

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2016–June 30, 2017

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

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Commonly Used Abbreviations and Acronyms

Following is a list of abbreviations and acronyms used throughout this report.

- ◆ **A&I**—Audits and Investigations Division
- ◆ **AHRQ**—Agency for Healthcare Research and Quality
- ◆ **CAHPS**[®]—Consumer Assessment of Healthcare Providers and Systems¹
- ◆ **CAP**—corrective action plan
- ◆ **CATI**—computer-assisted telephone interviewing
- ◆ **CCC**—Children with Chronic Conditions
- ◆ **CCI**—Coordinated Care Initiative
- ◆ **CFR**—Code of Federal Regulations
- ◆ **CHIP**—Children’s Health Insurance Program
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **COHS**—County Organized Health System
- ◆ **CP**—commercial plan
- ◆ **CPT**—Current Procedural Terminology
- ◆ **DHCS**—California Department of Health Care Services
- ◆ **DMHC**—California Department of Managed Health Care
- ◆ **EAS**—External Accountability Set
- ◆ **ED**—Emergency Department
- ◆ **EPSDT/CHDP**— Early Periodic Screening, Diagnostic, and Treatment/Child Health and Disability Prevention
- ◆ **EQR**—external quality review
- ◆ **EQRO**—external quality review organization
- ◆ **FFS**—fee-for-service
- ◆ **FMEA**—failure modes and effects analysis
- ◆ **FQHC**—Federally Qualified Health Center
- ◆ **GMC**—Geographic Managed Care
- ◆ **HEDIS**[®]—Healthcare Effectiveness Data and Information Set²
- ◆ **HPL**—high performance level

¹ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

² HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **IP**—improvement plan
- ◆ **IS**—information systems
- ◆ **LI**—Local Initiative
- ◆ **MCMC**—Medi-Cal Managed Care
- ◆ **MCAH**—maternal, child, and adolescent health
- ◆ **MCO**—managed care organization
- ◆ **MCP**—managed care health plan
- ◆ **MHP**—mental health plan
- ◆ **MLTSS**—Managed Long-Term Services and Supports
- ◆ **MLTSSP**—Managed Long-Term Services and Supports Plan
- ◆ **MPL**—minimum performance level
- ◆ **MY**—measurement year
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **Non-SPD**—Non-Seniors and Persons with Disabilities
- ◆ **PAHP**—prepaid ambulatory health plan
- ◆ **PCCM**—primary care case management
- ◆ **PCP**—primary care provider
- ◆ **PDSA**—Plan-Do-Study-Act
- ◆ **PIHP**—prepaid inpatient health plan
- ◆ **PIP**—performance improvement project (formerly referred to as quality improvement project [QIP])
- ◆ **PM 160**—Child Health Disability Prevention Information Only Confidential Screening/Billing Report
- ◆ **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- ◆ **RY**—reporting year
- ◆ **QAPI**—quality assessment and performance improvement
- ◆ **QIP**—quality improvement project
- ◆ **SFY**—State Fiscal Year
- ◆ **SHP**—specialty health plan
- ◆ **SMART**—Specific, Measurable, Achievable, Relevant, and Time-bound
- ◆ **SPD**—Seniors and Persons with Disabilities
- ◆ **TPM**—Two-Plan Model

1. Executive Summary

As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364,³ the California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access and quality of care, including:

- ◆ A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.
- ◆ For each external quality review (EQR)-related activity conducted in accordance with §438.358:
 - Objectives
 - Technical methods of data collection and analysis
 - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
 - Conclusions drawn from the data
- ◆ An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- ◆ Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- ◆ Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- ◆ An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. Accessed on: Nov 14, 2017.

The review period for this *2016–17 Medi-Cal Managed Care External Quality Review Technical Report* is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in the *2017–18 Medi-Cal Managed Care External Quality Review Technical Report*.

Medi-Cal Managed Care (MCMC) provides managed health care services to more than 10.72 million beneficiaries (as of June 2017)⁴ in the State of California through a combination of contracted full-scope managed care health plans (MCPs) and specialty health plans (SHPs). During the review period, DHCS contracted with 22 MCPs⁵ and three SHPs to provide health care services in all 58 counties throughout California. A summary of HSAG’s assessment of performance and notable results for the July 1, 2016, through June 30, 2017, review period follows.

Summary of Performance

Medi-Cal Managed Care Quality Strategy Annual Assessment

The quality strategy continued to focus and build on performance in the following three areas that are critical to the health of beneficiaries:

- ◆ Maternal and child health: timely postpartum care and immunizations of two-year-olds
- ◆ Chronic disease management: hypertension control and diabetes care
- ◆ Prevention: tobacco cessation

The quality strategy also continued to focus on two additional areas that are essential to addressing the health of beneficiaries:

- ◆ Identifying and reducing health disparities among beneficiaries
- ◆ Reducing opioid medication misuse and overuse to help foster healthier communities

DHCS monitors the quality and coverage of timely postpartum care, immunizations of two-year-olds, hypertension control, diabetes care, and tobacco cessation through specific performance measures. DHCS is engaging in non-measure-related interventions with both MCPs and external stakeholders to address the focus areas related to health disparities and opioid medication misuse.

⁴ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Nov 14, 2017.

⁵ Note: HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS holds just one contract with Kaiser (KP Cal, LLC).

Compliance Reviews

HSAG identified the following notable conclusions based on HSAG’s assessment of all relevant compliance-related documents provided by DHCS:

- ◆ Deficiencies identified during Audits & Investigations Division (A&I) Medical and State Supported Services Audits and California Department of Managed Health Care (DMHC) 1115 Waiver Seniors and Persons with Disabilities (SPD) enrollment surveys (referred to in this report as “SPD Medical Surveys”) cut across the areas of quality and timeliness of and access to health care.
- ◆ In instances where follow-up information was received and reviewed by HSAG, MCPs and SHPs provided documentation to DHCS that either resulted in DHCS provisionally closing or closing the MCPs’ or SHPs’ corrective action plans (CAPs). Findings within the assessed areas were MCP-/SHP-specific; therefore, across all MCPs/SHPs, HSAG identified no specific areas for improvement.
- ◆ DHCS continued to demonstrate ongoing efforts to follow up on deficiencies.

Performance Measures—Medi-Cal Managed Care Health Plans⁶

HSAG identified the following notable aggregate performance measure results:

- ◆ Across all measure domains in reporting year (RY) 2017, the MCMC weighted averages for all 18 measures for which DHCS held MCPs accountable to meet the DHCS-established minimum performance levels (MPLs) were above the MPLs.
- ◆ Sixteen of the 19 MCMC weighted averages for which HSAG made comparisons between RY 2016 and RY 2017 (84 percent) improved significantly from RY 2016 to RY 2017. MCPs’ quality improvement efforts, combined with DHCS’ quality improvement strategies, may have contributed to the improved performance across all measure domains from RY 2016 to RY 2017.
- ◆ The MCMC weighted averages for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Use of Imaging Studies for Low Back Pain* measures declined significantly from RY 2016 to RY 2017; however, the MCMC weighted averages for these two measures were above the MPLs in RY 2017. As applicable, HSAG provided recommendations to individual MCPs to identify the causes for the statistically significant decline in their rates for these measures; however, it should be noted that the significant decline in the rates for these measures from RY 2016 to RY 2017 may be due to the National Committee for Quality Assurance (NCQA’s) specification changes for these measures and therefore may not be related to MCPs’ performance.

⁶ Note that HSAG’s assessment related to performance measures does not include measures for which MCPs were not held accountable to meet the minimum performance levels (MPLs) in RY 2017.

Performance Measures—Specialty Health Plans

For SHP performance measure rates for which a comparison could be made between RY 2016 and RY 2017, no statistically significant changes occurred. Additionally, all SHP rates for performance measures for which MPLs were established in RY 2017 were above the MPLs.

Performance Improvement Projects

Through HSAG's performance improvement project (PIP) training, validation, and technical assistance, MCPs and SHPs became more proficient conducting PIPs using HSAG's rapid-cycle PIP process, which places emphasis on improving both health care outcomes and processes through the integration of continuous quality improvement science. This approach directs MCPs and SHPs through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation.

All MCPs and SHPs met the required criteria for the PIP modules that they completed and submitted during the review period. All MCPs and SHPs completed intervention testing, and one MCP progressed to submitting the final PIP modules to HSAG for validation during the review period. All other MCPs and SHPs were on schedule to submit their final modules to HSAG for validation by September 1, 2017.

Consumers Surveys

HSAG administered the 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Child Medicaid Health Plan Survey for the Children's Health Insurance Program (CHIP) population. The survey included the Healthcare Effectiveness Data and Information Set (HEDIS®) and children with chronic conditions (CCC) measurement sets. The rates for all measures with reportable results (i.e., measures with at least 100 responses) were below the 2016 NCQA national averages—except the rate for the *Rating of Specialist Seen Most Often* global rating for the CCC population, which was above the 2016 NCQA national average.

Focused Studies

The following are brief summaries of HSAG's notable conclusions from the focused studies that HSAG conducted and concluded during the review period.

Developmental Screening in the First Three Years of Life

HSAG conducted a focused study to help DHCS determine whether or not it should add the *Developmental Screening in the First Three Years of Life* measure to DHCS' External Accountability Set (EAS). DHCS had concerns that the rates for this measure would be artificially low due to provider lack of use of the Current Procedural Terminology (CPT) Code 96110 (i.e., providers who are capitated or working in Federally Qualified Health Centers [FQHCs] have no incentive to use the code as it does not result in additional payment). HSAG conducted stakeholder and MCP questionnaires and an

administrative analysis. The following are notable conclusions from the Developmental Screening in the First Three Years of Life Focused Study:

- ◆ Stakeholder Questionnaire
 - The survey responses indicated that stakeholders had increased interest in improving the *Developmental Screening in the First Three Years of Life* measure rate.
 - Stakeholders reported similar barriers to improving the rate, including lack of education regarding the importance of children receiving developmental screenings, billing and coding issues and best practices, referral services and/or pathways, and the use of American Academy of Pediatrics-recommended and -validated tools.
 - HSAG discovered that the focused study findings conflicted when comparing monetary incentives as a tool for promoting the administration of developmental screenings to proprietary incentives (i.e., providing ownership in costly screening tools as an incentive), which also drive providers and provider locations to conduct developmental screenings.
 - Stakeholders noted that data quality and completeness continue to be ongoing challenges in the ability to accurately assess developmental screenings in children, noting that the data accuracy problem is related to coding and billing practices, data collection and retention practices, and MCMC reporting standards.
- ◆ MCP Questionnaire
 - While MCPs recognize the importance of working with providers to ensure that children receive appropriate developmental screenings, the reported rate at which screenings are administered is lower than expected.
 - HSAG identified barriers to ensuring that providers administer appropriate developmental screenings, including caregiver and provider education; lack of education regarding general developmental milestones and the importance of screening; resource constraints; inconsistent use of standardized, validated tools; and a lack of access to and/or use of CPT Code 96110.
 - Providers do not use a standardized approach to administer and code developmental screenings; therefore, the developmental screenings rate may be underreported.
- ◆ Administrative Analysis
 - HSAG identified a large variation in the use and submission of CPT Code 96110 among MCP reporting units, which raised concerns that CPT Code 96110 in DHCS' encounter data may not reflect the true developmental screening services provided.
 - Although 10 MCPs provided four additional procedure codes to identify developmental screenings from encounter data, these additional codes improved the rates by no more than 1.6 percentage points.

Quality Team

The goal of the Quality Team Focused Study was to determine whether any specific structure, functions, or characteristics could be attributed to an effective MCP quality assessment and performance improvement (QAPI) team. SHPs were not included in the focused study.

Based on HSAG's comprehensive review of the MCPs' QAPI programs, review of all 50 state Medicaid program websites, and the literature review, HSAG concluded that QAPI team models, designs, and characteristics vary. Each model may have elements that have proven successful for an MCP in developing an effective QAPI team; however, HSAG identified no specific characteristics that, if implemented, will ensure that an MCP's QAPI team is effective.

Technical Assistance

The following are brief summaries of HSAG's notable conclusions from the technical assistance activities that HSAG conducted during the review period.

Technical Assistance Activity for Performance Measures

As a result of technical assistance that HSAG provided to DHCS, MCPs, and SHPs:

- ◆ DHCS found HSAG's secondary review of Plan-Do-Study-Act (PDSA) cycles and CAPs helpful as it reinforced DHCS' findings and created synergy to provide optimal recommendations to MCPs.
- ◆ DHCS decided to eliminate the *Clinical Depression and Follow-Up Plan* measure and add the *Depression Screening and Follow-Up for Adolescents and Adults* measure to the RY 2018 EAS.
- ◆ DHCS gained a better understanding of HEDIS measures and the performance measure validation processes.
- ◆ DHCS established a new PDSA cycle process, including a revised PDSA Cycle Worksheet and instructions.
- ◆ DHCS gained a better understanding of various baseline calculation methods and their applicable uses in different PDSA-cycle scenarios.
- ◆ MCPs under CAPs became more proficient conducting PIPs using the rapid-cycle PIP process.
- ◆ DHCS enhanced its understanding of EQRO activities.

Technical Assistance Activity for Quality Improvement Collaboration

MCPs and SHPs actively participated in the collaborative discussions by asking presenters questions and sharing about their own experiences, challenges, and lessons learned. The post-collaborative discussion surveys revealed that MCPs and SHPs found MCPs'/SHPs' presentations and sharing of ideas, successes, and lessons learned helpful; and MCPs and SHPs requested that DHCS and HSAG incorporate the following into future collaborative discussions:

- ◆ Select MCP/SHP presenters who can share interventions with outcomes.
- ◆ Limit didactic sessions to allow more time to discuss successes and challenges of quality improvement efforts.
- ◆ Provide discussion materials/PowerPoint presentations ahead of time, if possible.

Recommendations across All Assessed Activities

Based on HSAG's assessment of all activities that HSAG conducted during the review period, HSAG provides the following recommendations for DHCS. Note that MCP- and SHP-specific recommendations are included in appendices A through Z.

Performance Measures

When DHCS next evaluates whether or not to add or remove measures from the EAS, HSAG recommends the following:

- ◆ To help DHCS monitor MCMC's progress on the MCMC quality strategy area of reducing opioid medication misuse and overuse, obtain input from MCPs and other stakeholders through various methods such as questionnaires or focused studies regarding the feasibility and applicability of adding one of NCQA's *Use of Opioids* measures to the EAS.

Consumer Surveys

HSAG recommends that DHCS seek feedback on the 2017 CAHPS survey results for measures with at least 100 responses from MCPs and the Medi-Cal Children's Health Advisory Panel (MCHAP).⁷ DHCS should factor the feedback from MCPs and MCHAP into DHCS' determination of priority areas for improvement and strategies related to ensuring quality, accessible, and timely health care services for the Medi-Cal child population.

⁷ MCHAP operates as a stakeholder group for DHCS and advises DHCS on policy and operational issues that affect children in Medi-Cal. Information about MCHAP may be found at: http://www.dhcs.ca.gov/services/Pages/Medi-Cal_Childrens_Health_Advisory_Panel.aspx. Accessed on: Dec 19, 2017.

Purpose of Report

As required by 42 CFR §438.364,⁸ DHCS contracts with HSAG, an EQRO, to prepare an annual, independent, technical report that summarizes findings on access and quality of care related to the health care services provided by California’s Medi-Cal managed care health plans (MCPs) and specialty health plans (SHPs).

Note: 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.” CMS designates all DHCS-contracted MCPs and two DHCS-contracted SHPs as MCOs. CMS designates one DHCS-contracted SHP as a prepaid inpatient health plan (PIHP). Unless citing Title 42 CFR, this report will refer to DHCS’ MCOs as MCPs and the PIHP as an SHP.

As described in the CFR, the independent report must summarize findings on access and quality of care, including:

- ◆ A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.
- ◆ For each EQR-related activity conducted in accordance with §438.358:
 - Objectives
 - Technical methods of data collection and analysis
 - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
 - Conclusions drawn from the data
- ◆ An assessment of each MCO, PIHP, PAHP, or PCCM entity’s strengths and weaknesses for the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- ◆ Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.

⁸ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, 438, et al. Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. Accessed on: Nov 14, 2017.

- ◆ Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- ◆ An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Quality, Access, and Timeliness

The Centers for Medicare & Medicaid Services (CMS) requires that the EQR evaluate the performance of MCOs, PIHPs, PAHPs, and PCCM entities related to the quality and timeliness of, and access to care delivered by the MCOs, PIHPs, PAHPs, and PCCM entities.

- ◆ **Quality**—The CFR indicates that quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through:
 - Its structural and operational characteristics.
 - The provision of services that are consistent with current professional, evidence-based knowledge.
 - Interventions for performance improvement.
- ◆ **Access**—The CFR indicates that access, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).
- ◆ **Timeliness**—NCQA defines timeliness relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”⁹ NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require timely response by the MCP—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates that “timeliness is the health care system’s capacity to provide health care quickly after a need is recognized.”¹⁰ Timeliness includes the interval between identifying a need for specific tests and treatments and actually receiving those services.¹¹

This report includes conclusions drawn by HSAG related to MCPs’ and SHPs’ strengths and weaknesses with respect to the quality and timeliness of, and access to the health care services furnished to MCMC beneficiaries (referred to as “beneficiaries” in this report). While quality, access, and timeliness are distinct aspects of care, most MCP and SHP activities and services cut across more than one area.

⁹ National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

¹⁰ Agency for Healthcare Research and Quality. *National Healthcare Quality Report 2007*. AHRQ Publication No. 08-0040. February 2008.

¹¹ Ibid.

Collectively, all MCP and SHP activities and services affect the quality, access, and timeliness of care delivered to beneficiaries. In this report, when applicable, HSAG indicates instances in which MCP or SHP performance affects one specific aspect of care more than another.

Summary of Report Content

This report provides:

- ◆ A description of MCMC.
- ◆ A description of DHCS' annual assessment of the MCMC quality strategy.
- ◆ A description of the scope of EQR activities for the period of July 1, 2016, through June 30, 2017, including the methodology used for data collection and analysis, a description of the data for each activity, and an aggregate assessment of MCP and SHP performance related to each activity, as applicable.
- ◆ A description of HSAG's assessment related to the three federally mandated activities, three of the six optional activities, and the technical assistance provided to DHCS, MCPs, and SHPs as set forth in 42 CFR §438.358:
 - Mandatory activities:
 - Health plan compliance reviews
 - Validation of performance measures
 - Validation of PIPs
 - Optional activities:
 - Administration of consumer surveys
 - Focused studies
 - Technical assistance
- ◆ MCP- and SHP-specific evaluation reports, included as appendices (A through Z). Each MCP- and SHP-specific evaluation report provides an assessment of the MCP's and SHP's strengths and weaknesses with respect to the quality and timeliness of, and access to health care services as well as recommendations to the MCP and SHP for improving quality of health care services for its beneficiaries.

The technical report and MCP- and SHP-specific evaluation reports all align to the same review period—July 1, 2016, through June 30, 2017.

Medi-Cal Managed Care Overview

In the State of California, DHCS administers the Medicaid program (Medi-Cal) through its fee-for-service (FFS) and managed care delivery systems. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its MCPs and SHPs, making improvements to care and services, and ensuring that contracted MCPs and SHPs comply with federal and State standards.

MCMC provides managed health care services to more than 10.72 million beneficiaries (as of June 30, 2017)¹² in the State of California through a combination of contracted MCPs and SHPs. During the review period, DHCS contracted with 22 MCPs¹³ and three SHPs to provide health care services in all 58 counties throughout California. DHCS operates MCMC through a service delivery system that encompasses six models of managed care for its full-scope services as well as a model for SHPs. DHCS monitors MCP and SHP performance across model types. A link to the MCMC county map, which depicts the location of each model type, may be found at <http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>.

Following is a description of each managed care model type. HSAG includes the numbers of beneficiaries served by each model type as of June 30, 2017, within the model type descriptions. HSAG obtained the enrollment information from the *Medi-Cal Managed Care Enrollment Report—June 2017*.¹²

County Organized Health System (COHS) model. A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission. A COHS model has been implemented in 22 counties and operates in each as a single, county-operated health plan. This model does not offer FFS Medi-Cal. As of June 30, 2017, the COHS model was serving about 2.18 million beneficiaries through six health plans in 22 counties; six of those counties were added in 2013.

Two-Plan Model (TPM). Under TPM, beneficiaries may choose between two MCPs; typically, one MCP is a local initiative (LI) and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. As of June 30, 2017, the TPM was serving about 6.98 million beneficiaries through 12 health plans in 14 counties. Note that Anthem Blue Cross Partnership Plan serves as an LI in Tulare County and a CP in all other TPM counties.

¹² *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Nov 14, 2017.

¹³ Note: HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS holds just one contract with Kaiser (KP Cal, LLC).

Geographic Managed Care (GMC) model. Under a GMC model, DHCS allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county). As of June 30, 2017, the GMC model had seven health plans serving about 1.17 million beneficiaries in Sacramento and San Diego counties.

Regional model. This model consists of three commercial health plans that provide services to beneficiaries in the rural counties of the State, primarily in northern and eastern California. The Regional model was implemented in November 2013, bringing MCMC to counties that historically offered only FFS Medi-Cal. As of June 30, 2017, the Regional model was serving more than 300,000 beneficiaries in 18 counties.

Imperial model. This model operates in Imperial County with two commercial health plans. As of June 30, 2017, this model was serving more than 76,000 beneficiaries.

San Benito model. This model operates in San Benito County and provides services to beneficiaries through a CP and FFS Medi-Cal. As of June 30, 2017, the San Benito model was serving more than 8,000 beneficiaries. San Benito is California's only county where enrollment in managed care is not mandatory.

Specialty Health Plans. SHPs provide health care services to specialized populations. During the review period, DHCS held contracts with three SHPs:

- ◆ AIDS Healthcare Foundation—provides services in Los Angeles County primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). As of June 30, 2017, AIDS Healthcare Foundation was serving 681 beneficiaries.
- ◆ Family Mosaic Project—provides intensive case management and wraparound services in San Francisco County for MCMC children and adolescents at risk of out-of-home placement. As of June 30, 2017, Family Mosaic Project was serving 19 beneficiaries.
- ◆ SCAN Health Plan—is a Medicare Advantage Special Needs Plan that provides services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties. According to DHCS, as of June 30, 2017, SCAN Health Plan was serving 12,918 beneficiaries.

Table 2.1 shows participating MCPs and SHPs by model type.

Table 2.1—Medi-Cal Managed Care Health Plans by Model Type as of June 30, 2017

Model Type		MCP Name	Counties
Two-Plan	Commercial	Anthem Blue Cross Partnership Plan	Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara
		Health Net Community Solutions, Inc.	Kern, Los Angeles, San Joaquin, Stanislaus, Tulare
		Molina Healthcare of California Partner Plan, Inc.	Riverside, San Bernardino
	Local Initiative	Alameda Alliance for Health	Alameda
		Anthem Blue Cross Partnership Plan	Tulare
		CalViva Health	Fresno, Kings, Madera
		Contra Costa Health Plan	Contra Costa
		Health Plan of San Joaquin	San Joaquin, Stanislaus
		Inland Empire Health Plan	Riverside, San Bernardino
		Kern Health Systems	Kern
		L.A. Care Health Plan	Los Angeles
		San Francisco Health Plan	San Francisco
Santa Clara Family Health Plan	Santa Clara		
Geographic Managed Care	Anthem Blue Cross Partnership Plan	Sacramento	
	Health Net Community Solutions, Inc.		
	Kaiser NorCal (KP Cal, LLC)*		
	Molina Healthcare of California Partner Plan, Inc.		
	Care1st Partner Plan	San Diego	
	Community Health Group Partnership Plan		
	Health Net Community Solutions, Inc.		
	Kaiser SoCal (KP Cal, LLC)		
	Molina Healthcare of California Partner Plan, Inc.		
County-Organized Health System	CalOptima	Orange	
	CenCal Health	San Luis Obispo, Santa Barbara	
	Central California Alliance for Health	Merced, Monterey, Santa Cruz	
	Gold Coast Health Plan	Ventura	
	Health Plan of San Mateo	San Mateo	
	Partnership HealthPlan of California	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo	

Model Type	MCP Name	Counties
Imperial	Molina Healthcare of California Partner Plan, Inc.	Imperial
	California Health & Wellness Plan	
San Benito	Anthem Blue Cross Partnership Plan	San Benito
Regional	Anthem Blue Cross Partnership Plan	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama (MCPs will report a single, multi-county rate for these counties, which are collectively referred to as Region 1.)
	California Health & Wellness Plan	
	Anthem Blue Cross Partnership Plan	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba (MCPs will report a single, multi-county rate for these counties, which are collectively referred to as Region 2.)
	California Health & Wellness Plan	
Kaiser NorCal*	Amador, El Dorado, Placer	
Specialty MCPs	AIDS Healthcare Foundation	Los Angeles
	Family Mosaic Project	San Francisco
	SCAN Health Plan	Los Angeles, Riverside, San Bernardino

* Kaiser NorCal provides Medi-Cal services in Sacramento County as a GMC model type and in Amador, El Dorado, and Placer counties as a Regional model type; however, the MCP reports performance measure rates for all counties combined. DHCS' decision to have Kaiser NorCal report the combined rates ensures that the MCP has a sufficient sample size to compute accurate performance measure rates that represent the availability and quality of care provided for the population in the region and assists Kaiser NorCal with maximizing operational and financial efficiencies by reducing the number of encounter data validation, improvement plans, PIPs, and CAHPS survey activities.

For enrollment information on each county, go to

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>.

3. Medi-Cal Managed Care Quality Strategy

Medi-Cal Managed Care Quality Strategy Annual Assessment

In accordance with 42 CFR §438.340, each state contracting with an MCO, PIHP, or PAHP, as defined in §438.2 or with a PCCM entity as described in §438.310(c) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity.

Various DHCS staff members participated in the MCMC quality strategy annual assessment process, which included obtaining feedback from MCPs, SHPs, and DHCS advisory groups related to the quality strategy focus areas, objectives, and interventions. In October 2017, DHCS submitted to CMS its annual assessment update of the MCMC quality strategy. The quality strategy continued to focus and build on performance in the following three areas that are critical to the health of beneficiaries:

- ◆ Maternal and child health: timely postpartum care and immunizations of two-year-olds
- ◆ Chronic disease management: hypertension control and diabetes care
- ◆ Prevention: tobacco cessation

The quality strategy also continued to focus on two additional areas that are essential to addressing the health of beneficiaries:

- ◆ Identifying and reducing health disparities among beneficiaries
- ◆ Reducing opioid medication misuse and overuse to help foster healthier communities

DHCS monitors the quality and coverage of timely postpartum care, immunizations of two-year-olds, hypertension control, diabetes care, and tobacco cessation through specific performance measures. DHCS is engaging in non-measure-related interventions with both MCPs and external stakeholders to address the focus areas related to health disparities and opioid medication misuse. The annual assessment update provides detailed information on DHCS' quality improvement strategies and progress in meeting MCMC quality strategy goals.

The most recent publicly posted MCMC quality strategy documents may be found at <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfQSR.aspx>.

Note: DHCS completed its annual assessment of the MCMC quality strategy and submitted the assessment to CMS outside the review dates for this report; however, HSAG references information from the report at the request of DHCS and because the information was available at the time this report was produced.

4. Compliance Reviews

The Balanced Budget Act of 1997 (BBA) as set forth in 42 CFR §438.358 requires that the state or its designee conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM entity's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

Background

To ensure that MCPs and SHPs meet all federal requirements, DHCS incorporates into its contracts with MCPs and SHPs specific standards for elements outlined in the CFR.

