-0.51
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.98%	6.02%	0.04

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	17.88%	17.00%	-0.88
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.70%	28.26%	0.56
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	28.57%	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	6.97%	11.79%	4.82
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	31.58%	43.96%	12.38
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	21.84%	21.71%	-0.13
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	15.79%	34.07%	18.28
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	15.79%	24.81%	9.02
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	47.37%	61.54%	14.17
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.84%	48.88%	7.04
*Prenatal and Postpartum Care—Postpartum Care^*	84.18%	92.59%	8.41
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	87.59%	90.00%	2.41

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
HPSM—San Mateo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	19	31.58%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	19	26.32%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	67.02%	66.47%	-0.55
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	49.37%	51.09%	1.72
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**78.15%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	22.70%	22.88%	0.18
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	57.43%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	36.63%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	35.64%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	23.85%	27.33%	3.48
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	28.69%	29.85%	1.16
Screening for Depression and Follow-Up Plan—Ages 65+ Years	25.26%	24.25%	-1.01

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
HPSM—San Mateo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	6	33.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	49.88	36.99	Not Tested
Asthma Medication Ratio—Total	61.35%	70.06%	8.71
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	30.17%	37.23%	7.06

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	19.95%	20.04%	0.09
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	15.04%	15.29%	0.25
Controlling High Blood Pressure—Total	—	53.04%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.37%	9.65%	-0.72
Plan All-Cause Readmissions—Expected Readmissions—Total	10.45%	10.35%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.99	0.93	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	12.44%	11.43%	-1.01
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	5.07%	4.65%	-0.42

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.

- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
HPSM—San Mateo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of HPSM's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures

- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains HPSM—San Mateo County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	4	16	25.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	10	36	27.78%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	16	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	36	19.44%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of HPSM's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

HPSM conducted two PDSA cycles to improve the MCP's performance on the *Asthma Medication Ratio—Total* measure.

For the first PDSA cycle, the MCP conducted provider training during a monthly collaborative meeting about the new Global Initiative for Asthma (GINA) guidelines. During the meeting, HPSM experienced some technical challenges; therefore, following the meeting the MCP sent a follow-up email to all participants with additional information regarding the guidelines. HPSM reported reaching five new providers with the training, with three of these providers being in

the top 25 prescribers of asthma reliever medication. HPSM indicated that some providers who originally planned to attend the training were unable to do so due to being busy with COVID-19 response efforts. The MCP indicated that it is too early in the improvement process to determine if the intervention resulted in improvement in the *Asthma Medication Ratio—Total* measure rate.

For the second PDSA cycle, HPSM adapted the intervention from the first PDSA cycle to disseminate the GINA guidelines via fax and the MCP's website. HPSM expanded the outreach to include all primary care providers (PCPs) in the MCP's network. HPSM indicated that it saw no significant increase in asthma reliever medication prescriptions after the MCP sent the fax blast and after posting the information on the HPSM website. Moving forward, HPSM indicated that the MCP will include member outreach as part of the intervention and will include all eligible members.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, HPSM reported:

- Conducting outreach to encourage members to continue taking their asthma controller medications and to see their pharmacists or PCPs to obtain new prescriptions. The outreach served as a platform for HPSM to not only answer questions about asthma, but to also address concerns related to COVID-19. In addition, HPSM indicated being able to identify members with asthma who were affected by air quality due to the California fires and that the MCP provided these members with N95 masks. HPSM indicated that the civil unrest in San Mateo County resulted in members being hesitant to leave their homes and that the pharmacies closing their doors due to the civil unrest affected members' access to pharmacies.
- Conducting telephonic outreach to perinatal members to ensure they scheduled appointments with their providers for prenatal and postpartum care appointments. The MCP's health population team also worked with the provider services team to develop a survey to target HPSM network obstetricians to determine which offices were open and what safety protocols the obstetricians had in place. Over time, HPSM expanded the outreach calls to also address being pregnant during COVID-19, breastfeeding, and expected impacts on hospital delivery protocols. The MCP offered incentives to members who completed their prenatal and postpartum care visits. During the outreach, members expressed concerns regarding the shortage of diapers and baby wipes, and HPSM was able to provide some members with free diapers for three months. After diapers and wipes were being stocked regularly at stores, HPSM learned that many members had lost their jobs or were facing other financial difficulties; therefore, the MCP continued to provide diapers and wipes to members into 2021.
- Conducting telephonic outreach to encourage caregivers and parents of children between 0 and 2 years of age who had not been seen for a well-child visit in the previous six months to schedule an appointment. HPSM offered an incentive for members who completed six well-child visits by 15 months of age. HPSM reported having staffing resource constraints which resulted in the MCP halting the telephonic outreach and that HPSM began

outreaching to members who had been unable to see their provider for six or more months via a mailing that included educational materials.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In HPSM's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
HPSM—San Mateo County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	50.40	34.83	Not Tested	36.99
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.94%	9.35%	1.59	9.65%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only. For HPSM, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for this measure.

Strengths—Performance Measures

The HSAG auditor determined that HPSM followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for HPSM:

- The rates for the following measures were above the high performance levels:
  - Both *Antidepressant Medication Management* measures
  - *Childhood Immunization Status—Combination 10*
  - *Prenatal and Postpartum Care—Postpartum Care*

- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 10 of 36 rates (28 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.
  - Six of the 10 rates that improved significantly (60 percent) were in the Women's Health domain.

Opportunities for Improvement—Performance Measures

The rates for the following measures were below the minimum performance level in measurement year 2020:

- *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*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*

Although the Women's Health domain had the highest number of measures with rates that improved significantly from measurement year 2019 to measurement year 2020, this domain also had the highest number of measures for which HPSM's performance declined significantly from measurement year 2019 to measurement year 2020. Across all domains, the MCP's performance declined significantly for seven measures from measurement year 2019 to measurement year 2020, and of those seven, five were in the Women's Health domain.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, HPSM should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to HPSM's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in San Mateo County, DHCS required that HPSM report rates for four HEDIS measures that HSAG validated as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results HPSM—San Mateo County

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	79.02	66.20	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.84%	10.82%	-1.02
Plan All-Cause Readmissions—Expected Readmissions—Total	12.68%	12.73%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.93	0.85	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

HPSM determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, HPSM identified breast cancer screening among African-American members as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated Module 1 for the MCP's *Breast Cancer Screening* Health Equity PIP. HPSM met all validation criteria for Module 1 in its initial submission.

HPSM's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of African-American members ages 52 to 74 who complete their preventive mammography screenings. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in HPSM's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

HPSM determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—adolescent well-care visits.

HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of the modules, HSAG determined that HPSM met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Clearly labeling the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.

After receiving technical assistance from HSAG, HPSM incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. At the end of the review period for this report, HPSM was still in the process of incorporating HSAG's feedback into Module 2; therefore, HSAG includes no final validation results in this report.

HPSM's *Adolescent Well-Care Visits* PIP SMART Aim measures the percentage of members ages 18 to 21 who complete their adolescent well-care visit. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in HPSM's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

HPSM successfully met all validation criteria for Module 1 for both PIPs. The validation findings show that the MCP built a strong foundational framework for both PIPs. HPSM has progressed to Module 2 for both PIPs, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Opportunities for Improvement—Performance Improvement Projects

Based on HPSM's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

HPSM submitted the MCP's final PNA report to DHCS on August 6, 2021, and DHCS notified the MCP via email on the same date that DHCS approved the report as submitted. While HPSM submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with HPSM's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, the same, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By December 31, 2021, improve the *Getting Needed Care* Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] adult measure rate to at or above all other plans' rates.	No	Better	Ended in 2020
2	By December 31, 2021, improve the *Getting Care Quickly* CAHPS pediatric measure rate.	No	Same	Ended in 2020
3	By December 30, 2021, improve the CAHPS *Shared Decision Making* pediatric measure rate to above other health plans' rates.	No	Unknown	Ended in 2020
4	By December 31, 2021, decrease the number of members who report "inconvenient appointment" as an obstacle.	No	Unknown	Ended in 2020
5	By December 31, 2021, increase the number of members who engage with their assigned PCP.	No	Better	Ended in 2020
6	By December 31, 2021, improve the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate to above the HEDIS 2020 90th percentile.	No	Better	Continuing into 2021
7	By December 31, 2021, improve the *Prenatal and Postpartum Care—Postpartum Care* measure rate to above the HEDIS 2020 90th percentile and keep the rate at this level or higher.	No	Better	Continuing into 2021

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
8	By December 31, 2021, decrease the number of teen pregnancies for members between the ages of 15 and 19.	No	Worse	Continuing into 2021
9	By December 31, 2021, increase the number of high-risk members (i.e., those with HbA1c levels greater than 9.0 or with uncontrolled high blood pressure) who are referred to and engaged in chronic condition self-management programs.	No	Better	Ended in 2020
10	By December 31, 2021, increase compliance for the *Asthma Medication Ratio—Total* measure for the English language subgroup to equal to or greater than the rate for the entire population.	Yes	Better	Ended in 2020
11	By December 31, 2021, increase compliance for the *Breast Cancer Screening—Total* measure for the English language subgroup to equal to or greater than the rate for the entire population.	Yes	Worse	Changing for 2021
12	By December 31, 2021, increase compliance for the *Cervical Cancer Screening* measure for the English language subgroup to equal to or greater than the rate for the entire population.	Yes	Worse	Changing for 2021
13	By December 31, 2021, increase compliance for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure for the English language subgroup to equal to or less than the rate for the entire population.	Yes	Better	Ended in 2020

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
14	By December 31, 2021, increase compliance for the *Immunizations for Adolescents—Combination 2* measure for the English language subgroup to equal to or greater than the rate for the entire population.	Yes	Better	Ended in 2020
15	By December 31, 2021, increase compliance for the *Prenatal and Postpartum Care—Postpartum Care* measure for the English language subgroup to equal to or greater than the rate for the entire population.	Yes	Better	Ended in 2020
16	By December 31, 2021, increase compliance for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for the English language subgroup to equal to or greater than the rate for the entire population.	Yes	Unknown	Ended in 2020
17	By December 31, 2021, increase the *Cervical Cancer Screening* measure rate among disparate race/ethnicity subgroups (American Indian/Alaska Native and Caucasian), language subgroups (English and Russian) and the SPD population to equal to or greater than the rate for the entire population.	Yes	Worse	Changing for 2021
18	By December 31, 2021, increase the *Breast Cancer Screening—Total* measure rate among disparate race/ethnicity subgroups (Black and Caucasian) and the English language group.	Yes	Worse	Changing for 2021
19	By December 31, 2021, increase HbA1c testing among the Caucasian disparate race/ethnicity subgroup.	Yes	Worse	Ended in 2020

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
20	By December 31, 2021, decrease the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure rate for the Caucasian subgroup.	Yes	Better	Ended in 2020
21	By December 31, 2021, increase the percentage of HPSM provider requests for Spanish phone or video interpreters.	Yes	Better	Continuing into 2021

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By December 31, 2022, improve the *Customer Service* CAHPS adult measure rate to above all other health plans' top box scores.	No	New in 2021
2	By December 31, 2022, improve the *Customer Service* CAHPS pediatric measure rate.	No	New in 2021
3	By December 31, 2022, improve the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate to above the HEDIS 2020 90th percentile.	No	Continued from 2020
4	By December 31, 2022, improve the *Prenatal and Postpartum Care—Postpartum Care* measure rate to above the HEDIS 2020 90th percentile and keep the rate at this level or higher.	No	Continued from 2020

#	Objective Summary	Health Disparity (Yes/No)	Status
5	By December 31, 2022, see a decrease in the number of teen pregnancies for members between the ages of 15 and 19.	No	Continued from 2020
6	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	Changed from 2020
7	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	Changed from 2020
8	By December 31, 2022, increase the percentage of provider requests for Spanish-speaking phone or video interpreters.	No	Continued from 2020

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from HPSM's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of HPSM's self-reported actions.

Table 7.1—HPSM's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve the findings from the 2019 A&I Medical and State Supported Services Audits. HPSM should thoroughly review all findings and implement the actions recommended by A&I.	HPSM has closed all but two CAP findings from the 2019 A&I Medical and State Supported Services Audits. HPSM continues to work internally, and with DHCS, to complete any tasks related to those two remaining findings.
2. Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Asthma Medication Ratio* PIP.	We continued to outreach to members on their asthma medication management and helped members get their asthma medication, especially during the COVID-19 pandemic. The MCP continued the following interventions: ♦ Educate members on their asthma medications. ♦ Encourage members to outreach to their PCP. ♦ Encourage members to pick up their asthma medication at the pharmacy and provide information on pharmacy deliveries during the pandemic.

2019–20 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	♦ Provide information to members about where to obtain masks and provide N95 masks to certain high-risk members who were unable to find masks.
3. Apply lessons learned from the 2017–19 *Cervical Cancer Screening* Disparity PIP and *Asthma Medication Ratio* PIP to facilitate improvement of the adapted intervention and to strengthen future quality improvement efforts.	Lessons learned from our *Cervical Cancer Screening* Disparity PIP included expanding the phone outreach intervention to larger target populations, as a large proportion of the target denominator originally identified for this intervention was not accessible by phone. We will incorporate larger phone outreach campaigns as well as multiple communication/outreach methods in planning and development of future disparity PIP projects as well as include a qualitative data collection component to better understand and address disparities in timely access to care in our member populations. During the prior intervention of our *Asthma Medication Ratio* PIP, we learned that members would like to discuss their asthma medications with their providers and therefore further adapted the intervention to ensure that providers were informed of members who were non-compliant through a letter. HPSM provided to all PCPs the following information on each member: ♦ Name and address ♦ Asthma medication ratio ♦ Reliever medication pick-up status ♦ Controller medication pick-up status ♦ Most recent emergency department and inpatient visits related to asthma The feedback from providers on this added intervention has been very positive as members are able to speak directly to their PCPs, and providers are given an opportunity

2019–20 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	to learn about recent admissions and discuss these with the members, including any changes in medication that may be required.

Assessment of MCP's Self-Reported Actions

HSAG reviewed HPSM's self-reported actions in Table 7.1 and determined that HPSM adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. HPSM confirmed that the MCP is working with DHCS to resolve all findings from the 2019 A&I Medical and State Supported Services Audits. Additionally, the MCP described continued member outreach efforts adapted from the 2017–19 *Asthma Medication Ratio* PIP and how HPSM is applying lessons learned from both 2017–19 PIPs.

2020–21 Recommendations

Based on the overall assessment of HPSM's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that HPSM assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate HPSM's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix R:
Performance Evaluation Report
Inland Empire Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Inland Empire Health Plan ("IEHP" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that IEHP provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in IEHP's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

IEHP is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in IEHP, the Local Initiative MCP, or in Molina Healthcare of California Partner Plan, Inc., the alternative commercial plan.

IEHP became operational in Riverside and San Bernardino counties to provide MCMC services effective 1996. As of June 2021, IEHP had 698,963 members in Riverside County and 679,019 in San Bernardino County—for a total of 1,377,982 members.[1] This represents 88 percent of the beneficiaries enrolled in Riverside County and 90 percent in San Bernardino County.

DHCS allows IEHP to combine data for Riverside and San Bernardino counties for reporting purposes. For this report, Riverside and San Bernardino counties represent a single reporting unit.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for IEHP in 2019 for the review period of October 1, 2018, through September 30, 2019. HSAG included a summary of these audits in IEHP's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of IEHP during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of IEHP from September 27, 2021, through October 8, 2021, for the review period of October 1, 2019, through June 30, 2021. HSAG will include a summary of these audits in IEHP's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of IEHP, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Inland Empire Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for IEHP's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 27, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	38.93%	Not Comparable
Childhood Immunization Status—Combination 10	31.14%	**29.20%**	-1.94
Developmental Screening in the First Three Years of Life—Total	12.92%	21.72%	8.80
Immunizations for Adolescents—Combination 2	39.42%	41.12%	1.70
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	89.54%	81.02%	-8.52
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	77.37%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	76.40%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	28.87%	Not Comparable
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	—	61.05%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
IEHP—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	65.15%	59.76%	-5.39
*Cervical Cancer Screening^*	70.07%	62.04%	-8.03
Chlamydia Screening in Women—Ages 16–20 Years	60.22%	58.75%	-1.47
Chlamydia Screening in Women—Ages 21–24 Years	69.83%	65.97%	-3.86
Chlamydia Screening in Women—Total	65.03%	62.38%	-2.65
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.68%	2.27%	-0.41
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.30%	4.68%	-0.62
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.82%	14.91%	-0.91
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.59%	25.01%	-1.58

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	1.23%	2.07%	0.84
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.11%	1.93%	0.82
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	14.58%	14.34%	-0.24
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.88%	11.14%	0.26
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.79%	5.63%	2.84
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.34%	12.25%	1.91
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	37.47%	38.37%	0.90
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	39.69%	39.43%	-0.26
*Prenatal and Postpartum Care—Postpartum Care^*	77.13%	**75.18%**	-1.95
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	92.94%	89.05%	-3.89

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
IEHP—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	19	15.79%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	9	19	47.37%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.56%	65.41%	6.85
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.95%	50.26%	10.31
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**81.80%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	34.32%	40.50%	6.18
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	44.03%	48.31%	4.28
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	59.87%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	46.71%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	43.75%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	36.90%	45.88%	8.98
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	26.14%	35.47%	9.33
Screening for Depression and Follow-Up Plan—Ages 65+ Years	31.50%	37.88%	6.38

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
IEHP—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	7	85.71%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.41	33.00	Not Tested
Asthma Medication Ratio—Total	55.10%	**57.39%**	2.29
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	32.36%	**40.88%**	8.52
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.42%	12.40%	-1.02
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.28%	11.48%	-0.80
Controlling High Blood Pressure—Total	—	54.99%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.02%	8.32%	0.30

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Plan All-Cause Readmissions—Expected Readmissions—Total	9.54%	9.74%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.84	0.85	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.36%	2.95%	-0.41
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	3.48%	2.99%	-0.49

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
IEHP—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of IEHP's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains IEHP—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	13	37	35.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	16	31.25%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	11	37	29.73%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of IEHP's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

IEHP conducted two PDSA cycles to improve the MCP's performance on the *Asthma Medication Ratio—Total* measure.

For the first PDSA cycle, IEHP's quality and pharmacy teams collaborated on identifying members with an asthma medication ratio less than 0.50. The IEHP pharmacist sent to each member's primary care provider (PCP) a member-specific medication management recommendation that was written in alignment with asthma clinical practice guidelines. The pharmacist provided the recommendations to the PCPs via fax or phone. While IEHP reported that it did not meet the PDSA SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective, the MCP noted improvement in the *Asthma Medication Ratio—Total* measure rate for the target population. IEHP indicated that during the PDSA cycle, the MCP experienced challenges related to confirming that the correct PCP staff members received the recommendations. To address this challenge, IEHP stated that it would modify the provider engagement component to improve the PCP's receipt of the recommendations.

For the second PDSA cycle, IEHP expanded the target group from the first PDSA cycle to include members with an asthma medication ratio of zero across eight provider offices. IEHP identified a point of contact at the clinic level to whom the MCP faxed the targeted medication reviews, and the point of contact distributed the reviews to the appropriate clinical staff members. IEHP compared pharmacy claims data to monthly report data to determine if an increase in inhaled corticosteroids therapy occurred in the target population. While not meeting its PDSA goal, IEHP saw improvement in inhaled corticosteroids therapy at a single clinic that had a clinical pharmacist who was consistently engaged in the intervention. IEHP noted the following challenges during the PDSA cycle:

- The MCP was unable to establish a point of contact at some clinic sites due to the clinic staff members having competing priorities.
- When reviewing charts for some members, the MCP noted discrepancies between chart notes and pharmacy claims data.
- Some appointments did not allow enough time for the provider to conduct an asthma review due to members presenting more urgent concerns.

IEHP indicated that the intervention will be absorbed into the MCP's current pharmacy quality improvement efforts to improve the *Asthma Medication Ratio—Total* measure rate and that the MCP will expand the number of providers involved in the intervention.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, IEHP reported:

- Planning to partner with a clinic system in San Bernardino County to close immunization gaps for members 16 to 24 months of age and 9 to 12.75 years of age. IEHP reported that while the MCP and partner clinic system met to discuss initiating the intervention, IEHP was unable to launch the intervention due to limited staffing resources during the COVID-19 pandemic.
- Offering an incentive to members between the ages of 17 and 21 residing in Victorville and assigned to the PCP partners to complete their well-care visits by year end. IEHP sent mailings to members in July 2020 informing them of the incentive and partnered with a Management Services Organization (MSO) to engage PCPs and distribute monthly reports of eligible members. The MCP reported that members were hesitant to be seen in person because of COVID-19, and the MSO reported difficulty engaging with the providers during the pandemic. IEHP indicated that the MCP plans to send a second mailing to members who need to be seen for their well-care visits to encourage them to schedule appointments with their PCP.
- Adjusting the MCP's preventive screening guidance for members 2 years of age and older, allowing providers to use telehealth visits to provide preventive care to members. IEHP informed providers of the guidance change via fax. The target group for this intervention comprised members ages 2 to 21 for whom COVID-19 may be a barrier to obtaining a preventive care service. In the six-month period after the MCP sent the updated coding and billing guidance to providers, IEHP reported higher telehealth utilization rates for well-care visits. While telehealth visits increased, IEHP reported that members in need of in-person follow-up were reluctant to be seen due to concerns related to COVID-19.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In IEHP's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
IEHP—Riverside/San Bernardino Counties

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	56.17	31.37	Not Tested	33.00
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.10%	7.55%	3.55	8.32%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for IEHP:

- The rates for both *Antidepressant Medication Management* measures were above the high performance levels.
- Across all domains, for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 13 of 37 rates (35 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.
- Both measures with rates above the high performance levels and six of the 13 rates that improved significantly (46 percent) were in the Behavioral Health domain.

Opportunities for Improvement—Performance Measures

Across all domains, five of 16 measures for which HSAG compared rates to benchmarks (31 percent) were below the minimum performance levels. For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, IEHP's performance declined significantly from measurement year 2019 to measurement year 2020 for 11 of 37 measures (30 percent). IEHP has the greatest opportunity for improvement in the Women's Health domain, with one measure having a rate below the minimum performance level and the MCP's performance declining significantly from measurement year 2019 to measurement year 2020 for nine measures.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, IEHP should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to IEHP's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in Riverside and San Bernardino counties, DHCS required that IEHP report rates for four HEDIS measures that HSAG validated as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results IEHP—Riverside/San Bernardino Counties

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	47.08	34.21	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.26%	9.54%	2.28
Plan All-Cause Readmissions—Expected Readmissions—Total	9.67%	9.74%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.75	0.98	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

IEHP determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, IEHP identified controlling high blood pressure among African-American members as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated modules 1 and 2 for the MCP's *Controlling High Blood Pressure* Health Equity PIP. Upon initial review of Module 1, HSAG determined that IEHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, IEHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. IEHP met all validation criteria for Module 2 in its initial submission.

IEHP's *Controlling High Blood Pressure* Health Equity PIP SMART Aim measures the percentage of African-American members diagnosed with hypertension who were assigned to the PIP provider group partner and have controlled blood pressure (under 140/90 mm Hg). This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in IEHP's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

IEHP determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, IEHP selected adolescent well-care visits for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. IEHP met all validation criteria for both modules in its initial submissions.