In accordance with California Welfare & Institutions Code §19130(b)(3), DHCS directly conducts compliance reviews of MCPs and SHPs rather than contracting with the EQRO to conduct reviews on its behalf. DHCS applies the Generally Accepted Government Auditing Standards (GAGAS), also known as the Yellow Book. DHCS has determined that its auditing tools are proprietary. Thus, DHCS cannot provide the EQRO with information that would allow the EQRO to determine whether DHCS' tools assess compliance with all federal and State requirements.

DHCS' compliance review process includes, but is not limited to, a review of MCPs' and SHPs' policies and procedures, on-site interviews, on-site provider site visits, and file verification studies. Additionally, DHCS actively engages with MCPs and SHPs throughout the CAP process by providing technical assistance and ongoing monitoring to ensure full remediation of identified deficiencies.

Under DHCS monitoring protocols, DHCS oversees the CAP process to ensure that MCPs and SHPs address all deficiencies identified in the following types of compliance reviews: DHCS A&I Medical Audits, DHCS A&I State Supported Services Audits, DMHC 1115 Waiver SPD Medical Surveys, and DMHC Rural Expansion Medical Surveys. DHCS issues final closeout letters to MCPs and SHPs once MCPs and SHPs have submitted supporting documentation to substantiate that they have fully remediated all identified deficiencies and that the deficiencies are unlikely to recur. However, if corrective action requires more extensive changes to MCP and SHP operations and full implementation cannot be reasonably achieved without additional time, DHCS may provisionally close some deficiencies on the basis that sufficient progress has been made toward meeting set milestones. In these instances, DHCS may issue provisional closeout letters to MCPs and SHPs. DHCS will issue final closeout letters once MCPs and SHPs achieve full implementation of provisionally closed deficiencies and resolve all issues.

Compliance Reviews

DHCS and DMHC assess MCPs and SHPs through various compliance reviews. While most areas assessed under these reviews are similar, the results are reported separately and are distinct to specific populations. Descriptions of the various types of compliance reviews are indicated following, including the areas assessed along with the frequency of the reviews.

DHCS Audits & Investigations Division Medical Audits

Prior to 2015, DHCS conducted medical audits of MCPs and SHPs once every three years—sometimes in collaboration with DMHC. These medical audits assessed MCPs’ and SHPs’ compliance with contract requirements and State and federal regulations. In January 2015, California Welfare and Institutions Code §14456 became law, mandating annual audits for MCPs. In response, A&I currently conducts on-site medical audits of each MCP annually, alternating between comprehensive full-scope and reduced-scope audits. Additionally, A&I conducts annual follow-up on the previous year’s CAP. A&I Medical Audits cover the following review categories:

- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member’s Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS Audits & Investigations Division State Supported Services Audits

A&I conducts State Supported Services (abortion services) Audits in tandem with its A&I Medical Audits. State Supported Services Audits are conducted in accordance with California Welfare and Institutions Code §14456. In conducting this audit, the audit team evaluates the MCP’s compliance with the State Supported Services contract and regulations. A&I conducts these audits annually. Additionally, A&I conducts follow-up on the previous year’s CAP.

DMHC Seniors and Persons with Disabilities Medical Surveys

DHCS received an authorization “1115 Waiver” from the federal government to conduct mandatory enrollment of SPD beneficiaries into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes for those beneficiaries. DMHC entered into an interagency agreement with DHCS to conduct health plan medical surveys (SPD Medical Surveys) every three years to ensure that beneficiaries affected by this mandatory transition are assisted and protected under California’s strong patients’ rights laws. Mandatory enrollment began in June 2011. DMHC conducts

SPD Medical Surveys triennially, with ongoing follow-up on CAPs. These surveys cover the following review categories:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility
- ◆ Member Rights
- ◆ Quality Management

DMHC Rural Expansion Medical Surveys

Pursuant to California Welfare and Institutions Code §14005.27 and authorized under Assembly Bill 1467, DHCS expanded MCMC to Medi-Cal beneficiaries residing in 28 rural California counties. DHCS entered into an interagency agreement with DMHC to perform medical surveys of each health plan participating in the rural expansion. Mandatory enrollment of Medi-Cal beneficiaries from Fee-For-Service into MCMC began in September 2013. DMHC conducts Rural Expansion Medical Surveys triennially, providing ongoing follow-up on CAPs. These surveys cover the following review categories:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility
- ◆ Member Rights
- ◆ Quality Management

Specialty Health Plan Compliance Reviews

A&I conducted medical audits of two SHPs—AIDS Healthcare Foundation and SCAN Health Plan—to assess the SHPs' compliance with contract requirements and State and federal regulations. The audits covered the review categories listed previously under the “DHCS Audits & Investigations Division Medical Audits” heading. HSAG includes applicable findings, conclusions, and recommendations from these two audits within this section of this report.

Family Mosaic Project

DHCS' Mental Health Services Division conducted a triennial on-site review of the San Francisco County mental health plan (MHP) on April 24, 2017. Family Mosaic Project is part of the Child, Youth, and Family System of Care operated by the San Francisco Department of Public Health (SFDPH) Community Behavioral Health Services; therefore, the review included Family Mosaic Project. The system review included the following areas:

- ◆ Access
- ◆ Attestations related to compliance with regulatory and/or contractual requirements

- ◆ Authorization
- ◆ Beneficiary Protection
- ◆ Interface with Physical Health Care
- ◆ Mental Health Services Act
- ◆ Network Adequacy and Array of Services
- ◆ Program Integrity
- ◆ Provider Relations
- ◆ Quality Improvement

In response to the areas of non-compliance that DHCS identified during the review, the San Francisco MHP submitted a detailed plan of correction from the on-site review.

Family Mosaic Project's compliance review is unique to this SHP; therefore, HSAG does not include additional results, conclusions, or recommendations regarding Family Mosaic Project's review within this section of this report. Family Mosaic Project's compliance review information may be found in Appendix L.

Objectives

HSAG's objectives related to compliance reviews are to assess:

- ◆ DHCS' compliance with conducting reviews with all MCPs and SHPs within the three-year period prior to the review dates for this report.
- ◆ MCPs' and SHPs' compliance with the areas DHCS reviewed as part of the compliance review process.

Methodology

As part of the EQR technical report production, DHCS submitted to HSAG all compliance-related documentation for reviews occurring within the previous three-year period that HSAG had not already reported on in previous EQR technical reports.

HSAG determined whether or not DHCS conducted compliance monitoring reviews for all MCPs and SHPs at least once within the three-year period prior to the review dates for this report by assessing the dates of each MCP's and SHP's review. Unless noted, HSAG excluded from its analysis information from compliance reviews conducted earlier than three years prior to the start of the review period (July 1, 2016) and later than the end of the review period (June 30, 2017).

HSAG reviewed all compliance-related information to assess the degree to which MCPs and SHPs are meeting the standards assessed as part of the compliance review process. Additionally, HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw

conclusions about overall MCP and SHP performance in providing quality, accessible, and timely health care and services to beneficiaries.

In addition to summarizing the aggregated results, HSAG also summarized MCP- and SHP-specific results, including HSAG's recommendations. MCP- and SHP-specific compliance review results and HSAG's recommendations are included in appendices A through Z.

Results—Compliance Reviews

HSAG reviewed the dates on which DHCS conducted its most recent compliance reviews of MCPs and SHPs and determined that DHCS conducted a compliance review no earlier than three years from the start of the review period for this report (July 1, 2016) and no later than the end of the review period for this report (June 30, 2017) for all MCPs and SHPs.

The following is a summary of notable results from HSAG's assessment of the compliance review information submitted by DHCS to HSAG for production of the 2016–17 MCP- and SHP-specific evaluation reports and this EQR technical report. The summary includes new information not reported on in previous review periods.

- ◆ DHCS provided evidence to HSAG of DHCS' ongoing follow-up with MCPs and SHPs on deficiencies identified during A&I audits and DMHC surveys. DHCS sent HSAG copies of the CAP response and final closeout letters that DHCS issued to MCPs in response to MCPs submitting deficiency-related documentation to DHCS.
- ◆ HSAG received results from 20 State Supported Services audits of MCPs. A&I identified no deficiencies in 17 of the 20 audits (85 percent), reflecting full compliance with the State Supported Services contract and regulations.
- ◆ Nineteen of the 22 MCPs and SHPs for which HSAG received A&I Medical Audit and DMHC SPD Medical Survey results (86 percent) had a deficiency in at least one review area (e.g., Utilization Management, Member Rights). Deficiencies were MCP-/SHP-specific, with no specific findings cutting across most or all MCPs.

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

For the most up-to-date DMHC medical survey reports and CAP information, go to:
<http://www.dhcs.ca.gov/services/Pages/MngdHlthMedSrvyCAP.aspx>.

Conclusions—Compliance Reviews

Deficiencies identified during A&I audits and DMHC surveys cut across the areas of quality and timeliness of and access to health care. In instances where follow-up information was received and reviewed by HSAG, MCPs and SHPs provided documentation to DHCS that either resulted in DHCS provisionally closing or closing the MCPs' or SHPs' CAPs. Findings within the assessed areas were MCP-/SHP-specific; therefore, across all MCPs/SHPs, HSAG identified no specific areas for improvement. Additionally, DHCS continued to demonstrate ongoing efforts to follow up on deficiencies as evidenced in the CAP response and final closeout letters that DHCS submitted to HSAG for review.

Recommendations—Compliance Reviews

HSAG has no recommendations to DHCS related to compliance reviews.

5. Performance Measures

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of the MCOs', PIHPs', PAHPs', and PCCM entities' quality assessment and performance improvement programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). The EQR technical report must include information on the validation of MCO, PIHP, PAHP, or PCCM entity performance measures (as required by the state) or MCO, PIHP, PAHP, and PCCM entity performance measures calculated by the state during the preceding 12 months.

Background

To comply with §438.358, DHCS contracted with HSAG to conduct an independent validation, through NCQA HEDIS Compliance Audits^{TM,14} and performance measure validation for non-HEDIS measures, of the DHCS-selected performance measures calculated and submitted by MCPs and SHPs. Additionally, as part of California's Coordinated Care Initiative (CCI), DHCS contracted with HSAG to conduct an independent validation of the DHCS-selected performance measures calculated and submitted by Managed Long-Term Services and Supports Plans (MLTSSPs).

HSAG evaluates two aspects of performance measures for each MCP, SHP, and MLTSSP. First, HSAG assesses the validity of each MCP's, SHP's, and MLTSSP's data using protocols required by CMS.¹⁵ Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about MCPs', SHPs', and MLTSSPs' performances in providing quality, accessible, and timely care and services to beneficiaries.

Requirements

To comply with §438.330, DHCS selects a set of performance measures through which to evaluate the quality of care delivered by the contracted MCPs and SHPs to beneficiaries. DHCS consults with MCPs, SHPs, HSAG, and stakeholders to determine the performance measures DHCS will require. MCMC's quality strategy describes the program's processes to define, collect, and report MCP- and SHP-specific performance data, as well as overall MCMC performance data, on DHCS-required measures. MCPs and SHPs must report county/regional rates unless otherwise approved by DHCS.

¹⁴ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

¹⁵ The CMS EQR protocols may be found at <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Apr 11, 2018.

Full-Scope Managed Care Health Plans

External Accountability Set

DHCS refers to the DHCS-selected performance measures for MCPs as the External Accountability Set (EAS). MCPs' reporting of EAS rates provides DHCS with a standardized method for objectively evaluating MCPs' delivery of services to beneficiaries.

In alignment with the quality strategy report reassessment timeline, DHCS evaluates the EAS every three years using the following criteria:

1. **Meaningful** to the public, the beneficiaries, the State, and the MCPs.
2. **Improves quality of care** or services for the Medi-Cal population.
3. **High population impact** by affecting large numbers of beneficiaries or having substantial impact on smaller, special populations.
4. **Known impact of poor quality** linked with severe health outcomes (morbidity, mortality) or other consequences (high resource use).
5. **Performance improvement needed** based on available data demonstrating opportunity to improve, variation across performance, and disparities in care.
6. **Evidence-based practices available** to demonstrate that the problem is amenable to intervention and that there are pathways to improvement.
7. **Availability of standardized measures and data** that can be collected.
8. **Alignment** with other national and State priority areas.
9. **Health care system value** demonstrated through cost-savings, cost-effectiveness, risk-benefit balance, or health economic benefit.
10. **Avoid negative unintended consequences.**

DHCS also considers other issues when determining whether or not to add or remove measures from the EAS, including:

- ◆ Limiting burden and intrusion on primary care provider (PCP) offices (administrative versus hybrid measures, for instance).
- ◆ Needing to retain measures in the core set for three years for baseline and trend analysis.
- ◆ Considering the impact of adding/deleting measure(s) used in the auto-assignment and default algorithm.

As part of its evaluation of the EAS measures, DHCS seeks input from MCP medical directors and various stakeholder advisory groups.

DHCS’ RY¹⁶ 2017 EAS consisted of 15 HEDIS measures and two non-HEDIS measures—one measure originally developed by DHCS and MCPs (with guidance from HSAG) to be used for a statewide collaborative quality improvement project (QIP) and another measure from the CMS Adult Core Set. Several required measures include more than one indicator, bringing the total number of performance measure rates required for MCP reporting to 30. In this report, HSAG uses “performance measure” or “measure” (rather than indicator) to reference required EAS measures. Collectively, performance measure results reflect the quality and timeliness of and access to care provided by MCPs to beneficiaries.

Table 5.1 lists the RY 2017 EAS measures by measure domain. HSAG organized the measures into measure domains based on the health care areas they affect. Organizing the measures by domains allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS.

Table 5.1—RY 2017 (MY 2016) External Accountability Set Measures

Measure Domain	Measure	NCQA Method of Data Capture*
Preventive Screening and Children’s Health	<i>Childhood Immunization Status—Combination 3</i>	Hybrid
	<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	Admin
	<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	Admin
	<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	Admin
	<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	Admin
	<i>Immunizations for Adolescents—Combination 2</i>	Hybrid
	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total</i>	Hybrid
	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total</i>	Hybrid
	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Hybrid
Preventive Screening and Women’s Health	<i>Breast Cancer Screening</i>	Admin
	<i>Cervical Cancer Screening</i>	Hybrid
	<i>Prenatal and Postpartum Care—Postpartum Care</i>	Hybrid
	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	Hybrid

¹⁶ The RY is the year in which MCPs report the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Measure Domain	Measure	NCQA Method of Data Capture*
Care for Chronic Conditions	<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	Admin
	<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	Admin
	<i>Asthma Medication Ratio</i>	Admin
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	Hybrid
	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	Hybrid
	<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	Hybrid
	<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	Hybrid
	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	Hybrid
	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	Hybrid
	<i>Controlling High Blood Pressure</i>	Hybrid
Appropriate Treatment and Utilization	<i>All-Cause Readmissions (non-HEDIS measure originally developed for the Statewide Collaborative All-Cause Readmissions QIP)</i>	Admin
	<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	Admin
	<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	Admin
	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	Admin
	<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate (non-HEDIS measure)</i>	Hybrid***
	<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate (non-HEDIS measure)</i>	Hybrid***
	<i>Use of Imaging Studies for Low Back Pain</i>	Admin

* Admin = administrative method, which requires that MCPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MCPs derive the numerator, or services provided to beneficiaries in the eligible population, from administrative data sources and auditor-approved supplemental data sources. MCPs cannot use medical records to retrieve information. When using the administrative method, MCPs use the entire eligible population as the denominator because NCQA does not allow sampling.

Hybrid = hybrid method, which requires that MCPs identify the eligible population using administrative data, then extract a systematic sample of beneficiaries from the eligible population, which becomes the denominator. MCPs use administrative data to identify services provided to these beneficiaries. When administrative data do not show evidence that MCPs provided the service, MCPs review medical records for those beneficiaries to derive the numerator.

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

*** Although the methodology is hybrid for this measure, MCPs reported the rate administratively for RY 2017.

Seniors and Persons with Disabilities Performance Measure Stratification

In addition to requiring MCPs to report rates for EAS measures in RY 2017, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

- ◆ *All-Cause Readmissions*
- ◆ *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- ◆ *Ambulatory Care—Outpatient Visits per 1,000 Member Months*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years*

Reporting Year 2017 Encounter Data Diabetes Subset Comparing SPD and Non-SPD Rates

In RY 2015, DHCS initiated an encounter data validation and improvement project that significantly improves the quality of DHCS’ encounter data. As part of this project, DHCS augmented HSAG’s reporting of SPD performance by getting approval from CMS to calculate a subset of SPD rates using encounter data submitted by MCPs for the following indicators:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

These SPD and non-SPD rates were calculated by DHCS and were not validated by HSAG. Further, DHCS provided the results and findings for HSAG to include in this report.

DHCS-Established Performance Levels

To create a uniform standard for assessing MCPs on performance measures, DHCS established a high performance level (HPL) and MPL for each HEDIS measure except for the *Immunizations for Adolescents—Combination 2* measure. *Immunizations for Adolescents—Combination 2* is a new HEDIS measure for RY 2017; therefore, no benchmarks exist for DHCS to use to establish an HPL and MPL. Additionally, DHCS did not establish HPLs or MPLs for the non-HEDIS *All-Cause Readmissions* and both *Screening for Clinical Depression and Follow-Up Plan* measures.

To establish the HPLs and MPLs for the RY 2017 HEDIS measures, DHCS used NCQA's Quality Compass[®],¹⁷ HEDIS 2016 national Medicaid benchmarks. The Quality Compass HEDIS 2016 national Medicaid benchmarks reflect the previous year's benchmark percentiles (calendar year 2015).

DHCS based the HPLs for RY 2017 on the national Medicaid 90th percentiles and the MPLs for RY 2017 on the national Medicaid 25th percentiles. DHCS uses the established HPLs as performance goals and recognizes MCPs for outstanding performance. MCPs are contractually required to perform at or above DHCS-established MPLs. Per DHCS' license agreement with NCQA, HSAG includes in Table 5.2 the benchmarks that DHCS used to establish the HPLs and MPLs for the RY 2017 HEDIS measures.¹⁸

Table 5.2—High Performance Level and Minimum Performance Level Benchmark Values for RY 2017 (MY 2016)*

Measure	RY 2017 HPL	RY 2017 MPL
Preventive Screening and Children's Health		
<i>Childhood Immunization Status—Combination 3</i>	79.81%	64.30%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.85%	93.14%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	93.34%	84.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	96.10%	87.91%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	94.69%	85.84%
<i>Immunizations for Adolescents—Combination 2</i>	—	—
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	79.52%	51.84%
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	71.58%	45.09%
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	82.97%	64.72%
Preventive Screening and Women's Health		
<i>Breast Cancer Screening</i>	71.52%	52.24%
<i>Cervical Cancer Screening</i>	69.95%	48.18%
<i>Prenatal and Postpartum Care—Postpartum Care</i>	73.61%	55.47%
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	91.00%	74.21%
Care for Chronic Conditions		
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	92.13%	85.63%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	92.28%	85.18%

¹⁷ Quality Compass[®] is a registered trademark of NCQA.

¹⁸ The source for data contained in this publication is Quality Compass[®] 2016 and is used with the permission of NCQA. Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors; and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

Measure	RY 2017 HPL	RY 2017 MPL
<i>Asthma Medication Ratio—Total</i>	70.00%	54.55%
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	75.73%	52.26%
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	68.11%	44.53%
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	58.39%	39.80%
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	29.23%	52.31%
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	92.88%	82.98%
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	93.56%	88.32%
<i>Controlling High Blood Pressure</i>	70.69%	46.87%
Appropriate Treatment and Utilization		
<i>All-Cause Readmissions**</i>	—	—
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	87.57	53.23
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	450.33	303.40
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	38.91%	22.12%
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	—	—
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	—	—
<i>Use of Imaging Studies for Low Back Pain</i>	81.42%	69.88%

* RY 2017 HPL and MPL benchmark values represent NCQA’s Quality Compass HEDIS 2016 Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively, reflecting the MY from January 1, 2015, through December 31, 2015.

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

*** *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months* and *Outpatient Visits per 1,000 Member Months* summarize utilization of ambulatory care for outpatient and ED visits. Member months are a member’s “contribution” to the total yearly membership. DHCS establishes MPLs or HPLs for these utilization measures; however, as a higher or lower rate does not necessarily indicate better or worse performance, rates are not compared to benchmarks.

— DHCS did not establish an HPL or MPL for this measure because no comparable benchmark exists.

Although DHCS established HPLs and MPLs for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs] if their rates for the measures were below the MPLs):

- ◆ The two *Ambulatory Care* measures—due to these measures being utilization measures, which means that high and low rates do not necessarily indicate better or worse performance.
- ◆ *Asthma Medication Ratio* measure—due to RY 2017 being the first year that DHCS required MCPs to report rates for this measure.
- ◆ *Breast Cancer Screening* measure—due to RY 2017 being the first year that DHCS required MCPs to report rates for this measure.
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures—due to the small range of variation between the HPL and MPL threshold for each measure.

HSAG includes HPL and MPL information for the measures listed preceding in applicable tables in this report. However, DHCS did not hold MCPs accountable to meet the MPLs for these measures; therefore, HSAG drew no conclusions from the comparative analyses on these measures for RY 2017 and did not include these measures in its assessment of MCP performance.

HEDIS Improvement Plan Process

Annually, DHCS assesses each MCP's performance measure rates against the established MPLs and requires MCPs to submit to DHCS an IP for each measure with a rate below the MPL (unless the MCP is reporting a rate for the measure for the first time). IPs consist of PDSA Cycle Worksheets that each MCP completes and submits once every four months and that provide detailed descriptions of:

- ◆ The MCP's plan for improving performance, including what the MCP will test, how it will measure improvement, and the measurable target for the PDSA cycle.
- ◆ How the MCP carried out the test of change.
- ◆ The MCP's analysis of results.
- ◆ The MCP's decision regarding the test of change, based on the results.

DHCS reviews each IP/PDSA cycle for design soundness and anticipated intervention effectiveness. To avoid redundancy, if an MCP has an active PIP that addresses a measure with a rate below the MPL, DHCS allows the MCP to combine its PIP and IP/PDSA cycle.

The IP/PDSA cycle process is one way DHCS and MCPs engage in efforts to improve the quality and timeliness of, and access to care for beneficiaries, including targeting key quality improvement areas as outlined in California's MCMC Quality Strategy (i.e., immunizations, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs use a rapid-cycle approach (including the PDSA cycle process) to strengthen these key quality improvement areas and structured quality improvement resources accordingly. As a result, DHCS may not have required an MCP to submit IPs/PDSA cycles for all measures with rates below the MPLs. However, MCPs continue to be contractually required to meet MPLs for all EAS measures.

DHCS provides HSAG with an annual summary of MCPs' IPs/PDSA cycles for inclusion in the EQR technical report and in MCP-specific evaluation reports.

Corrective Action Plans

Annually, DHCS assesses each MCP's performance measure rates to determine if the MCP meets any of the following thresholds, which may result in DHCS placing the MCP on a CAP:

- ◆ The rates for three or more of the same EAS measures, for which DHCS holds MCPs accountable to meet the MPLs, are below the MPLs in the same reporting unit for the last three or more consecutive years.
- ◆ The rates for more than 50 percent of the total number of EAS measures, for which DHCS holds MCPs accountable to meet the MPLs, are below the MPLs for any reporting unit in the current RY.

- ◆ DHCS determines that the imposition of a CAP is necessary because the MCP is out of compliance with EAS requirements as set forth in its DHCS/MCP contract and/or the most recent DHCS Quality Improvement All Plan Letter (APL).¹⁹
- ◆ Nonsubmission of encounter data by an alternate health care service plan (AHCS) to a contracted MCP results in that MCP’s EAS indicators not meeting the MPLs.

DHCS provides HSAG with an annual summary of MCPs’ CAPs for inclusion in the EQR technical report and in MCP-specific evaluation reports.

Specialty Health Plans

Due to the specialized populations SHPs serve, DHCS establishes different performance measure requirements for SHPs. Instead of requiring SHPs to report rates for the EAS measures, DHCS collaborates with each SHP to select two measures appropriate to the SHP’s Medi-Cal population. SHPs may select HEDIS measures or develop SHP-specific measures. Table 5.3 lists the RY 2017 performance measures for each SHP.

Table 5.3—RY 2017 (MY 2016) Specialty Health Plan Performance Measures

Specialty Health Plan	Measure	NCQA Method of Data Capture***
AIDS Healthcare Foundation	<i>Colorectal Cancer Screening*</i>	Hybrid
	<i>Controlling High Blood Pressure*</i>	Hybrid
Family Mosaic Project	<i>Promotion of Positive Pro-Social Activity**</i>	Not Applicable
	<i>School Attendance**</i>	Not Applicable
SCAN Health Plan	<i>Colorectal Cancer Screening*</i>	Hybrid
	<i>Osteoporosis Management in Women Who Had a Fracture*</i>	Admin

* HEDIS measure

** Non-HEDIS measure; SHP designed the measure in collaboration with DHCS and HSAG to evaluate performance elements specific to the SHP.

*** Admin = administrative method, which requires that SHPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, SHPs derive the numerator, or services provided to beneficiaries in the eligible population, from administrative data sources and auditor-approved supplemental data sources. SHPs cannot use medical records to retrieve information. When using the administrative method, SHPs use the entire eligible population as the denominator because NCQA does not allow sampling.

Hybrid = hybrid method, which requires that SHPs identify the eligible population using administrative data, then extract a systematic sample of beneficiaries from the eligible population, which becomes the denominator. SHPs use administrative data to identify services provided to these beneficiaries. When administrative data do not show evidence that SHPs provided the service, SHPs review medical records for those beneficiaries to derive the numerator.

¹⁹ DHCS’ APLs may be found at <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>. Accessed on: Feb 16, 2018.

DHCS-Established Performance Levels for Specialty Health Plans

For SHPs, DHCS established the HPLs and MPLs for RY 2017 HEDIS measures based on NCQA’s Quality Compass HEDIS 2016 national Medicaid, national commercial, and national Medicare benchmarks, as appropriate to the performance measures being reported. The HPLs and MPLs align with NCQA’s national 90th percentiles and 25th percentiles, respectively. No national benchmarks exist for non-HEDIS measures; therefore, DHCS did not establish performance levels for non-HEDIS measures.

As applicable, SHPs are contractually required to perform at or above DHCS-established MPLs; and DHCS uses the established HPLs as performance goals, recognizing SHPs for outstanding performance. DHCS assesses each SHP’s performance measure rates against the established MPLs and requires SHPs to submit to DHCS an IP/PDSA cycle for each measure with a rate below the MPL. As with MCPs, IPs/PDSA cycles consist of PDSA Cycle Worksheets that SHPs complete and submit once every four months.

Managed Long-Term Services and Supports Plans

As part of the CCI, DHCS holds contracts with 11 MLTSSPs to provide long-term support services and Medicare wraparound benefits to dual eligible beneficiaries who have opted out of Cal MediConnect²⁰ or who are not eligible for Cal MediConnect. Table 5.4 lists MLTSSPs and the counties in which they operate.

Table 5.4—Managed Long-Term Services and Supports Plans

Managed Long-Term Services and Supports Plans	Counties
Anthem Blue Cross Partnership Plan	Santa Clara
CalOptima	Orange
Care1st Partner Plan	San Diego
Community Health Group Partnership Plan	San Diego
Health Net Community Solutions, Inc.	Los Angeles and San Diego
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	Riverside and San Bernardino
KP Cal, LLC Kaiser SoCal (Kaiser SoCal)	San Diego
L.A. Care Health Plan	Los Angeles
Molina Healthcare of California Partner Plan, Inc.	Riverside, San Bernardino, and San Diego
Santa Clara Family Health Plan	Santa Clara

²⁰ Cal MediConnect—All of a beneficiary’s medical, behavioral health, long-term institutional, and home-and community-based services are combined into a single health plan. This allows providers to better coordinate care and to simplify for beneficiaries the process of obtaining appropriate, timely, accessible care.

In RY 2017, DHCS required the MLTSSPs to report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit process. Table 5.5 lists the HEDIS performance measures which DHCS required that MLTSSPs report for RY 2017.

Table 5.5—RY 2017 (MY 2016) Managed Long-Term Services and Supports Plan Performance Measures

Measure	NCQA Method of Data Capture*
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	Admin
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	Admin
<i>Medication Reconciliation Post-Discharge</i>	Hybrid

* Admin = administrative method, which requires that MLTSSPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MLTSSPs derive the numerator, or services provided to beneficiaries in the eligible population, from administrative data sources and auditor-approved supplemental data sources. MLTSSPs cannot use medical records to retrieve information. When using the administrative method, MLTSSPs use the entire eligible population as the denominator because NCQA does not allow sampling.

Hybrid = hybrid method, which requires that MLTSSPs identify the eligible population using administrative data, then extract a systematic sample of beneficiaries from the eligible population, which becomes the denominator. MLTSSPs use administrative data to identify services provided to these beneficiaries. When administrative data do not show evidence that MLTSSPs provided the service, MLTSSPs review medical records for those beneficiaries to derive the numerator.

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

Upcoming Data Submission Changes

Beginning January 1, 2018, DHCS will no longer require MCPs to submit Child Health Disability Prevention information-only *Confidential Screening/Billing Report* (PM 160) claim forms to DHCS. For dates of service starting January 1, 2018, MCPs will report data for services previously reported on the PM 160 claim form through DHCS' existing encounter data reporting process. DHCS expects that prior to the discontinuation date MCPs will develop a plan to ensure that data previously captured on the PM 160 claim form are obtained through other data reporting mechanisms. Additionally, MCPs may continue to use their own forms to collect information from their providers that is not captured through encounter data reporting.

Objectives

The purpose of HSAG’s performance measure validation is to ensure that MCPs, SHPs, and MLTSSPs calculate and report performance measures consistent with the established specifications and that the results can be compared to one another.

HSAG conducts NCQA HEDIS Compliance Audits and performance measure validations and analyzes performance measures results to:

- ◆ Evaluate the accuracy of the performance measure data collected.
- ◆ Determine the extent to which the specific performance measures calculated by MCPs, SHPs, and MLTSSPs followed the specifications established for calculation of the performance measures.
- ◆ Identify overall strengths and areas for improvement in the performance measure process.

Methodology

HSAG adheres to NCQA’s *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information Systems (IS) capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. All of HSAG’s lead auditors are Certified HEDIS Compliance Auditors (CHCAs).

Validation Activities

Performance measure validation involved three phases: off-site, on-site, and post-on-site.²¹ The following provides a summary of HSAG’s activities with MCPs, SHPs, and MLTSSPs, as applicable, within each of the validation phases.

Off-Site Activity (October 2016 through May 2017)

- ◆ Forwarded HEDIS 2017 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- ◆ Conducted annual HEDIS Updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- ◆ Scheduled on-site visit dates.

²¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf>. Accessed on: Nov 20, 2017.

- ◆ Conducted kick-off calls to introduce the audit team; discuss the on-site agenda; provide guidance on HEDIS audit and performance measure validation processes; and ensure that MCPs, SHPs, and MLTSSPs were aware of important deadlines.
- ◆ Validated the CAHPS survey sample frames to allow the opportunity to correct any errors before the Certified CAHPS Survey Vendor drew the final sample and administered the survey.
- ◆ Reviewed completed HEDIS Roadmaps and Information Systems Capabilities Assessment Tool (ISCAT) to assess compliance with the audit standards and provided the IS standard tracking report that listed outstanding items and areas that required additional clarification.
- ◆ Reviewed source code used for calculating the HEDIS performance measure rates to ensure compliance with the technical specifications, unless the MCP/SHP/MLTSSP used a vendor whose measures were certified by NCQA.
- ◆ Reviewed source code used for calculating the non-HEDIS performance measure rates to ensure compliance with the specifications required by the State.
- ◆ Conducted supplemental data validation for all supplemental data sources intended for reporting, and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- ◆ Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- ◆ Conducted medical record review validation to validate the integrity of medical record review processes for performance measures that required medical record data for HEDIS reporting.

On-Site Activity (January 2017 through April 2017)

- ◆ Conducted on-site audits to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- ◆ Provided preliminary audit findings.

Post-On-Site Activity (May 2017 through July 2017)

- ◆ Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- ◆ Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS 2016 Audit Means, Percentiles, and Ratios. The report also included requests for clarification on any significant changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- ◆ Compared the final rates to the Patient Level Detail (PLD) files required by NCQA and DHCS, ensuring that data matched the final rate submission and met NCQA and DHCS requirements.
- ◆ Approved the final rates; and assigned a final, audited result to each selected measure.
- ◆ Produced and provided final audit reports containing a summary of all audit activities.

Description of Data Obtained

Through the methodology, HSAG obtained a number of different information sources to conduct the performance measure validation. These included:

- ◆ HEDIS Roadmap and ISCAT.
- ◆ Source code, computer programming, and query language (if applicable) used to calculate the selected measures.
- ◆ Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- ◆ Re-abstraction of a sample of medical records selected by HSAG auditors.

HSAG also obtained information through interaction, discussion, and formal interviews with key MCP, SHP, and MLTSSP staff members as well as through observing system demonstrations and data processing.

Performance Measure Results Analyses

Using the validated performance measure rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about MCP/SHP/MLTSSP performance in providing accessible, timely, and quality health care services to beneficiaries. To aid in the analyses, HSAG produced spreadsheets with detailed comparative results. Additionally, HSAG submitted to DHCS the spreadsheets for DHCS to use in its assessment of MCP/SHP/MLTSSP performance across all performance measures.

HSAG assessed for trends relative to MCPs'/SHPs'/MLTSSPs' performances in comparison to HPLs and MPLs and for statistically significant improvement or decline in performance from the previous RY. HSAG identified strengths, opportunities for improvement, and recommendations based on its assessment of MCP/SHP/MLTSSP performance.

MCP-, SHP-, and MLTSSP-specific performance measures results, including HSAG's recommendations, are included in appendices A through Z.

Performance Measure Validation Results

In RY 2017, HSAG conducted a total of 26 performance measure validations, with 25 of those being NCQA HEDIS Compliance Audits. The exception was Family Mosaic Project, an SHP that reported non-HEDIS measures and underwent performance measure validation consistent with CMS protocols. These 26 MCPs and SHPs represented 56 separate data submissions for performance measure rates at the reporting unit level. HSAG also conducted performance measure validations with 23 MCPs for a select set of measures that DHCS required MCPs to stratify by the SPD and non-SPD populations and with 11 MLTSSPs for their Managed Long-Term Services and Supports (MLTSS) populations.

Each performance measure validation included pre-on-site preparation, data source review, an on-site visit, medical record review validation when appropriate, primary source validation, preliminary and final rate review, and initial and final audit reports production.

Of the 23 MCPs and two SHPs that underwent NCQA HEDIS Compliance Audits, 23 used vendors with HEDIS Certified Measures^{SM,22} to calculate and produce measure rates. This was the same number as in RY 2016. The four vendors that represented these MCPs and SHPs each achieved full NCQA Measure Certification^{SM,23} status for the reported HEDIS measures. HSAG reviewed and approved the source code that Family Mosaic Project, Kaiser NorCal, and Kaiser SoCal each developed internally for measure calculation. Additionally, HSAG reviewed and approved the source code for the non-HEDIS *All-Cause Readmissions* and *Screening for Clinical Depression and Follow-Up Plan* measures defined by DHCS.

Strengths—Performance Measure Validation

HSAG auditors identified the following strengths during the performance measure validation process:

- ◆ Auditors noted that in general, with few exceptions, MCPs and SHPs have developed integrated teams comprised of necessary staff members from both quality and information technology departments. It was apparent that both areas worked closely together and had a sound understanding of the NCQA HEDIS Audit process. This multidisciplinary approach is key to reporting accurate and timely performance measure rates.
- ◆ MCPs and SHPs used enrollment data as the primary data source for determining the eligible population for most measures. The routine data transfer and longstanding relationship between MCPs/SHPs and DHCS has helped to create best practices and stable processes for acquiring membership data. In addition to smooth and accurate processing by MCPs and SHPs, the data itself included fewer issues and retrospective enrollment concerns.
- ◆ In RY 2017, MCPs and SHPs continued to increase use of supplemental data sources. These additional data sources offered MCPs and SHPs the opportunity to more accurately capture the services provided to beneficiaries. Reporting hybrid measures along with supplemental data reduced the burden and resources that MCPs and SHPs had to expend to abstract the clinical information. Moreover, measures reported with administrative data only, and for which MCPs and SHPs also included supplemental data, more accurately reflected performance rates for those measures.
- ◆ MCPs/SHPs had rigorous editing processes in place to ensure accurate and complete pharmacy data.
- ◆ Generally, and with few exceptions, MCPs and SHPs receive most claims data electronically and have a very small percentage of claims that require manual data entry, minimizing the potential for errors.

²² HEDIS Certified MeasuresSM is a service mark of NCQA.

²³ NCQA Measure CertificationSM is a service mark of NCQA.

Opportunities for Improvement—Performance Measure Validation

HSAG auditors identified the following challenges and opportunities for improvement during the performance measure validation process.

- ◆ Due to the increased number of supplemental data sources used for performance measure calculations, MCPs and SHPs have the opportunity to ensure that comprehensive and ongoing oversight processes are in place.
- ◆ RY 2017 was the first year that DHCS required full-scope MCPs to report rates for the non-HEDIS *Screening for Clinical Depression and Follow-Up Plan* measure. MCPs struggled with capturing all required data elements to calculate this measure according to the State-defined measure specifications.
- ◆ Most challenges and opportunities for improvement were MCP-/SHP-specific. HSAG identified few issues overall with provider data processing (IS Standard 3.0); however, HSAG auditors noted some issues with how MCPs and SHPs were mapping provider types to clinics. HSAG auditors determined that all but two MCPs/SHPs were fully compliant with this standard. While the two MCPs/SHPs were partially compliant with this standard, HSAG auditors determined that the identified issues had no impact on performance measure reporting.

Note that MCP- and SHP-specific recommendations related to the performance measure validation process are included, as applicable, in appendices A through Z.

Full-Scope Managed Care Health Plans Performance Measure Results

Statewide Medi-Cal Managed Care Weighted Average Results

Table 5.6 presents the MCMC weighted average rates for each EAS measure for RYs 2014–17 and compares the current year’s rates both to the prior year’s rates and to the DHCS-established HPLs and MPLs. Note the following regarding Table 5.6:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’ *All-Cause Readmissions* collaborative QIP; therefore, DHCS does not establish an HPL or MPL for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

- ◆ Although HSAG includes statewide performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures, and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ Table 5.2 includes the specific HPL and MPL values for RY 2017.
- ◆ In order to assess statewide performance, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RY 2016 and RY 2017, the HPLs and MPLs represent the NCQA Quality Compass Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RY 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ Although HSAG includes statewide performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit IPs/ PDSA cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL threshold for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

Table 5.6—Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results for Full-Scope Managed Care Health Plans*

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	75.07%	73.84%	70.59%	70.70%	0.11
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.25%	93.54%	92.40%	93.14%	0.74 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.27%	85.39%	84.20%	83.92%	-0.28^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	86.08%	87.24%	87.21%	86.29%	-0.92^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	82.90%	84.19%	84.56%	83.50%	-1.06^{^^}
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	26.89%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	71.37%	73.42%	73.43%	76.48%	3.05 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	59.53%	63.64%	64.57%	68.79%	4.22 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	73.29%	72.78%	71.30%	73.90%	2.60 [^]
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	59.16%	Not Comparable
<i>Cervical Cancer Screening</i>	63.69%	59.26%	53.61%	56.26%	2.65 [^]
<i>Prenatal and Postpartum Care—Postpartum Care</i>	56.99%	59.35%	59.29%	63.77%	4.48 [^]
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	81.33%	81.80%	79.17%	81.95%	2.78 [^]
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.15%	86.12%	86.60%	87.59%	0.99 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.86%	85.77%	86.23%	87.09%	0.86 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.14%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.25%	62.63%	60.51%	63.38%	2.87 [^]

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.69%	53.34%	55.29%	57.06%	1.77 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.64%	49.08%	49.71%	51.67%	1.96 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	43.73%	39.35%	39.74%	37.75%	-1.99 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	83.13%	85.81%	85.62%	86.82%	1.20 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.65%	84.45%	90.73% ⁺	90.35%	-0.38 ^{^^}
<i>Controlling High Blood Pressure</i>	56.34%	61.22%	61.18%	62.68%	1.50 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	14.17%	17.72%	17.24%	15.66%	-1.58 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	42.06	40.45	44.94	43.32	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	298.16	272.82	281.57	268.58	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.94%	28.81%	28.73%	31.00%	2.27 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	52.00%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	5.85%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	80.35%	79.54%	77.60%	72.87%	-4.73 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (⁺), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Statewide Medi-Cal Managed Care Weighted Average Performance Measure Findings

The following is a summary of HSAG’s assessment of MCP aggregated performance on the EAS measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG drew no conclusions from the comparative analyses on these measures for RY 2017 and did not include these measures in its assessment of MCP performance.

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Both Screening for Clinical Depression and Follow-Up Plan* measures

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

All MCMC weighted averages within the Preventive Screening and Children’s Health domain were between the HPLs and MPLs in RY 2017. The MCMC weighted averages improved significantly from RY 2016 to RY 2017 for the following measures within this domain:

- ◆ *Both Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

High- and Low-Performing Medi-Cal Managed Care Health Plans—Preventive Screening and Children’s Health

HSAG identified the following MCPs as the highest-performing MCPs within the Preventive Screening and Children’s Health domain in RY 2017, based on the MCPs having the highest percentage of reported rates within this domain above the HPLs in RY 2017—three of four rates (75 percent):

- ◆ Kaiser SoCal
- ◆ San Francisco Health Plan

HSAG identified Health Plan of San Joaquin as the lowest-performing MCP within the Preventive Screening and Children's Health domain in RY 2017, based on the MCP having the highest percentage of reported rates within this domain below the MPLs in RY 2017—three of eight rates (38 percent).

Preventive Screening and Women's Health

All MCMC weighted averages within the Preventive Screening and Women's Health domain were between the HPLs and MPLs in RY 2017. The MCMC weighted averages improved significantly from RY 2016 to RY 2017 for all three measures within this domain. The significant improvement for the *Cervical Cancer Screening* measure resulted in the MCMC weighted average improving from below the MPL in RY 2016 to above the MPL in RY 2017.

High- and Low-Performing Medi-Cal Managed Care Health Plans—Preventive Screening and Women's Health

HSAG identified Kaiser SoCal as the highest-performing MCP within the Preventive Screening and Women's Health domain in RY 2017, based on the MCP having the highest percentage of reported rates within this domain above the HPLs in RY 2017—three of three rates (100 percent).

HSAG identified Molina Healthcare of California Partner Plan, Inc. as the lowest-performing MCP within the Preventive Screening and Women's Health domain in RY 2017, based on the MCP having the highest percentage of reported rates within this domain below the MPLs in RY 2017—three of 12 rates (25 percent).

Care for Chronic Conditions

All MCMC weighted averages within the Care for Chronic Conditions domain were between the HPLs and MPLs in RY 2017. The MCMC weighted averages improved significantly from RY 2016 to RY 2017 for all measures within this domain except the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure declined significantly from RY 2016 to RY 2017, reflecting that MCPs have the opportunity for improvement related to ensuring that beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) each receive a nephropathy screening or monitoring test.

High- and Low-Performing Medi-Cal Managed Care Health Plans—Care for Chronic Conditions

HSAG identified Kaiser SoCal as the highest-performing MCP in RY 2017 within the Care for Chronic Conditions domain, based on the MCP having the highest percentage of reported rates within this domain above the HPLs in RY 2017—nine of nine rates (100 percent).

HSAG identified Gold Coast Health Plan as the lowest-performing MCP in RY 2017 within the Care for Chronic Conditions domain, based on the MCP having the highest percentage of reported rates within this domain below the MPLs in RY 2017—six of nine rates (67 percent).

Appropriate Treatment and Utilization

All MCMC weighted averages within the Care for Chronic Conditions domain were between the HPLs and MPLs in RY 2017. The MCMC weighted averages improved significantly from RY 2016 to RY 2017 for the following two measures:

- ◆ *All-Cause Readmissions*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

The MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017, reflecting that MCPs have the opportunity for improvement related to ensuring that only beneficiaries with lower back pain and who show clinical necessity receive an imaging study. Note that the significant decline in the MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's specification changes for this measure and therefore may not be related to MCPs' performance.

High- and Low-Performing Medi-Cal Managed Care Health Plans—Appropriate Treatment and Utilization

HSAG identified Kaiser SoCal as the highest-performing MCP in RY 2017 within the Appropriate Treatment and Utilization domain, based on the MCP having the highest percentage of reported rates within this domain above the HPLs in RY 2017—two of two rates (100 percent).

HSAG identified California Health & Wellness Plan as the lowest-performing MCP in RY 2017 within the Appropriate Treatment and Utilization domain, based on the MCP having the highest percentage of reported rates within this domain below the MPLs in RY 2017—four of six rates (67 percent).

Statewide Medi-Cal Managed Care Weighted Averages Compared to National Medicaid Averages

For each EAS measure for which HSAG made a comparison to the corresponding national Medicaid average for the measure, Table 5.7 presents the MCMC weighted average rates for RYs 2014–17 and displays if the rates are above or below the national Medicaid averages for each RY. Note the following regarding Table 5.7:

- ◆ To assess statewide performance, HSAG compares the rates to national Medicaid averages. Rates indicating performance above the national Medicaid averages are shaded in gray and denoted with a cross (+), and rates indicating performance below the national Medicaid averages are bolded.
- ◆ For RY 2016 and RY 2017, the benchmarks represent the NCQA Quality Compass national Medicaid averages.
- ◆ For RY 2014 and RY 2015, the benchmarks represent the NCQA HEDIS Audit Means, Percentiles, and Ratios national Medicaid averages.
- ◆ HSAG makes no comparisons to national Medicaid averages for the following measures:

- *All-Cause Readmissions* and both *Screening for Clinical Depression and Follow-Up Plan* measures because they are non-HEDIS measures; therefore, no national benchmarks exist for these measures.
- Both *Ambulatory Care* measures because a higher or lower rate does not necessarily indicate better or worse performance.
- *Immunizations for Adolescents—Combination 2* because no national benchmarks existed for this measure in RY 2017.

Table 5.7—Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages*

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴
Preventive Screening and Children’s Health				
<i>Childhood Immunization Status—Combination 3</i>	75.07% ⁺	73.84% ⁺	70.59% ⁺	70.70% ⁺
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.25%	93.54%	92.40%	93.14%
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.27%	85.39%	84.20%	83.92%
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	86.08%	87.24%	87.21%	86.29%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	82.90%	84.19%	84.56%	83.50%
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	71.37% ⁺	73.42% ⁺	73.43% ⁺	76.48% ⁺
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	59.53% ⁺	63.64% ⁺	64.57% ⁺	68.79% ⁺
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	73.29% ⁺	72.78% ⁺	71.30%	73.90% ⁺
Preventive Screening and Women’s Health				
<i>Breast Cancer Screening</i>	--	--	--	59.16% ⁺
<i>Cervical Cancer Screening</i>	63.69%	59.26%	53.61%	56.26% ⁺
<i>Prenatal and Postpartum Care—Postpartum Care</i>	56.99%	59.35%	59.29%	63.77% ⁺
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	81.33%	81.80%	79.17%	81.95% ⁺

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴
Care for Chronic Conditions				
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.15%	86.12%	86.60%	87.59% ⁺
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.86%	85.77%	86.23%	87.09%
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.14% ⁺
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.25% ⁺	62.63% ⁺	60.51%	63.38% ⁺
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.69%	53.34%	55.29% ⁺	57.06% ⁺
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.64% ⁺	49.08% ⁺	49.71% ⁺	51.67% ⁺
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	43.73% ⁺	39.35% ⁺	39.74% ⁺	37.75% ⁺
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	83.13% ⁺	85.81% ⁺	85.62%	86.82% ⁺
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.65% ⁺	84.45% ⁺	90.73% ⁺	90.35% ⁺
<i>Controlling High Blood Pressure</i>	56.34% ⁺	61.22% ⁺	61.18% ⁺	62.68% ⁺
Appropriate Treatment and Utilization				
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.94% ⁺	28.81% ⁺	28.73% ⁺	31.00% ⁺
<i>Use of Imaging Studies for Low Back Pain</i>	80.35% ⁺	79.54% ⁺	77.60% ⁺	72.87%

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

* Rates indicating performance above the national Medicaid averages are shaded in gray and denoted with a cross (+), and rates indicating performance below the national Medicaid averages are **bolded**.

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

-- Indicates that the rate is not available.

Statewide Medi-Cal Managed Care Weighted Averages Compared to National Medicaid Averages Findings

The following is a summary of HSAG's assessment of the MCMC weighted averages compared to the national Medicaid averages for measures included in Table 5.7. Note that while Table 5.7 presents comparisons to the national Medicaid averages for the following measures, to be consistent with other analyses in this report, HSAG drew no conclusions from the comparative analyses on these measures for RY 2017 and did not include these measures in its assessment of MCP performance:

- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- ◆ *Breast Cancer Screening*
- ◆ *Asthma Medication Ratio*

Preventive Screening and Children's Health

Within the Preventive Screening and Children's Health domain, aggregate MCP performance compared to the national Medicaid averages remained consistent for three of four measures (75 percent), with the MCMC weighted averages for the following three measures being above the national Medicaid averages for all RYs displayed in Table 5.7:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures

The MCMC weighted average for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure moved from below the national Medicaid average in RY 2016 to above the national Medicaid average in RY 2017.

Preventive Screening and Women's Health

Within the Preventive Screening and Women's Health domain, the MCMC weighted averages for all three measures moved from below the national Medicaid averages in RY 2016 to above the national Medicaid averages in RY 2017:

- ◆ *Cervical Cancer Screening*
- ◆ Both *Prenatal and Postpartum Care* measures

Care for Chronic Conditions

HSAG observed the following notable comparisons between the MCMC weighted averages and national Medicaid averages for measures within the Care for Chronic Conditions domain:

- ◆ The MCMC weighted averages were above the national Medicaid averages for the following eight of nine measures (89 percent) within this domain:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*—the MCMC weighted average moved from below the national Medicaid average in RY 2016 to above the national Medicaid average in RY 2017.
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*—the MCMC weighted average moved from below the national Medicaid average in RY 2016 to above the national Medicaid average in RY 2017.
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*—for all RYs displayed in Table 5.7.
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*—for all RYs displayed in Table 5.7.
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*—the MCMC weighted average moved from below the national Medicaid average in RY 2016 to above the national Medicaid average in RY 2017.
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*—for all RYs displayed in Table 5.7.
 - *Controlling High Blood Pressure Controlling High Blood Pressure*—for all RYs displayed in Table 5.7.
- ◆ The MCMC weighted averages were below the national Medicaid averages for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure for all RYs displayed in Table 5.7.

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, aggregate MCP performance compared to the national Medicaid average for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* remained consistent, with the MCMC weighted average for this measure being above the national Medicaid average for all RYs displayed in Table 5.7. The MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure moved from above the national Medicaid average in RY 2016 to below the national Medicaid average in RY 2017. As previously noted, the decline in the MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's specification changes for this measure and therefore may not be related to MCPs' performance.

Statewide Medi-Cal Managed Care Weighted Averages Compared to National Commercial Averages

For each EAS measure for which HSAG made a comparison to the corresponding national commercial average for the measure, Table 5.8 presents the MCMC weighted average rates for RYs 2014–17 and displays if the rates are above or below the national commercial averages for each RY. Note the following regarding Table 5.8:

- ◆ To assess statewide performance, HSAG compares the rates to national commercial averages. Rates indicating performance above the national commercial averages are shaded in gray and denoted with

a cross (+), and rates indicating performance below the national commercial averages are bolded. However, HSAG acknowledges the limitations of the comparison due to the differences in specifications used to derive the statewide MCMC weighted average and the national commercial averages.

- ◆ For RY 2016 and RY 2017, the benchmarks represent the NCQA Quality Compass national commercial averages.
- ◆ For RY 2014 and RY 2015, the benchmarks represent the NCQA HEDIS Audit Means, Percentiles, and Ratios national commercial averages.
- ◆ HSAG makes no comparisons to national commercial averages for the following measures:
 - *All-Cause Readmissions* and both *Screening for Clinical Depression and Follow-Up Plan* measures because they are non-HEDIS measures; therefore, no national benchmarks exist for these measures.
 - Both *Ambulatory Care* measures because a higher or lower rate does not necessarily indicate better or worse performance.
 - *Immunizations for Adolescents—Combination 2* because no national benchmarks existed for this measure in RY 2017.

Table 5.8—Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Commercial Averages*

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴
Preventive Screening and Children’s Health				
<i>Childhood Immunization Status—Combination 3</i>	75.07%	73.84%	70.59%	70.70%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.25%	93.54%	92.40%	93.14%
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.27%	85.39%	84.20%	83.92%
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	86.08%	87.24%	87.21%	86.29%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	82.90%	84.19%	84.56%	83.50%
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	71.37% ⁺	73.42% ⁺	73.43% ⁺	76.48% ⁺
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	59.53% ⁺	63.64% ⁺	64.57% ⁺	68.79% ⁺
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	73.29% ⁺	72.78%	71.30% ⁺	73.90% ⁺

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴
Preventive Screening and Women's Health				
<i>Breast Cancer Screening</i>	--	--	--	59.16%
<i>Cervical Cancer Screening</i>	63.69%	59.26%	53.61%	56.26%
<i>Prenatal and Postpartum Care—Postpartum Care</i>	56.99%	59.35%	59.29%	63.77%
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	81.33%	81.80%	79.17%	81.95% ⁺
Care for Chronic Conditions				
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.15% ⁺	86.12% ⁺	86.60% ⁺	87.59% ⁺
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.86% ⁺	85.77% ⁺	86.23% ⁺	87.09% ⁺
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.14%
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.25%	62.63%	60.51%	63.38%
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.69%	53.34%	55.29%	57.06% ⁺
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.64%	49.08%	49.71%	51.67%
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	43.73%	39.35%	39.74%	37.75%
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	83.13%	85.81%	85.62%	86.82%
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.65%	84.45%	90.73% ⁺	90.35%
<i>Controlling High Blood Pressure</i>	56.34%	61.22%	61.18%	62.68%
Appropriate Treatment and Utilization				
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.94% ⁺	28.81% ⁺	28.73%	31.00%
<i>Use of Imaging Studies for Low Back Pain</i>	80.35% ⁺	79.54% ⁺	77.60% ⁺	72.87%

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

* Rates indicating performance above the national commercial averages are shaded in gray and denoted with a cross (†), and rates indicating performance below the national commercial averages are **bolded**.

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

-- Indicates that the rate is not available.

Statewide Medi-Cal Managed Care Weighted Averages Compared to National Commercial Averages Findings

The following is a summary of HSAG’s assessment of the MCMC weighted averages compared to the national commercial averages for measures included in Table 5.8.

Note that while Table 5.8 presents comparisons to the national commercial averages for the following measures, to be consistent with other analyses in this report HSAG drew no conclusions from the comparative analyses on these measures for RY 2017 and did not include these measures in its assessment of MCP performance:

- ◆ All four *Children and Adolescents’ Access to Primary Care Practitioners* measures
- ◆ *Breast Cancer Screening*
- ◆ *Asthma Medication Ratio*

Preventive Screening and Children’s Health

HSAG observed the following notable comparisons between the MCMC weighted averages and national commercial averages for measures within the Preventive Screening and Children’s Health domain:

- ◆ The MCMC weighted averages were above the national commercial averages for the following three of four (75 percent) measures within the domain:
 - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures for all RYs displayed in Table 5.8.
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ The MCMC weighted averages for the *Childhood Immunization Status—Combination 3* measure were below the national commercial averages for all RYs displayed in Table 5.8.