IEHP's *Adolescent Well-Care Visits* PIP SMART Aim measures the percentage of members ages 18 to 21 who were assigned to the PIP health center partner and complete a well-care visit. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in IEHP's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

IEHP successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. IEHP has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on IEHP's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

IEHP submitted the MCP's PNA report to DHCS on June 21, 2021, and DHCS notified the MCP via email on July 7, 2021, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with IEHP's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2021, increase the percentage of members 18 to 74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year. Once these members are identified, ensure that they are linked to related MCP and community programs and resources to support achieving a healthy weight.	No	Worse	Ended in 2020
2	By June 30, 2021, improve asthma medication ratio compliance among members ages 0 to 21 living in San Bernardino proper through a health education and multidisciplinary care coordination program.	Yes	Worse	Continuing into 2021
3	By June 30, 2021, in the member population qualifying for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* measure, reduce the percentage point difference between the reference group of members who prefer English and the disparate group of members who prefer Spanish.	Yes	Better	Ended in 2020
4	By June 30, 2021, in the member population qualifying for the *Controlling High Blood Pressure*—Total measure, reduce the percentage point difference between the Caucasian reference group and the disparate group (Hispanic-identifying).	Yes	Better	Changing for 2021
5	By June 30, 2022, increase depression screening rates of members ages 12 years and older to at least the 50th percentile.	No	Better	Continuing into 2021

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
6	By June 30, 2021, strategically communicate member benefits in at least three communication campaigns or activities to better inform select member populations about MCP benefits.	No	Better	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	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	Changed from 2020
2	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	Continued from 2020
3	By July 1, 2022, improve the *Statin Therapy for People with Diabetes* measure rate.	No	New in 2021
4	By July 1, 2022, improve the depression screening rate across all age groups.	No	Continued from 2020
5	By July 1, 2022, improve the *Developmental Screening in the First Three Years of Life—Total* measure rate	Yes	New in 2021

#	Objective Summary	Health Disparity (Yes/No)	Status
	among IEHP members ages 0 to 3 years who prefer English.		
6	By July 1, 2022, improve the rate at which providers advise members about smoking or tobacco cessation.	No	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from IEHP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of IEHP's self-reported actions.

Table 7.1—IEHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Implement oversight processes to ensure that all data files are accurately mapped prior to the data being uploaded for HEDIS performance measure rate reporting.	IEHP has implemented an enhanced quality assurance oversight process to ensure that all data files are loaded into the certified HEDIS reporting tool with the correct source designation (encounter versus supplemental, standard versus non-standard, etc.). Process documentation is maintained and detailed reconciliation reports are produced and reviewed prior to each analytical run to ensure all source file designations are correct.
2. Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 10* Disparity PIP.	Monitoring of the adapted intervention beyond the 2017–19 *Childhood Immunization Status—Combination 10* Disparity PIP was significantly impacted by the public health emergency caused by the COVID-19 pandemic. During 2020 and for the first half of 2021, IEHP health navigators were limited in their scope to complete home visits, which created a barrier to obtaining access to members' immunization records. As health navigators resume home visits, scanning member immunization records continues to be a component of their standard work. These records are collected and

2019–20 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	leveraged to ensure immunization data reconciliation and data completeness.
3. Continue monitoring the adapted intervention and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Asthma Medication Ratio* PIP.	During 2020, IEHP adapted the 2017–19 *Asthma Medication Ratio* PIP intervention, transitioning the provider outreach and engagement from a vendor to IEHP's internal pharmacy team for the 2020–21 PDSA cycle. The population for the initial cycle included eight provider sites across the San Bernardino Proper, West San Bernardino, and Riverside regions. The IEHP pharmacy department conducted provider outreach to these sites, alerting them to their assigned members who may be non-adherent or missing asthma controller medications. The intended outcome of the targeted medication review process was to promote provider engagement with these members and encourage increased prescription adherence to asthma controller medications, thereby improving the member's management of asthma symptoms and asthma medication ratio compliance. The PDSA cycle concluded in June 2021, and the intervention modification demonstrated positive outcome results. For example, one clinical site demonstrated an increase in members with inhaled corticosteroid therapy during the second PDSA cycle. Based on these results and the projected success of the targeted medication review process, IEHP plans to adopt the intervention into current pharmacy quality improvement efforts to improve the HEDIS *Asthma Medication Ratio—Total* measure rate, expanding the number of providers who are sent a targeted medication review fax and contacted by the pharmacy team.

2019–20 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	IEHP's pharmacy department currently conducts an outreach fax blast intervention for various medication management measures. This program covers all providers within the IEHP network. Providers are sent a fax of targeted medication reviews for members indicated as being deficient in a medication for the condition in question. The measures targeted by the fax are rotated so that providers receive targeted medication reviews for various measures throughout the year. IEHP will adopt the asthma medication ratio PDSA intervention by incorporating the *Asthma Medication Ratio—Total* measure into the list of rotating measures addressed by the existing targeted medication review fax intervention in Quarter 3 of 2021. IEHP will continue to apply lessons learned and continue to identify opportunities to spread this quality improvement activity.

Assessment of MCP's Self-Reported Actions

HSAG reviewed IEHP's self-reported actions in Table 7.1 and determined that IEHP adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. IEHP indicated that the MCP implemented an enhanced quality assurance oversight process to ensure that all data files are loaded into the certified HEDIS reporting tool with the correct source designation. Additionally, the MCP described how COVID-19 impacted the ability of the MCP's health navigators to continue the home visits intervention initiated in the 2017–19 *Childhood Immunization Status—Combination 10* Disparity PIP. Finally, IEHP described in detail how the MCP adapted the 2017–19 *Asthma Medication Ratio* PIP intervention by transitioning provider outreach and engagement from a vendor to IEHP's internal pharmacy team, which tested interventions via PDSA cycles.

2020–21 Recommendations

Based on the overall assessment of IEHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that IEHP assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate IEHP's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix S:
Performance Evaluation Report
Kaiser NorCal (KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento Counties)
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento counties (commonly known as "Kaiser Permanente North" and referred to in this report as "Kaiser NorCal" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Kaiser NorCal provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Kaiser NorCal's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Kaiser NorCal is a full-scope MCP delivering services to its members under two health care models—the Geographic Managed Care (GMC) model and the Regional model.

Although the GMC model operates in the counties of San Diego and Sacramento, Kaiser NorCal only operates in Sacramento County. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to Kaiser NorCal, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- Health Net Community Solutions, Inc.
- Molina Healthcare of California

In Amador, El Dorado, and Placer counties, Kaiser NorCal delivers services to its members under the Regional model. In all three counties, beneficiaries may enroll in Kaiser NorCal or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan or California Health & Wellness Plan, the other commercial plans.

Kaiser NorCal became operational in Sacramento County to provide MCMC services effective April 1994. As part of MCMC's expansion under Section 1115 of the Social Security Act, Kaiser NorCal contracted with DHCS to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013. As of June 2021, Kaiser NorCal had 102,577 members in Sacramento County, 178 in Amador County, 2,722 in El Dorado County, and 10,494 in Placer County—for a total of 115,971 members.[1] This represents 21 percent of the beneficiaries enrolled in Sacramento County, 3 percent in Amador County, 8 percent in El Dorado County, and 19 percent in Placer County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

DHCS allows Kaiser NorCal to combine the data from Sacramento, Amador, El Dorado, and Placer counties for reporting purposes. For this report, these four counties are considered a single reporting unit (KP North).

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Follow-Up on 2019 A&I Medical and State Supported Services Audits

A&I conducted the most recent audits for Kaiser NorCal in 2019 for the review period of September 1, 2018, through August 31, 2019. HSAG included a summary of these audits in Kaiser NorCal's 2019–20 MCP-specific evaluation report. At the time of the 2019–20 MCP-specific evaluation report publication, Kaiser NorCal's CAP was in process and under DHCS review. A letter from DHCS dated June 2, 2021, stated that DHCS had analyzed additional information from the MCP and subsequently closed the CAP. The letter indicated that during future audits, DHCS would continue to assess the effectiveness of the CAP as well as the extent to which Kaiser NorCal has operationalized the proposed corrective actions.

Follow-Up on 2018 A&I Medical and State Supported Services Audits

A&I conducted Medical and State Supported Services Audits of Kaiser NorCal in 2018 for the review period of September 1, 2017, through August 31, 2018. HSAG included a summary of these audits in Kaiser NorCal's 2018–19 MCP-specific evaluation report, with the CAP being in process and under DHCS review. In Kaiser NorCal's 2019–20 MCP-specific evaluation report, HSAG reported that the CAP from the 2018 Medical Audit was still open. A letter from DHCS dated December 28, 2020, stated that DHCS had evaluated additional information from the MCP and subsequently closed the CAP. The letter indicated that during future audits, DHCS would continue to assess the effectiveness of the CAP as well as the extent to which Kaiser NorCal has operationalized the proposed corrective actions.

Compliance Reviews Conducted

Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of Kaiser NorCal during the review period for this report; therefore, HSAG includes no new compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of Kaiser NorCal from November 1, 2021, through November 12, 2021, for the review period of September 1, 2019, through October 31, 2021. HSAG will include a summary of these audits in Kaiser NorCal's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of Kaiser NorCal, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Kaiser NorCal* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that Kaiser NorCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for Kaiser NorCal's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 20, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	33.82%	Not Comparable
Childhood Immunization Status—Combination 10	54.72%	58.94%	4.22
Developmental Screening in the First Three Years of Life—Total	79.17%	11.97%	-67.20
Immunizations for Adolescents—Combination 2	68.87%	65.11%	-3.76
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	89.18%	**66.56%**	-22.62
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	71.94%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	71.95%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	68.17%	Not Comparable
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	—	61.70%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	4	75.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	82.19%	69.01%	-13.18
*Cervical Cancer Screening^*	87.44%	84.64%	-2.80
Chlamydia Screening in Women—Ages 16–20 Years	67.35%	56.38%	-10.97
Chlamydia Screening in Women—Ages 21–24 Years	75.80%	67.11%	-8.69
Chlamydia Screening in Women—Total	71.18%	61.38%	-9.80
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.67%	3.94%	-0.73
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.29%	5.65%	-0.64

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	24.21%	20.77%	-3.44
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.55%	27.61%	-2.94
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	5.95%	10.85%	4.90
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	25.84%	27.03%	1.19
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.48%	18.48%	2.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	19.10%	25.68%	6.58
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	17.24%	24.94%	7.70
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	52.81%	48.65%	-4.16
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.19%	41.26%	0.07
*Prenatal and Postpartum Care—Postpartum Care^*	82.45%	76.59%	-5.86
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	96.46%	93.29%	-3.17

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	19	52.63%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	69.25%	71.65%	2.40
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	49.84%	51.32%	1.48
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**81.71%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	48.60%	57.23%	8.63
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	58.82%	55.96%	-2.86
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	51.74%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	45.65%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	44.35%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.31%	0.47%	0.16
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	27.29%	20.79%	-6.50
Screening for Depression and Follow-Up Plan—Ages 65+ Years	17.05%	8.85%	-8.20

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.97	32.74	Not Tested
Asthma Medication Ratio—Total	87.80%	90.26%	2.46
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	24.84%	33.74%	8.90

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.49%	6.97%	-2.52
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	8.03%	4.82%	-3.21
Controlling High Blood Pressure—Total	—	54.39%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.40%	8.28%	-2.12
Plan All-Cause Readmissions—Expected Readmissions—Total	8.64%	9.51%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.20	0.87	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.76%	3.17%	-0.59
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	3.32%	3.68%	0.36

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.

- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	7	57.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of Kaiser NorCal's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates

because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Plan All-Cause Readmissions* measures
  - All three *Screening for Depression and Follow-Up Plan* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	6	16	37.50%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	8	37	21.62%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	16	12.50%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	16	37	43.24%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Kaiser NorCal's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

Kaiser NorCal conducted two PDSA cycles to improve the MCP's performance on the *Controlling High Blood Pressure—Total* measure.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, Kaiser NorCal used the MCP's monthly population management tool to identify African-American members residing in Sacramento County ages 18 to 65 with uncontrolled hypertension and assigned to a primary care provider (PCP) in South Sacramento. The MCP conducted outreach calls to these members to ask if they would be willing to receive a blood pressure monitor to take blood pressure measurements at home. During the 10-week PDSA cycle, the MCP delivered 56 blood pressure monitors, and the MCP reported an increase in the number of blood pressure measurements recorded in member medical charts. Kaiser NorCal identified several challenges and lessons learned, including:

- Encountering vendor supplier issues that resulted in the MCP having to identify a new vendor to fulfill the blood pressure monitor order.
- Realizing that education about using the blood pressure monitors was not a priority for members significantly impacted by COVID-19.
- Learning that building trust with members is an essential component to the success of the intervention.
- Recognizing that the MCP needed to modify the outreach script to emphasize lifestyle changes versus medication management and to clarify that the provider is available to support the members in their goal to have controlled blood pressure.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, the target population remained the same as for the first cycle. Kaiser NorCal conducted outreach via email to members not reached during the first PDSA cycle to ask if they would like a blood pressure monitor sent to them to help manage their hypertension. The MCP offered to schedule telehealth visits for members interested in discussing their hypertension with a pharmacist. Kaiser NorCal indicated that the MCP emailed 50 members and ordered 25 blood pressure machines to be sent to members. The MCP

reported an increase in the number of blood pressure measurements recorded in member medical charts and that some members indicated having controlled blood pressure. Kaiser NorCal identified several challenges and lessons learned, including:

- Learning that having only the pharmacist conduct follow-up on the blood pressure monitor orders was not adequate and as a result, identified dedicated outreach staff members to help implement the intervention.
- Recognizing the importance of a tracking mechanism for the blood pressure monitor orders and deliveries.
- Learning that the MCP needed to contract with more than one vendor to ensure timely delivery of the blood pressure monitors.
- Having ongoing communication with the vendor is essential to intervention success.

Kaiser NorCal indicated plans to adapt the tested intervention to include better tracking of the blood pressure monitor deliveries.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Kaiser NorCal reported:

- Conducting member outreach to increase kp.org member portal enrollment. The MCP targeted members 13 years of age and older and provided information to their parents and caregivers regarding how to become a proxy on the site. Kaiser NorCal reported an increase in the percentage of members enrolled on the site and that the MCP met its QIP goal.
- Conducting outreach to African-American members with hypertension to provide wellness coaching via video and phone calls. Kaiser NorCal offered to have members talk with a behavioral medicine physician to discuss feelings of mistrust and other barriers to health care as well as a virtual group visit with an African-American pharmacist and PCP to help manage and support members' health care. Kaiser NorCal outreached to 3,000 African-American members with hypertension, and 300 agreed to participate in a lifestyle change program. Additionally, in February 2021, the MCP launched a landing page on the Kaiser Permanente website specifically targeted for African-American members, which includes:
  - Resources and information about how to check blood pressure.
  - Information on upcoming conferences.
  - Recordings on various health topics, including hypertension, COVID-19 vaccine, and African-American cancer prevention.
- Conducting outreach calls to members identified as tobacco users who are assigned to a PCP in the North Valley service area to offer telephonic wellness coaching, screening, referrals, and prescriptions for tobacco cessation. Kaiser NorCal reported that the MCP successfully provided these services via virtual visits and was able to improve documentation of tobacco prevalence in the target population and update these members' social histories and smoking statuses in their electronic health records. Additionally, Kaiser NorCal indicated that the MCP added attendance at virtual wellness coaching visits and instances of members reporting they quit tobacco use to its data tracking.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Kaiser NorCal's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Kaiser NorCal—KP North

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	55.79	29.36	Not Tested	32.74
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.74%	6.94%	4.80	8.28%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that Kaiser NorCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for Kaiser NorCal:

- Across all domains, six of 16 measures for which HSAG compared rates to benchmarks (38 percent) were above the high performance levels.
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, eight of 37 rates (22 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.

Opportunities for Improvement—Performance Measures

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*

Across all domains for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the MCP's performance declined significantly for 16 of 37 measures (43 percent), with 10 of these 16 measures (63 percent) being in the Women's Health domain. Note that the 67.20 percentage point decline from measurement year 2019 to measurement year 2020 for the *Developmental Screening in the First Three Years of Life—Total* measure rate was due to Kaiser NorCal using a screening tool in measurement year 2020 that was not included in the CMS measure specification. For measurement year 2021, the MCP will use a developmental screening tool that is included in the measure specification.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, Kaiser NorCal should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

Kaiser NorCal determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—hypertension control among African-American members living in South Sacramento.

HSAG validated modules 1 through 3 for the MCP's *Hypertension Control* Health Equity PIP. Upon initial review of modules 1 and 2, HSAG determined that Kaiser NorCal met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Providing the description and rationale for the selected narrowed focus and reporting baseline data that support an opportunity for improvement.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Ensuring that the key drivers and interventions in the key driver diagram are dated according to the results of the corresponding process map and Failure Modes and Effects Analysis Table, and that the interventions are culturally and linguistically appropriate and have the potential to impact the SMART Aim goal.

After receiving technical assistance from HSAG, Kaiser NorCal incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. Kaiser NorCal met all validation criteria for Module 3 in its initial submission.

Kaiser NorCal's *Hypertension Control* Health Equity PIP SMART Aim measures the percentage of African-American members ages 18 to 65 living in South Sacramento who have controlled hypertension.

Table 4.1 presents a description of the interventions that Kaiser NorCal selected to test for its *Hypertension Control* Health Equity PIP. The table also indicates the key drivers and failure modes that each intervention aims to address. Key drivers are factors identified in the key driver diagram that are thought to influence the achievement of the SMART Aim. Failure modes, which are identified as a result of a failure modes and effects analysis, are ways or modes in which something might fail. They include any errors, defects, gaps, or flaws that may occur now or could occur in the future.

Table 4.1—Kaiser NorCal *Hypertension Control* Health Equity PIP Intervention Testing

Intervention	Key Drivers Addressed	Failure Modes Addressed
Conduct training to providers who already have a relationship with the patient population to order blood pressure monitors and provide member education resources	♦ Member trust in the health care system	♦ Members do not trust pharmacists or the health care system in general
Collect blood pressure readings taken at home via a Quick Response (QR) code that links to a secure Microsoft form	♦ Blood pressure screening	♦ Members do not comply with pharmacist's recommendations (i.e., taking blood pressure, changing behaviors, incorporating lifestyle changes) ♦ Members do not trust pharmacists or the health care system in general
Automatically order blood pressure machines and enroll eligible members in a health education class	♦ Blood pressure screening	♦ Members do not trust pharmacists or the health care system in general

During the review period, Kaiser NorCal began intervention testing for the *Hypertension Control* Health Equity PIP and will continue intervention testing through the SMART Aim end date of December 31, 2022. In Kaiser NorCal's 2021–22 MCP-specific evaluation report, HSAG will include information regarding Kaiser NorCal's intervention testing and any technical assistance HSAG provides to the MCP. HSAG will include a summary of the PIP outcomes in Kaiser NorCal's 2022–23 MCP-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Kaiser NorCal determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, Kaiser NorCal selected childhood immunizations for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunizations* PIP. Upon initial review of Module 1, HSAG determined that Kaiser NorCal met most of the required validation criteria; however, HSAG identified opportunities for improvement related to confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology. After receiving technical assistance from HSAG, Kaiser NorCal incorporated HSAG's feedback

into Module 1. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 1. Kaiser NorCal met all validation criteria for Module 2 in its initial submission.

Kaiser NorCal's *Childhood Immunization* PIP SMART Aim measures the percentage of children assigned to the PIP partner clinics who complete their *Childhood Immunization Status—Combination 10* measure doses. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Kaiser NorCal's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

Kaiser NorCal successfully met all validation criteria for modules 1, 2, and 3 for the *Hypertension Control* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework, used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim, established an intervention plan for each intervention to be tested for the *Hypertension Control* Health Equity PIP, and progressed to testing the interventions through a series of PDSA cycles.

Additionally, Kaiser NorCal successfully met all validation criteria for modules 1 and 2 for the *Childhood Immunization* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Childhood Immunization* PIP. Kaiser NorCal has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Kaiser NorCal's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Kaiser NorCal submitted the MCP's PNA report to DHCS on July 7, 2021, and DHCS notified the MCP via email on July 8, 2021, that DHCS approved the report as submitted. While Kaiser NorCal submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Kaiser NorCal's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Increase kp.org member portal activation for members 13 years of age and older.	No	Better	Continuing into 2021
2	By June 30, 2022, increase controlled hypertension among African-American members ages 18 to 65 in South Sacramento.	Yes	Worse	Continuing into 2021
3	Decrease tobacco prevalence among members with a PCP in the North Valley service area from Quarter 1 2020 to Quarter 1 2022.	No	Better	Continuing into 2021

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	Increase kp.org member portal activation for members 13 years of age and older from Quarter 1 2020 to Quarter 4 2022.	No	Continued from 2020
2	By December 31, 2022, increase controlled hypertension among African-American members ages 18 to 65 in South Sacramento.	Yes	Continued from 2020
3	Decrease tobacco prevalence among members with a PCP in the North Valley service area from Quarter 1 2020 to Quarter 1 2022.	No	Continued from 2020

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from Kaiser NorCal's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of Kaiser NorCal's self-reported actions.

Table 6.1—Kaiser NorCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical Audits. Kaiser NorCal should thoroughly review all findings and implement the actions recommended by A&I.	Kaiser NorCal has closed all deficiencies identified during the 2018 and 2019 A&I Medical and State Supported Services Audits. As of December 28, 2020, the 2018 audit is closed. As of June 2, 2021, the 2019 audit is closed.
2. Continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Contraception* Disparity PIP and *Initial Health Assessment* PIP.	Kaiser NorCal continues to track the rate of contraception use among our sexually active teens. Kaiser NorCal adapted the use of the contraception workflow to accommodate the changing COVID-19 environment. Standardized contraception education occurs for staff members, and the nurse referral pool inbox is used to trigger follow-up with sexually active teens. Kaiser NorCal continues to monitor and refine initial health assessment (IHA) interventions. Prior to the public health emergency, Kaiser NorCal developed and disseminated refresher

2019–20 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	materials for providers and medical assistants about Medi-Cal IHA coding requirements. Kaiser NorCal continues to use, and has further refined, the intervention "Smartphrase," developed to document resources offered to members as a tool for providers to understand what has been provided to the member.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Kaiser NorCal's self-reported actions in Table 6.1 and determined that Kaiser NorCal adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. The MCP reported fully resolving the findings from the 2018 and 2019 A&I Medical Audits and provided a summary of how the MCP has continued to monitor the interventions and outcomes from the 2017–19 *Contraception* Disparity and *Initial Health Assessment* PIPs.