Preventive Screening and Women’s Health

Within the Preventive Screening and Women’s health domain, the MCMC weighted averages for the *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care* measures were below the national commercial averages for all RYs displayed in Table 5.8. The MCMC weighted average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure moved from below the national commercial average in RY 2016 to above the national commercial average in RY 2017.

Care for Chronic Conditions

HSAG observed the following notable comparisons between the MCMC weighted averages and national commercial averages for measures within the Care for Chronic Conditions domain:

- ◆ The MCMC weighted averages were above the national commercial averages for the following three of nine measures (33 percent):
 - Both *Annual Monitoring for Patients on Persistent Medications* measures for all RYs displayed in Table 5.8.
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*—the MCMC weighted average moved from below the national commercial average in RY 2016 to above the national commercial average in RY 2017.
- ◆ The MCMC weighted averages were below the national commercial averages for the following six of nine measures (67 percent):
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*—for all RYs displayed in Table 5.8
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*—for all RYs displayed in Table 5.8
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*—for all RYs displayed in Table 5.8
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*—for all RYs displayed in Table 5.8
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
 - *Controlling High Blood Pressure*—for all RYs displayed in Table 5.8

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, the MCMC weighted averages for both measures were below the national commercial averages:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*—the MCMC weighted average for this measure moved from above the national commercial average in RY 2016 to below the national commercial average in RY 2017. As previously noted, the decline in the MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's specification changes for this measure and therefore may not be related to MCPs' performance.

Statewide Medi-Cal Managed Care Weighted Averages Compared to Healthy People 2020 Goals

For each EAS measure with a corresponding Healthy People 2020 goal, Table 5.9 presents the MCMC weighted average rate for RYs 2014–17 and displays if the rate is above or below the Healthy People 2020 Goal for that measure.²⁴ Note the following regarding Table 5.9:

- ◆ In order to assess statewide performance, HSAG compares the rates to Healthy People 2020 goals. Rates indicating performance above the Healthy People 2020 goals are shaded in gray and denoted with a cross (+), and rates indicating performance below the Healthy People 2020 goals are bolded. However, HSAG acknowledges the limitations of the comparison due to the differences in specifications used to derive the statewide MCMC weighted average and the Healthy People 2020 goals.

Table 5.9—Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to the Healthy People 2020 Goals*

Measure	Healthy People 2020 Goal	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴
Preventive Screening and Children’s Health					
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	22.90%	71.37% ⁺	73.42% ⁺	73.43% ⁺	76.48% ⁺
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	22.90%	59.53% ⁺	63.64% ⁺	64.57% ⁺	68.79% ⁺
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	81.10%	--	--	--	59.16%
<i>Cervical Cancer Screening</i>	93.00%	63.69%	59.26%	53.61%	56.26%
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	77.90%	81.33% ⁺	81.80% ⁺	79.17% ⁺	81.95% ⁺
Care for Chronic Conditions					
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.00%	60.25% ⁺	62.63% ⁺	60.51% ⁺	63.38% ⁺
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	58.70%	50.69%	53.34%	55.29%	57.06%

²⁴ Information on Healthy People 2020 is available at: <https://www.healthypeople.gov/>. Accessed on: Nov 28, 2017.

Measure	Healthy People 2020 Goal	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	16.10%	43.73%	39.35%	39.74%	37.75%
<i>Controlling High Blood Pressure</i>	61.20%	56.34%	61.22% ⁺	61.18%	62.68% ⁺

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

* Rates indicating performance above the Healthy People 2020 goals are shaded in gray and denoted with a cross (+), and rates indicating performance below the Healthy People 2020 goals are **bolded**.

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

-- Indicates that the rate is not available.

Statewide Medi-Cal Managed Care Weighted Averages Compared to Healthy People 2020 Goals Findings

The following is a summary of HSAG's assessment of the MCMC weighted averages compared to the Healthy People 2020 goal for each EAS measure with a corresponding Healthy People 2020 goal.

Note that while Table 5.9 presents comparison to the Healthy People 2020 goal for the *Breast Cancer Screening* measure, to be consistent with other analyses in this report, HSAG drew no conclusions from the comparative analysis on this measure for RY 2017 and did not include this measure in its assessment of MCP performance.

Preventive Screening and Children's Health

Aggregate MCP performance remained consistent for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, with the MCMC weighted averages being above the Healthy People 2020 goals for both measures for all RYs displayed in Table 5.9.

Preventive Screening and Women's Health

For both measures within this domain, aggregate MCP performance remained consistent:

- ◆ The MCMC weighted averages for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure were above the Healthy People 2020 goal for all RYs displayed in Table 5.9.
- ◆ The MCMC weighted averages for the *Cervical Cancer Screening* measure were below the Healthy People 2020 goal for all RYs displayed in Table 5.9.

Care for Chronic Conditions

- ◆ The MCMC weighted averages for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure were above the Healthy People 2020 goal for all RYs displayed in Table 5.9.
- ◆ The MCMC weighted average for the *Controlling High Blood Pressure* measure moved from below the Healthy People 2020 goal in RY 2016 to above the Healthy People 2020 goal in RY 2017.
- ◆ The MCMC weighted averages for the following two measures within this domain were worse than the respective Healthy People 2020 goals for the measures for all RYs displayed in Table 5.9:
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

Full-Scope Managed Care Health Plan Seniors and Persons with Disabilities Results

Table 5.10 presents the SPD and non-SPD MCMC weighted averages, a comparison of the SPD and non-SPD MCMC weighted averages, and the total MCMC weighted averages for all measures MCPs stratified by SPD and non-SPD populations for RY 2017.

Table 5.10—RY 2017 (MY 2016) Medi-Cal Managed Care Weighted Averages Comparison and Results for Measures Stratified by the SPD Population

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/ Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	20.88%	12.38%	8.50%^^	15.66%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.07	40.83	Not Tested	43.32
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	503.86	249.50	Not Tested	268.58
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.95%	86.46%	3.49%^	87.59%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.25%	85.45%	4.80%^	87.09%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	92.16%	93.14%	-0.98%	93.14%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.86%	83.88%	1.98%^	83.92%

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/ Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.67%	86.23%	1.44%^	86.29%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	82.67%	83.54%	-0.87%^^^	83.50%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ Total rates are based on the total statewide results, including the SPD and non-SPD populations. Please note, if data are not available for SPD or non-SPD, the total rate is based on the results reported for the population that is available.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

Full-Scope Managed Care Health Plan Seniors and Persons with Disabilities Findings

HSAG observed the following notable comparisons between the MCMC weighted averages for the SPD population and MCMC weighted averages for the non-SPD population in RY 2017:

- ◆ The RY 2017 MCMC weighted averages for the SPD population were significantly better than the RY 2017 MCMC weighted averages for the non-SPD population for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- ◆ The RY 2017 MCMC weighted averages for the SPD population were significantly worse than the RY 2017 MCMC weighted averages for the non-SPD population for the following measures:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*

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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* measure may be attributed to children and adolescents in the SPD population relying on specialist providers as their care sources rather than accessing care from primary care practitioners based on complicated health care needs.

Full-Scope Managed Care Health Plan Encounter Data Diabetes Subset Seniors and Persons with Disability Results

DHCS generated the data and findings for the diabetes subset comparison of SPD and non-SPD rates. HSAG has inserted this section at DHCS' request. HSAG as has not validated DHCS' data or findings.

DHCS initiated an encounter data validation and improvement project in 2015 that significantly improved encounter data quality. In RY 2017, DHCS continued to conform to the CMS requirements for reporting performance related to the SPD population enrolled in MCMC.

As approved by CMS, DHCS calculated a subset of SPD rates using encounter data submitted by MCPs. Table 5.11 presents the RY 2017 SPD and non-SPD rates that DHCS calculated using encounter data for the following indicators:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC-E)*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing (CDC-HT)*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC-N)*

DHCS calculated the rates displayed in Table 5.11 based on the administrative specifications.

Table 5.11—California Department of Health Care Services, RY 2017 Medi-Cal Managed Care Encounter Data Diabetes Subset Seniors and Persons with Disabilities Results

MCP Name	Reporting Units	SPD CDC-E Rate	Non-SPD CDC-E Rate	SPD CDC-HT Rate	Non-SPD CDC-HT Rate	SPD CDC-N Rate	Non-SPD CDC-N Rate
Alameda Alliance for Health	Alameda	41.9%	40.3%	79.3%	79.1%	89.6%	85.1%
Anthem Blue Cross Partnership Plan	Alameda	34.8%	35.2%	83.6%	81.1%	91.0%	84.2%
	Contra Costa	38.6%	34.1%	80.1%	76.9%	88.3%	85.1%
	Fresno	30.0%	35.3%	73.0%	75.2%	90.9%	86.9%
	Kings	46.2%	38.7%	76.9%	76.1%	90.9%	90.1%
	Madera	45.0%	49.8%	89.2%	86.9%	87.5%	89.9%
	Sacramento	40.2%	36.5%	78.5%	77.0%	93.5%	87.5%
	San Francisco	34.2%	29.9%	82.5%	82.7%	92.1%	85.6%
	Santa Clara	36.7%	34.0%	79.4%	81.2%	88.6%	86.3%
	Tulare	31.3%	28.9%	85.0%	83.8%	94.2%	90.9%
	Region 1	39.1%	39.7%	80.3%	81.9%	88.0%	84.0%
	Region 2	37.3%	33.6%	81.9%	82.7%	90.4%	86.4%
San Benito	NA	35.5%	NA	70.2%	NA	78.2%	
California Health & Wellness Plan	Imperial	55.5%	48.1%	89.3%	88.1%	94.8%	91.1%
	Region 1	39.6%	38.5%	79.7%	79.7%	88.8%	84.4%
	Region 2	38.3%	31.9%	87.1%	84.4%	92.7%	86.3%
CalOptima	Orange	44.9%	39.9%	84.3%	83.9%	92.4%	90.4%

MCP Name	Reporting Units	SPD CDC-E Rate	Non-SPD CDC-E Rate	SPD CDC-HT Rate	Non-SPD CDC-HT Rate	SPD CDC-N Rate	Non-SPD CDC-N Rate
CalViva Health	Fresno	30.8%	30.6%	76.9%	73.8%	91.3%	85.8%
	Kings	34.1%	28.0%	74.6%	76.9%	90.5%	87.6%
	Madera	52.6%	45.2%	89.7%	85.5%	93.9%	89.8%
Care1st Partner Plan	San Diego	42.8%	43.3%	91.0%	85.8%	94.3%	89.2%
CenCal Health	San Luis Obispo	51.2%	40.7%	52.3%	59.6%	86.3%	83.4%
	Santa Barbara	43.5%	43.3%	68.8%	68.5%	87.4%	83.3%
Central California Alliance for Health	Merced	40.5%	36.3%	78.2%	75.5%	92.2%	88.3%
	Monterey/Santa Cruz	48.7%	44.3%	86.8%	83.5%	90.6%	85.5%
Community Health Group Partnership Plan	San Diego	46.0%	43.8%	86.2%	83.6%	94.2%	90.9%
Contra Costa Health Plan	Contra Costa	39.0%	39.5%	78.6%	77.7%	88.3%	82.6%
Gold Coast Health Plan	Ventura	44.2%	38.1%	82.7%	79.0%	91.8%	87.3%
Health Net Community Solutions, Inc.	Kern	28.2%	30.7%	77.3%	79.4%	89.3%	88.1%
	Los Angeles	40.8%	37.5%	79.6%	77.9%	91.7%	87.9%
	Sacramento	32.7%	29.3%	76.5%	70.4%	90.9%	82.6%
	San Diego	37.8%	45.7%	74.3%	75.2%	88.3%	85.6%
	San Joaquin	24.4%	15.2%	69.9%	67.4%	89.4%	81.6%
	Stanislaus	17.1%	15.2%	83.0%	76.0%	91.4%	84.3%
	Tulare	27.4%	23.7%	85.6%	81.3%	92.5%	88.8%
Health Plan of San Joaquin	San Joaquin	32.9%	34.7%	77.9%	75.9%	90.8%	85.5%
	Stanislaus	29.8%	25.0%	78.3%	74.2%	89.1%	84.4%
Health Plan of San Mateo	San Mateo	47.8%	43.8%	86.0%	84.8%	90.5%	87.9%
Inland Empire Health Plan	Riverside/San Bernardino	30.8%	27.1%	79.6%	78.9%	92.6%	88.7%
Kern Family Health Care	Kern	24.6%	21.8%	82.9%	83.8%	92.9%	90.9%
Kaiser NorCal	KP North	53.2%	50.1%	90.3%	89.6%	87.9%	85.2%
Kaiser SoCal	San Diego	38.2%	38.2%	92.1%	93.8%	96.1%	92.5%
L.A. Care Health Plan	Los Angeles	41.2%	39.9%	77.9%	78.5%	92.3%	88.1%
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino	43.9%	43.8%	81.3%	78.5%	92.4%	87.9%
	Sacramento	48.5%	49.6%	83.7%	81.3%	92.8%	88.9%
	San Diego	54.1%	48.9%	88.6%	85.8%	94.6%	90.6%
	Imperial	46.8%	45.0%	88.5%	86.5%	92.9%	88.0%
Partnership HealthPlan of California	Southwest	23.8%	24.3%	69.9%	69.9%	90.7%	85.6%
	Southeast	34.2%	29.2%	81.9%	79.0%	91.0%	85.8%
	Northwest	28.0%	23.4%	88.6%	86.0%	89.6%	84.1%
	Northeast	27.0%	23.9%	88.2%	84.3%	91.2%	87.8%

MCP Name	Reporting Units	SPD CDC-E Rate	Non-SPD CDC-E Rate	SPD CDC-HT Rate	Non-SPD CDC-HT Rate	SPD CDC-N Rate	Non-SPD CDC-N Rate
San Francisco Health Plan	San Francisco	36.5%	43.2%	83.9%	85.6%	91.4%	87.7%
Santa Clara Family Health Plan	Santa Clara	45.2%	45.7%	85.4%	83.2%	89.7%	87.4%

NA = The denominator for the measure is too small to report (less than 30).

Full-Scope Managed Care Health Plan Encounter Data Diabetes Subset Seniors and Persons with Disabilities Findings

The results displayed in Table 5.11 show that the RY 2017 SPD rates were slightly higher than the RY 2017 non-SPD rates for all three indicators for most MCP reporting units. Higher SPD rates for all three indicators included in Table 5.11 indicate that rates for the SPD population were better than rates for the non-SPD population. These findings are consistent with SPD and non-SPD rates in RY 2013, RY 2014, RY 2015, and RY 2016. The higher rates for the SPD population are likely due to the greater and often more complicated health care needs of these beneficiaries, resulting in these beneficiaries being seen more regularly by providers and leading to better monitoring of care. Moreover, comparing the results from RY 2017 with those from RY 2016, MCPs improved performance an average of 3 to 4 percentage points on all three indicators for both the SPD and non-SPD populations.

Specialty Health Plan Performance Measure Results and Findings

The following is a summary of the SHPs' performance measure results:

- ◆ While AIDS Healthcare Foundation reported a rate for the *Colorectal Cancer Screening* measure in previous years, based on specification changes made by NCQA, this measure was considered a first-year measure in RY 2017; therefore, HSAG provides no assessment of the SHP's performance related to this measure. The rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from RY 2016 to RY 2017 and was between the HPL and MPL in RY 2017.
- ◆ RY 2017 was the first year that Family Mosaic Project reported a rate for the *Promotion of Positive Pro-Social Activity* measure. The denominator for the measure was less than 30, resulting in a *Not Applicable* audit finding. Additionally, the audit finding for the *School Attendance* measure was *Not Applicable*; therefore, HSAG could make no comparison between the RY 2016 rate and RY 2017 rate for this measure.
- ◆ RY 2017 was the first year that SCAN Health Plan reported a rate for the *Colorectal Cancer Screening* measure; therefore, HSAG provides no assessment of SCAN Health Plan's performance related to this measure. The rate for the *Osteoporosis Management in Women Who Had a Fracture* measure showed no statistically significant change from RY 2016 to RY 2017 and was between the HPL and MPL in RY 2017.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 5.12 presents the MLTSSP weighted averages for each required performance measure for RY 2016 and RY 2017 and compares the RY 2017 rates to the RY 2016 rates. Note that DHCS does not hold MLTSSPs accountable to meet MPLs for the required measures.

Table 5.12—Multi-Year Statewide Weighted Average Performance Measure Results for Managed Long-Term Services and Supports Plans

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	53.20	34.14	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	407.10	307.31	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	10.95%	19.71%	8.76% [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The MLTSS weighted average for the *Medication Reconciliation Post-Discharge* measure improved significantly from RY 2016 to RY 2017.

HEDIS Improvement Plans

During the review period, 16 of 23 MCPs (70 percent) had IPs/PDSA cycles in progress or were required to submit quality improvement summaries to DHCS and one SHP was required to submit quality improvement summaries to DHCS. Of the 16 MCPs with existing IPs/PDSA cycles or required to submit quality improvement summaries, four MCPs (25 percent) also were operating under a HEDIS CAP. Quarterly, at minimum, DHCS monitored MCPs and SHPs on quality improvement activities and progress being made on improving performance and provided technical assistance to MCPs and SHPs as needed, in collaboration with HSAG. IP/PDSA cycle summary information provided to HSAG by DHCS showed that 15 of the 16 MCPs (94 percent) and the one SHP had at least one measure with a rate that improved from below the MPL in RY 2016 to above the MPL in RY 2017.

Based on RY 2017 performance measure results, 11 of the 19 MCPs not under a HEDIS CAP in 2017 (58 percent) will be required to either continue conducting IP/PDSA cycles, continue submitting quality improvement summaries to DHCS, or submit new IP/PDSA cycles or quality improvement summaries to DHCS. No SHPs will be required to conduct IP/PDSA cycles or to submit quality improvement summaries to DHCS.

MCP- and SHP-specific information related to IPs/PDSA cycles and quality improvement summaries is included within the MCP- and SHP-specific evaluation reports, located in appendices A through Z.

HEDIS Corrective Action Plans

Summary of 2017 Corrective Action Plans

DHCS had four MCPs under HEDIS CAPs during the review period for this report:

- ◆ Anthem Blue Cross Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Health Plan of San Joaquin
- ◆ Molina Healthcare of California Partner Plan, Inc.

All four MCPs focused on quality improvement activities at the data, provider, and beneficiary levels. While all four MCPs demonstrated improvement from RY 2016 to RY 2017, all four also showed continued opportunities for improvement. A detailed summary of the MCPs' progress on their CAPs is included in their individual MCP-specific evaluation reports, located in the following appendices:

- ◆ Anthem Blue Cross Partnership Plan—Appendix C
- ◆ Health Net Community Solutions, Inc.—Appendix N
- ◆ Health Plan of San Joaquin—Appendix O
- ◆ Molina Healthcare of California Partner Plan, Inc.—Appendix V

Conclusions—Performance Measures

Aggregate Performance

DHCS' EAS includes measures that assess the quality and timeliness of and access to care that MCPs and SHPs provide to beneficiaries. The DHCS-established MPLs and DHCS' processes for monitoring MCPs and SHPs make DHCS' performance expectations clear and provide a framework from which DHCS, MCPs, and SHPs may prioritize improvement efforts.

For the 18 measures for which DHCS held MCPs accountable to meet the MPLs, all MCMC weighted averages were above the MPLs in RY 2017. Additionally, 16 of the 19 MCMC weighted averages for which HSAG made comparisons between RY 2016 and RY 2017 (84 percent) improved significantly from RY 2016 to RY 2017. MCPs' quality improvement efforts, combined with DHCS' quality improvement strategies, may have contributed to the improved performance across all measure domains from RY 2016 to RY 2017.

The MCMC weighted averages for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Use of Imaging Studies for Low Back Pain* measures declined significantly from RY 2016 to RY 2017; however, the MCMC weighted averages for these two measures were above the MPLs in RY 2017. As applicable, HSAG provided recommendations to individual MCPs to identify the causes for the statistically significant decline in their rates for these measures; however, it should be noted that the significant decline in the rates for these measures from RY 2016 to RY 2017 may be due to NCQA's specification changes for these measures and therefore may not be related to MCPs' performance.

Performance Measures Addressing Quality Strategy Focus Areas

HSAG reviewed DHCS' MCMC quality strategy annual assessment, *Medi-Cal Managed Care Quality Strategy Annual Assessment, October 2017*,²⁵ and identified the following notable information for the quality strategy focus areas that DHCS monitors through EAS performance measures:

- ◆ *Prenatal and Postpartum Care—Postpartum Care*
 - The MCMC weighted average for the *Prenatal and Postpartum Care—Postpartum Care* measure improved significantly from RY 2016 to RY 2017, reflecting MCPs' improved performance related to ensuring that women with live births are seen for their postpartum visits within the recommended time frame after delivery.
 - In RY 2017 and in advance of the target date, MCPs exceeded the MCMC quality strategy RY 2019 target of at least 80 percent of MCP reporting units meeting the MPL for the *Prenatal and Postpartum Care—Postpartum Care* measure, with 92 percent of MCP reporting units having rates meeting or exceeding the MPL.

²⁵ The *Medi-Cal Managed Care Quality Strategy Annual Assessment, October 2017* may be found at <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfQSR.aspx>.

- ◆ *Immunizations of Two-Year-Olds*
 - The MCMC weighted average for the *Childhood Immunization Status—Combination 3* measure remained consistent from RY 2016 to RY 2017 and did not decline as it had in previous RYs.
 - DHCS required that MCPs meeting any of the following criteria choose childhood immunizations as one of their required PIPs starting in July 2017:
 - Having a rate below the MPL for the *Childhood Immunization Status—Combination 3* measure.
 - Having a rate below the MCMC weighted average for the *Childhood Immunization Status—Combination 3* measure.
 - Having statistically significant decline in the rate for the *Childhood Immunization Status—Combination 3* measure from RY 2016 to RY 2017.
- ◆ *Comprehensive Diabetes Care*
 - In RY 2017, the MCMC weighted averages for all *Comprehensive Diabetes Care* measures were above the MPLs and the MCMC weighted averages for five of the six *Comprehensive Diabetes Care* measures (83 percent) improved significantly from RY 2016 to RY 2017. Aggregate performance measure results reflect MCPs' improved performance related to ensuring that beneficiaries with diabetes receive quality, accessible, and timely health care services.
- ◆ *Controlling High Blood Pressure*
 - The MCMC weighted average for the *Controlling High Blood Pressure* measure improved significantly from RY 2016 to RY 2017, reflecting MCPs' improved performance related to ensuring that beneficiaries ages 18 to 85 with diagnoses of hypertension had their blood pressure adequately controlled during the MY, based on specified criteria for their ages.

DHCS Initiatives to Support MCPs and SHPs in Improving Care

Throughout the review period, DHCS continued to support MCPs' and SHPs' efforts to provide quality, accessible, and timely care to beneficiaries, including:

- ◆ For each performance measure, focusing on MCPs with:
 - The largest numbers of beneficiaries not served.
 - Substandard performance.
 - The largest number of beneficiaries in underserved race-ethnic groups.
- ◆ Providing technical assistance to MCPs and SHPs in collaboration with HSAG on the implementation of rapid-cycle improvement strategies for measures with rates below the MPLs and measures with year-over-year declining rates.
- ◆ Assisting MCPs and SHPs with prioritizing measures in need of improvement and identifying measures to be used as focus areas for formal PIPs and PDSA cycles.
- ◆ Conducting monthly technical assistance calls with each MCP and meeting at least quarterly with MCPs on CAPs to provide technical assistance and support for MCPs' quality improvement efforts on those measures for which MCPs have had multiple years of performance below the MPLs.

- ◆ Providing opportunities through quarterly collaborative discussions for MCPs and SHPs to share information with each other about quality improvement efforts, successes, and lessons learned.
- ◆ Producing and disseminating to MCPs quality improvement briefs that highlight MCP promising practices and provide resources related to measures for which MCPs have opportunities for improvement (e.g., *Cervical Cancer Screening, Childhood Immunization Status—Combination 3*).
- ◆ Conducting a survey of MCPs to obtain feedback on the value and content of the quality improvement briefs to help DHCS identify opportunities for improvement.
- ◆ Assessing barriers to beneficiary engagement and assisting MCPs in their quality improvement efforts to improve beneficiary engagement.
- ◆ Identifying opportunities to improve upon the use of encounter data to drive program improvement.

Recommendations—Performance Measures

When DHCS next evaluates whether or not to add or remove measures from the EAS, HSAG recommends the following:

- ◆ To help DHCS monitor MCMC’s progress on the MCMC quality strategy area of reducing opioid medication misuse and overuse, obtain input from MCPs and other stakeholders through various methods such as questionnaires or focused studies regarding the feasibility and applicability of adding one of NCQA’s *Use of Opioids* measures to the EAS.

MCP-specific performance measure results, including HSAG’s recommendations, are included in appendices A through Z.

6. Performance Improvement Projects

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.358(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- ◆ Measuring performance using objective quality indicators
- ◆ Implementing system interventions to achieve quality improvement
- ◆ Evaluating effectiveness of the interventions
- ◆ Planning and initiating activities for increasing and sustaining improvement

The EQR technical report must include information on the validation of performance improvement projects required by the state and underway during the preceding 12 months.

Background

To comply with the CMS requirements, DHCS contracts with HSAG to conduct an independent validation of PIPs submitted by MCPs and SHPs. HSAG uses a two-pronged approach. First, HSAG provides training and technical assistance to MCPs and SHPs on how to design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. Then, HSAG assesses the validity and reliability of PIP submissions to draw conclusions about the quality and timeliness of, and access to care furnished by MCPs and SHPs.

Requirements

DHCS requires that each contracted MCP and SHP conduct a minimum of two DHCS-approved PIPs per each Medi-Cal contract held with DHCS. If the areas in need of improvement are similar across contracts, DHCS may approve an MCP to conduct the same two PIPs across all contracts (i.e., conduct two PIPs total).

DHCS has set two categories of topic selection. For MCPs, the first PIP topic must be one of the following four DHCS-priority PIP topics related to the MCMC quality strategy priority areas²⁶:

- ◆ Diabetes
- ◆ Hypertension
- ◆ Postpartum visits
- ◆ Immunizations of two-year-olds

²⁶ DHCS' Medi-Cal managed care quality strategy reports are available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>. Accessed on: Nov 28, 2017.

The second PIP topic for MCPs must target an MCP-specific area with demonstrated need for improvement. For SHPs, when DHCS-priority PIP topics are not applicable, DHCS requires SHPs to conduct two SHP-specific PIPs.

Performance Improvement Projects Approach

HSAG's rapid-cycle PIP approach places emphasis on improving both health care outcomes and processes through the integration of continuous quality improvement science. This approach directs MCPs and SHPs through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility to make adjustments throughout the improvement process. By piloting on a smaller scale, MCPs and SHPs have an opportunity to determine the effectiveness of changes prior to expanding the successful interventions to a larger scale. HSAG guides MCPs and SHPs through a series of five modules:

- ◆ Module 1: PIP Initiation
- ◆ Module 2: SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim Data Collection
- ◆ Module 3: Intervention Determination
- ◆ Module 4: PDSA
- ◆ Module 5: PIP Conclusions

The rapid-cycle PIP approach requires up-front preparation to allow for a structured, scientific approach to quality improvement. Modules 1 through 3 create the basic infrastructure and identify interventions to test. For each intervention tested on a small scale using the PDSA cycle, each MCP/SHP must submit a separate Module 4. Module 5 summarizes the results of the tested interventions. The MCP/SHP completes Module 5 after having tested all interventions and completed analyses of the PDSA cycles. At the end of a PIP, the MCP/SHP identifies successful interventions to expand on a larger scale to achieve the desired health care outcomes.