2020–21 Recommendations

Based on the overall assessment of Kaiser NorCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that Kaiser NorCal assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate Kaiser NorCal's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix T:
Performance Evaluation Report
Kaiser SoCal (KP Cal, LLC, in San Diego County)
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, KP Cal, LLC, in San Diego County (commonly known as "Kaiser Permanente South" and referred to in this report as "Kaiser SoCal" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Kaiser SoCal provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Kaiser SoCal's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Kaiser SoCal is a full-scope MCP delivering services to its members under a Geographic Managed Care (GMC) model. Although the GMC model operates in the counties of San Diego and Sacramento, Kaiser SoCal only operates in San Diego County. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Kaiser SoCal, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Molina Healthcare of California
- UnitedHealthcare Community Plan

Kaiser SoCal became operational in San Diego County to provide MCMC services effective January 1998. As of June 2021, Kaiser SoCal had 58,764 members.[1] This represents 7 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Follow-Up on 2019 A&I Medical and State Supported Services Audits

A&I conducted the most recent audits for Kaiser SoCal in 2019 for the review period of September 1, 2018, through August 31, 2019. HSAG included a summary of these audits in Kaiser SoCal's 2019–20 MCP-specific evaluation report. At the time of the 2019–20 MCP-specific evaluation report publication, Kaiser SoCal's CAP was in process and under DHCS review. A letter from DHCS dated June 2, 2021, stated that DHCS had analyzed additional information from the MCP and subsequently closed the CAP. The letter indicated that during future audits, DHCS would continue to assess the effectiveness of the CAP as well as the extent to which Kaiser SoCal has operationalized the proposed corrective actions.

Follow-Up on 2018 A&I Medical and State Supported Services Audits

A&I conducted Medical and State Supported Services Audits of Kaiser SoCal in 2018 for the review period of September 1, 2017, through August 31, 2018. HSAG included a summary of these audits in Kaiser SoCal's 2018–19 MCP-specific evaluation report, with the CAP being in process and under DHCS review. In Kaiser SoCal's 2019–20 MCP-specific evaluation report, HSAG reported that the CAP from the 2018 Medical Audit was still open. A letter from DHCS dated December 28, 2020, stated that DHCS had evaluated additional information from the MCP and subsequently closed the CAP. The letter indicated that during future audits, DHCS would continue to assess the effectiveness of the CAP as well as the extent to which Kaiser SoCal has operationalized the proposed corrective actions.

Compliance Reviews Conducted

Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of Kaiser SoCal during the review period for this report; therefore, HSAG includes no new compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of Kaiser SoCal from November 1, 2021, through November 12, 2021, for the review period of September 1, 2019, through October 31, 2021. HSAG will include a summary of these audits in Kaiser SoCal's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of Kaiser SoCal, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Kaiser SoCal* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that Kaiser SoCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for Kaiser SoCal's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 14, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	38.00%	Not Comparable
Childhood Immunization Status—Combination 10	57.07%	58.60%	1.53
Developmental Screening in the First Three Years of Life—Total	78.72%	S	S
Immunizations for Adolescents—Combination 2	58.65%	56.97%	-1.68

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	98.89%	94.90%	-3.99
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	87.70%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	88.34%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	74.12%	Not Comparable
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	—	70.74%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	4	50.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	84.02%	75.32%	-8.70
*Cervical Cancer Screening^*	83.12%	74.23%	-8.89
Chlamydia Screening in Women—Ages 16–20 Years	63.31%	53.15%	-10.16
Chlamydia Screening in Women—Ages 21–24 Years	83.42%	71.56%	-11.86
Chlamydia Screening in Women—Total	72.21%	61.53%	-10.68

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.19%	3.19%	-1.00
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.97%	4.88%	-2.09
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	25.41%	23.24%	-2.17
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	33.87%	30.31%	-3.56
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	12.21%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	3.14%	17.97%	14.83
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	20.29%	31.80%	11.51
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	47.58%	54.15%	6.57

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Prenatal and Postpartum Care—Postpartum Care^*	80.89%	81.22%	0.33
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	92.15%	95.31%	3.16

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	15	26.67%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	15	46.67%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	74.98%	77.88%	2.90
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	52.69%	51.43%	-1.26
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**74.80%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	63.21%	74.59%	11.38

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	63.79%	61.22%	-2.57
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	66.18%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	51.47%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	51.47%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	55.78%	50.16%	-5.62
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	17.34%	14.48%	-2.86
Screening for Depression and Follow-Up Plan—Ages 65+ Years	8.67%	7.53%	-1.14

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures;

therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed

for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All three *Plan All-Cause Readmissions* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	31.95	25.42	Not Tested
Asthma Medication Ratio—Total	88.44%	86.78%	-1.66
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	18.45%	22.91%	4.46
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	18.11%	11.93%	-6.18
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.83%	7.44%	-5.39
Controlling High Blood Pressure—Total	—	77.65%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	6.93%	6.95%	0.02
Plan All-Cause Readmissions—Expected Readmissions—Total	8.40%	9.67%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.83	0.72	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.62%	3.46%	-1.16
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of Kaiser SoCal's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	11	16	68.75%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	7	33	21.21%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	16	6.25%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	12	33	36.36%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Kaiser SoCal's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

Kaiser SoCal conducted two PDSA cycles to improve the MCP's performance on the *Child and Adolescent Well-Care Visits—Total* measure.

Plan-Do-Study Act Cycle #1

For the first PDSA cycle, the MCP tested whether having the Kaiser Permanente Notification System (KPNS) send automated voice or text messages to parents or guardians of children ages 3 to 6 years to remind them to schedule well-care visits for their children would improve the *Child and Adolescent Well-Care Visits—Total* measure rate. Parents opting to receive KPNS text messages received monthly reminders. Kaiser SoCal reported that although during the five-month intervention testing period 141 well-care visits were scheduled, the MCP did not meet the PDSA cycle's SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim goal. Kaiser SoCal reported that the MCP did not have a standardized process for tracking reasons for well-care visit cancellations and indicated that knowing why parents cancelled the well-care visits would have helped the MCP to determine if the cancellations were related to COVID-19. Kaiser SoCal determined that for the next cycle, the MCP would adapt the intervention to add telephonic outreach to the automated outreach approach.

Plan-Do-Study Act Cycle #2

For the second PDSA cycle, Kaiser SoCal planned to conduct two concurrent interventions at three clinic sites:

- Conduct telephonic outreach to parents or guardians of children ages 3 to 6 years who had not been seen for a well-care visit in the past 12 months to encourage them schedule the well-care visit.
- Contact via phone parents or guardians of members who did not attend the well-care visits that were scheduled as a result of the initial outreach.

Kaiser SoCal reported that although the MCP did not achieve the PDSA goal, conducting the initial outreach calls resulted in members completing more well-care visits. Kaiser SoCal indicated that due to unclear guidance, the providers conducted no follow-up calls to members who did not attend their scheduled well-care visits.

Kaiser SoCal indicated that it plans to adopt the first intervention in the three clinic sites; however, due to staffing challenges, the MCP will not expand the intervention. For the telephonic follow-up intervention, Kaiser SoCal described changes the MCP will make to support the providers in conducting the no-show outreach calls, including providing clear guidance to the clinic staff regarding how to conduct these calls and developing a new workflow that includes them.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Kaiser SoCal reported implementing the following strategies to improve the MCP's performance on the *Child and Adolescent Well-Care Visits—Total* measure:

- Conducting member outreach by sending automated messages via texting and voicemail and making phone calls to schedule child and adolescent well-care visits for members in need of these appointments. Kaiser SoCal indicated needing to make the following changes for the outreach efforts to be successful:
  - To increase the number of available well-care visit appointments for 12-year-old members, reduced the appointment time from 30 minutes to 15 minutes.
  - When needed, converted adolescent sick visits to well-care visits.
  - When confirming future appointments, providing nurse telephone advice, and conducting COVID-19 phone screenings, reviewed care gap reports and scheduled well-care visits when applicable.
- Offering telehealth visits as an alternative to in-person visits for members ages 12 to 17 in need of their well-care visit appointments. Prior to the telehealth visits, the MCP requested that members complete a questionnaire which assessed their nutrition, physical activity safety, dental health, mental health, sexual activity, and substance use. Kaiser SoCal conducted the intervention from October 2020 to November 2020 and reported some success with members scheduling and participating in telehealth well-care visit appointments. Kaiser SoCal reported that it was challenging to administer the questionnaires electronically, in part because of California minor consent and confidentiality laws affecting the target population. The MCP stated that it is discussing how to modify the intervention to eliminate the barriers encountered, including offering telehealth visits to members ages 18 to 21 since the minor consent and confidentiality laws do not apply to this population.
- Training Kaiser SoCal staff members on helping adolescent members in need of a well-care visit to enroll in the kp.org member portal. Through a survey, the MCP learned that more than half of the adolescent members surveyed did not know about the kp.org member portal or how to navigate the website. The MCP trained staff members on the member portal functionality so that they could demonstrate the functionality to adolescent members and encourage them to enroll in the site. Kaiser SoCal launched a contest in which staff members were recognized for the number of flyers distributed and the number of member passwords they reset. The MCP reported an increase in portal enrollment among members ages 13 to 17 from November 2020 to February 2021.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Kaiser SoCal's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Kaiser SoCal—San Diego County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be calculated because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.28	21.82	Not Tested	25.42
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	7.06%	Not Comparable	6.95%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

For Kaiser SoCal, HSAG was unable to compare the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for this measure because the denominator was too small (less than 150) for the MCP to report a valid SPD rate.

Strengths—Performance Measures

The HSAG auditor determined that Kaiser SoCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for Kaiser SoCal:

- Across all domains, 11 of 16 measures for which HSAG compared rates to benchmarks (69 percent) were above the high performance levels.
  - All five measures in the Children's Health domain that HSAG compared to benchmarks were above the high performance levels.
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, seven of 33 rates (21 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.

Opportunities for Improvement—Performance Measures

Across all domains, the rate for one measure, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, was below the minimum performance level in measurement year 2020. Across all domains, for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the MCP's performance declined significantly for 12 of 33 measures (36 percent), with seven of these 12 rates (58 percent) being in the Women's Health domain.

For the measure with a rate below the minimum performance level in measurement year 2020 or for measures for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, Kaiser SoCal should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Kaiser SoCal's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in San Diego County, DHCS required that Kaiser SoCal report rates for four HEDIS measures that HSAG validated as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results Kaiser SoCal—San Diego County

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	35.51	30.86	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	6.83%	7.30%	0.46
Plan All-Cause Readmissions—Expected Readmissions—Total	8.31%	9.64%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.82	0.76	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

Kaiser SoCal determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, Kaiser SoCal identified well-child visits among members 7 to 11 years of age as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated Module 1 for the MCP's *Well-Child Visits* Health Equity PIP. Kaiser SoCal met all validation criteria for Module 1 in its initial submission.

Kaiser SoCal's *Well-Child Visits* Health Equity PIP SMART Aim measures the percentage of members 7 to 11 years of age assigned to the PIP partner providers who complete at least one well-child visit. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Kaiser SoCal's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Kaiser SoCal determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—adolescent well-care visits.

HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of Module 1, HSAG determined that Kaiser SoCal met most of the required validation criteria; however, HSAG identified opportunities for improvement related to confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology. After receiving technical assistance from HSAG, Kaiser SoCal incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Kaiser SoCal met all validation criteria for Module 2 in its initial submission.

Kaiser SoCal's *Adolescent Well-Care Visits* PIP SMART Aim measures the percentage of members 12 to 21 years of age who are assigned to the PIP partner providers and complete at least one well-care visit. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Kaiser SoCal's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

Kaiser SoCal successfully met all validation criteria for Module 1 for the *Well-Child Visits* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Well-Child Visits* Health Equity PIP. Kaiser SoCal has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, Kaiser SoCal successfully met all validation criteria for modules 1 and 2 for the *Adolescent Well-Care Visits* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Adolescent Well-Care Visits* PIP. Kaiser SoCal has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Kaiser SoCal's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Kaiser SoCal submitted the MCP's PNA report to DHCS on July 13, 2021, and DHCS notified the MCP via email on the same date that DHCS approved the report as submitted. While Kaiser SoCal submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Kaiser SoCal's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Decrease the disparity in well-child visits for members ages 3 to 6 years in the White population compared to the Hispanic or Latino population.	Yes	Worse	Ended in 2020
2	By June 30, 2021, increase the percentage of members 12 to 17 years of age who have completed an adolescent well-care visit.	No	Worse	Ended in 2020
3	Increase engagement from Quarter 1 2020 to Quarter 1 2022 among members in one of four approved tobacco interventions.	No	Worse	Ended in 2020
4	Increase active member enrollment in the kp.org member portal by at least 585 members by 2021.	No	Better	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	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	New in 2021
2	By December 31, 2022, increase the percentage of members ages 12 to 21 who have completed an adolescent well-care visit.	No	New in 2021

#	Objective Summary	Health Disparity (Yes/No)	Status
3	From Quarter 1 2021 to Quarter 4 2022, decrease the prevalence of tobacco users among members.	No	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from Kaiser SoCal's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of Kaiser SoCal's self-reported actions.

Table 7.1—Kaiser SoCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical Audits. Kaiser SoCal should thoroughly review all findings and implement the actions recommended by A&I.	Kaiser SoCal has closed all deficiencies identified during the 2018 and 2019 A&I Medical and State Supported Services Audits. As of December 28, 2020, the 2018 audit is closed. As of June 2, 2021, the 2019 audit is closed.
2. Continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Depression Screening* Disparity PIP and *Adolescent Vaccinations* PIP.	Kaiser SoCal monitors the *Screening for Depression and Follow-up Plan* measure performance annually and the *Immunization for Adolescents—Combination 2* measure performance monthly. Kaiser SoCal providers and key stakeholders track and act on monthly performance reports published by Kaiser SoCal's clinical analysis team. Kaiser SoCal utilizes the HealthConnect electronic health record (EHR) Proactive Office Encounter workflow and integrated clinical decision support tools to drive the health care team and providers to address the need for

2019–20 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	depression screening and administration of vaccinations. **Depression Screening Disparity:** The 2017–19 PIP focused on improving depression screening in Latino/Hispanic members 18 years of age and older at one primary care medical office site. PIP data tracking was based on the HEDIS *Depression and Follow-Up for Adolescents and Adults* measure. However, the DHCS MCAS measure changed to the *Screening for Depression and Follow-up Plan* measure in measurement year 2020. Given the change in measure and impact of the COVID-19 public health emergency, it was determined that Kaiser SoCal would track *Screening for Depression and Follow-up Plan* measure performance for the entire Medi-Cal population on an annual basis. In the 2020 PNA, it was identified that the COVID-19 pandemic exacerbated and/or created new stressors in daily life that led to an increase in depression, anxiety, suicide, and alcohol and substance abuse issues. In measurement year 2019, the *Screening for Depression and Follow-up Plan* measure rates were highest among members ages 12 to 17, compared to members ages 18 to 64 and members ages 65 and older. To help Southern California communities, including San Diego GMC members, overcome the impact of COVID-19, Kaiser SoCal has established protocols, workflows, and programs to address and meet the complex behavioral health needs of its members.

2019–20 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	Ongoing initiatives to promote depression screening and follow-up in the primary care setting include: ♦ Patient Health Questionnaire (PHQ)-2, PHQ-9, and Edinburg Postnatal Depression Scale Screening tools are integrated in the electronic health record (EHR). ♦ An EHR best practice alert is triggered based on key words entered in the visit chief complaint field for back-office staff to administer a depression screening before the patient sees the physician. ♦ Providers can order a series of PHQ-9 questionnaires to be sent periodically to patients with a diagnosis of depression to monitor the severity of their depression over time. ♦ Patients are referred for depression follow-up based on their PHQ-9 score severity of depression, to Center for Healthy Living programs, self-care apps, the depression care management team, and psychiatry. ♦ Physicians are educated to offer patients other options as the first line of treatment for depression other than medication, primarily by referring to the depression care management team for further assessment. ♦ In 2020, e-visits for depression and anxiety screenings were developed to more quickly connect Kaiser SoCal members to mental health services. **Adolescent Vaccinations:** The 2017–19 PIP focused on improving human papillomavirus (HPV) vaccinations at the 13 San Diego ambulatory pediatric offices. The HPV vaccination rate improved from November 2017 to June 2019 at the

2019–20 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	conclusion of the PIP. HPV vaccination performance in April 2021 also increased. The Kaiser San Diego Ambulatory Pediatric Quality Committee reviews adolescent vaccination rates monthly and takes proactive action to maintain and improve performance. Committee members include pediatric and primary care physician leadership; executive and medical office clinical, administrative, and quality improvement leadership; and data/analytic membership. Ongoing efforts to sustain and improve adolescent HPV vaccination performance include: ♦ Administration of HPV vaccines during non-well-care visits. ♦ Administration of HPV vaccines beginning at 10 years of age. ♦ A reminder letter is sent to adolescents 11 years of age who are due for vaccines needed before their 13th birthday. ♦ An automated text or phone call reminder is sent to adolescents for vaccines needed before their 13th birthday. ♦ The appointment reminder letter sent for all scheduled pediatric appointments includes the vaccination and well-care visit schedule.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Kaiser SoCal's self-reported actions in Table 7.1 and determined that Kaiser SoCal adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. The MCP reported fully resolving the findings from the 2018 and 2019 A&I Medical Audits and provided a detailed summary of how the MCP has continued to monitor the interventions and outcomes from the 2017–19 *Depression Screening* Disparity and *Adolescent Vaccinations* PIPs. Kaiser SoCal also described ongoing initiatives related to depression screenings and adolescent vaccinations.

2020–21 Recommendations

Based on the overall assessment of Kaiser SoCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for the measure with a rate below the minimum performance level in measurement year 2020 or for measures for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that Kaiser SoCal assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate Kaiser SoCal's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix U:
Performance Evaluation Report
Kern Health Systems
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Kern Health Systems ("KHS" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that KHS provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in KHS' 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the

coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

KHS is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in KHS, the Local Initiative MCP, or in Health Net Community Solutions, Inc. (Health Net), the alternative commercial plan.

KHS became operational in Kern County to provide MCMC services effective July 1996. As of June 2021, KHS had 301,277 members.[1] This represents 81 percent of the beneficiaries enrolled in Kern County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for KHS in 2019 for the review period of August 1, 2018, through July 31, 2019. HSAG included a summary of these audits in KHS' 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of KHS during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of KHS from September 13, 2021, through September 24, 2021, for the review period of August 1, 2019, through July 31, 2021. HSAG will include a summary of these audits in KHS' 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of KHS, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Kern Health Systems* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that KHS followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for KHS' performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 17, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
KHS—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	36.16%	Not Comparable
Childhood Immunization Status—Combination 10	29.93%	**22.87%**	-7.06
Developmental Screening in the First Three Years of Life—Total	5.86%	10.23%	4.37
Immunizations for Adolescents—Combination 2	41.36%	**33.09%**	-8.27
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	66.42%	**63.50%**	-2.92
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**52.80%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**51.09%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	30.55%	Not Comparable
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	—	55.70%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
KHS—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	4	50.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
KHS—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	57.29%	**54.50%**	-2.79
*Cervical Cancer Screening^*	56.20%	**54.01%**	-2.19
Chlamydia Screening in Women—Ages 16–20 Years	45.22%	45.91%	0.69
Chlamydia Screening in Women—Ages 21–24 Years	64.87%	61.51%	-3.36
Chlamydia Screening in Women—Total	55.29%	**54.02%**	-1.27
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.94%	2.16%	-0.78
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.51%	5.11%	-0.40

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.76%	13.06%	-1.70
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.35%	23.92%	-2.43
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	0.00%	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	0.31%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	14.32%	11.47%	-2.85
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.33%	9.88%	0.55
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.42%	5.55%	-0.87
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	41.24%	33.67%	-7.57
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	39.67%	38.43%	-1.24
*Prenatal and Postpartum Care—Postpartum Care^*	81.02%	77.62%	-3.40
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	84.18%	**70.07%**	-14.11

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
KHS—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	19	42.11%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
KHS—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.24%	**48.05%**	-2.19
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	32.64%	**31.77%**	-0.87
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	32.45%	34.46%	2.01
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	29.73%	38.96%	9.23
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	S	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.09%	0.02%	-0.07
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	0.00%	S

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures
- HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
KHS—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	7	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results KHS—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	45.67	32.25	Not Tested
Asthma Medication Ratio—Total	48.78%	**54.39%**	5.61
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	57.91%	**50.85%**	-7.06
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	6.53%	5.63%	-0.90
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	52.07%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.04%	11.95%	0.91
Plan All-Cause Readmissions—Expected Readmissions—Total	9.75%	10.01%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.13	1.19	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	29.25%	28.47%	-0.78
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	22.64%	S

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
KHS—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of KHS' measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Plan All-Cause Readmissions* measures
  - All three *Screening for Depression and Follow-Up Plan* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains KHS—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	14	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	37	8.11%
Measurement Year 2020 Rates Below Minimum Performance Levels	13	14	92.86%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	11	37	29.73%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of KHS' SWOT analysis and COVID-19 QIP. Note that while MCPs and PSPs submitted their final SWOT analysis information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Strengths, Weaknesses, Opportunities, Threats Analysis Summary

KHS reported that it implemented the following quality improvement strategies related to its SWOT analysis:

- Established an MCAS Committee that met three times during the year to discuss the SWOT's evolving activities, priorities, and progressive goals.
- Expanded outreach efforts, including launching a robocall project in December 2020. Additionally, as a result of a "Back to Care" preventive care campaign conducted by a Spanish-speaking health educator, a high percentage of members in the Taft area completed their mammograms via a mobile radiology van conveniently located at a local clinic. KHS noted that because of Kern County stay-at-home orders, the MCP had to delay some of its preventive care campaign efforts, including stakeholder collaborative and training activities. The MCP also noted learning the importance of communicating information about the COVID-19 vaccinations to improve member confidence in accessing preventive care services.
- To increase well-care, prenatal, and postpartum visits, completed an outreach and member incentive dashboard in May 2021. The dashboard helps the MCP monitor the effectiveness of its outreach and incentive efforts that are tied to the completion of preventive care visits and documented via administrative data. The MCP indicated that demonstrating to KHS team members a link between outreach and incentive efforts and results led to the team members becoming more engaged in the efforts.
- To increase adolescent well-care visits, worked collaboratively with Health Net to co-brand messaging on member outreach and provider educational materials.
  - KHS indicated that the MCPs have reviewed and shared common trends in provider data. Additionally, the MCPs discussed and developed outreach messaging about the importance of well-child visits, including using telehealth as an option for completing the visits. Due to organizational reprioritization based on resource capacity and time-sensitive projects that could immediately impact KHS performance measures, the MCP decided to postpone further collaboration with Health Net and resume plans for shared collaborative activities as soon as KHS determines it is feasible. KHS indicated that the collaboration with Health Net has been helpful in that it resulted in both MCPs having consistent messaging to providers.

- Conducted telephonic outreach to members with gaps in care. Multiple teams within the MCP participated in the outreach efforts, including the case management team, which provided education to 47 members regarding their individual care gaps.
- To improve member knowledge of health-related issues, opened member portal access on the MCP's website to 254 more members than in the previous year. KHS attributes this success to having scripts written in English and Spanish promoting the information, along with information on member incentives.
- Collaborated with the Asthma Coalition of Kern County so that KHS-eligible members can access the coalition's home asthma visiting program that will provide education about how to prevent asthma triggers within the member's immediate environment. Due to COVID-19, visits are virtual. KHS will continue to promote the program to providers and conduct outreach to members regarding the program.