Objectives

The purpose of HSAG's PIP validation is to ensure that MCPs, SHPs, DHCS, and stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted through the PIPs.

HSAG evaluates two key components of each PIP:

- ◆ Technical structure, to determine whether a PIP's initiation (i.e., topic rationale, PIP team, global aim, SMART aim, key driver diagram, and data collection methodology) is based on sound methodology and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

- ◆ Conducting of quality improvement activities. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing, evaluation using PDSA cycles, sustainability, and spreading successful change. This component evaluates how well MCPs and SHPs execute quality improvement activities and whether the PIP achieves and sustains the desired aim.

Methodology

Based on the agreed-upon timeline, MCPs and SHPs submitted each PIP module to HSAG for validation and feedback. HSAG reviewed each PIP module using standard validation criteria. To ensure compliance with CMS requirements, HSAG presented a crosswalk to CMS to demonstrate how HSAG's rapid-cycle PIP process and validation aligned with the guidelines established in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.²⁷ CMS approved HSAG's PIP process due to the pace of quality improvement science and the prolific use of PDSA cycles within health care settings. Following are the validation criteria HSAG used for each module:

- ◆ Module 1:
 - The topic selected was supported by data and the MCP's/SHP's expertise, and it was aligned with the State's quality strategy.
 - The MCP/SHP identified team members that included both internal MCP/SHP staff and external partners.
 - The SMART Aim included all required components; and the MCP/SHP developed the SMART Aim based on literature review, MCP/SHP data, and/or experience.
 - The Global Aim, SMART Aim, and key driver diagram aligned with identified problem(s) the PIP will address.
- ◆ Module 2:
 - The SMART Aim data collection methodology included the data source(s), step-by-step process, and list of all team members responsible for collecting data.
 - The baseline measurement period and calculated rate were appropriate for the SMART Aim measure.
 - The SMART Aim measure included all of the following components:
 - Well-defined numerator and denominator to measure outcomes for the SMART Aim
 - Appropriate baseline measurement period
 - Appropriate measurement intervals for the SMART Aim
 - The data collection tool(s) was appropriate and captured all required data elements.
 - The run/control chart included the SMART Aim goal, baseline rate, and data collection interval.

²⁷ The CMS protocols may be found at <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Nov 28, 2017.

- ◆ Module 3:
 - The documentation included the step-by-step flow of the current overall process and when the process mapping was completed.
 - The documentation included the team members responsible for completing the process mapping and FMEA.
 - The MCP/SHP included a narrative description of the method used to select the sub-processes. The process described included MCP/SHP data and/or experience to support the selection of the sub-processes for the FMEA.
 - The FMEA included modes, causes, effects, and priority ranking.
 - The team described its priority ranking process to determine interventions.
 - The potential interventions listed in the Intervention Determination Table were appropriate based on the ranked failure modes.
 - The potential interventions have the potential to impact the SMART Aim.
 - The team, in its selection process, considered the potential intervention's reliability and sustainability.
- ◆ Module 4:
 - The team provided details on each intervention tested (who, what, where, when, why, and how).
 - The interventions developed and tested addressed at least one or more of the key drivers, identified failures, or other identified opportunities for improvement.
 - The documentation included the data source(s) for each intervention and details of the data collection process.
 - The documentation included the tracking of events/activities and any challenges and/or confounding factors identified.
 - The team provided an accurate summary of the findings.
 - The MCP/SHP appropriately revised the key driver diagram, FMEA, and interventions based on the analysis of findings.
 - The MCP/SHP expanded successful interventions and provided rationale for expanding the interventions. The MCP/SHP adapted or abandoned unsuccessful interventions and provided rationale for adapting or abandoning the interventions.
 - The team submitted the final PDSA run/control chart(s) illustrating the effect of the intervention(s).
- ◆ Module 5:
 - The narrative summary of overall key findings and interpretation of results was accurate.
 - The PIP demonstrated evidence of achieving the SMART Aim goal.
 - The PIP demonstrated evidence of sustained improvement over comparable consecutive measurements.
 - The team documented its plan for evaluating the expansion of successful interventions beyond the initial scope of the project.
 - The team documented lessons learned.

Once a PIP reaches completion, HSAG determines the following confidence level in the reported PIP findings:

- ◆ *High confidence:* The PIP was methodologically sound and achieved meaningful improvement for the SMART Aim measure, and a clear link existed between all quality improvement processes implemented and the demonstrated improvement.
- ◆ *Confidence:* The PIP was methodologically sound and achieved meaningful improvement for the SMART Aim measures; and a clear link existed between some, but not all, of the quality improvement processes and the demonstrated improvement.
- ◆ *Low confidence:* Either (a) the PIP was methodologically sound but did not achieve improvement for the SMART Aim measure; or (b) the PIP achieved improvement for the SMART Aim measure, but the MCP/SHP poorly executed the quality improvement processes and interventions and the quality improvement processes implemented could not be linked to the demonstrated improvement.
- ◆ *Reported PIP results were not credible:* The MCP/SHP did not execute the PIP methodology as approved.

During the review period, after validating each PIP module submitted by an MCP or SHP, HSAG provided written feedback. HSAG also provided technical assistance throughout the PIP process, with frequent contact and feedback to ensure that projects were well-designed and that MCPs and SHPs had opportunities to make corrections as soon as HSAG identified areas of concern. MCPs and SHPs were required to resubmit modules 1 through 3 until each module met all validation criteria.

HSAG also provided pre-validation review comments on the Plan portion of Module 4s for MCPs and SHPs to consider prior to beginning the intervention testing. HSAG requested status updates from MCPs and SHPs over the course of the intervention testing phase of the PIP process and, when needed, provided technical assistance. Although MCPs and SHPs completed intervention testing through the SMART Aim end date of June 30, 2017, MCPs and SHPs did not progress to submitting modules 4 and 5 to HSAG for validation during the review period. Therefore, HSAG includes no outcomes information in this report. HSAG validated up to the point of PIP progression for each MCP/SHP as of June 30, 2017; and results of the validation activities completed by June 30, 2017, are included in this report.

MCP- and SHP-specific PIP activities are included in the MCP- and SHP-specific evaluation reports in appendices A through Z.

Results—Performance Improvement Projects

During the review period, HSAG validated the following numbers of PIP modules and notified MCPs, SHPs, and DHCS of the validation results:

- ◆ Module 1—two initial submissions and 16 resubmissions
- ◆ Module 2—two initial submissions and 16 resubmissions
- ◆ Module 3—23 initial submissions and 40 resubmissions

HSAG pre-validated 41 Plan portions of PIP Module 4 submissions to ensure that MCPs and SHPs were on track to complete the intervention testing phase of the PIP process. Additionally, HSAG completed Module 4 progress update check-ins with MCPs and SHPs to follow up on the status of intervention testing and provided technical assistance through conference calls and email communications with MCPs and SHPs.

Anthem Blue Cross Partnership Plan concluded its *Prenatal and Postpartum Care* PIP early and therefore submitted modules 4 and 5 during this review period. HSAG provided the MCP and DHCS with the validation results and final confidence level for the PIP. Information regarding Anthem Blue Cross Partnership Plan’s *Prenatal and Postpartum Care* PIP maybe found in Appendix C of this report.

Table 6.1 lists MCPs’ and SHPs’ PIP topics for the July 1, 2016, through June 30, 2017, review period.

Table 6.1—Medi-Cal Managed Care Performance Improvement Project Topics

MCP/SHP Name	PIP Topic
AIDS Healthcare Foundation	<i>Hypertension</i>
	<i>Viral Load Suppression</i>
Alameda Alliance for Health	<i>Postpartum Care</i>
	<i>Prenatal Visits</i>
Anthem Blue Cross Partnership Plan	<i>Controlling Blood Pressure*</i>
	<i>Prenatal and Postpartum Care*</i>
	<i>Comprehensive Diabetes Care*</i>
	<i>Asthma Controller Medication Refill*</i>
California Health & Wellness Plan	<i>Immunizations of Two-Year-Olds</i>
	<i>Cervical Cancer Screening</i>
CalOptima	<i>Diabetes</i>
	<i>Access to Care—Initial Health Assessment</i>
CalViva Health	<i>Postpartum Care</i>
	<i>Diabetes Care</i>

MCP/SHP Name	PIP Topic
Care1st Partner Plan	<i>Diabetes</i>
	<i>Cervical Cancer Screening</i>
CenCal Health	<i>Diabetes</i>
	<i>Initial Health Assessment</i>
Central California Alliance for Health	<i>Immunizations of Two-Year-Olds</i>
	<i>Improving Health Outcomes of Persons Living with Asthma in Merced County</i>
Community Health Group Partnership Plan	<i>Diabetes</i>
	<i>Annual Monitoring of Patients on Persistent Medication—ACE/ARB</i>
Contra Costa Health Plan	<i>Postpartum Care</i>
	<i>Asthma Medication Compliance West County Health Center</i>
Family Mosaic Project	<i>Promoting Caregiver Engagement and Participation</i>
	<i>Ensuring Primary Care Connections</i>
Gold Coast Health Plan	<i>Immunizations of Two-Year-Olds</i>
	<i>Increase Developmental Screening for Children</i>
Health Net Community Solutions, Inc.	<i>Postpartum Care*</i>
	<i>Comprehensive Diabetes Care*</i>
Health Plan of San Joaquin	<i>Diabetes*</i>
	<i>Cervical Cancer Screening*</i>
Health Plan of San Mateo	<i>Postpartum Care</i>
	<i>Cervical Cancer Screening</i>
Inland Empire Health Plan	<i>Diabetes</i>
	<i>Cervical Cancer Screening</i>
Kaiser NorCal	<i>Postpartum Care</i>
	<i>Initial Health Assessment Completion for Adults</i>
Kaiser SoCal	<i>Diabetes</i>
	<i>Initial Health Assessment within 120 Days of Enrollment</i>
Kern Family Health Care	<i>Immunizations of Two-Year-Olds</i>
	<i>Medication Management for People with Asthma</i>
L.A. Care Health Plan	<i>Immunizations of Two-Year-Olds</i>
	<i>Medication Management for People with Asthma</i>

MCP/SHP Name	PIP Topic
Molina Healthcare of California Partner Plan, Inc.	<i>Postpartum Care*</i>
	<i>Annual Monitoring of Patients on Persistent Medications*</i>
Partnership HealthPlan of California	<i>Hypertension</i>
	<i>Reducing Diabetes-Associated Vision Loss through Expanded Primary Care Retinopathy Screening</i>
San Francisco Health Plan	<i>Postpartum Care</i>
	<i>Patient Experience</i>
Santa Clara Family Health Plan	<i>Diabetes</i>
	<i>Controlling High Blood Pressure</i>
SCAN Health Plan	<i>Diabetes Medication Adherence</i>
	<i>Statin Use in Persons with Diabetes</i>

* PIP conducted as part of CAP process.

Performance Improvement Project Validation Findings

During the review period, HSAG noted the following PIP validation findings:

- ◆ All 54 PIPs achieved the required criteria for modules 1, 2, and 3.
- ◆ All MCPs and SHPs concluded their DHCS-priority and MCP- and SHP-specific PIPs by June 30, 2017, and were on schedule to submit modules 4 and 5 for HSAG’s validation.

Performance Improvement Project Technical Assistance Findings

The following are the areas for which MCPs and SHPs requested technical assistance from HSAG during the review period:

- ◆ Questions on the PIP requirements and due dates for submissions:
 - Revising modules 1, 2, and 3 based on changes made to intervention testing.
 - Seeking clarification on whether or not the revisions to modules 1 through 3 will satisfactorily meet the validation criteria.
 - Clarifying HSAG’s feedback on modules 1 through 3, and on the Plan portion of Module 4.
 - Obtaining guidance on what is expected in the Module 4 progress update and submission.
 - Obtaining guidance on what is expected in the modules 4 and 5 submissions.
- ◆ Assistance with the PIP methodology:
 - Developing the PIP baseline and SMART Aim measure.
 - Implementing process mapping and FMEA quality tools.
 - Determining potential interventions and planning intervention testing.

- Measuring intervention effectiveness.
- Calculating data results for the PIP.
- Clarifying the run chart requirements.
- ◆ Recommendations for alleviating barriers and challenges with intervention testing:
 - Addressing challenges with the narrowed focus for the PIP.
 - Resolving narrowed focus provider partner and data collection issues.
 - Abandoning an intervention/beginning a new intervention.

Conclusions—Performance Improvement Projects

Through HSAG’s PIP training, validation, and technical assistance, MCPs and SHPs became more proficient conducting PIPs using the rapid-cycle PIP process. All MCPs and SHPs met the required criteria for the PIP modules that they completed and submitted during the review period. Anthem Blue Cross Partnership Plan is the only MCP that submitted modules 4 and 5 during the review period because the MCP concluded its PIP early. All other MCPs and SHPs completed intervention testing through the SMART Aim end date of June 30, 2017, and were on schedule to submit modules 4 and 5 to HSAG for validation by September 1, 2017. HSAG therefore includes no aggregate outcome information in this report. HSAG will include aggregate outcome information in the *2017–18 Medi-Cal Managed Care External Quality Review Technical Report*.

Recommendations—Performance Improvement Projects

HSAG has no recommendations to DHCS related to PIPs.

7. Consumer Surveys

Administration of consumer surveys of quality of care is one of the optional external quality review activities described at 42 CFR §438.358(c)(2).

Background

DHCS assesses perceptions and experiences of beneficiaries as part of its evaluation of the quality of health care services provided by MCPs to their beneficiaries. To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Survey for the CHIP population.

Objective

The primary objective of the CAHPS survey was to obtain information about the level of satisfaction that CHIP beneficiaries experience with their health care services.

Methodology

During the review period, HSAG administered the standardized survey instrument CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS CCC measurement sets to a statewide sample of CHIP beneficiaries enrolled in MCPs.

Survey Sampling Procedures

CHIP beneficiaries eligible for sampling included those who were enrolled in CHIP at the time the sample was drawn, continuously enrolled in CHIP for at least five of the last six months of 2016 (July through December), and 17 years of age or younger (as of December 31, 2016).

For the CHIP population, HSAG selected a random sample of CHIP beneficiaries for surveying. From the general child population, HSAG selected a random sample of 1,650 CHIP beneficiaries for the CAHPS 5.0 general child sample. After selecting child beneficiaries for the CAHPS general child sample, HSAG selected a random sample of 1,840 child beneficiaries for the CCC supplemental sample, which represented the population of children more likely to have a chronic condition. Additionally, HSAG oversampled the CCC supplemental sample by 825 child beneficiaries to help accomplish DHCS' goal of increased survey responses.

Table 7.1 lists the global ratings, composite measures, and CCC composite measures and items included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the CCC measurement set.

Table 7.1—CAHPS Measures for Child Medicaid Health Plan Survey with CCC Measure Set

Global Ratings	Composite Measures	CCC Composite Measures and Items
<i>Rating of Health Plan</i>	<i>Getting Needed Care</i>	<i>Access to Specialized Services</i>
<i>Rating of All Health Care</i>	<i>Getting Care Quickly</i>	<i>Family-Centered Care (FCC): Personal Doctor Who Knows Child</i>
<i>Rating of Personal Doctor</i>	<i>How Well Doctors Communicate</i>	<i>Coordination of Care (COC) for CCC</i>
<i>Rating of Specialist Seen Most Often</i>	<i>Customer Service</i>	<i>Access to Prescription Medicines</i>
	<i>Shared Decision Making</i>	<i>FCC: Getting Needed Information</i>

Survey Administration

HSAG designed the 2017 survey administration protocol to achieve a high response rate from beneficiaries, thus minimizing the potential effects of nonresponse bias. The survey process allowed beneficiaries two methods by which they could complete the surveys. The first, mail phase, consisted of surveys being mailed to the sampled beneficiaries. Beneficiaries identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Beneficiaries not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing beneficiaries that they could call a toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire had an English cover letter on the back side informing beneficiaries that they could call a toll-free number to request an English version of the CAHPS questionnaire. All nonrespondents received a reminder postcard followed by a second survey mailing and reminder postcard. The second phase, telephone phase, consisted of conducting computer-assisted telephone interviewing (CATI) of sampled beneficiaries who had not returned a completed survey. HSAG conducted a series of at least three CATI calls to each nonrespondent.²⁸

Rates and Proportions

HSAG calculated both the question summary rates and global proportions in accordance with NCQA HEDIS Specifications for Survey Measures.²⁹ For the scoring of the global ratings and composite measures, HSAG assigned top-level responses a score of 1 and all other responses a score of zero. HSAG defined a “top-level” response as follows:

- ◆ “9” or “10” for the global ratings.
- ◆ “Usually” or “Always” for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites; the Access to Specialized Services CCC composite; and the FCC: Getting Needed Information and Access to Prescription Medicines CCC composite items.
- ◆ “Yes” for the Shared Decision Making composite and the FCC: Personal Doctor Who Knows Child and COC for Children with Chronic Conditions CCC composites.

²⁸ National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2017 Survey Measures*. Washington, DC: NCQA; 2016.

²⁹ National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication; 2016.

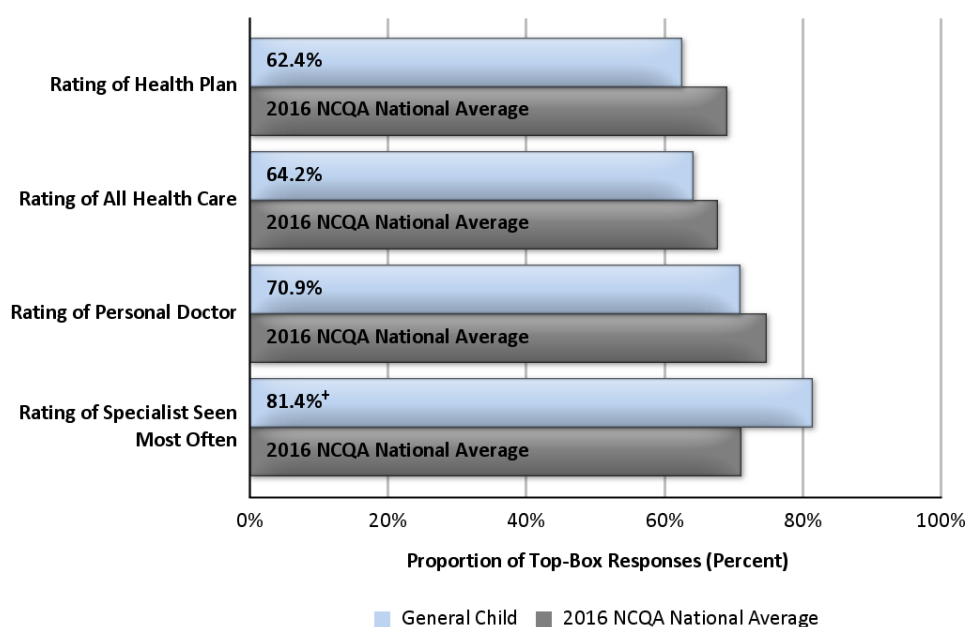
After applying this scoring methodology, HSAG calculated the percentage of top-level responses to determine the question summary rates and global proportions. While NCQA HEDIS Specifications for Survey Measures indicates that a measure must have 100 responses to obtain a reportable result,³⁰ HSAG presents CAHPS scores for all measures, including those that did not achieve the minimum reporting threshold of 100 respondents. Therefore, caution should be exercised when interpreting the results. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

Results—Consumer Surveys

General Child Rates and Proportions

Figure 7.1 displays the general child population question summary rates for the four global ratings and the 2016 NCQA National Child Medicaid averages.^{31,32}

Figure 7.1—Global Ratings: General Child Question Summary Rates



⁺ This measure had fewer than 100 respondents; therefore, caution should be exercised when interpreting the results.

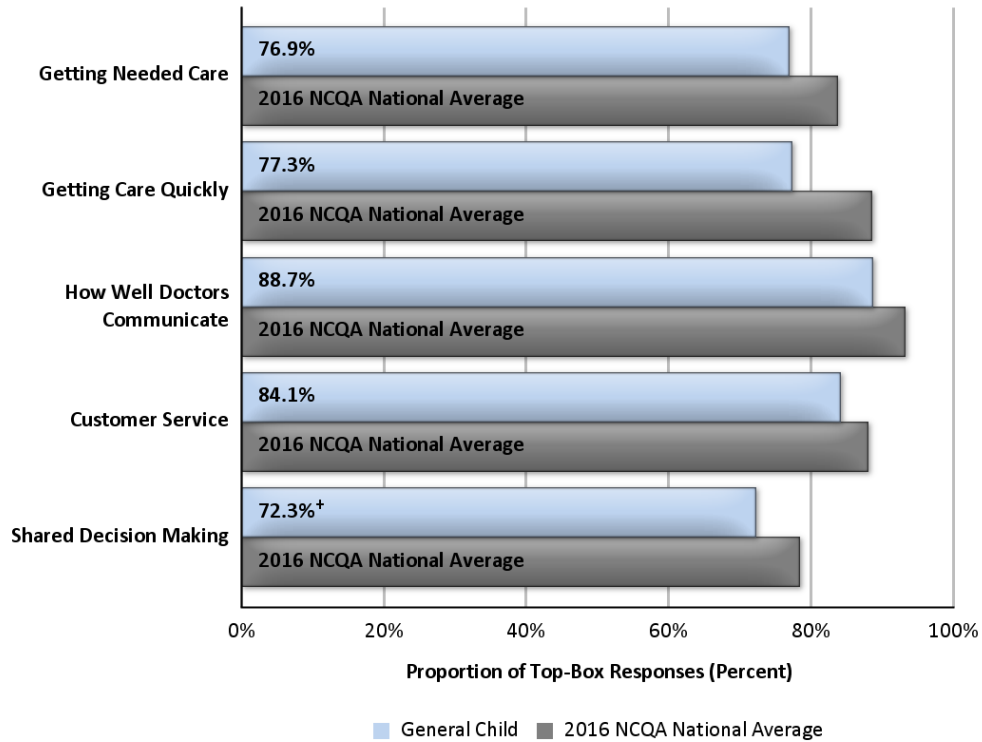
³⁰ National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

³¹ NCQA national averages for 2017 were not available at the time that this report was prepared; therefore, 2016 NCQA national averages are presented in this section. In addition, NCQA national averages for the child Medicaid population are used for comparative purposes since NCQA does not publish separate benchmarking data for the CHIP population.

³² For the NCQA national child Medicaid averages, the source for data contained in this publication is Quality Compass® 2016 data, used with permission of NCQA. Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors; and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

Figure 7.2 displays the general child population global proportions for the five composite measures and the 2016 NCQA National Child Medicaid averages for those measures.

Figure 7.2—Composite Measures: General Child Global Proportions

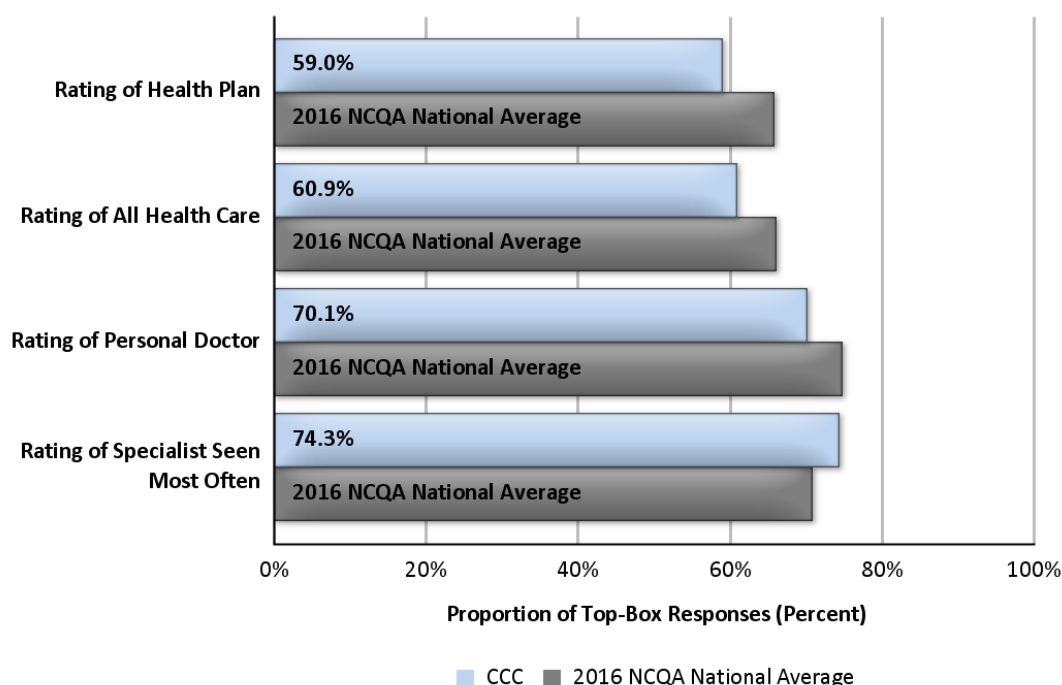


⁺ This measure had fewer than 100 respondents; therefore, caution should be exercised when interpreting the results.

Children With Chronic Conditions—Rates and Proportions

Figure 7.3 displays the CCC population question summary rates for the four global ratings and the 2016 NCQA National CCC Medicaid averages for those ratings.³³

Figure 7.3—Global Ratings: CCC Question Summary Rates



³³ For the NCQA national CCC Medicaid averages, the source for data contained in this publication is Quality Compass[®] 2016 data and is used with the permission of NCQA. Quality Compass 2016 includes certain CAHPS data. Any data displayed, analyses, interpretations, or conclusions based on these data is solely that of the authors; and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

Figure 7.4 displays the CCC population global proportions for the five composite measures and the 2016 NCQA National CCC Medicaid averages for those measures.