KHS reported that it has begun to analyze telehealth utilization. Once it completes the analysis, the MCP plans to incorporate telehealth utilization into the MCP's provider pay-for-performance incentive program, promote telehealth utilization during provider meetings, and address providers' hesitancy to use telehealth.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, KHS reported:

- Conducting interactive voice response (IVR) calls and mailing postcards to educate members on health care services and inform them of member incentives to improve the MCP's performance on the *Well-Child Visits in the First 30 Months of Life* measures. KHS attempted 405 IVR calls and mailed 38,022 postcards to members with access barriers to well-child visits. The MCP mailed gift card incentives with a total value of nearly $225,000 to the parents or guardians of members who completed their well-child visits. KHS indicated that it learned the importance of the timing of interventions given that the MCP initiated these interventions at the same time new COVID-19 cases and deaths were occurring. Additionally, KHS stated that it learned the importance of obtaining written consent for IVR calls to provide the opportunity for the MCP to reach more members with this strategy.
- Planning a media campaign targeting children, teens, and pregnant and postpartum moms to inform them that provider offices were open and providing safe health care services in the midst of COVD-19, with an emphasis on the importance of preventive care. KHS planned to use billboards, television, and radio for the campaign. The MCP indicated that the stay-at-home directives and increased spread of COVID-19 and death rates caused multiple delays in the MCP being able to implement the media campaign.
- Modifying member messaging within the MCP's organizational outlets to include voicemail, on-hold telephonic messages, and alerts on KHS' website and member portal advising members of the availability and importance of flu shots. In addition, KHS provided a total of 1,200 flu shots for two flu vaccine events that were held by the Kern County Public Health Department.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In KHS' 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
KHS—Kern County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	43.31	31.53	Not Tested	32.25
*Plan All-Cause Readmissions—Observed Readmissions—Total***	16.07%	10.26%	5.81	11.95%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

KHS' SPD population had a significantly higher hospitalization readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that KHS followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for KHS:

- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the rates for the following three measures improved significantly from measurement year 2019 to measurement year 2020:
  - *Asthma Medication Ratio—Total*

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
- *Developmental Screening in the First Three Years of Life—Total*

Opportunities for Improvement—Performance Measures

KHS has opportunities for improvement across all measure domains and related to access to and quality and timeliness of 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, KHS should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

KHS determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—children's health among members living in Central Bakersfield.

HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits* Health Equity PIP. KHS met all validation criteria for modules 1 and 2 in its initial submission.

KHS' *Well-Child Visits* Health Equity PIP SMART Aim measures the percentage of well-care visits among members 8 to 10 years of age assigned to the PIP provider partner. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in KHS' 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

KHS determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—asthma medication ratio among children and adolescents.

HSAG validated modules 1 and 2 for the MCP's *Asthma Medication Ratio* PIP. Upon initial review of Module 1, HSAG determined that KHS met some required validation criteria; however, HSAG identified opportunities for improvement related to completing all required components of the key driver diagram. After receiving technical assistance from HSAG, KHS incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. KHS met all validation criteria for Module 2 in its initial submission.

KHS' *Asthma Medication Ratio* PIP SMART Aim measures the percentage of asthma medication ratio of 0.50 or greater among members 5 to 21 years of age who were diagnosed with persistent asthma and assigned to the PIP provider group partners. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in KHS' 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

KHS successfully met all validation criteria for modules 1 and 2 for both PIPs. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for both PIPs. KHS has progressed to Module 3 for both PIPs, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on KHS' PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

KHS submitted the final MCP's PNA report to DHCS on July 12, 2021, and DHCS notified the MCP via email on the same date that DHCS approved the report as submitted. While KHS submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with KHS' 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By May 2023, increase the percentage of newly enrolled members and members ages 0 to 15 months, 3 to 6 years, and 12 to 21 years accessing preventive care services.	No	Unknown	Changing for 2021
2	By June 2021, increase the percentage of African-American members who receive all recommended childhood immunizations by 2 years of age.	Yes	Worse	Ended in 2020

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 2023, increase the initial health assessment completion rate.	No	Changed from 2020
2	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	Changed from 2020
3	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	Changed from 2020
4	By June 2023, increase the *Child and Adolescent Well-Care Visits—Total* measure rate.	No	Changed from 2020

#	Objective Summary	Health Disparity (Yes/No)	Status
5	By June 2023, increase the average class participation rate in the asthma education class series.	No	New in 2021
6	By June 2024, increase the percentage of Black pediatric members who complete at least six well-child visits by 15 months of age.	Yes	New in 2021
7	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	New in 2021

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from KHS' July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of KHS' self-reported actions.

Table 6.1—KHS' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Evaluate the possibility of implementing standardized procedures within the MCP's enrollment/claims system to link newborns to their mothers' identification numbers. If a system-based solution is not feasible for the next reporting period, KHS should expand the use of its member identification number crosswalk and incorporate the crosswalk at the initial stages of HEDIS data integration to eliminate the potential of biased eligible populations and rates.	KHS implemented an ongoing manual process for any newborn member records that do not have a Client Index Number (CIN) tied to the member. Below are detailed steps for the manual process used. KHS receives newborn information from physician face sheets through a fax machine. These data are automatically sent to our optical character reader to generate the newborn data into an electronic format and fed into our internal customer service application (QNXT). Within QNXT, the newborn records are manually reviewed to match the information of the newborn's mother, and the newborn's information is linked to the mother's account. Eligibility dates are added to the newborn's enrollment record for the current and succeeding month. KHS will use the crosswalk between the newborn's and mother's records based on case number to link the newborn record to the member CIN.

2019–20 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
2. Apply the lessons learned from the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP and *Use of Imaging Studies for Lower Back Pain* PIP to facilitate improvement for future PIPs.	Evaluation of the 2017–19, *Childhood Immunization Status—Combination 3* Disparity PIP led us to conclude that a key factor in the success of a PIP is effective selection of partners to engage in the PIP. As a result, we approached the new PIPs for 2020–22 by selecting providers to participate who had a high level of commitment to engaging and actively participating in the *Well–Child Visits* Health Equity PIP. So far, the clinic selected has been actively and appropriately participating in this PIP. For the *Asthma Medication Ratio* PIP, we took a similar path to select partners who expressed a significant level of commitment and motivation to actively participate in the PIP. Instead of focusing on the provider community, we opted to partner with KHS' Asthma Disease Management Team and Central California Asthma Coalition's Asthma Mitigation Project (AMP). So far, both teams have been highly engaged and committed to participation in this PIP.

Assessment of MCP's Self-Reported Actions

HSAG reviewed KHS' self-reported actions in Table 6.1 and determined that KHS adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. KHS described in detail:

- The process the MCP implemented to link newborns to their mothers' identification numbers.
- How the MCP applied lessons learned from the 2017–19 PIPs when establishing partnerships for the 2020–22 PIPs.

2020–21 Recommendations

Based on the overall assessment of KHS' delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that 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, KHS assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate KHS' continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix V:
Performance Evaluation Report
L.A. Care Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, L.A. Care Health Plan ("L.A. Care" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that L.A. Care provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in L.A. Care's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

L.A. Care is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in L.A. Care, the Local Initiative MCP, or Health Net Community Solutions, Inc., the alternative commercial plan.

L.A. Care became operational in Los Angeles County to provide MCMC services effective March 1997. As of June 2021, L.A. Care had 2,262,340 members in Los Angeles County.[1] This represents 70 percent of the beneficiaries enrolled in Los Angeles County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

The most recent audits A&I conducted for L.A. Care were in 2019 for the review period of July 1, 2018, through June 30, 2019. HSAG included a summary of these audits in L.A. Care's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of L.A. Care during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of L.A. Care from July 12, 2021, through July 23, 2021, for the review period of July 1, 2019, through June 30, 2021. HSAG will include a summary of these audits in L.A. Care's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of L.A. Care, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for L.A. Care Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that L.A. Care followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for L.A. Care's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 3, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	40.61%	Not Comparable
Childhood Immunization Status—Combination 10	37.47%	**35.77%**	-1.70
Developmental Screening in the First Three Years of Life—Total	15.14%	17.65%	2.51
Immunizations for Adolescents—Combination 2	41.12%	43.55%	2.43
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	85.83%	82.64%	-3.19
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	77.78%	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	76.39%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	36.62%	Not Comparable
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	—	65.49%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	62.65%	**57.75%**	-4.90
*Cervical Cancer Screening^*	66.91%	61.73%	-5.18
Chlamydia Screening in Women—Ages 16–20 Years	63.54%	61.55%	-1.99
Chlamydia Screening in Women—Ages 21–24 Years	72.29%	69.19%	-3.10
Chlamydia Screening in Women—Total	68.01%	65.56%	-2.45
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	1.74%	1.64%	-0.10
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.94%	3.75%	-0.19
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	12.36%	11.34%	-1.02
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	22.49%	20.99%	-1.50

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.60%	1.80%	1.20
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.47%	2.48%	2.01
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	7.05%	8.88%	1.83
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	5.76%	8.78%	3.02
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	1.48%	4.63%	3.15
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	3.30%	9.40%	6.10
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	22.82%	28.57%	5.75
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	22.33%	29.96%	7.63
*Prenatal and Postpartum Care—Postpartum Care^*	73.48%	**76.16%**	2.68
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	90.75%	**88.08%**	-2.67

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	8	19	42.11%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	19	36.84%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.50%	59.89%	1.39
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.04%	40.80%	0.76
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**71.98%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	57.18%	60.62%	3.44
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	68.47%	70.39%	1.92
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	58.27%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	44.58%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	43.25%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	14.53%	13.87%	-0.66
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	6.09%	5.36%	-0.73
Screening for Depression and Follow-Up Plan—Ages 65+ Years	7.30%	6.78%	-0.52

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	7	42.86%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.45	30.48	Not Tested
Asthma Medication Ratio—Total	59.56%	**62.27%**	2.71
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	36.74%	**45.01%**	8.27
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.80%	14.15%	-0.65
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.53%	12.24%	-0.29
Controlling High Blood Pressure—Total	—	61.31%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.74%	9.29%	1.55

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Plan All-Cause Readmissions—Expected Readmissions—Total	9.66%	9.98%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.80	0.93	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.11%	3.97%	-0.14
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	1.87%	1.64%	-0.23

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain
Measurement Year 2020 Performance Measure Findings
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	7	28.57%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of L.A. Care's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- *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*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	13	37	35.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	7	16	43.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	12	37	32.43%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of L.A. Care's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

L.A. Care conducted two PDSA cycles to improve the MCP's performance on the *Well-Child Visits in the First 30 Months of Life* measures.

For the first PDSA cycle, L.A. Care planned to conduct member outreach to parents and caregivers of children in the target population to assist them with scheduling well-child visits with their assigned primary care providers. The MCP reported being unable to carry out the intervention as planned due to multiple barriers which included not being able to access the clinics' scheduling systems to schedule the appointments, a surge in COVID-19 cases during this PDSA cycle, clinics being challenged with high call volumes, clinics having extensive hold times, and clinics having limited staffing. The MCP noted that one of the partner clinics offered to conduct the member outreach and schedule the appointments on behalf of L.A. Care, which resulted in successful scheduling of well-child visits for this clinic. L.A. Care partnered with three clinics to conduct outreach to the target population to schedule their well-child visits.

For the second PDSA cycle, L.A. Care conducted an outcomes measure evaluation of the completed well-child visits for the three partner clinics. To evaluate the outcomes of the first PDSA cycle, L.A. Care reviewed claims and encounter data. Although L.A. Care reported some barriers related to communication with the partner clinics due to COVID-19 response efforts, the MCP reported exceeding the monthly PDSA cycle goals. L.A. Care indicated that moving forward, the MCP will target its outreach efforts toward children ages 15 months and younger and work with the partner clinics to further streamline their processes for documenting member outreach.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, L.A. Care reported:

- Mailing 6,276 asthma informational kits to members with persistent asthma and a ratio of controller medications to total asthma medications of 0.6 or lower in 2020. The kits included asthma educational materials, reminders for the members to take their asthma controller medications, and instructional handouts with stickers to help the members differentiate between controller and reliever medications. The MCP reported that shifting from field

testing the kits in-person to testing them virtually and changing the focus group feedback mechanism from in-person to telephonic was challenging. Based on focus groups' feedback, L.A. Care increased the text size in the materials and used brighter colors for the mailings.

- Conducting targeted outreach using social media toward members eligible for flu vaccinations. The MCP aligned the outreach efforts with the flu season and targeted members at higher risk for flu-related complications. L.A. Care reached 200,000 members via Facebook and Instagram and mailed more than 1 million reminder postcards. The MCP reported conducting nine flu events which yielded 2,500 flu shots to health plan and community members. L.A. Care reported that its biggest challenge was the inability to make interactive voice response calls to members due to the moratorium related to changes in the Telephone Consumer Protection Act.
- Developing a "Meals to You" program to coordinate meals for homebound members who were unable to safely leave their homes during the COVID-19 pandemic due to medical or other high-risk conditions. The MCP coordinated meals for eligible members for up to 30 days and linked members needing meals beyond 30 days with programs that could provide long-term meal support. L.A. Care indicated that it provided approximately 11,000 meals to members within the budget allotted for the program. The MCP indicated that to meet the urgent needs of members during the pandemic, it partnered with a vendor that helped to coordinate services between members and the meal delivery vendor. Additionally, L.A. Care created eligibility criteria to ensure members with the most critical needs were provided meals. The MCP noted that not knowing how long the pandemic would last made it challenging to accurately plan the time frame for the program.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In L.A. Care's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
L.A. Care—Los Angeles County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	52.81	28.91	Not Tested	30.48
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.90%	8.77%	2.13	9.29%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that L.A. Care followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for L.A. Care:

- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 13 of 37 rates (35 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.
  - Eight of the 13 rates that improved significantly (62 percent) were in the Women's Health domain.

Opportunities for Improvement—Performance Measures

Although the Women's Health domain had the highest percentage of measures with rates that improved significantly from measurement year 2019 to measurement year 2020, this domain also had the highest percentage of measures for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020. In total, the MCP's performance declined significantly for 12 of 37 measures from measurement year 2019 to measurement year 2020 (32 percent), and of those 12, seven (58 percent) were within the Women's Health domain. Additionally, of the seven total measures with rates below the minimum performance levels in measurement year 2020, three measures (43 percent) were within the Women's Health domain.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, L.A. Care should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to L.A. Care's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in Los Angeles County, DHCS required that L.A. Care report rates for four HEDIS measures that HSAG validated as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results L.A. Care—Los Angeles County

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	64.76	39.99	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.40%	10.99%	1.59
Plan All-Cause Readmissions—Expected Readmissions—Total	10.45%	11.03%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.90	1.00	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

L.A. Care determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, L.A. Care identified comprehensive diabetes care among African-American members with an HbA1c level greater than 9 percent as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated Module 1 for the MCP's *Diabetes* Health Equity PIP. Upon initial review of the module, HSAG determined that L.A. Care met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, L.A. Care incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

L.A. Care's *Diabetes* Health Equity PIP SMART Aim measures the percentage of African-American members diagnosed with diabetes who have an HbA1c level greater than 9 percent. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in L.A. Care's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

L.A. Care determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—childhood immunization status.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunization Status* PIP. Upon initial review of Module 1, HSAG determined that L.A. Care met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, L.A. Care incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. L.A. Care met all validation criteria for Module 2 in its initial submission.

L.A. Care's *Childhood Immunization Status* PIP SMART Aim measures the percentage of members assigned to a PIP partner clinic who meet the *Childhood Immunization Status—Combination 10* measure criteria. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in L.A. Care's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

L.A. Care successfully met all validation criteria for Module 1 for the *Diabetes* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Diabetes* Health Equity PIP. L.A. Care has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, L.A. Care successfully met all validation criteria for modules 1 and 2 for the *Childhood Immunization Status* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Childhood Immunization Status* PIP. L.A. Care has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on L.A. Care's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

L.A. Care submitted the MCP's PNA report to DHCS on June 17, 2021, and DHCS notified the MCP via email on July 2, 2021, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with L.A. Care's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	By June 30, 2023, increase the percentage of members receiving their postpartum visit.	No	Better	Ended in 2020
2	By June 30, 2023, decrease the percentage of people between the ages of 19 and 50 years in Regional Community Advisory Committee Region 6 diagnosed with persistent asthma who have not filled a prescription for a controller medication in the past 12 months.	Yes	Unknown	Ended in 2020
3	By June 30, 2023, increase the percentage of adult members who report receiving their annual flu vaccination.	No	Better	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By December 31, 2022, decrease the percentage of members reporting consumption of less than one daily serving of fruits and vegetables.	No	New in 2021
2	By December 31, 2022, increase the percentage of members reporting that their doctor spoke with them about eating healthy foods.	No	New in 2021
3	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	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from L.A. Care's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of L.A. Care's self-reported actions.

Table 7.1—L.A. Care's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* PIP.	During the 2017–19 *Childhood Immunization Status—Combination 3* PIP, one of the tried and effective methods was providing care gap lists to providers. Many providers found that a more detailed care gap list would be valuable for their outreach purposes (covering compliance by antigen rather than stating if the members were compliant or not for the *Childhood Immunization Status—Combination 3* measure). As a result of the PIP, we have provided the detailed reports to our entire provider network with regular updates. The current 2020–22 PIP cycle is now focusing on this antigen-specific report, which is called the Missing Vaccination Report. The reports are available for the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measures, showcasing by antigen if the child was compliant or not for the specific vaccination. Our current clinic partner will be utilizing these Missing Vaccination Reports to conduct

2019–20 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	outreach calls to members and schedule members for their missing vaccinations starting in fall 2021. L.A. Care has also provided stamps to the clinic partner and created a fillable postcard to help the clinic with multiple outreach methods to patients who are on the Missing Vaccination Report.
2. Continue testing the health messaging campaign intervention from the 2017–19 *Diabetes Medication Adherence* Disparity PIP to determine its effectiveness for improving diabetes medication adherence in areas with low adherence rates.	Due to the pandemic and limited results, we did not continue the campaign. However, we shifted to interventions more directly targeted at members with uncontrolled diabetes. L.A. Care's health education team continues to make informative phone calls to members with diabetes to educate them regarding medication management. L.A. Care has also partnered with an external vendor and launched more than 50,000 calls to members with diabetes to provide health information and promote medication adherence. L.A. Care has partnered with a community health center as part of the 2020–22 *Diabetes* Health Equity PIP focusing on African-American members with an HbA1c level greater than 9. The community health center was chosen due to its geographic disparity as well as its high volume of underserved community members. In a collaborative effort for the PIP, L.A. Care's quality improvement team has partnered with the pharmacy department to deliver case management and access to pharmacists for the community health center's members.

Assessment of MCP's Self-Reported Actions

HSAG reviewed L.A. Care's self-reported actions in Table 7.1 and determined that L.A. Care adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. L.A. Care described how the MCP adapted the intervention from the 2017–19 *Childhood Immunization Status—Combination 3* PIP to add more details to the care gap lists and indicated that the MCP has expanded distribution of the lists to its entire provider network. The MCP also explained why it did not continue testing the health messaging campaign intervention from the 2017–19 *Diabetes Medication Adherence* Disparity PIP and how the MCP has shifted its focus to members with uncontrolled diabetes.

2020–21 Recommendations

Based on the overall assessment of L.A. Care's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that L.A. Care assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate L.A. Care's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix W:
Performance Evaluation Report
Molina Healthcare of California
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Molina Healthcare of California ("Molina" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Molina provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Molina's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

In Riverside and San Bernardino counties, Molina is a full-scope MCP delivering services to its members as a commercial plan under the Two-Plan Model. Beneficiaries may enroll in Molina, the commercial plan, or in Inland Empire Health Plan, the alternative "local initiative".

In Sacramento and San Diego counties, Molina delivers services to its members under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Molina, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser NorCal

In addition to Molina, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- UnitedHealthcare Community Plan

In Imperial County, Molina delivers services to its members under the Imperial model. Beneficiaries may enroll in Molina or California Health & Wellness Plan, the other commercial plan.

Molina became operational in Riverside and San Bernardino counties to provide MCMC services effective December 1997. Molina expanded to Sacramento County in 2000 and San Diego County in 2005. The MCP began providing services in Imperial County effective November 1, 2013.

DHCS allows Molina to combine data for Riverside and San Bernardino counties for reporting purposes. For this report, Riverside and San Bernardino counties represent a single reporting unit. Sacramento County, San Diego County, and Imperial County each represent a single reporting unit.

Table 1.1 shows the number of members for Molina for each county, the percentage of beneficiaries in the county enrolled in Molina, and the MCP's total number of members as of June 2021.[1]

Table 1.1—Molina Enrollment as of June 2021

* Note that DHCS allows Molina to report Riverside and San Bernardino counties as a combined (i.e., single reporting unit) rate.

County	Enrollment as of June 2021	Percentage of Beneficiaries in the County Enrolled in Molina
Imperial	15,572	19%
Riverside*	93,341	12%
Sacramento	53,078	11%
San Bernardino*	76,688	10%
San Diego	224,781	28%
Total	463,460	

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for Molina in 2019 for the review period of August 1, 2018, through July 31, 2019. HSAG included a summary of these audits in Molina's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of Molina during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

As of the date HSAG was producing this MCP-specific evaluation report, A&I had not yet scheduled the next Medical and State Supported Services Audits of Molina.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of Molina, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Molina Healthcare of California* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that Molina followed the appropriate specifications to produce valid rates; however, Molina had significant issues with reporting accuracy for the Seniors and Persons with Disabilities (SPD) population and state-required patient-level detail (PLD) file. Ultimately, Molina was able to resolve the issues, and there was no impact to performance measure reporting; however, the MCP was required to submit multiple iterations of the PLD files and SPD rates during the audit process.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.36 for Molina's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.36:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table

3.32 present the performance measure results and findings by domain, and Table 3.33 through Table 3.36 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.4 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 through Table 3.4:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 10, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	32.64%	Not Comparable
Childhood Immunization Status—Combination 10	38.84%	40.85%	2.01
Developmental Screening in the First Three Years of Life—Total	35.82%	41.89%	6.07
Immunizations for Adolescents—Combination 2	32.14%	37.73%	5.59
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	91.00%	81.02%	-9.98

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	71.78%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	72.26%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	31.13%	Not Comparable
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	—	63.18%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	31.70%	Not Comparable
Childhood Immunization Status—Combination 10	36.01%	**24.33%**	-11.68
Developmental Screening in the First Three Years of Life—Total	18.83%	27.37%	8.54
Immunizations for Adolescents—Combination 2	38.44%	**33.33%**	-5.11
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	83.45%	81.27%	-2.18
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	73.72%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	72.99%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	14.45%	Not Comparable
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	—	54.34%	Not Comparable

Table 3.3—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	44.33%	Not Comparable
Childhood Immunization Status—Combination 10	36.01%	**35.52%**	-0.49
Developmental Screening in the First Three Years of Life—Total	32.01%	36.27%	4.26
Immunizations for Adolescents—Combination 2	41.85%	41.85%	0.00
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	80.54%	81.75%	1.21

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	77.86%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	75.43%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	27.45%	Not Comparable
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	—	66.55%	Not Comparable

Table 3.4—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	46.72%	Not Comparable
Childhood Immunization Status—Combination 10	48.23%	46.47%	-1.76
Developmental Screening in the First Three Years of Life—Total	44.86%	49.28%	4.42
Immunizations for Adolescents—Combination 2	43.80%	39.65%	-4.15
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	91.73%	86.37%	-5.36
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	80.54%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	79.56%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	21.32%	Not Comparable
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	—	70.72%	Not Comparable

Findings—Children's Health Domain

Table 3.5 through Table 3.8 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.5 through Table 3.8:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.5—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.6—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.7—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.8—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.9 through Table 3.12 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.9—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Breast Cancer Screening—Total	57.35%	**53.24%**	-4.11
*Cervical Cancer Screening^*	64.23%	**55.23%**	-9.00
Chlamydia Screening in Women—Ages 16–20 Years	54.25%	47.46%	-6.79
Chlamydia Screening in Women—Ages 21–24 Years	70.11%	64.85%	-5.26
Chlamydia Screening in Women—Total	62.91%	**57.60%**	-5.31

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.85%	S	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.65%	3.26%	-1.39
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	12.12%	11.67%	-0.45
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.60%	21.90%	-4.70
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S	10.23%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	15.38%	7.39%	-7.99
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	43.79%	39.20%	-4.59

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Prenatal and Postpartum Care—Postpartum Care^*	72.61%	**73.23%**	0.62
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	95.65%	**84.34%**	-11.31

Table 3.10—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	57.16%	**51.18%**	-5.98
*Cervical Cancer Screening^*	60.34%	**45.01%**	-15.33
Chlamydia Screening in Women—Ages 16–20 Years	58.42%	55.40%	-3.02

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Chlamydia Screening in Women—Ages 21–24 Years	66.02%	63.09%	-2.93
Chlamydia Screening in Women—Total	61.71%	59.03%	-2.68
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	1.63%	1.30%	-0.33
Contraceptive Care—All Women—LARC—Ages 21–44 Years	2.68%	2.87%	0.19
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	10.90%	10.47%	-0.43
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	19.67%	19.56%	-0.11
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	1.37%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	5.36%	7.10%	1.74
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.35%	11.80%	2.45
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	29.47%	32.56%	3.09

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	32.95%	32.76%	-0.19
*Prenatal and Postpartum Care—Postpartum Care^*	68.37%	**71.53%**	3.16
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	94.65%	**80.29%**	-14.36

Table 3.11—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	50.06%	**44.30%**	-5.76
*Cervical Cancer Screening^*	59.12%	**51.09%**	-8.03
Chlamydia Screening in Women—Ages 16–20 Years	66.67%	65.67%	-1.00
Chlamydia Screening in Women—Ages 21–24 Years	69.06%	66.32%	-2.74
Chlamydia Screening in Women—Total	67.82%	65.96%	-1.86
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	1.87%	2.01%	0.14
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.90%	4.19%	0.29
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.27%	13.70%	0.43
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.23%	20.89%	-0.34
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.93%	9.88%	-0.05
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	4.02%	5.52%	1.50

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	S	37.84%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	30.73%	34.30%	3.57
*Prenatal and Postpartum Care—Postpartum Care^*	68.86%	77.09%	8.23
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	96.84%	**83.29%**	-13.55

Table 3.12—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	64.65%	61.22%	-3.43
*Cervical Cancer Screening^*	63.75%	**59.12%**	-4.63
Chlamydia Screening in Women—Ages 16–20 Years	62.83%	58.17%	-4.66
Chlamydia Screening in Women—Ages 21–24 Years	70.44%	65.53%	-4.91
Chlamydia Screening in Women—Total	66.59%	61.76%	-4.83
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.88%	2.92%	0.04
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.45%	5.58%	-0.87
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.98%	17.27%	0.29
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.12%	26.57%	-1.55
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.03%	0.64%	-0.39
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	10.67%	18.28%	7.61
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.78%	12.07%	1.29
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.22%	7.65%	-1.57

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	29.21%	40.32%	11.11
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	35.67%	35.01%	-0.66
*Prenatal and Postpartum Care—Postpartum Care^*	79.08%	81.27%	2.19
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	96.11%	90.75%	-5.36

Findings—Women's Health Domain

Table 3.13 through Table 3.16 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.13 through Table 3.16:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- For Imperial County, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*

Table 3.13—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	15	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	15	33.33%

Table 3.14—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	19	5.26%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	4	19	21.05%

Table 3.15—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	19	5.26%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Table 3.16—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	19	42.11%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.17 through Table 3.20 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.17 through Table 3.20:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.17—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.14%	62.26%	5.12
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.66%	48.11%	9.45
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	29.73%	35.56%	5.83
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	4.85%	4.33%	-0.52
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	2.29%	1.33%	-0.96
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	S	S

Table 3.18—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.55%	57.75%	3.20
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.48%	39.32%	2.84
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	33.79%	37.61%	3.82
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	36.37%	39.69%	3.32
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	20.30%	27.51%	7.21
Screening for Depression and Follow-Up Plan—Ages 65+ Years	24.94%	29.54%	4.60

Table 3.19—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.31%	57.57%	6.26
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	34.85%	41.36%	6.51
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	21.84%	28.40%	6.56
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	8.99%	2.47%	-6.52
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	4.25%	2.15%	-2.10
Screening for Depression and Follow-Up Plan—Ages 65+ Years	5.17%	S	S

Table 3.20—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.74%	58.97%	-0.77
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	44.04%	41.58%	-2.46
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	NA	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	40.10%	36.29%	-3.81
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	42.50%	40.58%	-1.92
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	21.52%	34.22%	12.70
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	15.39%	23.04%	7.65
Screening for Depression and Follow-Up Plan—Ages 65+ Years	15.07%	19.23%	4.16

Findings—Behavioral Health Domain

Table 3.21 through Table 3.24 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.21 through Table 3.24:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- For Imperial, Riverside/San Bernardino, and Sacramento counties, HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for this measure in all three reporting units was too small (less than 30) for the MCP to report valid rates.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

- For all four reporting units, HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*

Table 3.21—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	6	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	6	16.67%

Table 3.22—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	6	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Table 3.23—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	6	33.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	6	50.00%

Table 3.24—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	7	42.86%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.25 through Table 3.28 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.25 through Table 3.28:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.25—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	46.90	35.35	Not Tested
Asthma Medication Ratio—Total	60.00%	72.41%	12.41

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	37.96%	**40.88%**	2.92
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.95%	10.53%	0.58
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	63.50%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.85%	9.72%	1.87
Plan All-Cause Readmissions—Expected Readmissions—Total	9.21%	9.69%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.85	1.00	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.52%	5.39%	-2.13
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.26—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	40.43	29.80	Not Tested
Asthma Medication Ratio—Total	53.75%	**54.83%**	1.08

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	35.52%	**46.72%**	11.20
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.55%	11.69%	-0.86
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	46.47%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	6.37%	9.32%	2.95
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%	9.66%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.68	0.96	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	2.91%	3.02%	0.11
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.27—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	57.80	44.82	Not Tested
Asthma Medication Ratio—Total	54.06%	**55.68%**	1.62

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	44.28%	**45.01%**	0.73
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	7.07%	7.70%	0.63
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	49.88%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.99%	10.81%	1.82
Plan All-Cause Readmissions—Expected Readmissions—Total	10.64%	10.56%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.85	1.02	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	6.13%	4.26%	-1.87
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.28—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	44.18	33.73	Not Tested

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Asthma Medication Ratio—Total	57.85%	62.58%	4.73
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	33.33%	37.47%	4.14
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	8.88%	10.80%	1.92
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	61.80%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.09%	8.39%	0.30
Plan All-Cause Readmissions—Expected Readmissions—Total	9.53%	9.91%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.85	0.85	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.87%	3.36%	-0.51
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%	0.00%	0.00

Findings—Acute and Chronic Disease Management Domain

Table 3.29 through Table 3.32 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.29 through Table 3.32:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- For Imperial, Riverside/San Bernardino, and Sacramento counties, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures in all three reporting units was too small (less than 30) for the MCP to report valid rates:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.29—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	5	20.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.30—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	5	40.00%

Table 3.31—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.32—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	7	14.29%

Performance Measure Findings—All Domains

Table 3.33 through Table 3.36 present a summary of Molina's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.33 through Table 3.36:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years* for Imperial, Riverside/San Bernardino, and Sacramento counties
  - *Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years* for Imperial County
  - *Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years* for Imperial County
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years* for Imperial County

- *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years* for Imperial County
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* for Imperial, Riverside/San Bernardino, and Sacramento counties
- *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years* for Imperial, Riverside/San Bernardino, and Sacramento counties

♦ Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:

- *Child and Adolescent Well-Care Visits—Total*
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ For all four reporting units, HSAG did not include the following measures in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*

Table 3.33—Measurement Year 2020 Performance Measure Findings for All Domains Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	14	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	30	3.33%
Measurement Year 2020 Rates Below Minimum Performance Levels	6	14	42.86%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	30	23.33%

Table 3.34—Measurement Year 2020 Performance Measure Findings for All Domains Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	14	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	34	14.71%
Measurement Year 2020 Rates Below Minimum Performance Levels	8	14	57.14%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	34	20.59%

Table 3.35—Measurement Year 2020 Performance Measure Findings for All Domains Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	14	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	34	11.76%
Measurement Year 2020 Rates Below Minimum Performance Levels	6	14	42.86%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	34	17.65%

Table 3.36—Measurement Year 2020 Performance Measure Findings for All Domains Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	14	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	7	37	18.92%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	14	7.14%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	10	37	27.03%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Molina's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

Molina conducted two PDSA cycles to improve member completion of recommended well-child visits in San Diego County.

For the first PDSA cycle, Molina partnered with a third-party vendor to conduct member outreach via texting or phone calls to offer to schedule members for telehealth or in-person well-child visits. While well-child visit rates steadily increased throughout the intervention, the MCP indicated that once the second stay-at-home order was issued December 2020, rates drastically declined. In addition to the second stay-at-home order affecting members

scheduling well-child visits, Molina indicated challenges related to member hesitancy to attending an in-person visit, being unable to contact members due to missing or invalid phone numbers, delays with implementing the mechanism for sharing data between Molina and the clinic partner, and changes in how data were being collected. Molina indicated that the MCP would continue having the vendor conduct member outreach and modify the intervention to include the option for members to opt in rather than opt out of receiving text messages.

For the second PDSA cycle, Molina continued its partnership with the same third-party vendor from the first PDSA cycle and modified the intervention to include the option for members to opt in rather than opt out of receiving text messages. Molina notified members of the texting campaign and informed members that they would be receiving a text message asking them to choose to opt in for receiving text messages. The MCP indicated that modifying the outreach strategy resulted in an increase in total members reached and the number of members who were scheduled for well-child visits. While the changes to the intervention resulted in positive outcomes, participating providers experienced delays in scheduling the in-person well-child visits in Quarter 1 of 2021 due to prioritization of COVID-19 vaccinations during this time frame. Additionally, Molina reported that the MCP experienced a mailing fulfillment error with the vendor, resulting in the vendor not sending the letters to members about the incoming text messages. Molina indicated that the MCP and its corporate entity plan to implement the call and text messaging strategy nationwide.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Molina reported:

- Implementing a multi-pronged member outreach strategy in all four reporting units using mailings, text messaging, and phone calls to inform eligible members ages 18 to 75 with type 1 or type 2 diabetes and no evidence of an HbA1c test in 2020 that the MCP had issued a standing order for their lab tests. Issuing standing orders eliminated the need for the members to attend a telehealth or in-person visit to obtain their HbA1c lab orders. The MCP reported an increase in HbA1c testing in all reporting units during the intervention period of October 2020 through January 2021. All January 2021 reporting unit rates indicated gap reductions when compared to August 2020 rates, except Sacramento County. Molina indicated challenges with implementing the intervention, including:
  - Having difficulty notifying members of the lab location where their standing lab orders were made.
  - Members being afraid to go to the provider sites during the pandemic and stay-at-home orders time period.
  - Some sites being closed due to COVID-19 exposure or lack of staffing.
  - Having outdated member contact information.
  - Members changing primary care providers (PCPs), resulting in the lab location needing to be changed due to the new PCP not having a contract with the initial lab location.

- Conducting member outreach in all four reporting units via text messaging to remind eligible members to have their cervical cancer screening and/or breast cancer screening completed. Molina targeted eligible women ages 21 to 64 with no evidence of a cervical cancer screening in 2020 and ages 50 to 74 with no evidence of a mammogram in 2020. The MCP conducted telephonic outreach to members without texting capability or who opted out of texting. Molina reported that the *Breast Cancer Screening—Total* and *Cervical Cancer Screening* measure rates improved in all reporting units during the intervention period of October 2020 through January 2021. Molina indicated challenges with implementing the intervention, including:
  - Members residing in counties with COVID-19 restrictions that differed from State restrictions, resulting in fewer opportunities to complete screenings in a timely manner.
  - Difficulties scheduling mammograms.
  - Limited appointment availability at radiology sites due to many being closed due to COVID-19.
- Partnering with a vendor to conduct outreach in all four reporting units to parents/guardians of all eligible members ages 3 to 21 with no evidence of a well-child or adolescent well-care visit in 2020 to schedule a telehealth visit with a nurse practitioner. Completion of well-child and adolescent well-care visits improved in all reporting units during the intervention period of October 2020 through January 2021. The January 2021 well-child visit rates indicated gap reductions when compared to August 2020 in all reporting units, and January 2021 adolescent well-care visit rates indicated gap reductions in all reporting units except Riverside/San Bernardino and Imperial counties. Molina indicated that the vendor had limited resources due to the surge in demand for in-person visits during the period when COVID-19 county regulations allowed in-person visits and that the vendor was unable to track incoming calls from members reached through the intervention.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Molina's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.37 through Table 3.40 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.37—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Molina—Imperial County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be calculated because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	59.90	33.58	Not Tested	35.35
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA	8.37%	Not Comparable	9.72%

Table 3.38—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Molina—Riverside/San Bernardino Counties

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	55.58	28.39	Not Tested	29.80
*Plan All-Cause Readmissions—Observed Readmissions—Total***	13.69%	7.99%	5.70	9.32%

Table 3.39—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Molina—Sacramento County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	77.35	40.65	Not Tested	44.82
*Plan All-Cause Readmissions—Observed Readmissions—Total***	12.27%	9.90%	2.37	10.81%

Table 3.40—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Molina—San Diego County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	63.87	31.60	Not Tested	33.73
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.94%	7.10%	4.84	8.39%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

For reporting units for which HSAG could compare measurement year 2020 SPD rates to measurement year 2020 non-SPD rates, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in measurement year 2020 in Riverside/San Bernardino and San Diego counties. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that Molina followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for Molina:

- The MCP performed best in San Diego County, with seven rates in this reporting unit improving significantly from measurement year 2019 to measurement year 2020.
- Across all reporting units and domains for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 17 rates improved significantly from measurement year 2019 to measurement year 2020. Of these 17 rates, eight (47 percent) were in the Behavioral Health domain.

Opportunities for Improvement—Performance Measures

To ensure accurate reporting in the Medi-Cal custom rate reporting templates and the PLD file, Molina should 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 MCP's calculation vendor to ensure accurate production of the PLD file.

Across all reporting units and domains, 21 rates were below the minimum performance levels in measurement year 2020. For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, the MCP's performance declined significantly for 30 rates from measurement year 2019 to measurement year 2020. Thirteen of the 21 rates below the minimum performance levels (62 percent) and 20 of the 30 rates for which the MCP's performance declined significantly (67 percent) were within the Women's Health domain, reflecting that Molina has the greatest opportunities for improvement in the Women's Health domain.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, Molina should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Molina's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in Riverside/San Bernardino and San Diego counties, DHCS required that Molina report rates for four HEDIS measures that HSAG validated as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 and Table 4.2 present the rates for each required MLTSSP performance measure for measurement years 2019 and 2020.

Table 4.1—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results Molina—Riverside/San Bernardino Counties

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MLTSSP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	76.49	39.97	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.84%	NA	Not Tested
Plan All-Cause Readmissions—Expected Readmissions—Total	13.32%	NA	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.89	NA	Not Tested

Table 4.2—Measurement Years 2019 and 2020 MLTSSP Performance Measure Results Molina—San Diego County

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* summarizes utilization of ambulatory care for emergency department visits. Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	74.08	40.16	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.03%	11.26%	1.23
Plan All-Cause Readmissions—Expected Readmissions—Total	12.05%	14.04%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.83	0.80	Not Tested

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

Molina determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, Molina identified diabetes control among African-American members residing in Sacramento County as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated Module 1 for the MCP's *Diabetes Control* Health Equity PIP. Upon initial review of the module, HSAG determined that Molina met most of the required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the narrowed focus baseline specifications and data collection methodology. After receiving technical assistance from HSAG, Molina incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1.

Molina's *Diabetes* Health Equity PIP SMART Aim measures the percentage of African-American members residing in Sacramento County diagnosed with diabetes who have an HbA1c level less than 8.0 percent. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Molina's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Molina determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—childhood immunizations.

HSAG validated modules 1 and 2 for the MCP's *Childhood Immunization Status* PIP. Upon initial review of the modules, HSAG determined that Molina met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Completing all required components of the key driver diagram.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

After receiving technical assistance from HSAG, Molina incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2.

Molina's *Childhood Immunization Status* PIP SMART Aim measures the percentage of members residing in Sacramento County assigned to the PIP clinic partner who complete their *Childhood Immunization Status—Combination 10* measure doses prior to their second birthday. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Molina's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

Molina successfully met all validation criteria for Module 1 for the *Diabetes Control* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework for the *Diabetes Control* Health Equity PIP. Molina has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Additionally, Molina successfully met all validation criteria for modules 1 and 2 for the *Childhood Immunization Status* PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Childhood Immunization Status* PIP. Molina has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Molina's PIP progression, HSAG identified no opportunities for improvement.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Molina submitted the MCP's PNA report to DHCS on June 30, 2021, and DHCS notified the MCP via email on July 26, 2021, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Molina's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 6.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 6.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	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	Worse	Changing for 2021
2	By December 31, 2021, increase access to face-to-face interpretation, including video remote interpreting (VRI), for limited English proficient (LEP) members in Molina's counties of operation.	No	Worse	Continuing into 2021
3	By June 30, 2021, increase the percentage of members with diabetes who are 18 to 75 years of age, reside in Sacramento County, and have a documented HbA1c test completed during the measurement period.	Yes	Unknown	Ended in 2020

Table 6.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 6.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	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	New in 2021
2	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	New in 2021
3	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	Changed from 2020
4	By June 30, 2022, increase the percentage of members identified as having a diagnosis of prediabetes who participate in the Diabetes Prevention Program.	No	New in 2021
5	By December 31, 2022, increase access to face-to-face interpretation, including VRI, for LEP members in Molina's counties of operation.	No	Continued from 2020
6	By December 31, 2022, 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	New in 2021

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 7.1 provides EQR recommendations from Molina's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of Molina's self-reported actions.

Table 7.1—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Continue monitoring the adopted intervention and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Postpartum Care* Disparity PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.	Molina continues to monitor the adopted *Postpartum Care* Disparity PIP intervention of performing in-home postpartum assessments within 21 to 56 days post-delivery. Molina has refined this intervention to include additional high-priority members and to provide weekly delivery lists to PCPs that include the appropriate postpartum visit time frame, which is now seven to 84 days. Molina has sustained improvement when comparing measurement year 2020 *Prenatal and Postpartum Care—Postpartum Care* measure rates with measurement year 2019 rates. The improvement was noted in all counties, despite the challenges presented by the COVID-19 pandemic. Member outreach efforts continued during the pandemic, tailoring the messages to remind members of the importance of completing critical services,

2019–20 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	offering telehealth visits when appropriate, and completing some direct scheduling for in-office appointments. As a result of these efforts, the measurement year 2020 rate in Sacramento County achieved the goal of exceeding the NCQA 50th percentile, and the San Diego County rate exceeded the NCQA 75th percentile. The 50th percentile goal was not reached for Riverside/San Bernardino and Imperial counties. Of note, there was an 8.5 percent rate increase in the measurement year 2020 NCQA 50th percentile, which is adjusted annually based on national Medicaid performance. Molina will continue efforts to achieve optimal outcomes and exceed the NCQA 50th percentile goal in all counties.
2. Apply the lessons learned from the 2017–19 *Postpartum Care* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP to facilitate improvement for future PIPs.	Molina will apply the following lessons learned from the 2017–19 *Postpartum Care* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP to facilitate improvement for future PIPs: ♦ Frequent data quality review for early identification and correction of missing data and/or data elements. ♦ Ongoing member outreach and visit reminders to reduce missed appointments. ♦ Strong workflows with buy-in from MCP staff members and external partners. ♦ Careful selection of multiple external partners to ensure continuance of the intervention in the event one partner withdraws from the project. ♦ Ongoing communication with all MCP staff members who may interact with the

2019–20 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	members included in the intervention to reinforce the intervention. ♦ Provide incentives to reward members for completing visits/immunizations. ♦ MCP control of members' incentive distribution to ensure timely receipt and to optimize member satisfaction.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Molina's self-reported actions in Table 7.1 and determined that Molina adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. Molina described how the MCP has monitored the intervention from the 2017–19 *Postpartum Care* Disparity PIP and actions the MCP took to educate the members about the importance of seeking postpartum care services during the COVID-19 pandemic. Additionally, Molina described in detail the lessons learned from the 2017–19 PIPs that the MCP will apply to facilitate improvement for future PIPs.

2020–21 Recommendations

Based on the overall assessment of Molina's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- To ensure accurate reporting in the Medi-Cal custom rate reporting templates and the 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 MCP's calculation vendor to ensure accurate production of the PLD file.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate Molina's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix X:
Performance Evaluation Report
Partnership HealthPlan of California
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, Partnership HealthPlan of California ("Partnership" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that Partnership provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in Partnership's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Partnership is a full-scope MCP delivering services to its members in the County Organized Health System model.

Partnership became operational to provide MCMC services in Solano County effective May 1994, Napa County in March 1998, in Yolo County in March 2001, in Sonoma County in October 2009, and in Marin and Mendocino counties in July 2011. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural northern counties of California in 2013. Under the expansion, Partnership contracted with DHCS to provide MCMC services in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning November 1, 2013.

Table 1.1 shows Partnership's enrollment for each county and the MCP's total number of members as of June 2021.[1]

Table 1.1—Partnership Enrollment as of June 2021

County	Enrollment as of June 2021
Del Norte	12,063
Humboldt	57,173
Lake	32,613
Lassen	8,021
Marin	43,415
Mendocino	38,482
Modoc	3,709

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

County	Enrollment as of June 2021
Napa	31,558
Shasta	65,778
Siskiyou	18,557
Solano	121,199
Sonoma	116,499
Trinity	5,112
Yolo	55,638
Total	609,817

For reporting purposes, DHCS allows Partnership to combine data from multiple counties into regions to make up four single reporting units. Partnership's regions are as follows:

- **Northeast**—Lassen, Modoc, Shasta, Siskiyou, and Trinity counties
- **Northwest**—Del Norte and Humboldt counties
- **Southeast**—Napa, Solano, and Yolo counties
- **Southwest**—Lake, Marin, Mendocino, and Sonoma counties

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

A&I conducted the most recent audits for Partnership in 2020 for the review period of January 1, 2019, through December 31, 2019. HSAG included a summary of these audits in Partnership's 2019–20 MCP-specific evaluation report. Based on the status of the MCP's COVID-19 response efforts, A&I conducted no audits of Partnership during the review period for this report; therefore, HSAG includes no compliance review information for the MCP in this report.

A&I is scheduled to conduct Medical and State Supported Services Audits of Partnership from November 1, 2021, through November 12, 2021, for the review period of January 1, 2020, through June 30, 2021. HSAG will include a summary of these audits in Partnership's 2021–22 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of Partnership, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Partnership HealthPlan of California* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that Partnership followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.36 for Partnership's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.36:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.32 present the performance measure results and findings by domain, and Table 3.33 through Table 3.36 present the measurement year 2020 performance measure findings for the domains combined.