Figure 7.4—Composite Measures: CCC Global Proportions

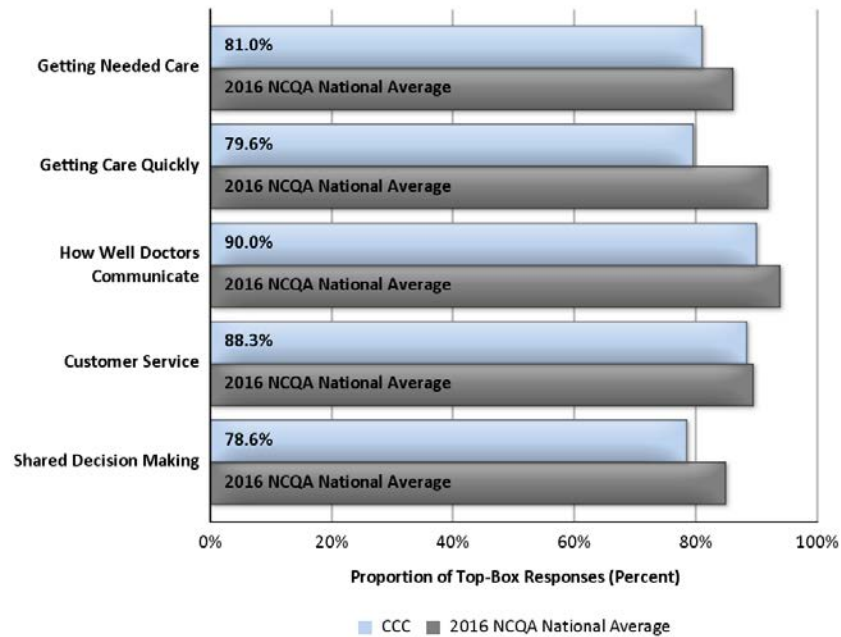
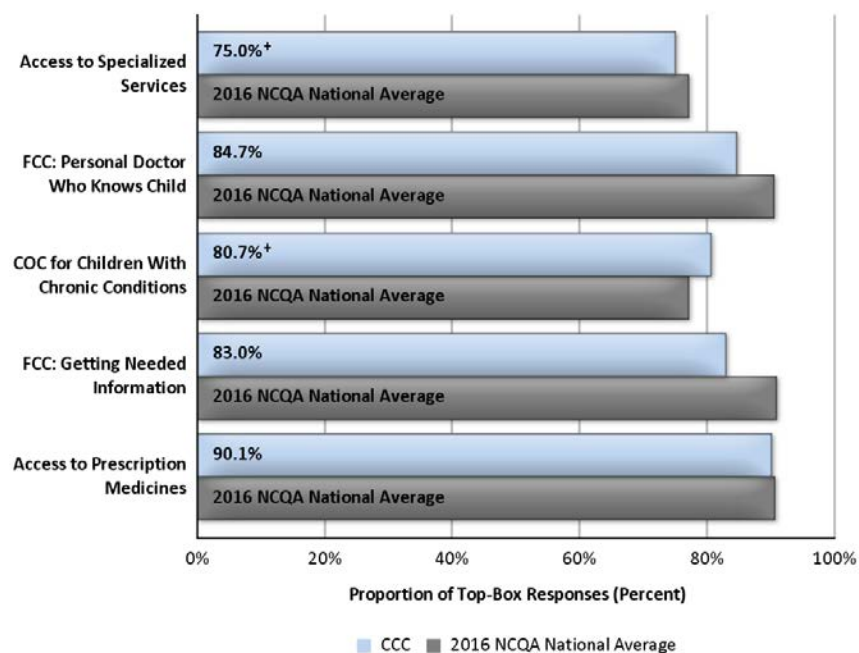


Figure 7.5 displays the CCC population question summary rates and global proportions for the CCC composite measures and items and the 2016 NCQA National CCC Medicaid averages for those measures and items.

Figure 7.5—CCC Composite Measures and Items: CCC Question Summary Rates and Global Proportions



⁺ This measure had fewer than 100 respondents; therefore, caution should be exercised when interpreting the results.

Consumer Survey Findings

The rates for all measures with reportable results were below the 2016 NCQA national averages except the rate for the *Rating of Specialist Seen Most Often* global rating for the CCC population, which was above the 2016 NCQA national average.

Conclusions—Consumer Surveys

DHCS demonstrates a commitment to assess beneficiaries' satisfaction through the administration of CAHPS surveys. CAHPS survey results can assist DHCS and MCPs with identifying opportunities for improvement and prioritizing areas on which to focus quality improvement strategies. Based on 2017 CAHPS survey results, MCPs have opportunities to improve beneficiaries' satisfaction with various aspects of their health care and services.

Recommendations—Consumer Surveys

HSAG recommends that DHCS seek feedback on the 2017 CAHPS survey results for measures with at least 100 responses from MCPs and from MCHAP,³⁴ the latter of which operates as a stakeholder group for DHCS and advises DHCS on policy and operational issues that affect children in Medi-Cal. DHCS should factor the feedback from MCPs and MCHAP into DHCS' determination of priority areas for improvement and strategies related to ensuring quality, accessible, and timely health care services for the Medi-Cal child population.

³⁴ Information about MCHAP may be found at: http://www.dhcs.ca.gov/services/Pages/Medi-Cal_Childrens_Health_Advisory_Panel.aspx. Accessed on: Dec 19, 2017.

8. Focused Studies

Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time is one of the optional external quality review activities described at 42 CFR §438.358(c)(5).

Background

During the review period, DHCS contracted with HSAG to conduct focused studies to gain better understanding of and identify opportunities for improving care provided to beneficiaries. HSAG conducted and concluded the following focused studies during the review period:

- ◆ Developmental Screening in the First Three Years of Life
- ◆ Quality Improvement Team

HSAG began conducting but did not conclude the following focused studies during the review period:

- ◆ Disparities Analysis
- ◆ MLTSS Population Identification and Demographics
- ◆ Timely Access

HSAG's Approach to Focused Studies

HSAG conducts each focused study in accordance with CMS' *EQR Protocol 8, Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.³⁵

Study Design

HSAG defines the scope of work and expected objectives for the focused study topic. HSAG then conducts an in-depth literature review to identify the best practices for the populations under study and develops a study proposal encompassing the study question, study population, measurement period(s), data sources, study indicators, data collection process, and analytic plan. Each focused study may require the adaptation of standard health care quality measures for applicability to special populations; therefore, HSAG's analytic plan details the technical specification for these measures to ensure methodological soundness and reliable calculability for the populations under study.

³⁵ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Nov 28, 2017.

Data Collection

As much as possible, HSAG uses administrative data to conduct focused studies. While medical record review may provide valuable insight into selected focused study topics, HSAG uses this approach sparingly in order to provide focused study results within a single contract year. After finalizing the methodology for each focused study, HSAG works with DHCS to develop study-specific data submission file layout.

Data Analyses

HSAG conducts statistical analyses according to the approved analytic plan. Primary analysis addresses the study question and provides results for the study indicators. HSAG also performs a secondary analysis to examine variation among subgroups (e.g., male and female), patterns of care and outcomes, impact of explanatory variables on indicators, and correlation among variables. HSAG is cognizant of the various threats to internal and external validity outlined by Cook & Campbell (1979).³⁶ In designing each focused study, HSAG addresses and minimizes each threat to the extent possible. A staff member not involved in initial calculation of results validates all final results.

Final Report

At the end of each focused study, HSAG produces a report that includes a stand-alone executive summary, study methodology including data collection and analysis processes, study results, and conclusions and recommendations. In addition to presenting the findings associated with the study question(s), the report discusses the implications of the results in light of the policy environment within the State and presents actionable recommendations to improve the delivery of health care to beneficiaries.

Developmental Screening in the First Three Years of Life Focused Study

DHCS contracted with HSAG to conduct a focused study to help DHCS determine if CPT Code 96110 could be used to evaluate MCPs' rates for the *Developmental Screening in the First Three Years of Life* measure in California as DHCS considered the potential inclusion of this measure in the EAS. DHCS had concerns that the rates for this measure would be artificially low due to provider lack of use of the CPT Code 96110 (i.e., providers who are capitated or working in FQHCs have no incentive to use the code as it does not result in additional payment).

The *State Fiscal Year (SFY) 2016–17 Developmental Screening Focused Study Aggregate Report* includes detailed methodology, study results, and recommendations. Following are brief summaries of the objectives, methodology, study results, conclusions, and recommendations.

³⁶ Cook, TD & Campbell, DT. *Quasi-Experimentation: Design & Analysis Issues for Field Settings*. Boston, MA: Houghton-Mifflin; 1979.

Objective

The purpose of the Developmental Screening Focused Study was to address the following question:

- ◆ *To what extent can CPT Code 96110 be used to evaluate MCPs' rates for the Developmental Screening in the First Three Years of Life measure in California?*

Methodology

HSAG collaborated with key DHCS staff, stakeholders, and MCPs to perform the following activities:

- ◆ Collect information from stakeholders regarding historical studies, interventions, and any known potential barriers.
- ◆ Collect information from MCPs regarding historical studies; interventions; and guidelines to providers regarding the use of CPT Code 96110, additional codes used for calculating developmental screening rates, and any known potential barriers.
- ◆ Calculate the administrative rates for the *Developmental Screening in the First Three Years of Life* measure based on CPT Code 96110 for calendar year 2015 and evaluate whether any disparities of using/submitting CPT Code 96110 exist among different types of providers.
- ◆ Evaluate the effectiveness of the interventions based on questionnaire responses from stakeholders.
- ◆ Recalculate the administrative rates by adding additional codes that MCPs indicated using for calculating developmental screening rates.

Results—Developmental Screening Focused Study

Questionnaire for Stakeholders

Seven stakeholders submitted responses to the stakeholder questionnaire. Stakeholder respondents answered eight questions and submitted supporting documentation, as appropriate. Respondents varied in their interests related to the *Developmental Screening in the First Three Years of Life* measure, but the main emphasis for participating in the focused study was to promote improvements for administering developmental screenings to:

- ◆ Ensure that all Medi-Cal beneficiaries in local maternal, child, and adolescent health (MCAH) home visiting and other MCAH case management programs receive appropriate developmental screenings and improve the linkage of information to those beneficiaries' primary care providers and/or medical homes for further assessment or connection to appropriate services, as needed.
- ◆ Encourage the adoption of developmental screenings as a quality measure.
- ◆ Support routine developmental/behavioral health screenings, with linkage to appropriate intervention services in pediatric clinics and community health settings.
- ◆ Support efforts for improved coordination of care for children diagnosed with developmental delays across the continuum of care—from the initial screening through to referral(s) and obtaining the needed interventions and/or services.

- ◆ Acquire a population-based, unbiased metric that can be measured regularly to establish baseline and trends in developmental screening rates statewide and at the local level, thus assessing the effectiveness of local intervention activities designed to improve developmental screening rates for low-income families, many of whom are Medi-Cal eligible.
- ◆ Support the adoption of a screening measure so that there is a statewide understanding of developmental screening rates and screening consistency among providers and subpopulations.

The *SFY 2016–17 Developmental Screening Focused Study Aggregate Report* includes detailed findings related to stakeholder responses about historical studies, past and/or future interventions and/or campaigns, and barriers identified regarding the *Developmental Screening in the First Three Years of Life* measure or use of CPT Code 96110.

Questionnaire for MCPs

HSAG distributed the *Developmental Screening in the First Three Years of Life* measure questionnaire to 23 MCPs in February 2017. HSAG then reviewed MCPs' questionnaire responses and followed up with them, if necessary, in March and April 2017. Of the 23 MCPs that received the questionnaire, HSAG received 20 distinct responses, with two MCPs not responding and two MCPs submitting a combined response due to their contractual setup. MCPs responded to 12 questions, providing both general and specific information related to the following:

- ◆ Guidelines submitted to providers by MCPs for the use of CPT Code 96110 and conducting child developmental screenings.
- ◆ Additional procedure codes that providers may use to bill for child development screenings.
- ◆ Information both about historical studies that MCPs conducted for the *Developmental Screening in the First Three Years of Life* measure and the use of CPT Code 96110.
- ◆ Information regarding any intervention(s) that MCPs conducted or will conduct to improve rates for the *Developmental Screening in the First Three Years of Life* measure and to increase the appropriate use of CPT Code 96110.
- ◆ Description of any known barrier(s) for beneficiaries seeking developmental screenings.
- ◆ Description of any known barrier(s) for providers administering developmental screenings.
- ◆ Description of any known barrier(s) for providers billing/coding/submitting CPT Code 96110 for developmental screening services.
- ◆ Description of any other known barrier(s) to improve developmental screening rates in the Medi-Cal population.

The *SFY 2016–17 Developmental Screening Focused Study Aggregate Report* includes detailed summary of findings based on the responses from the 21 MCPs that participated in the Developmental Screening Focused Study.

Administrative Analysis

The following are notable findings from the administrative analysis that HSAG conducted based on the beneficiary and encounter data extracted by DHCS:

- ◆ CPT Code 96110 exists in three encounter types: Early Periodic Screening, Diagnostic, and Treatment/Child Health and Disability Prevention (EPSDT/CHDP); Medical/Physician; and Outpatient.
- ◆ At the statewide level, 84.3 percent of services with CPT Code 96110 were from the EPSDT/CHDP encounters.
- ◆ While 12.8 percent of statewide services with CPT Code 96110 were from Medical/Physician encounters, more than 90 percent of services with CPT Code 96110 were from the Medical/Physician encounters for 11 reporting units.
- ◆ The statewide percentage of services with CPT Code 96110 from the Outpatient encounters was 1.0 percent. However, 98.8 percent of the Gold Coast Health Plan—Ventura services with CPT Code 96110 were from Outpatient encounters.
- ◆ At the statewide level, 1.9 percent of services with CPT Code 96110 were found in more than one encounter type. Among the reporting units, one reporting unit had a rate of 15.5 percent and six reporting units had rates between 5 percent and 10 percent.
- ◆ For Anthem Blue Cross Partnership Plan, California Health & Wellness Plan, Molina Healthcare of California Partner Plan, Inc., and Partnership HealthPlan of California, the primary encounter type for submitting CPT Code 96110 was sometimes different for reporting units with the same MCP. For example, more than 90 percent of the services with CPT Code 96110 were from Medical/Physician encounters for California Health & Wellness Plan—Imperial and Region 1. However, 80.5 percent of the services with CPT Code 96110 were from EPSDT/CHDP encounters for California Health & Wellness Plan—Region 2.

The *SFY 2016–17 Developmental Screening Focused Study Aggregate Report* includes detailed encounter data review results, rates for the *Developmental Screening in the First Three Years of Life* measure based on CPT Code 96110, provider disparity analysis, modified developmental screening rates based on CPT Code 96110 and additional CPT codes from MCPs' questionnaire responses, and interventions' impact analyses.

Conclusions—Developmental Screening Focused Study

Questionnaire for Stakeholders

HSAG's review of historical studies and interventions helped to identify barriers related to the *Developmental Screening in the First Three Years of Life* measure and/or use of CPT Code 96110. While the rate for administration of developmental screenings was still lower than expected, the survey responses indicated increased interest in improving the rate. To facilitate this improvement, it is necessary to understand each significant barrier type and make recommendations as appropriate. HSAG noted significant gaps in three categories: MCMC barriers, beneficiary barriers, and provider barriers.

Overall, respondents identified similar barriers. In reviewing the stakeholder responses, HSAG noted among all barrier categories the identification of a consistent lack of education regarding the importance of children receiving developmental screenings, billing and coding issues and best practices, referral services and/or pathways, and the use of American Academy of Pediatrics-recommended and validated tools. HSAG also discovered that the findings conflicted when comparing monetary incentives as a tool for promoting the administration of developmental screenings to proprietary incentives (i.e., providing ownership in costly screening tools as an incentive), which also drive providers and provider locations to conduct developmental screenings. Lastly, respondents noted that data quality and completeness continue to be ongoing challenges in the ability to accurately assess developmental screenings in children. The respondents noted that the data accuracy problem is related to coding and billing practices, data collection and retention practices, and MCMC reporting standards.

Questionnaire for MCPs

HSAG's review of MCPs' policies and procedures, historical studies, and interventions provided valuable information regarding the barriers that providers, MCPs, and parents of Med-Cal beneficiaries face concerning the *Developmental Screening in the First Three Years of Life* measure and use of CPT Code 96110. To promote an increased rate of developmental screening and/or use of CPT Code 96110, it is essential to understand barriers affecting the administration of developmental screenings as well as changes required to facilitate greater screening rates and accurate billing and coding practices.

While MCPs recognize the importance of working with providers to ensure that children receive appropriate developmental screenings, the reported rate at which screenings are administered is lower than expected. This low rate of utilization is affected by various Medi-Cal beneficiary and provider barriers, including, but not limited to caregiver and provider education regarding general developmental milestones and the importance of screening; resource constraints; inconsistent use of standardized, validated tools; and a lack of access to and/or use of CPT Code 96110. Importantly, MCPs noted that data reporting is an ongoing challenge in terms of accurately assessing whether or not a child has received a developmental screening. Providers do not use a standardized approach to administer and code developmental screenings; therefore, the rate of screenings may be underreported.

Administrative Analysis

While most services with CPT Code 96110 were from the EPSDT/CHDP encounters at the statewide level, some reporting units included most services with CPT Code 96110 from Medical/Physician encounters or Outpatient encounters. In addition, CPT Code 96110 from the EPSDT/CHDP encounters was based on the "Developmental Assessment" checkbox from the PM 160 claim form, which defines developmental screening differently than does CPT Code 96110 from Medical/Physician encounters or Outpatient encounters. The statewide coding rates for use of CPT Code 96110 were 54.8 percent, 41.1 percent, and 30.8 percent for beneficiaries 1, 2, and 3 years of age, respectively. The rates varied considerably among reporting units. For example, one MCP showed the highest reportable rates (i.e., all above 75 percent) for all age categories due to the historical and ongoing interventions implemented since 2009. However, seven reporting units had rates of less than 10 percent for all age groups with numerical rates. Overall, the large variation in the use and submission of CPT Code 96110 among

reporting units raised concerns that CPT Code 96110 in DHCS' encounters may not reflect the true developmental screening services provided in CY 2015 for all reporting units.

Although 10 MCPs provided four additional procedure codes to identify developmental screenings from encounters, these additional codes improved the rates by no more than 1.6 percentage points. The disparity analysis showed that the percentages of active providers who submitted CPT Code 96110 were 18.0 percent, 11.9 percent, 12.0 percent, and 7.5 percent for the provider categories of Certified Nurse Practitioner, Clinic, Physicians/Physician Group: PCP, and Rural Health Clinic/FQHC, respectively, while the percentage for the remaining types of providers was much lower (i.e., 1.5 percent). However, please use caution when interpreting disparity analysis results because EPSDT/CHDP encounters were not included in the analysis—due to invalid provider information—although most services with CPT Code 96110 were from the EPSDT/CHDP encounters. Lastly, among beneficiaries with EPSDT/CHDP encounters, 94.8 percent had at least one encounter with CPT Code 96110 in the 12 months preceding their birthdays in CY 2015, which demonstrates that beneficiaries generally did receive developmental screenings during their EPSDT visits.

Recommendations—Developmental Screening Focused Study

HSAG recommends that DHCS review the detailed recommendations in the *SFY 2016–17 Developmental Screening Focused Study Aggregate Report* to determine priority areas for action.

Quality Team Focused Study

DHCS contracted with HSAG to conduct a focused study to gain an understanding of the structure and functions of the MCPs' QAPI teams. The *2016–17 Quality Team Focused Study Report* includes the detailed methodology, study results, and recommendations. Following are brief summaries of the objectives, methodology, study results, conclusions, and recommendations.

Objective

The goal of the Quality Team Focused Study was to determine whether any specific structure, functions, or characteristics could be attributed to an effective MCP QAPI team. SHPs were not included in the focused study. For purposes of the study, HSAG assumed that certain QAPI team functions and characteristics, including an MCP's structure and organization, staff qualifications, and health information systems, may be successful in supporting performance improvement.

Methodology

HSAG conducted a qualitative study that defined the study group as DHCS-contracted MCPs and the activity or process as the QAPI process. HSAG used the following data collection methods to obtain data for the focused study:

- ◆ Telephonic survey with DHCS related to contract and policy requirements for MCPs' QAPI programs.
- ◆ Data collection and review of DHCS contract language and policy requirements for MCPs' QAPI programs.
- ◆ Telephonic surveys with MCPs' quality improvement leaders and staff members.
- ◆ Data and document collection and review of the organizational structures, functions, and staff members' qualifications and experience related to the MCPs' QAPI programs.
- ◆ Internet search of state Medicaid contract and policy requirements related to QAPI programs.
- ◆ Internet literature search of published articles and reports regarding effective QAPI teams.

The methodology for this focused study included both qualitative and quantitative analyses of the MCP survey response data to determine whether certain MCP characteristics contribute to an effective QAPI team. Based on a review of the data collected, however, HSAG determined that it could not conduct a correlation analysis because the data were qualitative and could not be uniformly coded to yield viable correlation comparisons.

HSAG used 2016 HEDIS and CAHPS results to identify high- and low-performing MCPs. HSAG used all 30 performance measures that MCPs were required to report in RY 2016 and 16 measures from the 2016 CAHPS survey—eight adult measures and eight child measures. HSAG then calculated the MCPs' average ranking across all these measures. HSAG used the MCPs' aggregate performance measure and CAHPS results to determine “high performers” and “low performers.”

Study Limitations

HSAG identified the following study limitations during the planning and data collection phases of the project.

- ◆ The MCP staff members participating in the calls represented different levels within their organizations and may have had different experience and involvement in the QAPI work.
- ◆ Not all state Medicaid program websites were transparent; and the Medicaid programs did not consistently post information on their websites regarding MCO contracts, policy and procedure documents, and performance improvement results.
- ◆ Limited studies were published regarding the organizational structural and functional characteristics that resulted in an effective QAPI team.
- ◆ HSAG used qualitative methods to collect data, including surveys and review of literature and websites. Qualitative methods provide important descriptive information about patterns and relationships, and a context for improvement; however, using qualitative methods limited HSAG's ability to measure or assign a numeric value to the collected information.

Results—Quality Team Focused Study

HSAG completed a comprehensive review of the MCPs' QAPI programs. HSAG also conducted a thorough review of all 50 state Medicaid program websites and a literature search for articles and reports related to what makes an effective QAPI team. HSAG attempted to conduct a correlation analysis to determine if any specific QAPI team functions and characteristics correlated with better MCP performance and CAHPS measure results. The data collected for this focused study were qualitative; therefore, HSAG was unable to uniformly code the data to yield viable correlation comparisons. The *2016–17 Quality Team Focused Study Report* includes more detailed study results.

Conclusions—Quality Team Focused Study

Based on the comprehensive review of the MCPs' QAPI programs, review of all 50 state Medicaid program websites, and the literature review, HSAG concluded that QAPI team models, designs, and characteristics vary. Each model may have elements that have proven successful for an MCP in developing an effective QAPI team. However, HSAG identified no specific characteristics that, if implemented, would ensure that an MCP's QAPI team is effective.

The availability of information was limited based on the transparency of state Medicaid program websites and information available regarding how the states applied the MCP requirements. States that published MCP policy and contract requirements and that also appeared to have seen improvement in an MCP's performance referenced senior leadership support of QAPI work and minimum qualifications for key QAPI team member positions as necessary components of successful quality improvement work. In addition, certain elements identified through MCP surveys, literature search, and review of the state Medicaid program websites assisted HSAG in drawing conclusions regarding characteristics that may be indicative of an effective QAPI team. A review of state Medicaid program websites as well as information from the literature review suggested key areas of focus for effective QAPI teams:

- ◆ MCPs that promoted strong QAPI team job descriptions with stated minimum requirements for education, quality certification, and quality improvement experience were better able to develop, implement, and monitor quality improvement work.
- ◆ State Medicaid program contract and policy language which includes requirements that focus the MCP's attention on quality improvement expectations allowed states to require best practices for organization, staffing, and use of health information systems.

Recommendations—Quality Team Focused Study

HSAG recommends that DHCS consider whether or not implementing any of the detailed recommendations in the *2016–17 Quality Team Focused Study Report* will support DHCS in helping MCPs to strengthen their QAPI teams.

Disparities Analysis Focused Study

DHCS contracted with HSAG to conduct a focused study on health care disparities using RY 2016 EAS measure rates reported by MCPs. During the review period for this EQR technical report, HSAG continued to work with MCPs to obtain the most complete and accurate patient-level data possible. Additionally, using focused study results and available data, HSAG and DHCS engaged in numerous collaborative discussions to determine the scope and content of the Disparities Analysis Focused Study reports.

Due to the extensive process of obtaining complete and accurate patient-level data from MCPs, as well as the process for determining the scope and content of the focused study reports taking longer than anticipated, the results of this focused study were not available to include in this EQR technical report. HSAG will include the results in the 2017–18 EQR technical report.

Managed Long-Term Services and Supports Plans Focused Study

DHCS contracted with HSAG to conduct a focused study assessing the segment of the population receiving MLTSS benefits solely through the Medi-Cal program. The goal of this study is to determine the most effective methodology for identifying this segment of the overall MLTSS population.

During the review period, HSAG began to conduct the following three main activities using RY 2016 data to recommend to DHCS a standardized process for identifying the Medi-Cal-only MLTSS population:

- ◆ Partnered with DHCS and two MLTSSPs to understand and describe existing methods for identifying the Medi-Cal-only MLTSS population.
- ◆ Applied the identified methods for identifying the Medi-Cal only MLTSS population to the appropriate administrative data for RY 2016 and compared the resulting populations, focusing on beneficiaries who were excluded or included based on the method used.
- ◆ Collaborated with DHCS to begin to determine the best method for identifying the MLTSS population.

Although HSAG began conducting the MLTSSP Focused Study during the review period for this report, the results of this focused study were not available to include in this EQR technical report. HSAG will include a summary of the results in the 2017–18 EQR technical report.

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 8.1. During the review period for this report, DHCS contracted with HSAG to conduct a focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 8.1.

Table 8.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment	10 business days	48 hours
Specialist appointment	15 business days	96 hours
Appointment with a mental health (MH) care provider (who is not a physician)	10 business days	96 hours
First prenatal visits	2 weeks GMC and TPM (including both LI and CP); 10 business days COHS	—
Appointment with ancillary providers	15 business days	—

During the review period, HSAG began to collaborate with key DHCS staff to develop the methodology for this focused study. However, due to the provider data being available later than anticipated, HSAG did not perform key activities of this focused study; therefore, the results of this focused study were not available to include in this EQR technical report. HSAG will include the results in the 2017–18 EQR technical report.

Recommendations across All Focused Studies

HSAG recommends that DHCS thoroughly review HSAG’s recommendations from all focused studies, prioritize areas for action, and develop plans for taking action on the prioritized areas.

9. Technical Assistance

At the State’s direction, the EQRO may provide technical guidance to groups of MCPs, PIHPs, PAHPs, or PCCM entities as described at 42 CFR §438.358(d).

Background

In addition to the technical assistance provided to MCPs and SHPs as part of the PIP process, DHCS contracted with HSAG to provide supplemental technical assistance to help improve overall statewide performance. DHCS selected three Technical Assistance Activity Sets for HSAG to conduct during the July 1, 2016, through June 30, 2017, review period.

Technical Assistance Activity for Performance Measures

Objective

Under the Technical Assistance Activity for Performance Measures, HSAG provided technical assistance to DHCS to:

- ◆ Help build the DHCS quality improvement team’s capacity to work directly with MCPs and SHPs to improve performance on EAS measures.
- ◆ Assist DHCS in identifying priority performance measures. Specifically, assist DHCS in developing and monitoring a strategy to raise performance on each of the priority focus areas identified in DHCS’ annual *Medi-Cal Managed Care Quality Strategy Report*.
- ◆ Aid DHCS with developing and monitoring CAPs and IPs/PDSA cycles for MCPs and SHPs with persistent substandard performance on multiple measures.
- ◆ Provide guidance to DHCS on improving monitoring activities and make recommendations, as appropriate, for improving DHCS’ processes for holding MCPs and SHPs accountable for meeting contractual requirements.
- ◆ Review and provide feedback to DHCS on an array of documents related to quality improvement activities.
- ◆ Respond to requests from DHCS for input on a variety of quality improvement-related issues and topics via telephone and email.

Under the Technical Assistance Activity for Performance Measures, HSAG also provided technical assistance to MCPs and SHPs requiring additional guidance with IPs/PDSA cycles, and/or CAPs, as identified by DHCS.

Methodology

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each technical assistance session to ensure the most efficient provision of technical assistance with the greatest likelihood of resulting in enhanced skills and, ultimately, improved performance. To promote timely and flexible delivery, HSAG conducted technical assistance with DHCS, MCPs, and SHPs by email, telephone, and Web conferences.

Results—Technical Assistance Activity for Performance Measures

During the review period, HSAG provided technical assistance to DHCS on various topics related to improving statewide performance.

Improvement Plans/Plan-Do-Study-Act Cycles and Corrective Action Plans

During the July 1, 2016, through June 30, 2017, review period, DHCS required MCPs and SHPs to conduct PDSA cycles and submit PDSA Cycle Worksheets quarterly or submit quality improvement summaries for performance measures with rates that did not meet the MPLs for the previous year. At DHCS' request, HSAG conducted secondary reviews of the PDSA Cycle Worksheets and provided recommendations to DHCS on the next steps for MCPs and SHPs. As part of conducting secondary reviews, HSAG reviewed both PDSA Cycle Worksheets and DHCS' initial feedback on the PDSA Cycle Worksheets.