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.4 present the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1 through Table 3.4:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Sep 30, 2021.

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	34.58%	Not Comparable
Childhood Immunization Status—Combination 10	15.33%	**19.22%**	3.89
Developmental Screening in the First Three Years of Life—Total	1.99%	5.43%	3.44
Immunizations for Adolescents—Combination 2	18.98%	**21.17%**	2.19
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	83.94%	84.91%	0.97

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**60.58%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**56.45%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	29.48%	Not Comparable
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	—	56.88%	Not Comparable

Table 3.2—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	32.49%	Not Comparable
Childhood Immunization Status—Combination 10	20.19%	**27.98%**	7.79
Developmental Screening in the First Three Years of Life—Total	2.77%	5.76%	2.99
Immunizations for Adolescents—Combination 2	30.90%	**27.74%**	-3.16
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	79.32%	**76.16%**	-3.16
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**64.72%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**63.99%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	29.60%	Not Comparable
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	—	61.08%	Not Comparable

Table 3.3—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	34.33%	Not Comparable
Childhood Immunization Status—Combination 10	43.31%	40.63%	-2.68
Developmental Screening in the First Three Years of Life—Total	32.79%	31.39%	-1.40
Immunizations for Adolescents—Combination 2	52.31%	46.83%	-5.48
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	89.78%	**70.32%**	-19.46

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**63.02%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**60.10%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	28.30%	Not Comparable
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	—	61.89%	Not Comparable

Table 3.4—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	34.08%	Not Comparable
Childhood Immunization Status—Combination 10	43.07%	43.55%	0.48
Developmental Screening in the First Three Years of Life—Total	34.80%	34.28%	-0.52
Immunizations for Adolescents—Combination 2	46.47%	46.23%	-0.24
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	84.91%	**77.37%**	-7.54
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	**67.40%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	**63.26%**	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	35.89%	Not Comparable
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	—	66.77%	Not Comparable

Findings—Children's Health Domain

Table 3.5 through Table 3.8 present the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.5 through Table 3.8:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.5—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	4	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.6—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	4	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	4	0.00%

Table 3.7—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Table 3.8—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	4	25.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.9 through Table 3.12 present the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.9—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	55.13%	**50.09%**	-5.04
*Cervical Cancer Screening^*	55.96%	**51.35%**	-4.61
Chlamydia Screening in Women—Ages 16–20 Years	50.85%	43.19%	-7.66
Chlamydia Screening in Women—Ages 21–24 Years	60.10%	56.29%	-3.81
Chlamydia Screening in Women—Total	54.96%	**49.04%**	-5.92
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	5.38%	4.35%	-1.03
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.88%	4.35%	-0.53

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	30.93%	28.44%	-2.49
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.50%	23.03%	-2.47
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	11.34%	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.42%	8.87%	1.45
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.32%	6.89%	-1.43
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.02%	23.38%	-10.64
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	32.62%	29.65%	-2.97
*Prenatal and Postpartum Care—Postpartum Care^*	77.86%	**74.21%**	-3.65
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	92.94%	**81.27%**	-11.67

Table 3.10—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	47.96%	**42.41%**	-5.55
*Cervical Cancer Screening^*	50.85%	**53.53%**	2.68
Chlamydia Screening in Women—Ages 16–20 Years	53.48%	44.83%	-8.65
Chlamydia Screening in Women—Ages 21–24 Years	62.31%	59.29%	-3.02
Chlamydia Screening in Women—Total	57.82%	**51.87%**	-5.95
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.91%	3.86%	-1.05
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.69%	4.46%	-0.23

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	30.84%	28.65%	-2.19
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.95%	23.12%	-1.83
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.72%	14.17%	2.45
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%	0.00%	0.00
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.56%	7.25%	0.69
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	38.98%	37.50%	-1.48
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	38.59%	40.20%	1.61
*Prenatal and Postpartum Care—Postpartum Care^*	87.10%	87.59%	0.49
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	91.97%	**81.51%**	-10.46

Table 3.11—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	64.54%	**56.64%**	-7.90
*Cervical Cancer Screening^*	67.40%	**60.38%**	-7.02
Chlamydia Screening in Women—Ages 16–20 Years	66.47%	59.53%	-6.94
Chlamydia Screening in Women—Ages 21–24 Years	74.49%	67.23%	-7.26
Chlamydia Screening in Women—Total	70.13%	63.21%	-6.92
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.00%	3.50%	-0.50
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.75%	5.69%	-1.06

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	21.22%	19.28%	-1.94
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.74%	27.54%	-3.20
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.18%	2.84%	1.66
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	19.89%	19.63%	-0.26
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.30%	20.99%	1.69
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	11.81%	14.04%	2.23
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	38.71%	41.10%	2.39
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	45.57%	47.01%	1.44
*Prenatal and Postpartum Care—Postpartum Care^*	78.10%	86.13%	8.03
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	94.89%	89.05%	-5.84

Table 3.12—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	60.26%	**52.88%**	-7.38
*Cervical Cancer Screening^*	68.37%	65.28%	-3.09
Chlamydia Screening in Women—Ages 16–20 Years	62.06%	52.41%	-9.65
Chlamydia Screening in Women—Ages 21–24 Years	67.90%	57.50%	-10.40
Chlamydia Screening in Women—Total	64.53%	**54.68%**	-9.85
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	4.86%	4.77%	-0.09
Contraceptive Care—All Women—LARC—Ages 21–44 Years	7.29%	6.17%	-1.12

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	24.96%	23.68%	-1.28
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	31.18%	28.31%	-2.87
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.72%	1.65%	-0.07
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	31.65%	32.75%	1.10
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	21.59%	19.83%	-1.76
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	7.02%	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.20%	9.62%	-0.58
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	54.43%	55.56%	1.13
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	46.92%	43.98%	-2.94
*Prenatal and Postpartum Care—Postpartum Care^*	86.86%	87.59%	0.73
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	95.38%	**86.13%**	-9.25

Findings—Women's Health Domain

Table 3.13 through Table 3.16 present the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.13 through Table 3.16:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.13—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	5	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	5	5	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	19	36.84%

Table 3.14—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	4	5	80.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	5	19	26.32%

Table 3.15—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	19	10.53%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	9	19	47.37%

Table 3.16—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	19	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	5	60.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	8	19	42.11%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.17 through Table 3.20 present the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.17 through Table 3.20:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.17—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	56.81%	62.25%	5.44
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.93%	44.54%	4.61
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**77.34%**	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	31.22%	28.64%	-2.58
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	33.80%	25.76%	-8.04
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	58.11%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	31.32%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**30.94%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.56%	1.71%	0.15
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.64%	0.98%	0.34
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	1.76%	S

Table 3.18—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.60%	61.09%	1.49
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	42.60%	44.78%	2.18
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**78.68%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	34.51%	34.19%	-0.32

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	51.61%	33.33%	-18.28
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	53.72%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	32.23%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**32.23%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S	S	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.12%	0.19%	0.07
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%	S	S

Table 3.19—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	62.02%	64.53%	2.51
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.16%	46.15%	2.99
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**75.65%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	23.75%	39.53%	15.78
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	23.85%	35.92%	12.07
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	49.78%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	30.74%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	**29.87%**	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.70%	12.48%	5.78
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	8.53%	9.57%	1.04
Screening for Depression and Follow-Up Plan—Ages 65+ Years	5.27%	4.52%	-0.75

Table 3.20—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.24%	58.62%	0.38
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.42%	40.22%	-0.20
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**75.71%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	28.46%	42.56%	14.10
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	27.52%	48.45%	20.93

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	66.98%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	45.28%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	45.28%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.56%	5.26%	1.70
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	5.82%	6.43%	0.61
Screening for Depression and Follow-Up Plan—Ages 65+ Years	3.17%	2.72%	-0.45

Findings—Behavioral Health Domain

Table 3.21 through Table 3.24 present the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.21 through Table 3.24:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Screening for Depression and Follow-Up Plan* measures

Table 3.21—Behavioral Health Domain Measurement Year 2020 Performance Measure Findings Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	7	57.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.22—Behavioral Health Domain Measurement Year 2020 Performance Measure Findings Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	7	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.23—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	7	57.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	4	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Table 3.24—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	4	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	4	7	57.14%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	4	25.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.25 through Table 3.28 present the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.25 through Table 3.28:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rates are displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.25—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	53.55	41.02	Not Tested
Asthma Medication Ratio—Total	52.23%	**56.28%**	4.05
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	36.48%	**38.93%**	2.45
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.46%	13.53%	-0.93
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	59.85%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.49%	8.19%	0.70
Plan All-Cause Readmissions—Expected Readmissions—Total	9.78%	9.13%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.77	0.90	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.30%	3.52%	-0.78
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.26—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	41.58	30.97	Not Tested
Asthma Medication Ratio—Total	51.85%	**56.04%**	4.19

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	32.85%	**39.90%**	7.05
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.09%	15.15%	-0.94
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	51.82%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.26%	8.22%	0.96
Plan All-Cause Readmissions—Expected Readmissions—Total	9.88%	9.33%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.74	0.88	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.87%	4.63%	-0.24
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA	NA	Not Comparable

Table 3.27—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	48.93	36.20	Not Tested
Asthma Medication Ratio—Total	71.26%	73.50%	2.24
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	31.30%	**37.96%**	6.66
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	7.79%	7.12%	-0.67
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	0.00%	S
Controlling High Blood Pressure—Total	—	53.28%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.85%	9.33%	1.48
Plan All-Cause Readmissions—Expected Readmissions—Total	9.89%	9.31%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.79	1.00	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.39%	4.79%	0.40
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Table 3.28—Acute and Chronic Disease Management Domain Measurement Years 2019 and 2020 Performance Measure Results Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	47.04	35.54	Not Tested
Asthma Medication Ratio—Total	63.86%	68.74%	4.88
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	32.52%	36.50%	3.98
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.86%	13.19%	-1.67
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	55.47%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.12%	8.81%	-0.31
Plan All-Cause Readmissions—Expected Readmissions—Total	9.96%	9.27%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.92	0.95	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	6.15%	7.38%	1.23
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.29 through Table 3.32 present the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.29 through Table 3.32:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- For the Northeast and Northwest regions, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.29—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	5	0.00%

Table 3.30—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	5	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	2	2	100.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	1	5	20.00%

Table 3.31—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	7	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Table 3.32—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	1	7	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	7	0.00%

Performance Measure Findings—All Domains

Table 3.33 through Table 3.36 present a summary of Partnership's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.33 through Table 3.36:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- For the Northeast and Northwest regions, HSAG did not include the following measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominators for these measures were too small (less than 30) for the MCP to report valid rates:
  - *Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years*
  - *Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years*
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*

- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All 12 *Contraceptive Care* measures
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- All three *Plan All-Cause Readmissions* measures
- All three *Screening for Depression and Follow-Up Plan* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.33—Measurement Year 2020 Performance Measure Findings for All Domains Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	16	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	35	14.29%
Measurement Year 2020 Rates Below Minimum Performance Levels	13	16	81.25%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	35	20.00%

Table 3.34—Measurement Year 2020 Performance Measure Findings for All Domains Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	16	6.25%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	2	35	5.71%
Measurement Year 2020 Rates Below Minimum Performance Levels	13	16	81.25%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	6	35	17.14%

Table 3.35—Measurement Year 2020 Performance Measure Findings for All Domains Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	3	16	18.75%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	37	16.22%
Measurement Year 2020 Rates Below Minimum Performance Levels	8	16	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	12	37	32.43%

Table 3.36—Measurement Year 2020 Performance Measure Findings for All Domains Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	16	6.25%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	5	37	13.51%
Measurement Year 2020 Rates Below Minimum Performance Levels	7	16	43.75%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	9	37	24.32%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Note that during the review period for this report, Partnership was one of the MCPs DHCS required to meet quarterly via telephone with its assigned DHCS nurse consultant to enable DHCS to continue monitoring the MCP's performance.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.

Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of Partnership's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

Partnership conducted two PDSA cycles to improve the MCP's performance on the *Asthma Medication Ratio—Total* measure for the Northwest Region. For the first PDSA cycle, Partnership tested whether conducting asthma-related academic detailing training to providers would change their asthma treatment practices and result in improvement in the *Asthma Medication Ratio—Total* measure rate. The MCP reported exceeding the PDSA SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective and learning the importance of frequently updating the member gap-in-care reports to ensure accurate monitoring of members' asthma medication ratios.

For the second PDSA cycle, Partnership tested whether conducting virtual asthma-related academic detailing training to providers would help improve prescriber knowledge and understanding of updated asthma treatment guidelines and ensure the providers are prescribing the correct asthma medications and doses. During the training, Partnership also discussed asthma action plans and the provider's role in empowering members to control their asthma and seek care when needed. Although Partnership did not meet the PDSA cycle SMART objective, the MCP reported some improvement in the *Asthma Medication Ratio—Total* measure rate. Partnership reported that it did not have an effective mechanism to determine which prescribers warranted additional training. To address this challenge, the MCP developed a report that lists prescribers and members with a high number of rescue medication fills. This report will help Partnership to better monitor the effectiveness of future academic detailing trainings.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, Partnership reported:

- Offering a member incentive via the Birthday Club program to motivate eligible members in the Northeast and Northwest regions to complete their well-child visits. Partnership reported that the incentives contributed to improvement in well-child visits completed.

- Promoting provider use of Partnership's formulary to assure members with hypertension receive a digital blood pressure monitor to use at home and communicating with providers about the appropriate documentation of remote blood pressure readings. The MCP noted that one of the largest provider organizations in Mendocino County consistently used the pharmacy benefit to ensure member access to blood pressure monitors through all five of its clinic sites. Partnership indicated learning that many providers were not aware they could prescribe home blood pressure monitors and determined that offering provider training regarding member benefit coverage will benefit both providers and members.
- Piloting electronic prompts within Partnership's call center system and member Web portal that notify members and call center staff of screenings due for members. The prompts were related to measures that represented opportunities for improvement for the MCP in the Northeast and Northwest regions regarding chronic disease and preventive screenings. Partnership reported seeing a higher screening completion rate for members engaged in the intervention and learning the value of interacting with members about their individual gaps in care.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In Partnership's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.37 through Table 3.40 present the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.37—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	74.08	37.60	Not Tested	41.02
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.69%	7.30%	2.39	8.19%

Table 3.38—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
Partnership—Northwest (Del Norte and Humboldt Counties)

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	58.64	28.72	Not Tested	30.97
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.62%	7.06%	3.56	8.22%

Table 3.39—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	70.37	33.49	Not Tested	36.20
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.43%	8.47%	2.96	9.33%

Table 3.40—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	72.69	33.20	Not Tested	35.54
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.63%	8.16%	2.47	8.81%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

In measurement year 2020, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population for the Northwest, Southeast, and Southwest regions. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members. For the Northeast Region, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for this measure.

Strengths—Performance Measures

The HSAG auditor determined that Partnership followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable measurement year 2020 performance measure results for Partnership across all reporting units and domains:

- The following measures for which HSAG compared rates to benchmarks were above the high performance levels:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment—Total* for the Southeast Region
  - *Asthma Medication Ratio—Total* for the Southeast Region
  - *Prenatal and Postpartum Care—Postpartum Care* for the Northwest, Southeast, and Southwest regions
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, 18 rates showed statistically significant improvement from measurement year 2019 to measurement year 2020. Twelve of these rates (67 percent) were for measures within the Behavioral Health domain.

Opportunities for Improvement—Performance Measures

Across all reporting units and domains, 41 of 64 rates HSAG compared to benchmarks (64 percent) were below the minimum performance levels in measurement year 2020. Additionally, for measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, Partnership's performance declined significantly from measurement year 2019 to measurement year 2020 for 34 of 144 rates (24 percent). Partnership has the most opportunities for improvement in the Children's Health and Women's Health domains. In the Children's Health domain, 15 rates were below the minimum performance levels in

measurement year 2020, and Partnership's performance declined significantly from measurement year 2019 to measurement year 2020 for two rates. In the Women's Health domain, 14 rates were below the minimum performance levels, and the MCP's performance declined significantly from measurement year 2019 to measurement year 2020 for 29 rates.

For all measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, Partnership should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

Partnership determined to select a new topic for its Health Equity PIP. Using its MCP-specific data, Partnership identified breast cancer screening among members living in rural and small counties as the topic for its 2020–22 Health Equity PIP by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

HSAG validated modules 1 and 2 for the MCP's *Breast Cancer Screening* Health Equity PIP. Upon initial review of Module 1, HSAG determined that Partnership met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, Partnership incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Partnership met all validation criteria for Module 2 in its initial submission.

Partnership's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of female members ages 52 to 74 who complete their breast cancer screening. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in Partnership's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

Partnership determined to select a new topic for its 2020–22 Child and Adolescent Health PIP. Based on MCP-specific data, Partnership selected well-child visits in the first 15 months of life for its 2020–22 Child and Adolescent Health PIP.

HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits* PIP. Upon initial review of the modules, HSAG determined that Partnership met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Clearly labeling the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Ensuring that the key drivers and interventions in the key driver diagram are dated according to the results of the corresponding process map and Failure Modes and Effects Analysis Table, and that the interventions are culturally and linguistically appropriate and have the potential to impact the SMART Aim goal.
- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure is appropriate for the intervention.

After receiving technical assistance from HSAG, Partnership incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Partnership's *Well-Child Visits* PIP SMART Aim measures the percentage of members assigned to the PIP provider partner who complete six or more well-child visits by 15 months of age.

Table 4.1 presents a description of the intervention that Partnership selected to test for its *Well-Child Visits* PIP. The table also indicates the key driver and failure modes that the intervention aims to address. Key drivers are factors identified in the key driver diagram that are thought to influence the achievement of the SMART Aim. Failure modes, which are identified as a result of a failure modes and effects analysis, are ways or modes in which something might fail. They include any errors, defects, gaps, or flaws that may occur now or could occur in the future.

Table 4.1—Partnership *Well-Child Visits* PIP Intervention Testing

Intervention	Key Drivers Addressed	Failure Modes Addressed
Implement Saturday clinics specifically for well-child visit appointments for members 0 to 15 months old	♦ Schedule availability (ensure schedule availability outside of normal business hours)	♦ Next available well-child visit appointment can be booked up to 3 months in advance ♦ Parents/guardians are not available during normal business hours

During the review period, Partnership began intervention testing. The MCP will continue intervention testing through the SMART Aim end date of December 31, 2022. In Partnership's 2021–22 MCP-specific evaluation report, HSAG will include information regarding Partnership's intervention testing and any technical assistance HSAG provides to the MCP. HSAG will include a summary of the PIP outcomes in Partnership's 2022–23 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Partnership successfully met all validation criteria for modules 1 and 2 for the *Breast Cancer Screening* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Breast Cancer Screening* Health Equity PIP. Partnership has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Additionally, Partnership successfully met all validation criteria for modules 1, 2, and 3 for the *Well-Child Visits* PIP. The validation findings show that the MCP built a strong foundational framework, used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim, established an intervention plan for the intervention to be tested for the *Well-Child Visits* PIP, and progressed to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on Partnership's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

Partnership submitted the MCP's final PNA report to DHCS on June 25, 2021, and DHCS notified the MCP via email on June 28, 2021, that DHCS approved the report as submitted.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with Partnership's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, same, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate for Hispanic/Latino members in the Northeast and Northwest regions.	Yes	Better	Continuing into 2021
2	By February 2021, maintain or improve the *Asthma Medication Ratio—Total* measure rate for pediatric members in the Northeast and Northwest regions.	No	Better	Continuing into 2021
3	Improve the gender sensitivity awareness of staff members to create an environment that is supportive of members' culture, ethnicity, sexual orientation, and gender identity.	No	Same	Continuing into 2021
4	By February 2021, improve access to timely prenatal care (first visit in the first trimester) for all eligible members.	No	Same	Ended in 2020
5	Maintain or improve the *Breast Cancer Screening—Total* measure rate for American Indian/Alaska Native members in the Northwestern Region	Yes	Better	Continuing into 2021

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By March 1, 2022, increase the proportion of non-English-speaking/non-White members reporting grievances.	No	New in 2021
2	By December 31, 2021, promote members' use of video remote interpreter services at provider sites.	No	New in 2021
3	By December 31, 2021, provide two trainings to address health equity knowledge gaps for internal staff members.	No	New in 2021
4	By March 1, 2022, increase the *Breast Cancer Screening—Total* measure rate among American Indians/Alaska Native members.	Yes	Continued from 2020
5	By March 1, 2022, improve the *Asthma Medication Ratio—Total* measure rate for pediatric members in the Northeast and Northwest regions.	Yes	Continued from 2020
6	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	Continued from 2020

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from Partnership's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of Partnership's self-reported actions.

Table 6.1—Partnership's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Continue testing interventions and monitor outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Diabetes Nephropathy Screening* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP.	***Diabetes Nephropathy Screening*** **Disparity PIP** Intervention testing in support of diabetes nephropathy screening was discontinued for fiscal year 2020–21. Partnership selected this measure for the PIP based on HEDIS reporting year 2017 (measurement year 2016) performance that was below the NCQA Medicaid 50th percentile for the Southeast Region and below the 25th percentile for the Southwest Region. We were attempting to close the gap in performance of the disparate number of members in rural areas in our Southwest Region compared to the Southeast Region. The aim of the PIP was to improve performance on the measure through partnering with one of the provider sites in Sonoma County. By HEDIS reporting year 2018 (measurement year 2017), the rates in the Southwest Region and Sonoma County improved. In HEDIS reporting year 2019 (measurement year 2018), the rates improved more in both the Southwest Region and Sonoma County. The minimum performance level also changed for this measure. While there was work that occurred with other provider partners in the Southwest Region along with our PIP partner site to

2019–20 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	improve nephropathy rates, with the removal of the measure from the MCAS measurement year 2019 measure set, Partnership shifted resources to focus on the remaining diabetes measure indicators. ***Childhood Immunization Status—Combination 3* PIP** To continue the sustained improvement realized in the 2017–19 *Childhood Immunization Status—Combination 3* PIP, Partnership has taken the initial intervention of focusing on members approaching 2 years of age and adapted the discoveries made in the original PIP as follows: ♦ Conducted research across many provider sites to confirm they also have a significant portion of their 0- to 2-year-old patient population that only needed one to two doses to complete the *Childhood Immunization Status—Combination 3* measure immunization series and encouraged all providers to review all patients' immunization statuses as they approach 2 years of age to complete any final doses needed. ♦ Created provider-specific, population-wide immunization reporting (Partnership has since named this report the "Immunization Dose Report") that includes all patients and dosage dates on a single report that can be easily manipulated by providers for analysis of their *Childhood Immunization Status—Combination 3* measure patient population. ♦ From the expansion of the *Childhood Immunization Status—Combination 3* measure to the *Childhood Immunization Status—Combination 10* measure, this reporting has further evolved to include additional dose requirements (flu and rotavirus). The reporting has enabled annual flu vaccination targeting, as well as assessing the status of rotavirus doses given the final rotavirus

2019–20 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	dose cannot be administered after 8 months of age. ♦ The Immunization Dose Reports are now available to all primary care providers (PCPs) in the Partnership network (118 organizations across 281 clinic sites) with refreshed monthly data in Partnership's online provider portal. ♦ Partnership has expanded the Immunization Dose Reports to include patient populations for both childhood immunizations as well as adolescent immunizations in a separate report for all providers. ♦ In response to these new reports made available to PCPs, Partnership has learned from many providers that they are continually utilizing the Immunization Dose Reports to analyze and outreach to their patient population. Some of our larger provider organizations have utilized the Partnership reports to create similar reporting available in their electronic health records. ♦ Promoted the Immunization Dose Reports to assist providers in outreach to members in need of immunizations, including multiple written communications to providers that included information about a promising practice called "Shot at Success". In addition to the direct PIP intervention follow-up above, Partnership has also made many efforts to close the gap in improving childhood immunizations, including: ♦ Partnering with providers and community organizations to promote childhood immunizations in the local community through the ShastaVaxFacts campaign, which was a multi-pronged approached that included focus groups, website and Facebook creation, public service announcements, and a targeted digital media campaign. This campaign ran from November 2020 through January 2021.

2019–20 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	♦ Formation of a new county immunization coalition, which is co-led with a local clinic and now meets quarterly. ♦ Launch of a new multi-year effort to spread components of the ShastaVaxFacts campaign and formation of new immunization coalitions across other Partnership counties. This effort is being adapted to an approach that can be executed and sustained long term (years), versus what was previously a high financial investment for a relatively short campaign. ♦ Educate and promote the importance of proactive immunization tracking, addressing vaccine hesitancy, and administration of timely immunizations across Partnership's network through multiple venues, including provider educational webinars, written communication, and focused discussion with multiple key provider partner stakeholders. ♦ Launch of a Healthy Babies program outreach and case management to new Partnership babies and moms, including education and the importance of timely childhood immunizations. ♦ Engaging in a new PIP that is currently focusing on well-child visits for members 0 to 15 months via Saturday clinics. This will directly impact immunization performance if successful, as members who are receiving more timely well-child visits are also more likely to complete more timely immunizations. ♦ Current production of videos in Humboldt County to engage and promote the importance of well-child visits (for babies and young children) and of timely and complete immunizations.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Partnership's self-reported actions in Table 6.1 and determined that the MCP adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. Partnership described in detail the MCP's efforts related to interventions it tested for the 2017–19 *Diabetes Nephropathy Screening* Disparity and *Childhood Immunization Status—Combination 3* PIPs. Partnership explained that it is no longer focusing on diabetes nephropathy screening due to DHCS removing the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure from the MCAS. Partnership also described how the MCP is partnering with providers and community organizations to improve childhood immunization rates.

2020–21 Recommendations

Based on the overall assessment of Partnership's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that for measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, that Partnership assess the factors, which may include COVID-19, that affected the MCP'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 the next annual review, HSAG will evaluate Partnership's continued successes as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix Y:
Performance Evaluation Report
Rady Children's Hospital—San Diego
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted PSP, Rady Children's Hospital—San Diego ("RCHSD" or "the PSP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that RCHSD provides to its members. HSAG provides a summary of the PSP-specific results and findings for each activity and an assessment of the PSP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this PSP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in RCHSD's 2021–22 PSP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Population-Specific Health Plan Overview

RCHSD is a full-scope MCP delivering services to beneficiaries with specialized health care needs under the PSP model. RCHSD became operational in San Diego County to provide MCMC services effective July 1, 2018. As of June 2021, RCHSD had 384 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCMC plans. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCMC plans to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for RCHSD. HSAG's compliance review summaries are based on final audit reports issued and CAP closeout letters dated on or before the end of the review period for this report (June 30, 2021).

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of RCHSD. A&I conducted the audits from September 8, 2020, through September 11, 2020.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of RCHSD
Audit Review Period: September 1, 2019, through August 31, 2020

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP imposed and findings in this category rectified.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	Yes	CAP imposed and findings in this category rectified.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Administrative and Organizational Capacity and State Supported Services categories during the 2020 Medical and State Supported Services of RCHSD. Additionally, in response to the CAP from the 2020 audits, RCHSD provided additional information to DHCS that resulted in DHCS closing the CAP. The information reflected changes in policies, procedures, and documents that addressed the identified findings.

Opportunities for Improvement—Compliance Reviews

RCHSD has no outstanding findings from the 2020 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the PSP in the area of compliance reviews.

3. Population-Specific Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs and PSPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs and PSPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's and PSP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

progress update on the interventions and/or strategies. Additionally, DHCS will require MCPs and PSPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP/PSP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP and PSP contracts authorize DHCS to impose sanctions on MCPs and PSPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs and PSPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of RCHSD, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for Rady Children's Hospital—San Diego* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that RCHSD followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the PSP's performance measure rates, HSAG assessed the results. See Table 3.1 for RCHSD's performance measure results for measurement years 2019 and 2020.

Note the following regarding Table 3.1:

- 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 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.

  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures because no national benchmarks existed for these measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - *Child and Adolescent Well-Care Visits—Total*
  - Both *Contraceptive Care* measures
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Table 3.1—Measurement Years 2019 and 2020 Performance Measure Results RCHSD—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Nov 9, 2021.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

^ Caution should be exercised when assessing PSP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— 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 2019–20 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 Years 2019–20 Rate Difference
Children's Health Domain			
Child and Adolescent Well-Care Visits—Total	—	43.30%	Not Comparable
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	99.46%	98.30%	-1.16
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	89.20%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	84.66%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	NA	Not Comparable
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	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Women's Health Domain			
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	NA	NA	Not Comparable
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	NA	NA	Not Comparable
Acute and Chronic Disease Management Domain			
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	73.86	51.72	Not Tested

Measurement Year 2019 Quality Monitoring Summary

To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities. Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.
- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of RCHSD's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

RCHSD conducted two PDSA cycles to improve the PSP's performance for the *Child and Adolescent Well-Care Visits—Total* measure.

Plan-Do-Study-Act Cycle #1

For the first PDSA cycle, RCHSD registered nurse (RN) care navigators conducted outreach calls to members with acute lymphoblastic leukemia who were not currently in treatment to encourage them to schedule and complete their well-care visits and offer to help schedule their appointments. RCHSD reported that the intervention resulted in some members completing their well-care visits; however, the PSP noted the following challenges:

- Long wait times on the phone with the scheduling office due to the provider upgrading its office phone system.
- Primary care offices preferred speaking with families instead of the RN care navigators to schedule the members' well-care visits.
- Some families who had successfully scheduled their well-care visits during the outreach calls indicated that they did not attend their scheduled appointment due to concerns about COVID-19.

RCHSD reported the following lessons learned:

- Providing reminders and education to families on the importance of well-care visits, as well as specialist appointments, and the importance of completing both appointments will help facilitate well-care visit completion.
- Simplifying the appointment scheduling process for families that do not make an effort to schedule their appointments will encourage the completion of well-care visits.
- Providing one-on-one education helped medically fragile families who were worried about potential COVID-19 exposure feel more comfortable scheduling their appointments.

RCHSD indicated plans to:

- Streamline the workflow with community clinics to help reduce phone wait times.
- Begin educating specialist providers about the importance of their teams connecting with families on the importance of well-care visits.
- Develop an educational handout for families that addresses the differences between specialty care and primary care and describes the importance of primary care to overall health and compliance.

Plan-Do-Study-Act Cycle #2

For the second PDSA cycle, RCHSD RN care navigators conducted outreach calls to all members who were not currently in treatment to encourage them to schedule and complete their well-care visits and offer to help schedule their appointments. RCHSD reported that the PSP met the PDSA goal for the percentage of members reached who completed their well-care visit. RCHSD indicated having challenges reaching members via phone and that the PSP was unable to reach many members after three contact attempts. The PSP noted that the lessons learned during the second PDSA cycle were the same as those learned during the first cycle.

RCHSD indicated plans to continue the intervention efforts to promote well-care visits for all members, track well-care visit rates for all members to determine the intervention's effect, and incorporate the intervention into the PSP's standard workflow.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, RCHSD reported:

- Having the PSP's care navigation team conduct outreach calls to all members to assist them with various needs, including providing transportation and establishing primary care provider (PCP) care. RCHSD developed targeted member education to achieve better outreach efforts and initiated meetings with its clinical teams to discuss the importance of informing members to seek care with both their specialists and PCPs. On July 1, 2020, RCHSD began mailing postcard reminders to members for dental, vision, and immunization appointments. The PSP implemented the postcard mailing based on feedback received from its July 2020 Family Advisory Council that mail reminders were helpful given the increase in electronic communications from organizations during the COVID-19 pandemic. RCHSD indicated that the PSP continues to make quarterly outreach calls to all members and hold meetings with its clinical teams to stress the importance of well-care visits with families during specialty appointments. Additionally, the PSP continues to mail monthly postcard reminders to members. RCHSD reported that the care navigation team experienced long wait times on the phone with the PCP office when trying to schedule member appointments and noted the following lessons learned:
  - Simplifying the appointment scheduling process resulted in the completion of more well-care visits.
  - Families need reminders and education about the importance of well-care visits and specialist appointments.
  - Providing one-on-one education helped medically fragile families who were worried about potential COVID-19 exposure feel more comfortable scheduling their appointments.
- Facilitating collaboration among internal teams to develop a system that reconciles immunizations from the PCP's electronic health record (EHR) and the hard copy medical record, RCHSD specialists' records, and the San Diego Immunization Registry. The PSP's health educator performs monthly manual reconciliation for non-electronic records and

contacts the PCP offices, as needed. RCHSD indicated learning that immunization records that are not available electronically do not get populated on the report created by the PSP's informatics team; therefore, the PSP had to conduct additional manual review of immunization records. RCHSD will be requesting claims data from its pharmacy benefit manager to help the PSP more efficiently reconcile member immunization records.

- Collaborating with RCHSD specialists to improve chronic disease care by providing coordination of care support to members. The PSP's care navigation team assisted members with scheduling in-person and telemedicine appointments, made reminder calls, communicated with members via the online appointment application, and arranged transportation for members who had expressed difficulty getting to appointments. The PSP met monthly with the specialty care teams to discuss intervention goals. RCHSD indicated that as a result of the collaboration, some members completed their specialty visits and received referrals for other needed services. RCHSD indicated learning that significant collaboration is required with specialty teams and the Family Advisory Council for intervention success. The PSP noted that the collaborative process is ongoing and evolving and that the PSP may modify the intervention in the future. RCHSD indicated that the PSP obtained approval for educational materials on sickle cell medication and that it drafted a workflow to help increase the well-care visit compliance rate for all members.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs and PSPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs and PSPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP/PSP, excluding the ongoing PIPs.

In RCHSD's 2021–22 PSP-specific evaluation report, HSAG will provide a high-level summary of the PSP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Strengths—Performance Measures

The HSAG auditor determined that RCHSD followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

For the three measures for which HSAG compared rates to benchmarks, the rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures were above the high performance levels for measurement year 2020.

Opportunities for Improvement—Performance Measures

Based on performance measure results, HSAG identified no opportunities for improvement for RCHSD in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Note that based on RCHSD's specialized population and population size, DHCS allowed RCHSD to focus both 2020–22 PIP topics on child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the PSP's module submissions for the 2020–22 PIPs, as well as HSAG's validation findings from the review period.

Diabetes Performance Improvement Project

RCHSD determined to resume one of the PSP's 2019–21 PIP topics for one of its 2020–22 PIPs—diabetes.

HSAG validated modules 1 through 3 for the PSP's *Diabetes* PIP. Upon initial review of the modules 1 and 3, HSAG determined that RCHSD met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Completing all required components of the key driver diagram.
- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure is appropriate for the intervention.

After receiving technical assistance from HSAG, RCHSD incorporated HSAG's feedback into modules 1 and 3. Upon final review, HSAG determined that the PSP met all validation criteria for modules 1 and 3. RCHSD met all validation criteria for Module 2 in its initial submission.

RCHSD's *Diabetes* PIP SMART Aim measures the percentage of members diagnosed with diabetes who have HbA1c levels less than or equal to 7.5 percent. Table 4.1 presents a description of the intervention that RCHSD selected to test for its *Diabetes* PIP. The table also indicates the key driver and failure mode that the intervention aims to address. Key drivers are factors identified in the key driver diagram that are thought to influence the achievement of the SMART Aim. Failure modes, which are identified as a result of a failure modes and effects analysis, are ways or modes in which something might fail. They include any errors, defects, gaps, or flaws that may occur now or could occur in the future.

Table 4.1—RCHSD *Diabetes* PIP Intervention Testing

Intervention	Key Driver Addressed	Failure Mode Addressed
Scheduling child life appointments based on provider referral	Parents, guardians, and members have information and understanding of the diabetes treatment plan	Unable to contact the parents or guardians to schedule members' appointments

During the review period, RCHSD began intervention testing. Based on RCHSD's contract with DHCS ending December 31, 2021, the PSP will continue intervention testing through the December 31, 2021. In RCHSD's 2021–22 PSP-specific evaluation report, HSAG will include information regarding RCHSD's intervention testing and any technical assistance HSAG provides to the PSP.

Blood Lead Test Performance Improvement Project

Based on PSP-specific data, RCHSD selected blood lead test for its other 2020–22 PIP.

HSAG validated modules 1 and 2 for the PSP's *Blood Lead Test* PIP. RCHSD met all validation criteria for both modules in its initial submissions.

RCHSD's *Blood Lead Test* PIP SMART Aim measures the percentage of members ages 24 months to 6 years who completed their blood lead test. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in RCHSD's 2021–22 PSP plan-specific evaluation report.

Strengths—Performance Improvement Projects

RCHSD successfully met all validation criteria for modules 1, 2, and 3 for the *Diabetes* PIP. The validation findings show that the PSP built a strong foundational framework, used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim, established an intervention plan for each intervention to be tested for the *Diabetes* PIP, and progressed to testing the interventions through a series of PDSA cycles.

Additionally, RCHSD successfully met all validation criteria for modules 1 and 2 for the *Blood Lead Screening* PIP. The validation findings show that the PSP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Blood Lead Screening* PIP. RCHSD has progressed to Module 3, in which the PSP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Opportunities for Improvement—Performance Improvement Projects

Based on RCHSD's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

RCHSD submitted the PSP's final PNA report to DHCS on July 13, 2021, and DHCS notified the PSP via email on July 14, 2021, that DHCS approved the report as submitted. While RCHSD submitted the PNA report and DHCS sent the email outside the review period for this PSP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Population Needs Assessment Summary

DHCS requires MCPs and PSPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with RCHSD's 2021 PNA Action Plan objectives and the PSP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the PSP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:
  - Continuing into 2021
  - Changing for 2021
  - Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Maintain (in light of COVID-19 challenges) or increase the percentage of parents or guardians who feel they are getting the needed care for their child (including, but not limited to, White, Hispanic/Latino, and members diagnosed with diabetes).	No	Better	Changing for 2021
2	Maintain (in light of COVID-19 challenges) or increase the percentage of parents or guardians reporting their child's overall mental or emotional health as good or excellent.	No	Worse	Continuing for 2021
3	Update and incorporate emergency preparedness interventions into procedures, education, care navigation, and patient and family materials to reflect COVID-19 pandemic needs.	No	Unknown	Ended in 2020

Table 5.2 provides the following:

- High-level summaries of the MCP's 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 2022, increase the percentage of Spanish-speaking or Latino/Hispanic parents or guardians who feel they are always able to get the care, tests, or treatment their child needs.	Yes	New in 2021

#	Objective Summary	Health Disparity (Yes/No)	Status
2	Maintain (in light of COVID-19 challenges) or increase the percentage of parents or guardians reporting their child's overall mental or emotional health as good or excellent.	No	Continued from 2020

6. Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Based on HSAG's assessment of RCHSD's delivery of quality, accessible, and timely care through the activities described in the PSP's 2019–20 PSP-specific evaluation report, HSAG included no recommendations in RCHSD's 2019–20 PSP-specific evaluation report. Therefore, RCHSD had no recommendations for which it was required to provide the PSP's self-reported actions.

Based on the overall assessment of RCHSD's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the PSP.

In the next annual review, HSAG will evaluate RCHSD's continued successes.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix Z:
Performance Evaluation Report
San Francisco Health Plan
July 1, 2020–June 30, 2021

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Sections (§)438.364 and §457.1250. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2020–June 30, 2021,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs. Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable) and the PIHP with a specialized population as an SHP.

This appendix is specific to DHCS' contracted MCP, San Francisco Health Plan ("SFHP" or "the MCP"). The purpose of this appendix is to provide HSAG's external, independent assessment of the quality and timeliness of, and access to health care that SFHP provides to its members. HSAG provides a summary of the MCP-specific results and findings for each activity and an assessment of the MCP's strengths and opportunities for improvement. In *Volume 1 of 4* of this EQR technical report (Main Report), HSAG provides an aggregate assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note the following regarding terms HSAG uses in this report:

- "MCMC plans" refers to MCPs, PSPs, and the SHP collectively.
- "Beneficiary" refers to a person entitled to receive benefits under MCMC.
- "Member" refers to a person enrolled in an MCMC plan.

The review period for this MCP-specific evaluation report is July 1, 2020, through June 30, 2021. The report references activities and methodologies described in detail in the Main Report. HSAG will report on activities that take place beyond the review period in SFHP's 2021–22 MCP-specific evaluation report.

Note that during the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that these plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities to respond to concerns and changing circumstances resulting from the COVID-19 public health emergency. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

SFHP is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in SFHP, the Local Initiative MCP, or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, the alternative commercial plan.

SFHP became operational in San Francisco County to provide MCMC services effective January 1997. As of June 2021, SFHP had 149,263 members in San Francisco County.[1] This represents 88 percent of the beneficiaries enrolled in San Francisco County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2021 enrollment information from the report downloaded on Jul 29, 2021.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, are included in Section 4 of the Main Report ("Compliance Reviews"). DHCS Audits & Investigations Division (A&I) continued its suspension of the in-person Medical and State Supported Services Audits of MCPs. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to the public health emergency.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SFHP.

Table 2.1 summarizes the results and status of the virtual A&I Medical and State Supported Services Audits of SFHP. A&I conducted the audits from March 8, 2021, through March 19, 2021. As part of the Medical Audit, A&I included a review of the Seniors and Persons with Disabilities (SPD) population in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management categories. A&I also examined the extent to which SFHP had implemented its CAP from the 2020 Medical Audit. DHCS issued the final audit reports on July 27, 2021, which is outside the review period for this report; however, HSAG includes the information because A&I conducted the audits during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SFHP
Audit Review Period: March 1, 2020, through February 28, 2021

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Administrative and Organizational Capacity and State Supported Services categories during the March 2021 Medical and State Supported Services Audits of SFHP.

Opportunities for Improvement—Compliance Reviews

SFHP has the opportunity to work with DHCS to ensure the MCP fully resolves all findings from the March 2021 Medical Audit. During this audit, A&I identified repeat findings in the Utilization Management and Access and Availability of Care categories. SFHP should thoroughly review all findings and implement the actions recommended by A&I.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS refers to the DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures. DHCS consults with HSAG and reviews feedback from MCPs, PSPs, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs and PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[3] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs and PSPs.

DHCS-Established Performance Levels

Each year, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. HSAG includes the specific high performance level and minimum performance level values for measurement year 2020 in Section 6 of the Main Report.

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume CAPs for measurement year 2021.

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update

[2] HEDIS® is a registered trademark of NCQA.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

[4] Quality Compass® is a registered trademark of NCQA.

on the interventions and/or strategies. Additionally, DHCS will require MCPs with two or more measure rates below the minimum performance levels in any one measure domain in measurement year 2020 to conduct a quality improvement project for that domain. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing performance improvement projects (PIPs).

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose financial sanctions on MCPs based on measurement year 2020 MCAS performance measure results. DHCS will resume financial sanctions for measurement year 2021.

Performance Measure Validation Results

HSAG conducted an independent audit of SFHP, and the *HEDIS Measurement Year 2020 Compliance Audit Final Report of Findings for San Francisco Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid rates. The auditor noted that based on the prior year's recommendation, SFHP made incremental improvements to its enrollment span determination to ensure that dual eligible members remain in Medi-Cal reporting during the months in which they are not covered by primary insurance through Medicare or commercial insurers. While SFHP revised its process, the auditor noted that the MCP excluded some enrollment spans that should not have been excluded. To ensure the MCP accurately excludes enrollment spans, SFHP should update its 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. This process change will require SFHP to populate key data elements associated with the start date and end date of non-Medicaid enrollment spans.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for SFHP's performance measure results for measurement years 2019 and 2020 and performance measure findings for measurement year 2020.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the measurement year 2020 performance measure findings for the domains combined.
- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[5] due to the 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.

Please refer to Table 6.1 in Section 6 of the Main Report ("Managed Care Health Plan Performance Measures") for descriptions of all performance measures.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the performance measures and rates for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 3.1:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

[5] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 6, 2021.

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

♦ HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain because no national benchmarks existed for these measures:

- *Child and Adolescent Well-Care Visits—Total*
- *Developmental Screening in the First Three Years of Life—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.1—Children's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	47.83%	Not Comparable
Childhood Immunization Status—Combination 10	61.11%	61.22%	0.11
Developmental Screening in the First Three Years of Life—Total	22.00%	18.97%	-3.03

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Immunizations for Adolescents—Combination 2	61.60%	57.91%	-3.69
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^*	83.57%	**72.02%**	-11.55
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	77.62%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	75.43%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	46.87%	Not Comparable
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	—	76.09%	Not Comparable

Findings—Children's Health Domain

Table 3.2 presents the findings for measurement year 2020 performance measures within the Children's Health domain.

Note the following regarding Table 3.2:

- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—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*

  - Both *Well-Child Visits in the First 30 Months of Life* measures
- No national benchmarks existed for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

Table 3.2—Children's Health Domain
Measurement Year 2020 Performance Measure Findings
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	2	5	40.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	4	0.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	4	50.00%

Women's Health Domain

Results—Women's Health Domain

Table 3.3 presents the performance measures and rates for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- All 12 *Contraceptive Care* measures
- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.3—Women's Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	65.89%	**55.99%**	-9.90
*Cervical Cancer Screening^*	68.10%	68.06%	-0.04
Chlamydia Screening in Women—Ages 16–20 Years	55.56%	60.93%	5.37
Chlamydia Screening in Women—Ages 21–24 Years	60.74%	59.35%	-1.39
Chlamydia Screening in Women—Total	58.06%	60.15%	2.09
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.77%	2.32%	-0.45
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.47%	3.45%	-1.02

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.78%	12.45%	-1.33
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.25%	18.46%	-1.79
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S	6.83%	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	23.08%	41.30%	18.22
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.98%	15.49%	4.51
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S	S	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.55%	13.41%	7.86
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	32.69%	52.17%	19.48
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	27.38%	31.71%	4.33
*Prenatal and Postpartum Care—Postpartum Care^*	82.24%	91.22%	8.98
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	93.19%	92.29%	-0.90

Findings—Women's Health Domain

Table 3.4 presents the findings for measurement year 2020 performance measures within the Women's Health domain.