As part of the CAP process, DHCS also required MCPs under CAPs to conduct PDSA cycles and submit PDSA Cycle Worksheets quarterly for performance measures with rates below the MPLs for multiple years. HSAG conducted a secondary review of PDSA Cycle Worksheets submitted by MCPs under CAPs. For each PDSA Cycle Worksheet, HSAG focused on how the MCP carried out and evaluated the intervention testing. When indicated through HSAG's assessment of the PDSA cycles, HSAG conducted technical assistance during DHCS' CAP monitoring calls with MCPs. Additionally, HSAG validated PIPs submitted by MCPs under CAPs and, when needed, conducted individual technical assistance calls with MCPs to assist those MCPs with the rapid-cycle PIP approach.

As applicable, HSAG includes information on MCP- and SHP-specific technical assistance related to IPs/PDSA cycles and CAPs in appendices A through Z.

DHCS Nurse Consultant—HSAG Technical Assistance Meetings

During the review period, DHCS nurse consultants and HSAG staff met by teleconference, as needed, to discuss PDSA cycle reviews, PIP progress, and other pertinent information related to work between DHCS nurse consultants and HSAG.

2018 External Accountability Set

During the review period, DHCS requested HSAG's feedback on the *Depression Screening and Follow-Up for Adolescents and Adults* measure, a new NCQA HEDIS measure for RY 2018. HSAG provided thorough feedback and recommendations to DHCS regarding the measure. HSAG coordinated with staff members from NCQA to conduct a webinar introducing the new HEDIS *Depression Screening and Follow-Up for Adolescents and Adults* measure to MCPs. Prior to the webinar, HSAG engaged in conference calls and communicated with NCQA and DHCS by email regarding the content and structure of the webinar. The purpose of the webinar was to introduce the new *Depression Screening and Follow-Up for Adolescents and Adults* measure to MCPs to obtain their input on replacing the *Clinical Depression and Follow-Up Plan* measure with the *Depression Screening and Follow-Up for Adolescents and Adults* measure for the RY 2018 EAS. Following the webinar, HSAG worked with DHCS and NCQA to create a document that includes responses to questions that MCPs asked during the webinar. Due to HSAG's technical assistance, DHCS determined to replace the *Clinical Depression and Follow-Up Plan* measure with the *Depression Screening and Follow-Up for Adolescents and Adults* measure for the RY 2018 EAS.

Other Technical Assistance

HSAG provided DHCS with technical assistance on various topics, including:

- ◆ HEDIS measure and performance measure specifications and validation processes.
- ◆ CAHPS survey administration and data submission processes.
- ◆ PDSA cycle requirement modifications.
- ◆ Rapid-cycle PIP methodology and validation criteria.
- ◆ Comprehensive compilation of changes to the Code of Federal Regulations 438.360.
- ◆ Methodology options for setting MCMC quality strategy goals.

Additionally, at DHCS' request, HSAG reviewed and provided feedback on numerous documents related to statewide performance quality improvement efforts.

Conclusions—Technical Assistance Activity for Performance Measures

Due to the technical assistance that HSAG provided to DHCS, MCPs, and SHPs during the review period:

- ◆ DHCS found HSAG's secondary review of PDSA cycles and CAPs helpful as it reinforced DHCS' findings and created synergy to provide optimal recommendations to MCPs.
- ◆ DHCS decided to eliminate the *Clinical Depression and Follow-Up Plan* measure and add the *Depression Screening and Follow-Up for Adolescents and Adults* measure to the RY 2018 EAS.
- ◆ DHCS gained a better understanding of HEDIS measures and the performance measure validation processes.

- ◆ DHCS established a new PDSA cycle process, including a revised PDSA Cycle Worksheet and instructions.
- ◆ DHCS gained a better understanding of various baseline calculation methods and their applicable uses in different PDSA-cycle scenarios.
- ◆ MCPs under CAPs became more proficient conducting PIPs using the rapid-cycle PIP process.
- ◆ DHCS enhanced its understanding of EQRO activities.

Recommendations—Technical Assistance Activity for Performance Measures

HSAG has no recommendations to DHCS related to technical assistance activity for performance measures.

Technical Assistance Activity for Quality Improvement Collaboration

Objective

Under the Technical Assistance Activity for Quality Improvement Collaboration, HSAG facilitated quarterly collaborative discussions with MCPs and SHPs for each DHCS-priority PIP topic. The purposes of the collaborative discussions were to provide the opportunity for MCPs and SHPs to discuss successes and challenges related to implementing rapid-cycle PIPs and other quality improvement strategies, and to share resources and evidence-based practices.

Methodology

With DHCS' input, HSAG determined the topic for each quarterly collaborative discussion based on MCPs' and SHPs' progression in the PIP process and other quality improvement activities related to the DHCS-priority PIP topics. HSAG identified potential focus areas through its review and validation of PIPs and conversations held with MCPs and SHPs during plan-specific technical assistance calls. In the initial collaborative discussions, HSAG requested that MCPs and SHPs share preferred topics for future discussions and administered a survey following the discussions to request the same information. Through joint planning meetings, HSAG and DHCS discussed potential topics for the collaborative discussions and the appropriate structure for the meetings based on the topics.

Once DHCS and HSAG selected topics, HSAG conducted four quarterly collaborative discussion sessions through webinars and conference calls—one for each of the four DHCS-priority PIP topics. All MCPs and SHPs were encouraged to participate in all four collaborative discussions each quarter; however, DHCS required MCPs and SHPs to participate in the applicable collaborative discussions:

- ◆ If the MCP/SHP selected the topic for either its DHCS-priority PIP or MCP-/SHP-specific PIP.
- ◆ If the topic was applicable to the MCP's/SHP's CAP PIP or any CAP PDSA cycles.

Additionally, DHCS strongly encouraged MCPs and SHPs to participate in the applicable collaborative discussions:

- ◆ If the topic was applicable to any of the MCP's/SHP's PDSA cycles.
- ◆ If the MCP's/SHP's performance related to the topic declined year over year.

After each collaborative discussion, HSAG provided meeting minutes for DHCS', MCPs', and SHPs' reference.

Results—Technical Assistance Activity for Quality Improvement Collaboration

HSAG and DHCS jointly facilitated four collaborative discussions during each quarter of the review period.

At the beginning of each collaborative discussion, DHCS provided an update on statewide efforts, partnerships, resources, and other pertinent information related to the collaborative discussion topic. Following DHCS' updates, HSAG facilitated topic-specific MCP/SHP presentations followed by an open discussion that provided the opportunity for MCPs and SHPs to share about successful quality improvement efforts as well as challenges and potential solutions related to the topic.

During the review period, HSAG and DHCS worked with the following MCPs and SHPs to present about their successful quality improvement efforts related to the listed topics:

- ◆ Diabetes
 - Alameda Alliance for Health
 - Anthem Blue Cross Partnership Plan
 - Contra Costa Health Plan
 - San Francisco Health Plan
 - Santa Clara Family Health Plan
- ◆ Hypertension
 - CalOptima
 - CalViva Health
 - Health Plan of San Mateo
 - Molina Healthcare of California Partnership Plan, Inc.
 - Partnership HealthPlan of California
- ◆ Immunizations of Two-Year-Olds
 - Central California Alliance for Health
 - Gold Coast Health Plan
 - L.A. Care Health Plan

- ◆ Postpartum Care
 - Anthem Blue Cross Partnership Plan
 - CenCal Health
 - Central California Alliance for Health
 - L.A. Care Health Plan
 - Molina Healthcare of California Partnership Plan, Inc.

Additionally, for one of the immunizations of two-year-olds collaborative discussions, DHCS and HSAG worked with staff members from the California Department of Public Health to present about the California Immunization Registry 2.

Immediately following each collaborative discussion, HSAG emailed an online survey link to participants for their anonymous feedback about the discussion and input for future discussions. Within 10 business days following each collaborative discussion, HSAG also distributed minutes by email to MCPs and SHPs and reminded collaborative discussion participants to complete the surveys. Based on information received, the survey respondents rated all collaborative discussions held during the review period “better than average.” Respondents also requested that future collaborative discussions include more specific information and dialogue on strategies and interventions for each topic.

Conclusions—Technical Assistance Activity for Quality Improvement Collaboration

MCPs and SHPs actively participated in the collaborative discussions by asking presenters questions and sharing about their own experiences, challenges, and lessons learned. The post-collaborative discussion surveys revealed that MCPs and SHPs found MCPs’/SHPs’ presentations and sharing of ideas, successes, and lessons learned helpful; and MCPs and SHPs requested that DHCS and HSAG incorporate the following into future collaborative discussions:

- ◆ Select MCP/SHP presenters who can share interventions with outcomes.
- ◆ Limit didactic sessions to allow more time to discuss successes and challenges of quality improvement efforts.
- ◆ Provide discussion materials/PowerPoint presentations ahead of time, if possible.

Recommendations—Technical Assistance Activity for Quality Improvement Collaboration

HSAG has no recommendations to DHCS related to technical assistance activity for quality improvement collaboration.

Technical Assistance Activity for ArcGIS Template Development

Under the Technical Assistance Activity for ArcGIS Template Development, HSAG provided technical assistance to DHCS through development of geographic information mapping reports to support DHCS' network monitoring activities. The key objective of this activity was to assist DHCS in developing and implementing reporting templates to augment existing network monitoring reports with relevant geographic information system (GIS) maps, as well as to develop reports that address new network monitoring requirements outlined in the managed care final rule (i.e., CFR 438.68, 438.206, and 438.207).

In collaboration with DHCS, HSAG developed the methodology for this technical assistance activity that involved the development of reporting templates using ArcGIS Desktop (ArcGIS) software³⁷ to address DHCS' network monitoring requirements. To maximize portability and future utility, the methodology for this technical assistance activity included four distinct stages:

- ◆ Gathering reporting requirements
- ◆ Developing network-monitoring input datasets
- ◆ Designing and developing ArcGIS reporting templates
- ◆ Implementing ArcGIS reporting templates and training

Although the technical assistance activity for ArcGIS template development began during the review period for this report, it was still ongoing at the time that this EQR technical report was produced. HSAG will include a summary of the aggregate results in the 2017–18 EQR technical report.

³⁷ ESRI 2017. ArcGIS Desktop: Release 10. Redlands, CA: Environmental Systems Research Institute.

10. Follow-Up on Prior Year’s Recommendations

As part of the process for producing the *2016–17 Medi-Cal Managed Care Technical Report*, DHCS provided the following information on the actions that DHCS took to address recommendations that HSAG made in the *2015–16 Medi-Cal Managed Care Technical Report*. Table 10.1 provides EQR recommendations from the *2015–16 Medi-Cal Managed Care Technical Report*, along with the DHCS’ self-reported actions taken through June 30, 2017, that address the EQR recommendations. Please note that HSAG made minimal edits to Table 10.1 to preserve the accuracy of DHCS’ self-reported actions.

Table 10.1—DHCS’ Self-Reported Follow-Up on External Quality Review Recommendations from the 2015–16 Medi-Cal Managed Care Technical Report

2015–16 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period July 1, 2016, through June 30, 2017, that Address the External Quality Review Recommendations
<p>1. When DHCS conducts its next annual review of performance measure results to determine whether or not DHCS should modify the priority areas or interventions included in the MCMC quality strategy, DHCS should:</p> <ul style="list-style-type: none"> a. Consider adding strategies related to ensuring that female beneficiaries ages 21 to 64 are screened for cervical cancer in the appropriate time frames. b. Consider adding improvement strategies not already included in the MCMC quality strategy and related to the following measures for which MCPs showed statistically significant declining performance from RY 2015 to RY 2016: <ul style="list-style-type: none"> i. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> ii. <i>Use of Imaging Studies for Low Back Pain</i> iii. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> 	<ul style="list-style-type: none"> a. <i>Cervical Cancer Screening</i> was considered as a possible addition as an MCMC quality strategy focus area. To enhance the ability to capture provided care, DHCS has increased data sharing with MCPs to include data on cervical cancer screenings that happened outside the MCP; however, the current data sharing capabilities do not capture provided care that may have occurred during the entire three to five year lookback period for this metric. DHCS will continue to assess the feasibility of enhanced data sharing to capture additional cervical cancer screenings that may have occurred and will consider the availability of this historical data while continuing to consider this metric as a focus area. b. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> was considered as a possible addition as an MCMC quality strategy focus area. Given the findings of one of the focus studies that suggested that quality improvement efforts targeting a single MCH topic may enhance MCPs’ performance on other MCH metrics, DHCS determined to continue to focus on an area with needed improvement, <i>Prenatal and Postpartum Care—Postpartum Care</i>, with the additional goal of seeing enhancements in performance on <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>. c. While the <i>Use of Imaging Studies for Low Back Pain</i> measure rates declined significantly, the NCQA made changes to the technical specifications for this measure and cautioned that interpretations of this measure should be considered with caution based on these changes. DHCS looks forward to assessing the impact of the technical specification changes as well as the relationship this metric may have to efforts to

2015–16 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period July 1, 2016, through June 30, 2017, that Address the External Quality Review Recommendations
	<p>reduce opioid misuse while continuing to consider this as an area for focus.</p> <p>d. DHCS will continue to consider the <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> measure as a possible new MCMC quality strategy focus area. Given the findings of one of the focus studies that suggested that quality improvement efforts targeting a related topic may enhance MCPs' performance on other metrics, we felt that continued focus on two related metrics may enhance performance on <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>.</p>
<p>2. DHCS should review the <i>2016 CAHPS CHIP Survey Summary Report</i> and <i>2016 CAHPS Medicaid Managed Care Survey Summary Report</i> for detailed results and recommendations. Based on the 2016 CHIP and Medicaid managed care CAHPS survey results, HSAG provides the following global recommendations for improvement:</p> <p>a. For survey areas showing the most opportunities for improvement, DHCS should consider conducting a barrier analysis or focus groups to identify appropriate interventions to implement.</p> <p>b. To improve beneficiary perceived experience, DHCS should consider selecting a beneficiary satisfaction measure(s) as a formal PIP.</p>	<p>Due to the low response rate, the sample size of the CAHPS survey results does not meet the required size for NCQA validity and does not allow for appropriate analysis and interpretation at a level of statistical significance. Additionally, limitations in survey frequency and language availability impact the ability to complete effective quality improvement work.</p> <p>DHCS is in the process of reviewing the CAHPS survey report to determine next steps to be taken based on statistically significant data. DHCS is closely monitoring grievance and State hearing data for beneficiaries' experience and is dedicated to health care quality improvement. DHCS awards MCPs for high health care quality performance and has launched several network adequacy projects to improve and ensure beneficiaries' access to health care services.</p>
<p>3. Review the detailed recommendations in the <i>SFY 2015–16 Encounter Data Validation Study Aggregate Report</i> to determine priority areas for action for improving encounter data quality for future medical record review activities.</p>	<p>We have reviewed recommendations from HSAG. We have incorporated some recommendations such as providing clarification on rendering provider reporting in our reporting standards. Other recommendations will be implemented in the future, as appropriate.</p>

2015–16 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period July 1, 2016, through June 30, 2017, that Address the External Quality Review Recommendations
<p>4. Thoroughly review HSAG’s recommendations from all focused studies, prioritize areas for action, and develop plans for taking action on the prioritized areas. Focused studies for which final reports were delivered were:</p> <ul style="list-style-type: none"> a. Clinical Focused Study b. Quality Improvement in Rural Communities Focused Study c. Validation of DHCS’ Methodology for Calculating Measures Focused Study 	<p>We have undertaken review of recommendations from HSAG and are prioritizing work with the recommendations from the focus studies in mind. Examples of additional work moving forward related to the focused studies recommendations include, but are not limited to, the health disparities report; the next round of PIP topics, including a health disparities PIP; and a new set of collaborative discussions on specified quality improvement topics, including health disparities.</p>
<p>5. Evaluate annually the focus of and need for the collaborative discussions based on any changes in DHCS-priority focus areas, MCPs’ and SHPs’ feedback, and MCP/SHP performance measure results.</p>	<p>This recommendation is operationalized, and this evaluation is done more frequently than annually.</p>
<p>6. Using the skills and lessons learned from the TA that HSAG conducted on-site with specified DHCS staff, develop a plan for spreading and expanding the use of quality improvement science tools and techniques to other existing DHCS projects, future DHCS projects, and new DHCS staff orientation sessions.</p>	<p>This recommendation is operationalized, both to spread the skills and lessons learned with DHCS staff, as well as with MCP staff.</p>

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix A:
Performance Evaluation Report
AIDS Healthcare Foundation
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care specialty health plan (SHP), AIDS Healthcare Foundation (“AHF” or “the SHP”). The purpose of this appendix is to provide SHP-specific results of each activity and an assessment of the SHP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this SHP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in AHF’s 2017–18 SHP-specific evaluation report. This SHP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all Medi-Cal full-scope managed care health plan (MCP)- and SHP-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Specialty Health Plan Overview

AHF is an SHP 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 SHP’s contract requirements are different from MCP contract requirements. AHF became operational in Los Angeles County to provide MCMC services effective April 1995. As of June 30, 2017, AHF had 681 beneficiaries.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Nov 6, 2017.

2. Specialty Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for AHF. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical Audit of AHF. A&I conducted the on-site audit from October 31, 2016, through November 10, 2016. Note that while DHCS issued the final audit report on August 29, 2017, and the final CAP closeout letter on October 20, 2017, which are outside the review period for this SHP-specific evaluation report, HSAG includes the audit results and status because A&I conducted the on-site audit during the review period for this report.

Table 2.1—DHCS A&I Medical Audit of AHF
Audit Review Period: October 1, 2015, through September 30, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	Yes	Closed.
Administrative and Organizational Capacity	Yes	Closed.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Utilization Management and Case Management and Coordination of Care categories during the October 31, 2016, through November 10, 2016, Medical Audit of AHF. Additionally, AHF’s responses to the SHP’s CAP for the deficiencies A&I identified during the audit resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

AHF has no outstanding deficiencies from the October 31, 2016, through November 10, 2016, A&I Medical Audit; therefore, HSAG has no recommendations for the SHP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for AIDS Healthcare Foundation* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that AHF followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the SHP’s performance measure rates, HSAG assessed the results. See Table 3.1 for AHF’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the SHP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Although AHF reported rates for the *Colorectal Cancer Screening* measure in prior years, due to specification changes that NCQA made to the *Colorectal Cancer Screening* measure in RY 2017, NCQA recommended a break in trending for this measure. Therefore, HSAG only displays the RY 2017 rate for the *Colorectal Cancer Screening* measure. While DHCS established a RY 2017 high performance level (HPL) and minimum performance level (MPL) for the *Colorectal Cancer Screening* measure, DHCS did not hold AHF accountable to meet the MPL for this measure in RY 2017 because the measure was considered a first-year measure in RY 2017.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

Table 3.1—Multi-Year Performance Measure Results*
AHF—Los Angeles County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Colorectal Cancer Screening</i> **	--	--	--	58.26%	Not Comparable
<i>Controlling High Blood Pressure</i> ***	61.07%	61.16%	66.67%	57.89%	-8.78

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

** The RY 2017 MPL and HPL for *Colorectal Cancer Screening* are based on the HEDIS 2016 national commercial HMO 25th and 90th percentiles, respectively, from NCQA's Quality Compass.

*** The RY 2016 and RY 2017 MPLs and HPLs for *Controlling High Blood Pressure* are based on the HEDIS 2015 and HEDIS 2016 national Medicaid HMO 25th and 90th percentiles, respectively, from NCQA's Quality Compass. The MPL and HPL for previous RYs are based on the corresponding HEDIS years' national Medicaid HMO 25th and 90th percentiles, respectively, from NCQA's HEDIS Audit Means, Percentiles, and Ratios.

-- Indicates that the rate is not available.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Performance Measure Findings

The *Colorectal Cancer Screening* measure was considered a first-year measure in RY 2017; therefore, HSAG provides no assessment of AHF's performance related to this measure.

The rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from RY 2016 to RY 2017 and was between the HPL and MPL in RY 2017.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, AHF was required to submit triannual quality improvement summaries to DHCS for the *Colorectal Cancer Screening* measure. AHF reported that the SHP initiated several quality improvement activities, including:

- ◆ Implemented an incentive program for beneficiaries who completed an immunochemical fecal occult blood test (iFOBT).
- ◆ Implemented an incentive program for beneficiaries who had colonoscopies conducted.
- ◆ Worked with a provider to put a contract in place for “contracted companion” support and transportation assistance to help beneficiaries complete testing requirements.

- ◆ Through targeted mailings and beneficiary and provider newsletters, conducted beneficiary and provider education about incentives and the need to be screened for colorectal cancer.

AHF reported that the SHP experienced and addressed multiple barriers with the active (versus passive) interventions.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, AHF will not be required to submit any improvement plan (IP)/Plan-Do-Study-Act (PDSA) cycles.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on AHF's RY 2017 performance measure results, HSAG has no recommendations for the SHP in the area of performance measures.

4. Performance Improvement Projects

AHF had one DHCS-priority performance improvement project (PIP) and one SHP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

AHF selected hypertension as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG reviewed and provided feedback to AHF on the revised Plan portion of the PDSA cycle for an intervention the SHP selected to test. HSAG sent periodic check-in email communications to AHF and conducted a technical assistance call with the SHP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

AHF set the SMART Aim for the *Hypertension* PIP as follows:

By June 30, 2017, increase from 61.16 percent to 70.00 percent the rate of controlled blood pressure among beneficiaries between the ages of 18 to 85 years and living with HIV/AIDS.

Failure Modes

The following, listed in priority order, are the failure modes that AHF identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not understand the blood pressure monitoring information provided by the provider.
- ◆ Beneficiary is not interested in understanding the blood pressure monitoring instructions provided.
- ◆ Provider does not give the beneficiary blood pressure monitoring instructions.
- ◆ Provider is not available to the beneficiary.
- ◆ Beneficiary records inaccurate blood pressure readings.
- ◆ Beneficiary does not have access to a blood pressure monitor.
- ◆ Provider does not offer convenient office hours.

Intervention Testing

During the reporting period, AHF selected to test a registered nurse care manager working directly with beneficiaries with blood pressure greater than 140/90 mm Hg to present risk factors, causes, preventions, lifestyle changes, and complications for hypertension. This intervention addresses the key driver of beneficiary engagement.

Although AHF completed testing the intervention through the SMART Aim end date of June 30, 2017, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in AHF's 2017–18 SHP-specific evaluation report.

SHP-Specific Performance Improvement Project

AHF selected viral load suppression as its SHP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated module 3 for AHF's SHP-specific PIP.

Upon initial review of the module, HSAG determined that AHF met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, AHF incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the SHP met all validation criteria for module 3.

During the reporting period, HSAG also reviewed and provided feedback to AHF on the Plan portion of the PDSA cycle for the intervention the SHP selected to test. HSAG sent periodic check-in email communications to AHF to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

AHF set the SMART Aim for the *Viral Load Suppression* PIP as follows:

By June 30, 2017, increase from 68 percent to 78 percent the percentage of beneficiaries whose viral load is fewer than 200 copies/mL (viral load suppression) among all active beneficiaries (regardless of age).

Failure Modes

The following, listed in priority order, are the failure modes that AHF identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not go to follow-up appointment.
- ◆ Beneficiary does not go to initial appointment.
- ◆ Beneficiary is not adherent with antiretroviral therapy.
- ◆ Beneficiary is unaware of his or her viral load status.
- ◆ Beneficiary does not understand what the provider explains.
- ◆ Beneficiary is not interested in understanding the instruction(s) provided.
- ◆ Provider does not provide the beneficiary with instructions.

Intervention Testing

During the reporting period, AHF selected to test registered nurse care managers calling to assist beneficiaries with appointment scheduling, specifically, directing beneficiaries to see primary care providers for medical assessment(s). This intervention addresses the beneficiary engagement key driver.

Although AHF completed testing the intervention through the SMART Aim end date of June 30, 2017, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in AHF's 2017–18 SHP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, AHF improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the SHP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 SHP-specific evaluation report. Table 5.1 provides EQR recommendations from AHF’s July 1, 2015, through June 30, 2016, SHP-specific evaluation report, along with the SHP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of AHF’s self-reported actions.

Table 5.1—AHF’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, SHP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to AHF	Self-Reported Actions Taken by AHF during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Identify the causes for the SHP’s performance below the MPL for the <i>Colorectal Cancer Screening</i> measure.	The SHP’s decrease in census during the measurement period caused the decrease in the <i>Colorectal Cancer Screening</i> rate. Because of the small denominator, every non-compliant member reduces the rate by approximately 3 percentage points rather than the approximate 0.5 percent rate it would be if the denominator was the normal sample size of 411. AHF instituted an iFOBT incentive in 2016 and is now offering a colonoscopy incentive in 2017 to improve and maintain <i>Colorectal Cancer Screening</i> rates.
2. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Hypertension PIP</i> .	AHF’s new quality improvement registered nurse manager called HSAG for consultation and set up a training session, which was completed on June 27, 2017.
3. Based on the SHP’s 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) ⁴ survey results, identify strategies that will ensure: <ol style="list-style-type: none"> Beneficiaries are satisfied with health care overall. Customer Service team members provide needed information to 	AHF hired a director of client experience to improve the member/patient experience across all product lines, including the Managed Care Division. In addition, the SHP developed a training curriculum around CAHPS and the SHP’s results. The SHP provided this training to all Managed Care Division and network primary care provider office staff members. Plan leadership discusses CAHPS regularly and identifies barriers to care and other concerns—the main one being mental health issues and substance abuse. Analysis revealed (2016 HEDIS; 2015 data) that more than 70 percent of the SHP’s population had a diagnosis for mental

⁴ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

2015–16 External Quality Review Recommendations Directed to AHF	Self-Reported Actions Taken by AHF during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>beneficiaries and treat beneficiaries with courtesy and respect.</p> <p>c. Beneficiaries are able to easily obtain care, tests, or treatment.</p> <p>d. Beneficiaries are able to easily see a specialist.</p> <p>e. Providers listen carefully to, show respect to, and spend adequate time with beneficiaries.</p>	<p>health and/or substance abuse. AHF’s case managers and Member Services Department agents continually discuss how to communicate competently with these patients since many demonstrate volatile behavior including yelling, swearing, and threats. Processes have been put in place for repeated threatening member behavior. Finally, small denominator syndrome affects CAHPS too, as described in the colorectal issues listed preceding.</p>

2016–17 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 has no recommendations for the SHP.

In the next annual review, HSAG will evaluate continued successes of AHF.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix B:
Performance Evaluation Report
Alameda Alliance for Health
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Alameda Alliance for Health (“AAH” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in AAH’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

AAH is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in AAH, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan (CP).