Note the following regarding Table 3.4:

- Either no national benchmarks existed or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - All 12 *Contraceptive Care* measures
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures

Table 3.4—Women's Health Domain
Measurement Year 2020 Performance Measure Findings
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	6	19	31.58%
Measurement Year 2020 Rates Below Minimum Performance Levels	1	5	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	3	19	15.79%

Behavioral Health Domain

Results—Behavioral Health Domain

Table 3.5 presents the performance measures and rates for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 3.5:

- The following measures are new for measurement year 2020; therefore, no measurement year 2019 rates are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

Table 3.5—Behavioral Health Domain
Measurement Years 2019 and 2020 Performance Measure Results
SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for measurement year 2020.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	66.32%	65.25%	-1.07
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	45.85%	48.86%	3.01
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	82.16%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	43.48%	30.36%	-13.12
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	NA	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	NA	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.49%	6.71%	6.22
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.93%	6.94%	6.01
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S	9.19%	S

Findings—Behavioral Health Domain

Table 3.6 presents the findings for measurement year 2020 performance measures within the Behavioral Health domain.

Note the following regarding Table 3.6:

- The following measures are new measures for measurement year 2020; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Screening for Depression and Follow-Up Plan* measures

- HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.6—Behavioral Health Domain
Measurement Year 2020 Performance Measure Findings
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	1	3	33.33%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	3	6	50.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	0	3	0.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	0	6	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 presents the performance measures and rates for measurement years 2019 and 2020 within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.7:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, no measurement year 2019 rate is displayed for this measure.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*

- Both *Concurrent Use of Opioids and Benzodiazepines* measures
- *Controlling High Blood Pressure—Total*
- All three *Plan All-Cause Readmissions* measures
- Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.7—Acute and Chronic Disease Management Domain
Measurement Years 2019 and 2020 Performance Measure Results
SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the measurement year 2020 rate is significantly better than the measurement year 2019 rate.

= Statistical testing result indicates that the measurement year 2020 rate is significantly worse than the measurement year 2019 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.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard. If a measurement year 2019 or measurement year 2020 rate is suppressed, HSAG also suppresses the measurement year 2019–20 rate difference.

Not Tested = A measurement year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Not Comparable = A measurement year 2019–20 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 Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	40.14	31.24	Not Tested
Asthma Medication Ratio—Total	72.79%	68.55%	-4.24
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	27.11%	**41.05%**	13.94
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.96%	12.09%	0.13
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S	S	S
Controlling High Blood Pressure—Total	—	63.99%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.57%	10.45%	-0.12
Plan All-Cause Readmissions—Expected Readmissions—Total	10.14%	10.28%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	1.04	1.02	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.17%	5.52%	0.35
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S	S	S

Findings—Acute and Chronic Disease Management Domain

Table 3.8 presents the findings for measurement year 2020 performance measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 3.8:

- NCQA recommended a break in trending for the *Controlling High Blood Pressure—Total* measure; therefore, HSAG did not include this measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 3.8—Acute and Chronic Disease Management Domain Measurement Year 2020 Performance Measure Findings SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	0	2	0.00%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	0	7	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Below Minimum Performance Levels	1	2	50.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	2	7	28.57%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of SFHP's measurement year 2020 performance across all MCAS measures.

Note the following regarding Table 3.9:

- The *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total* measure is a utilization measure, which measures the volume of services used and for which a higher or lower rate does not necessarily indicate better or worse performance; therefore, HSAG excluded this measure from the calculations for all findings.
- HSAG did not include the *Plan All-Cause Readmissions—Expected Readmissions—Total* and *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total* measures in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the data for these measures do not meet the assumptions for a Chi-square test of statistical significance.
- The following measures only have measurement year 2020 rates due to a break in trending from the previous year or because they are new measures; therefore, HSAG did not include them in the calculations comparing measurement year 2020 rates to measurement year 2019 rates:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Controlling High Blood Pressure—Total*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - *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*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

- HSAG did not include the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure in the calculations comparing measurement year 2020 rates to measurement year 2019 rates because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.
- Either no national benchmarks existed for the following measures or DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures; therefore, HSAG did not include them in the calculations for the percentage of measures with rates above the high performance levels or below the minimum performance levels:
  - *Child and Adolescent Well-Care Visits—Total*
  - The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - *Controlling High Blood Pressure—Total*
  - All 12 *Contraceptive Care* measures
  - *Developmental Screening in the First Three Years of Life—Total*
  - Both *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measures
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
  - All three *Plan All-Cause Readmissions* measures
  - All three *Screening for Depression and Follow-Up Plan* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG did not include the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure in the calculation for the percentage of measures with rates above the high performance levels or below the minimum performance levels because the denominator for this measure was too small (less than 30) for the MCP to report a valid rate.

Table 3.9—Measurement Year 2020 Performance Measure Findings for All Domains SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Measurement Year 2020 Rates Above High Performance Levels	4	15	26.67%
Measurement Year 2020 Rates Significantly Better than Measurement Year 2019 Rates*	9	36	25.00%
Measurement Year 2020 Rates Below Minimum Performance Levels	3	15	20.00%
Measurement Year 2020 Rates Significantly Worse than Measurement Year 2019 Rates*	7	36	19.44%

Measurement Year 2019 Quality Monitoring and Corrective Action Plan Summary

In September 2020, DHCS notified all MCPs with CAPs that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (External Accountability Set). To allow MCPs and providers to prioritize their resources on activities related to the public health emergency, DHCS did not enforce the minimum performance levels for measurement year 2019 but instead chose to impose quality improvement activities as described below. Therefore, DHCS issued no new CAPs based on measurement year 2019 performance measure results. Further, MCPs previously under CAPs were required to meet quarterly via telephone with their assigned DHCS nurse consultant.

Following measurement year 2019 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Conduct Plan-Do-Study-Act (PDSA) cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs and PSPs were required to provide evidence to support their measure choice. To accommodate barriers related to COVID-19, DHCS allowed MCPs and PSPs flexibility regarding the PDSA cycle format and interventions. MCPs and PSPs were required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet. Note that when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCPs and PSPs to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative to the PDSA cycles.

- Develop and submit to DHCS a brief COVID-19 QIP that includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs and PSPs were required to submit an initial COVID-19 QIP on October 2, 2020, and a six-month progress update on March 1, 2021.

Following is a summary of SFHP's PDSA cycles and COVID-19 QIP. Note that while MCPs and PSPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle Summary

SFHP conducted two PDSA cycles to improve member completion of chlamydia testing.

For the first PDSA cycle, SFHP tested whether offering a member incentive would result in an increase in the number of members completing their chlamydia testing. The MCP reported that the intervention did not lead to improvement. Due to the COVID-19 pandemic, SFHP determined to postpone mailing incentive reminders until 2021. Since SFHP mailed no incentive reminders for the majority of the PDSA cycle period, the number of incentive claims and chlamydia testing completions were low.

For the second PDSA cycle, the MCP used a telephonic vendor to test whether conducting outreach using a script would result in improved chlamydia screening rates for female members 18 to 24 years of age who had not had a chlamydia screening in the past year. The MCP reported that the intervention did not lead to improvement. The vendor reported that it was unsuccessful in reaching most members called, even after making an additional attempt to reach them.

SFHP indicated that the MCP's HEDIS and incentives teams will reevaluate the member incentive programs to determine the overall success of offering incentives and will determine next steps based on the evaluation results.

COVID-19 Quality Improvement Plan Summary

In its COVID-19 QIP, SFHP reported:

- Offering a $50 incentive to select members who qualify for adult wellness visits to increase member engagement with preventive services and to close disparity gaps. SFHP determined the target population based on population assessments, identified disparities in HEDIS rates, and priority populations for the adult well-visit incentive program. This intervention had the potential to affect rates for several performance measures that assess access to and utilization of preventive services. The MCP reported that it was delayed in launching the incentive program due to limited staff resources and not wanting to overburden providers during COVID-19 and had therefore not conducted an evaluation of the program.

- Allocating 50 percent of its pay-for-performance incentives to providers who completed a quality improvement project focused on engaging members at high risk for severe illness from COVID-19, increasing the use of telehealth modalities, improving MCAS measure rates, or improving primary care provider (PCP) visit rates to pre-COVID-19 levels. All seven projects that SFHP approved successfully met their objectives, with the MCP highlighting the following accomplishments by providers:
  - Development of member education materials in English, Spanish, and Chinese regarding how to enroll in telehealth.
  - Creating outreach lists to help with scheduling preventive care visits.
  - Purchasing licenses for HIPAA-compliant telehealth modalities, webcams, and speakers for offices without video conferencing capabilities.
- Conducting an outreach campaign targeting members under 21 years of age to increase awareness of the availability of free preventive services and how to access them. The MCP also mailed materials to parents of members under age 7, highlighting the importance of partnering with a PCP, getting vaccinations, and completing a blood lead screening.

Quality Monitoring and Corrective Action Plan Requirements for 2021

As indicated under the "Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process" heading in this section of the report, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 QIP, similar to what DHCS required for measurement year 2019. Additionally, DHCS will require that MCPs conduct quality improvement projects based on measurement year 2020 performance. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

In SFHP's 2021–22 MCP-specific evaluation report, HSAG will provide a high-level summary of the MCP's measurement year 2020 COVID-19 QIP and quality improvement projects, if applicable.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Table 3.10 presents the measurement year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure.

Table 3.10—Measurement Year 2020 Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations
SFHP—San Francisco County

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly better than the measurement year 2020 non-SPD rate.

= Statistical testing result indicates that the measurement year 2020 SPD rate is significantly worse than the measurement year 2020 non-SPD rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The measurement year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	76.71	26.24	Not Tested	31.24
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.52%	10.40%	0.12	10.45%

Seniors and Persons with Disabilities—Performance Measure Findings

For measurement year 2020, HSAG compared the measurement year 2020 SPD rate to the measurement year 2020 non-SPD rate for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only.

For SFHP, HSAG identified no statistically significant difference between the measurement year 2020 SPD rate and measurement year 2020 non-SPD rate for this measure.

Strengths—Performance Measures

The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid rates.

HSAG identified the following notable measurement year 2020 performance measure results for SFHP:

- The following four measures had rates above the high performance levels:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- For measures for which HSAG compared measurement year 2020 rates to measurement year 2019 rates, nine of 36 rates (25 percent) showed statistically significant improvement from measurement year 2019 to measurement year 2020.
  - Six of the nine rates that improved significantly (67 percent) were in the Women's Health domain, and the other three (33 percent) were in the Behavioral Health domain.

Opportunities for Improvement—Performance Measures

To ensure the MCP accurately excludes enrollment spans for performance measure reporting, SFHP should update its 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. This process change will require SFHP to populate key data elements associated with the start date and end date of non-Medicaid enrollment spans.

For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, SFHP should assess the factors, which may include COVID-19, that affected the MCP'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.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - PIP team member identification.
    - Topic rationale.
    - Narrowed focus description.
    - Narrowed focus measure baseline data collection specifications and methodology.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim statement.
    - SMART Aim run chart.
    - Initial key driver diagram.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test the intervention through a series of PDSA cycles.
  - MCMC plans complete the PDSA worksheet to track and evaluate intervention effectiveness.
- Module 4—PIP Conclusions
  - MCMC plans summarize interpretation of PIP results and key findings and submit the following:
    - Completed PDSA worksheet(s).
    - Final SMART Aim run chart.
    - Final SMART Aim measure data table.
    - Final key driver diagram.

- MCMC plans provide narrative summaries to address the following:
  - Project conclusions.
  - Intervention testing conclusions.
  - Plans for spreading successful intervention(s), as applicable.
  - Challenges encountered.
  - Lessons learned and information gained.
  - Plans for sustaining any improvement achieved beyond the SMART Aim end date.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, they test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to assess whether MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

When validating Module 4, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final 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 Requirements

In October 2020, DHCS announced to the MCMC plans the requirements for the 2020–22 PIPs. The topic categories for these PIPs (Health Equity and Child and Adolescent Health) are the same as those used for the 2019–21 PIPs that DHCS elected to end early due to the COVID-19 public health emergency. Due to MCMC plans' continuing need to focus on COVID-19 response efforts, DHCS allowed plans flexibility related to their PIPs' narrowed focuses and partnerships with external organizations. Additionally, for MCMC plans' 2020–22 PIPs, DHCS allowed the plans to continue their 2019–21 PIP topics or to select new PIP topics.

DHCS requires that the Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. For Child and Adolescent Health PIPs, DHCS requires MCMC plans to identify an area in need of improvement related to child and adolescent health.

Performance Improvement Project Results and Findings

In this report, HSAG includes summaries of the MCP's module submissions for the 2020–22 Health Equity PIP and the 2020–22 Child and Adolescent Health PIP, as well as HSAG's validation findings from the review period.

Health Equity Performance Improvement Project

SFHP determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Health Equity PIP—breast cancer screening among African-American members.

HSAG validated modules 1 and 2 for the MCP's *Breast Cancer Screening* Health Equity PIP. Upon initial review of Module 1, HSAG determined that SFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.

After receiving technical assistance from HSAG, SFHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. SFHP met all validation criteria for Module 2 in its initial submission.

SFHP's *Breast Cancer Screening* Health Equity PIP SMART Aim measures the percentage of breast cancer screenings completed among African-American members. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in SFHP's 2021–22 MCP plan-specific evaluation report.

Child and Adolescent Health Performance Improvement Project

SFHP determined to resume the MCP's 2019–21 PIP topic for its 2020–22 Child and Adolescent Health PIP—well-child visits in the first 15 months of life.

HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review of the modules, HSAG determined that SFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Providing the description and rationale for the selected narrowed focus and reporting baseline data that support an opportunity for improvement.
- Including all required components of the narrowed focus baseline specifications and data collection methodology.
- Including all required components of the SMART Aim.

- Including all required components of the SMART Aim run chart.
- Completing all required components of the key driver diagram.
- Logically linking the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.
- Ensuring that the key drivers and interventions in the key driver diagram are dated according to the results of the corresponding process map and Failure Modes and Effects Analysis Table, and that the interventions are culturally and linguistically appropriate and have the potential to impact the SMART Aim goal.

After receiving technical assistance from HSAG, SFHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. At the end of the review period for this report, SFHP was still in the process of incorporating HSAG's feedback into Module 2; therefore, HSAG includes no final validation results for Module 2 in this report.

SFHP's *Well-Child Visits in the First 15 Months of Life* PIP SMART Aim measures the percentage of eligible members who received at least six well-child visits by 15 months of age. This PIP did not progress to intervention testing during the review period for this report. HSAG will include intervention information in SFHP's 2021–22 MCP plan-specific evaluation report.

Strengths—Performance Improvement Projects

SFHP successfully met all validation criteria for modules 1 and 2 for the *Breast Cancer Screening* Health Equity PIP. The validation findings show that the MCP built a strong foundational framework and used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim for the *Breast Cancer Screening* Health Equity PIP. SFHP has progressed to Module 3, in which the MCP will establish a plan for each intervention prior to testing the intervention through a series of PDSA cycles.

Additionally, SFHP successfully met all validation criteria for Module 1 for the *Well-Child Visits in the First 15 Months of Life* PIP. The validation findings show that the MCP built a strong foundational framework for the *Well-Child Visits in the First 15 Months of Life* PIP. SFHP has progressed to Module 2, in which the MCP will use quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim.

Opportunities for Improvement—Performance Improvement Projects

Based on SFHP's PIP progression, HSAG identified no opportunities for improvement.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 18 of the Main Report ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Population Needs Assessment Submission Status

SFHP submitted the MCP's final PNA report to DHCS on September 30, 2021, and DHCS notified the MCP via email on the same date that DHCS could not approve the report as submitted. While SFHP submitted the final PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

To ensure SFHP produces a PNA report in 2022 that meets DHCS' requirements, DHCS is requiring the MCP to identify two MCP staff members who will be responsible for the content and timely submission of the PNA report. DHCS will require at least one of the two MCP staff members to attend all technical assistance sessions offered by DHCS health education consultants. DHCS will expect SFHP to adhere to the MCP-specific technical assistance it provides to SFHP, including feedback provided by DHCS via previous PNA rubrics. Prior to the 2022 PNA report due date on a date to be determined by DHCS and MCP staff, DHCS will require SFHP to submit a draft PNA report to DHCS for review.

Population Needs Assessment Summary

DHCS requires MCPs to establish SMART objectives as part of their PNA Action Plans and to track these objectives over time. DHCS provided HSAG with SFHP's 2021 PNA Action Plan objectives and the MCP's reported progress toward achieving the 2020 PNA Action Plan objectives.

Table 5.1 provides the following:

- High-level summaries of the MCP's 2020 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, or unknown
- The status of each objective:

- Continuing into 2021
- Changing for 2021
- Ended in 2020

Table 5.1—2020 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Progress	Status
1	Improve chlamydia screening in women 16 to 24 years of age.	No	Better	Ended in 2020
2	Improve depression screening in members 12 years of age and older.	No	Worse	Ended in 2020
3	Reach most members with a diagnosis of prediabetes with information about the Diabetes Prevention Program (DPP).	No	Better	Ended in 2020
4	Enroll a portion of eligible members in DPP.	No	Unknown	Ended in 2020
5	Achieve at least 5 percent weight loss for a portion of eligible members completing the DPP.	No	Better	Ended in 2020
6	Reduce hospital readmissions for a targeted medical group.	No	Worse	Ended in 2020
7	Ensure most members engaged in the Complex Case Management Program attend at least one primary care appointment.	No	Better	Ended in 2020
8	Most members engaged in the Complex Case Management Program will self-report an improved health status between intake and closing.	No	Worse	Ended in 2020
9	Most members engaged in the Complex Case Management Program will have in-progress or completed chronic condition self-management care plan goals.	No	Worse	Ended in 2020

Table 5.2 provides the following:

- A high-level summary of the MCP's 2021 PNA Action Plan objective
  - Note that while DHCS did not approve SFHP's PNA report as submitted, the listed objective is the objective on record as of September 30, 2021.
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2021
  - Continued from 2020
  - Changed from 2020

Table 5.2—2021 Population Needs Assessment Action Plan Objectives

#	Objective Summary	Health Disparity (Yes/No)	Status
1	By June 2022, improve the *Breast Cancer Screening—Total* measure rate for Black/African-American members.	Yes	New in 2021

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2019–20 MCMC plan-specific evaluation report. Table 6.1 provides EQR recommendations from SFHP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2021, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of SFHP's self-reported actions.

Table 6.1—SFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2019, through June 30, 2020, MCP-Specific Evaluation Report

2019–20 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. Continue to work with DHCS to ensure the MCP submits all documentation necessary for DHCS to close the CAP from the 2018 and 2019 Medical and State Supported Services Audits.	SFHP developed a CAP and has worked with the Managed Care Quality and Monitoring Division (MCQMD) to provide evidence of correction. DHCS has closed all open findings from the 2018 audits and all but one finding from the 2019 Medical Audit. SFHP is working closely with MCQMD to find a solution for this finding that the MCP can implement. One of the findings in the 2020 Medical Audit is duplicative of the finding that is still open from the 2019 Medical Audit. The 2019 Medical and State Supported Services Audits were conducted at SFHP from February 25, 2019, through March 1, 2019. SFHP submitted the CAP for the 2019 audits on August 12, 2019. Additional documentation was submitted on December 19, 2019; January 14, 2020; February 20, 2020; February 26, 2020; April 24, 2020; July 10, 2020; November 5, 2020; December 1, 2020; April 2, 2021; and June 4, 2021. SFHP is working closely with MCQMD to remediate all findings and will continue to work

2019–20 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
	with MCQMD to close the remaining open finding.
2. Address findings from the 2020 Medical and State Supported Services Audits by implementing the actions recommended by A&I.	The 2020 Medical and State Supported Services Audits were conducted at SFHP from March 2, 2020, through March 12, 2020. SFHP submitted the CAP for the 2020 audits on August 20, 2020. The MCP's Compliance and Oversight Department worked with MCQMD to submit documentation on a monthly basis. There are three outstanding CAPs open as of August 16, 2021.
3. Update enrollment determinations to monthly spans to ensure that dual eligible members remain in Medi-Cal reporting during those months in which their primary insurance coverage is not through Medicare or commercial insurers. Additionally, the MCP should assess which fields and values are used for coordination of benefit configurations to confirm that only valid, full medical coverage through a primary payer counts as an excluded enrollment segment.	SFHP worked with the HSAG auditor to exclude Medicaid members who had full commercial or Medicare (Part A and Part B) or Part C coverage for at least two months during measurement year 2020. For measurement year 2021, SFHP will update the exclusion methodology to include the start date and end date of the external comprehensive commercial or Medicare (Part A and B) or Part C coverage in the Cotiviti Quality Intelligence application enrollment input file so that members' enrollment spans are excluded only for the spans with dual coverage. This will automate the logic and allow the Cotiviti Quality Intelligence application to exclude the enrollment spans through the NCQA HEDIS Certified Measures[6] algorithms.

[6] NCQA Measure Certification℠ is a service mark of the NCQA.

2019–20 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
4. Continue monitoring adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Postpartum Care* Disparity PIP and *Immunizations for Adolescents—Combination 2* PIP.	SFHP continued to monitor the *Prenatal and Postpartum Care—Postpartum Care* measure rates with the providers with which we collaborated on this PIP intervention to address disparities for Black members. For reporting year 2020, the provider reported a 6 percentage point improvement in the postpartum compliance rate from reporting year 2019 at the clinical site chosen. This improvement was 10.2 percentage points higher than the baseline rate. However, the denominator size did not continue to increase over time due to capacity at the clinical site, creating a mean denominator of less than 30 over the course of the provider reporting the data to us. Due to the consistent small sample sizes and no improvement in the SMART AIM of improving *Prenatal and Postpartum Care—Postpartum Care* measure rates for Black members at SFHP, it was determined that measuring this intervention for effectiveness was instable and the MCP therefore discontinued monitoring. Further, current data shows SFHP's *Prenatal and Postpartum Care—Postpartum Care* measure rate to be above the 90th percentile, with no disparities noted when stratified by race/ethnicity or spoken language. The *Immunization for Adolescents—Combination 2* intervention was abandoned due to COVID-19 response efforts and network providers redirecting resources to testing, outreach, and subsequently vaccination.

Assessment of MCP's Self-Reported Actions

HSAG reviewed SFHP's self-reported actions in Table 6.1 and determined that SFHP adequately addressed HSAG's recommendations from the MCP's July 1, 2019, through June 30, 2020, MCP-specific evaluation report. SFHP described in detail:

- The steps the MCP has taken to resolve all findings from the 2018, 2019, and 2020 A&I audits.
- The process the MCP implemented to ensure that dual eligible members remain in Medi-Cal reporting during those months in which their primary insurance is not through Medicare or commercial insurers.
- How the MCP monitored adapted interventions and outcomes from the 2017–19 PIPs, including decisions made based on the monitoring results.

2020–21 Recommendations

Based on the overall assessment of SFHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- 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.
- To ensure the MCP accurately excludes enrollment spans for performance measure reporting, update its 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.
- For measures with rates below the minimum performance levels in measurement year 2020 or for which the MCP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCP'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.
- To ensure SFHP produces a PNA report in 2022 that meets DHCS' requirements, complete the following:
  - Identify two MCP staff members who will be responsible for the content and timely submission of the PNA report.
  - Ensure at least one of the two identified MCP staff members attends all technical assistance sessions offered by DHCS health education consultants.
  - Adhere to DHCS' MCP-specific technical assistance, including feedback provided by DHCS via previous PNA rubrics.

- On a date to be determined by DHCS and MCP staff, submit a draft PNA report to DHCS for review.

In the next annual review, HSAG will evaluate SFHP's continued successes as well as the MCP's progress with these recommendations.