AAH became operational in Alameda County to provide MCMC services effective 1996. As of June 30, 2017, AAH had 262,318 beneficiaries.¹ This represents 80 percent of the beneficiaries enrolled in Alameda County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 15, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The Audits & Investigations Division (A&I) conducted on-site Medical and State Supported Services audits from June 27, 2016, through July 7, 2016, covering the review period of June 1, 2015, through May 31, 2016. Due to subsequent information received, DHCS expanded its review and conducted additional on-site reviews in intervals from February 7, 2017, through May 9, 2017. The initial audit review period of June 1, 2015, through May 31, 2016 was extended through May 31, 2017. At the time of this report, the final audit reports were pending and had not yet been issued to the MCP. HSAG will include the results of the audits in AAH’s 2017–18 MCP-specific evaluation report.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Alameda Alliance for Health* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that AAH followed the appropriate specifications to produce valid rates, and identified no issues of concern. The auditors noted that AAH made significant improvements to the MCP’s provider file from the previous audit year by implementing an electronic provider data validation process.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. See Table 3.1 for AAH’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’ *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
AAH—Alameda County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYS 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	67.40%	75.91%	66.42%	74.45%	8.03 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	94.34%	88.24%	92.61%	92.00%	-0.61
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	85.10%	81.44%	84.00%	84.40%	0.40
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	87.07%	84.77%	86.97%	87.19%	0.22
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	83.24%	81.65%	84.60%	84.75%	0.15
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	30.17%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	71.29%	57.42%	65.69%	79.56% ⁺	13.87 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	61.31%	48.42%	60.10%	74.70% ⁺	14.60 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	70.80%	71.53%	68.61%	73.13%	4.52
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	62.52%	Not Comparable
<i>Cervical Cancer Screening</i>	59.85%	53.53%	51.09%	60.34%	9.25 [^]
<i>Prenatal and Postpartum Care—Postpartum Care</i>	49.39%	55.47%	59.61%	67.15%	7.54 [^]
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	79.56%	66.67%	73.97%	84.43%	10.46 [^]
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.78%	83.12%	84.27%	86.06%	1.79 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.34%	81.67%	83.22%	85.14%	1.92 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.65%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.66%	40.39%	58.64%	61.56%	2.92

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	45.26%	46.23%	49.64%	55.23%	5.59
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.18%	41.85%	48.42%	50.12%	1.70
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	51.82%	51.09%	40.63%	37.96%	-2.67
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	81.75%	87.10%	83.21%	85.89%	2.68
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.05%	80.05%	88.08% ⁺	88.81%	0.73
<i>Controlling High Blood Pressure</i>	45.99%	43.07%	57.66%	65.21%	7.55 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	17.42%	16.44%	20.03%	16.00%	-4.03 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	29.28	35.88	60.05	46.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	240.12	275.87	286.41	253.95	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	40.90% ⁺	34.48%	32.80%	38.05%	5.25 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	16.04%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	88.58% ⁺	87.33% ⁺	83.45% ⁺	76.28%	-7.17 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of AAH's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

Within the Preventive Screening and Children's Health domain, the rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures improved significantly from RY 2016 to RY 2017, resulting in the rates for both measures being above the HPLs in RY 2017. The rate for the *Childhood Immunization Status—Combination 3* measure also improved significantly from RY 2016 to RY 2017. The actions that AAH reported during the review period to improve the MCP's performance on the *Childhood Immunization Status—Combination 3* measure (see Table 5.1) may have contributed to the significant improvement in the rate for this measure from RY 2016 to RY 2017.

Preventive Screening and Women's Health

The rates for all three measures within the Preventive Screening and Women's Health domain improved significantly from RY 2016 to RY 2017. The improvement for the *Cervical Cancer Screening and Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures resulted in the rates for these two measures moving from below the MPLs in RY 2016 to above the MPLs in RY 2017.

AAH provided information on actions that the MCP took during the review period to address the rates for the *Cervical Cancer Screening and Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures being below the MPLs in RY 2016. (See Table 5.1.) Additionally, under the "Assessment of Improvement Plans" heading in this section of the report, HSAG provides a summary of the PDSA

cycles that AAH conducted during the review period to improve the MCP's performance on the *Cervical Cancer Screening* measure. Finally, HSAG includes information on AAH's *Prenatal Visits* performance improvement project (PIP) in Section 4 of this report ("Performance Improvement Projects"). AAH's efforts may have contributed to the rates for the *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures improving from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Care for Chronic Conditions

The rates for the following measures within the Care for Chronic Conditions domain improved significantly from RY 2016 to RY 2017:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
 - The improvement for the *ACE Inhibitors or ARBs* measure resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.
 - Despite the significant improvement, the rate for the *Diuretics* measure remained below the MPL for the third consecutive year.
- ◆ *Controlling High Blood Pressure*

AAH provided information related to actions that the MCP took during the review period to address the MCP's performance below the MPLs in RY 2016 for both *Annual Monitoring for Patients on Persistent Medications* measures. (See Table 5.1.) Additionally, under the "Assessment of Improvement Plans" heading in this section of the report, HSAG provides a summary of the PDSA cycles that AAH conducted during the review period to improve the MCP's performance on these measures. AAH's efforts may have contributed to the rates for both measures improving significantly from RY 2016 to RY 2017.

Based on the performance measure results within the Care for Chronic Conditions domain, AAH has the opportunity to assess whether current improvement efforts should be modified or expanded, to ensure that beneficiaries 18 and older on diuretics receive annual monitoring.

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, the MCP performed between the HPLs and MPLs for the two measures for which DHCS held MCPs accountable to meet the MPLs in RY 2017.

The rates for the *All-Cause Readmissions* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measures improved significantly from RY 2016 to RY 2017.

The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. AAH has the opportunity to explore the causes for the MCP's decline in performance for this measure, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to AAH's performance.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, AAH was required to submit IP/PDSA cycles for the following measures:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Cervical Cancer Screening*

The rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Cervical Cancer Screening* measures improved from below the MPLs in RY 2016 to above the MPLs in RY 2017. The rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure remained below the MPL in RY 2017.

Annual Monitoring for Patients on Persistent Medications

For both *Annual Monitoring for Patients on Persistent Medications* measures, AAH conducted two PDSA cycles. For the first PDSA cycle, AAH set SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objectives to reduce from baseline, by 15 percentage points, the number of eligible beneficiaries without lab monitoring at a designated wellness center. The MCP tested whether or not conducting telephone outreach would improve lab testing compliance for beneficiaries receiving angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), and diuretics treatments. AAH and the designated wellness center worked together to confirm the list of beneficiaries needing lab testing, and AAH used this list to contact eligible beneficiaries to coordinate them receiving pre-ordered lab tests from the provider. The outreach targeted beneficiaries with hypertension who met the following criteria:

- ◆ Age 18 or older.
- ◆ Prescribed ACE inhibitors, ARBs, and diuretics for at least 180 days.
- ◆ No annual lab monitoring event documented in the medical record.
- ◆ No appointment scheduled with primary care provider (PCP).

Following intervention testing, AAH reported that it met the SMART objectives and that the MCP decided to adopt the intervention.

For the second PDSA cycle, the MCP expanded the same intervention to two new providers. As with the first PDSA cycle, the MCP set SMART objectives to reduce from baseline, by 15 percentage points, the number of eligible beneficiaries without lab monitoring. AAH reported that it met the SMART objectives and that the MCP decided to adopt the intervention.

AAH reported on lessons learned through the PDSA cycle process, including:

- ◆ Sharing responsibilities with the providers improved the success of the intervention.
- ◆ Conducting outreach at various times of the day improved the chances of reaching more beneficiaries.

- ◆ Requesting updated beneficiary contact information from beneficiaries' pharmacies when the information that the MCP and provider had was no longer accurate helped AAH to reach more beneficiaries.
- ◆ Duplicating the intervention for other conditions that require lab monitoring may lead to similar results.

Cervical Cancer Screening

AAH conducted two PDSA cycles to improve the MCP's performance on the *Cervical Cancer Screening* measure. The following is a summary of the PDSA cycles.

Plan-Do-Study-Act Cycle 1

AAH set the following SMART objective for the first PDSA cycle:

By December 31, 2016, increase the timely cervical cancer screening rate from 22.37 percent to 42.11 percent among female beneficiaries (ages 21 to 64) at a designated health center, by conducting targeted telephone outreach to 118 beneficiaries.

AAH tested whether or not targeted telephone outreach using an outreach tracker collection tool would improve the timely cervical cancer screening for beneficiaries identified as being overdue for their cervical cancer screenings at the designated health center.

AAH reported that it did not meet the SMART objective and that the MCP decided to adapt the intervention. AAH noted that the contact information was more reliable for beneficiaries with established relationships with the health center and that these beneficiaries were more likely to follow their providers' recommendations.

Plan-Do-Study-Act Cycle 2

AAH set the following SMART objective for the second PDSA cycle:

By April 30, 2017, increase the timely cervical cancer screening rate from 34.27 percent to 43.00 percent among female beneficiaries (ages 21 to 64) who are assigned to and have been seen at a designated health center, by conducting targeted telephone outreach to 36 beneficiaries.

AAH partnered with the same health center as during the first PDSA cycle and adjusted the intervention to only conduct outreach with beneficiaries currently assigned to and previously seen by the designated health center. The MCP also collected additional data elements, including beneficiary demographics, language preference, call attempts, scheduled appointments, and dates of completed tests.

AAH reported that the MCP met the SMART objective and that the MCP decided to adopt the intervention. AAH also reported on the following lessons learned:

- ◆ Assessing provider resources prior to initiating an intervention was helpful for mobilizing additional support such as educating the provider staff members on how to link beneficiaries to AAH resources.

- ◆ Validating beneficiary contact information prior to conducting outreach calls led to greater success of the outreach efforts.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, DHCS will require AAH to submit quality improvement summaries indicating strategies and efforts for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for AAH—Alameda County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.24%	13.18%	6.06^^	16.00%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	84.58	41.83	Not Tested	46.02
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	480.14	229.36	Not Tested	253.95
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.70%	84.95%	2.75^	85.98%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.57%	83.39%	4.18^	84.99%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.37%	91.93%	5.44	92.00%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.94%	84.27%	5.67^	84.40%

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.2.

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.81%	87.12%	1.69	87.19%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.38%	84.77%	-0.39	84.75%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
AAH—Alameda County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	19.54%	19.60%	25.11%	19.24%	-5.87 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	53.35	59.71	150.09	84.58	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	387.05	422.12	507.83	480.14	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.69%	85.09%	87.44%	87.70%	0.26
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.18%	84.74%	86.89%	87.57%	0.68
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	100.00%	90.91%	NA	97.37%	Not Comparable

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.01%	84.62%	92.52%	89.94%	-2.58
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.57%	84.47%	93.82%	88.81%	-5.01^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.65%	77.91%	86.62%	84.38%	-2.24

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
AAH—Alameda County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	13.64%	13.50%	15.00%	13.18%	-1.82 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	24.72	32.31	51.93	41.83	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	212.26	253.99	266.44	229.36	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.91%	81.83%	82.44%	84.95%	2.51 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.90%	79.71%	81.06%	83.39%	2.33 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.25%	88.22%	92.55%	91.93%	-0.62
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.07%	81.35%	83.85%	84.27%	0.42
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.03%	84.78%	86.75%	87.12%	0.37
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.59%	81.92%	84.53%	84.77%	0.24

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that AAH stratified by the SPD and non-SPD populations:

- ◆ The SPD rate for the *All-Cause Readmissions* measure improved significantly from RY 2016 to RY 2017.
- ◆ The non-SPD rates for the following measures improved significantly from RY 2016 to RY 2017:
 - *All-Cause Readmissions*
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ The SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* measure declined significantly from RY 2016 to RY 2017.
- ◆ The RY 2017 SPD rate was significantly better than the RY 2017 non-SPD rate for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ The RY 2017 SPD rate was significantly worse than the RY 2017 non-SPD rate for the *All-Cause Readmissions* measure; however, 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 beneficiaries.

Strengths—Performance Measures

HSAG auditors determined that AAH followed the appropriate specifications to produce valid rates, and identified no issues of concern. The auditors noted that AAH made significant improvements to the MCP's provider file from the previous audit year by implementing an electronic provider data validation process.

The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures were above the HPLs in RY 2017. Across all domains, the rates for 11 of 19 measures for which a comparison could be made between RY 2016 and RY 2017 (58 percent) improved significantly from RY 2016 to RY 2017. Three of the four rates that were below the MPLs in RY 2016 (75 percent) improved to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

AAH has the opportunity to assess whether current improvement efforts need to be modified or expanded to ensure that beneficiaries 18 and older on diuretics receive annual monitoring. The MCP also has the opportunity to explore the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

AAH had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

AAH selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG also reviewed and provided feedback to AAH on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to AAH and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

AAH set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, increase among African-American women, from 38.19 percent to 45.19 percent, the administrative rate of postpartum visits that occur between 21 and 56 days' post-delivery.

Failure Modes

The following, listed in priority order, are the failure modes that AAH identified during the Intervention Determination phase of the PIP process:

- ◆ Obstetrician and gynecologist (OB/GYN) do not prioritize to achieve timely postpartum visit beneficiary compliance.
- ◆ Inadequate education provided to beneficiaries about postpartum care importance.
- ◆ OB/GYN does not have a registry to prompt postpartum visit scheduling.
- ◆ Beneficiary does not have transportation to keep appointment.
- ◆ OB/GYN office does not effectively schedule and track postpartum visit appointments.
- ◆ OB/GYN unable to reach beneficiary.
- ◆ Beneficiary has no childcare, resulting in her inability to keep postpartum-visit appointment.

Intervention Testing

During the reporting period, AAH selected to test having the obstetric case management program provide support to African-American female beneficiaries for attending their postpartum visits between 21 to 56 days after delivery. This intervention addresses the following barriers:

- ◆ Beneficiaries' lack of understanding of the need and importance of timely postpartum care
- ◆ Lack of transportation
- ◆ Complex health care system
- ◆ Lack of support systems for beneficiaries

Although AAH completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in AAH's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

AAH selected prenatal visits as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for AAH's MCP-specific PIP.

Upon initial review of the module, HSAG determined that AAH met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis (FMEA).
- ◆ Describing the priority-ranking process to determine potential interventions.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, AAH incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to AAH on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to AAH and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

AAH set the SMART Aim for the *Prenatal Visits* PIP as follows:

By June 30, 2017, increase among African-American women, from 43.24 percent to 49.24 percent, the administrative rate of prenatal visits that occur within the first trimester or 42 days of enrollment.

Failure Modes

The following, listed in priority order, are the failure modes that AAH identified during the Intervention Determination phase of the PIP process:

- ◆ Provider does not inform the MCP of newly pregnant beneficiaries.
- ◆ Provider does not prioritize scheduling timely prenatal visits.
- ◆ Beneficiary is not provided with assistance to access prenatal care benefits.
- ◆ PCP does not assist beneficiaries with establishing prenatal care.
- ◆ Beneficiary is unfamiliar with prenatal care benefits and services.
- ◆ Beneficiary is mailed prenatal resource information with no follow-up occurring after the mailing.
- ◆ Beneficiary is unaware of the risks of delaying prenatal care.
- ◆ Beneficiary does not prioritize the need for the visit.
- ◆ Beneficiary is unaware of pregnancy until second or third trimester.

Intervention Testing

During the reporting period, AAH selected to test the obstetrics case management program for African-American female beneficiaries attending their initial prenatal visits within the first trimester (for existing beneficiaries) or within 42 days of enrollment in AAH (for new beneficiaries). This intervention addresses the following barriers:

- ◆ Beneficiaries' lack of understanding of the need and importance of timely prenatal care
- ◆ Lack of transportation
- ◆ Complex health care system
- ◆ Lack of support systems for beneficiaries
- ◆ Beneficiaries not provided assistance to identify and access prenatal care
- ◆ PCP not assisting beneficiaries to establish prenatal care

Although AAH completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in AAH's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG’s PIP validation and technical assistance, AAH improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

Based on AAH’s PIP progression, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from AAH’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of AAH’s self-reported actions.

Table 5.1—AAH’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure oversight of HEDIS vendors to ensure that timelines are met and accurate data are available as needed.	In early fall of 2016, AAH opened the HEDIS certified software and HEDIS retrieval and abstraction request for proposal process for selecting a competitive and experienced vendor. In November 2016, a single-source vendor was selected by AAH. In December 2016, AAH assigned an internal senior project manager to track the HEDIS project. Weekly communication meetings with the HEDIS vendor and AAH were held to ensure ongoing oversight of the project and to follow trends in hybrid measure rate progress very closely. AAH identified critical stages during the hybrid pursuit, which resulted in the AAH team intervening directly during these periods to increase the vendor’s retrieval efforts. AAH identified the critical sites, leveraged relationships, and actively engaged with these sites to successfully procure the records. AAH ultimately chased approximately 50 percent of the retrieval project directly during these critical stages. Overall, AAH successfully retrieved more than 95 percent of the records identified.
2. Formalize and document new HEDIS-related procedures to ensure consistency in training for new staff.	AAH created medical record retrieval training manuals and on-site checklists for staff members conducting the retrieval to ensure consistency in training. AAH coordinated scheduling efforts with other MCPs at large-volume sites. AAH also identified new supplemental data sources and created tracking tools for the ROADMAP deliverables. AAH created checklists for key audit deliverables and a master contact list for provider medical record outreach.

2015–16 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>3. Assess whether or not changes are needed in the MCP’s current improvement strategies related to the following measures:</p> <ul style="list-style-type: none"> a. <i>All-Cause Readmissions</i>—specifically related to the SPD population b. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> c. <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> d. <i>Cervical Cancer Screening</i> e. <i>Childhood Immunization Status—Combination 3</i> f. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> 	<p>AAH adopted a number of strategies to improve HEDIS rates overall. AAH identified additional supplemental data sources, implemented best practice chase logic, expanded chase logic, improved vendor oversight, and created training materials for medical record retrievers.</p> <p>AAH performed data validation on both test and production data and drilled in to provider and visit data tables to identify potential data gaps. These practices are memorialized in written communications and will be adopted year over year.</p> <p>AAH also implemented targeted improvements using small tests of change following the FOCUS (SMART Aim) PDSA methodology.</p> <p>A. AAH’s SPD <i>All-Cause Readmissions</i> rate was 10 percent higher than the non-SPD population for RY 2016. In RY 2017 the difference between SPD and non-SPD is less extreme. The readmissions rate for SPD members ages 18 to 64 is 4 percentage points higher than the Medi-Cal population overall. The Transitions of Care program is successfully linking members to post-hospitalization care. AAH is evaluating enhancements to the Transitions of Care program.</p> <p>B & C. AAH will adopt and expand its performance improvement interventions for <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> and <i>Diuretics</i>. AAH realized significant gains in its screening rates based on this intervention.</p> <p>D. AAH’s cervical cancer intervention very successfully closed the barriers to care identified in the initial analysis. The target was not met with this health center, but overall rates are improving. Through this intervention, AAH very successfully improved health center preventive screening as well as health center staff members’ knowledge of the linguistic services and transportation benefits.</p> <p>E. AAH improved California Immunization Registry (CAIR) data capture during RY 2017. Large delegate encounter data validation checks continue to be performed by AAH. Therefore, AAH expects to continue improvements in this area.</p> <p>F. AAH’s Obstetric Case Management program is designed to facilitate access to care for pregnant members. It is fully operationalized and will continue until further notice. Overall timeliness with prenatal care increased 9.7 percentage points, and postpartum care timeliness improved 7.7 percentage points in RY 2017. The case management program has served 179 members to date. Thirty-two members were surveyed for specific process and outcome measures identified in the intervention planning phase. The data is under evaluation and will be submitted in August 2017.</p>

2016–17 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:

- ◆ Assess whether current improvement efforts for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure need to be modified or expanded to ensure that beneficiaries 18 and older on diuretics receive annual monitoring.
- ◆ Explore the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017. Identifying the causes will help AAH to develop strategies, as applicable, to address the MCP’s declining performance for this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix C:
Performance Evaluation Report
Anthem Blue Cross Partnership Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Anthem Blue Cross Partnership Plan (“Anthem” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Anthem’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Anthem, formerly Blue Cross of California prior to April 1, 2008, operated in 28 counties during the July 1, 2016, through June 30, 2017, review period for this report. Anthem, a full-scope MCP, delivers care to beneficiaries under the Two-Plan Model (TPM) 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 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 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 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’s Two-Plan Model

Anthem delivers services to beneficiaries as a “Local Initiative” (LI) MCP and commercial plan (CP) under the TPM. Table 1.1 shows the counties in which Anthem provided services to beneficiaries under the TPM and denotes for each county which MCP is the CP and which is the LI.

Table 1.1—Anthem Counties Under the Two-Plan Model

County	Commercial Plan	Local Initiative Plan
Alameda	Anthem	Alameda Alliance for Health
Contra Costa	Anthem	Contra Costa Health Plan
Fresno	Anthem	CalViva Health
Kings	Anthem	CalViva Health
Madera	Anthem	CalViva Health
San Francisco	Anthem	San Francisco Health Plan
Santa Clara	Anthem	Santa Clara Family Health Plan
Tulare	Health Net Community Solutions, Inc.	Anthem

Anthem’s Geographic Managed Care 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). Anthem operates in Sacramento County under the GMC model.

In addition to Anthem, Sacramento County’s beneficiaries may select from the following MCPs:

- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser NorCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

Anthem’s Regional Model

Anthem delivers services to its beneficiaries 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 or in the alternative CP in the respective counties.

Anthem's Enrollment

Table 1.2 shows the number of beneficiaries for Anthem for each county, the percentage of Anthem's beneficiaries enrolled in the county, and the MCP's total number of beneficiaries as of June 30, 2017.¹

Table 1.2—Anthem Enrollment as of June 30, 2017

County	Anthem Enrollment as of June 30, 2017	Percentage of Anthem Beneficiaries Enrolled in the County
Alameda	63,598	20%
Alpine	139	57%
Amador	5,392	83%
Butte	31,126	47%
Calaveras	3,740	39%
Colusa	4,742	66%
Contra Costa	28,204	13%
El Dorado	8,957	29%
Fresno	112,448	27%
Glenn	4,066	41%
Inyo	1,930	51%
Kings	20,027	43%
Madera	19,254	35%
Mariposa	2,869	77%
Mono	1,702	63%
Nevada	12,511	62%
Placer	30,804	66%
Plumas	2,671	53%
Sacramento	181,661	41%
San Benito	8,196	100%
San Francisco	20,307	13%
Santa Clara	76,068	22%
Sierra	385	64%
Sutter	22,671	68%
Tehama	9,601	47%
Tulare	95,222	46%
Tuolumne	5,057	47%
Yuba	16,618	65%
Total	789,966	

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Oct 31, 2017.

DHCS allows Anthem to combine data from multiple counties to make up single reporting units for 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

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Anthem. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Anthem. A&I conducted the on-site audits from October 31, 2016, through November 10, 2016. Note that while DHCS issued the final closeout letter on August 17, 2017, which is outside the review period for this MCP-specific evaluation report, HSAG includes the audit status information from this letter 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 Anthem
 Audit Review Period: October 1, 2015, through September 30, 2016**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	Yes	Closed.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Table 2.2 summarizes the results and status of the Department of Managed Health Care (DMHC) Seniors and Persons with Disabilities (SPD) Medical Survey of Anthem. DMHC conducted the on-site survey from October 31, 2016, through November 4, 2016.

Table 2.2—DMHC SPD Medical Survey of Anthem
Survey Review Period: October 1, 2015, through September 30, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Continuity of Care	No	Not applicable.
Availability and Accessibility	Yes	CAP in process and under review by DHCS.
Member Rights	Yes	MCP to submit to DHCS documented evidence of full remediation of identified issues in the area of Grievances and Appeals.
Quality Management	Yes	CAP in process and under review by DHCS.

Follow-Up on November 2015 Medical Audit

A&I conducted a Medical Audit of Anthem from November 2, 2015, through November 13, 2015, covering the review period of November 1, 2014, through October 31, 2015. HSAG provided a summary of the survey results and status in Anthem’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, Anthem’s CAP was in process and under review by DHCS. A letter from DHCS dated June 15, 2017, stated that Anthem provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Utilization Management, Access and Availability of Care, Member’s Rights, Quality Management, Administrative and Organizational Capacity, and State Supported Services categories during the October 31, 2016, through November 10, 2016, Medical and State Supported Services Audits of Anthem. DMHC identified no deficiencies in the Utilization Management and Continuity of Care categories during the October 31, 2016, through November 4, 2016, SPD Medical Survey of Anthem. The MCP fully resolved all deficiencies from the 2015 and 2016 Medical Audits.

Opportunities for Improvement—Compliance Reviews

Anthem has the opportunity to work with DHCS to ensure that the MCP resolves all deficiencies from the October 31, 2016, through November 4, 2016, SPD Medical Survey, particularly in the area of Grievances and Appeals within the Member Rights category.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Anthem Blue Cross Partnership Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that Anthem followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.12 for Anthem's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.12:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Anthem—Alameda County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	71.30%	71.00%	66.67%	69.68%	3.01
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	85.16%	87.06%	88.48%	86.91%	-1.57
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	77.82%	82.88%	78.86%	78.08%	-0.78
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	78.58%	84.49%	84.58%	82.66%	-1.92^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	75.18%	80.02%	80.25%	77.34%	-2.91^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	22.22%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	47.33%	61.81%	59.95%	71.99%	12.04^
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	40.84%	49.77%	53.01%	63.89%	10.88^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	65.51%	72.41%	66.44%	69.44%	3.00
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	51.34%	Not Comparable
<i>Cervical Cancer Screening</i>	49.18%	56.88%	43.46%	50.58%	7.12^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	50.23%	50.46%	52.56%	57.08%	4.52
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	73.95%	77.08%	75.81%	76.10%	0.29
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.73%	84.87%	85.78%	86.62%	0.84
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.81%	82.88%	84.01%	85.64%	1.63
<i>Asthma Medication Ratio—Total</i>	--	--	--	53.78%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	38.41%	45.58%	47.92%	58.33%	10.41^
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	35.10%	39.53%	47.69%	51.16%	3.47

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	26.05%	40.93%	50.69%	53.94%	3.25
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	67.55%	50.23%	42.13%	35.65%	-6.48
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	75.94%	83.02%	84.26%	85.65%	1.39
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	73.95%	77.67%	84.49%	86.34%	1.85
<i>Controlling High Blood Pressure</i>	34.15%	42.42%	51.28%	52.67%	1.39
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	18.16%	23.31%	17.60%	16.97%	-0.63
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	67.55	61.74	51.37	48.13	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	212.17	191.03	170.67	175.42	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	33.83%	32.65%	41.32% ⁺	49.04% ⁺	7.72
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	88.04% ⁺	84.68% ⁺	82.19%	81.87% ⁺	-0.32

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
Anthem—Contra Costa County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	75.46%	68.29%	67.99%	64.94%	-3.05
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.12%	93.77%	90.76%	89.37%	-1.39
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.44%	85.36%	83.81%	82.28%	-1.53
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	88.29%	88.50%	87.58%	85.82%	-1.76
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	84.96%	87.31%	83.87%	81.82%	-2.05^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	21.06%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	55.09%	55.79%	56.94%	71.76%	14.82^
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	47.92%	46.99%	51.62%	65.74%	14.12^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	75.83%	66.87%	67.13%	71.99%	4.86
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	42.98%	Not Comparable
<i>Cervical Cancer Screening</i>	53.94%	48.38%	41.07%	43.49%	2.42
<i>Prenatal and Postpartum Care—Postpartum Care</i>	44.26%	43.70%	49.13%	56.62%	7.49
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	72.95%	72.27%	82.08%	79.45%	-2.63
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.33%	80.22%	85.25%	84.88%	-0.37
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	75.90%	81.74%	85.07%	80.00%	-5.07
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.74%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	46.13%	52.30%	58.00%	56.25%	-1.75
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	37.64%	45.94%	47.33%	47.92%	0.59

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	36.16%	46.64%	49.88%	53.70%	3.82
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	56.83%	42.40%	39.44%	38.43%	-1.01
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	75.28%	81.27%	80.51%	84.26%	3.75
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	78.60%	79.15%	84.45%	88.19%	3.74
<i>Controlling High Blood Pressure</i>	43.88%	49.71%	51.85%	53.72%	1.87
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	17.30%	16.77%	14.26%	16.01%	1.75
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	62.60	59.90	49.15	44.93	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	234.67	201.00	167.21	169.14	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	42.42% ⁺	NA	53.66% ⁺	62.03% ⁺	8.37
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	S ⁺	S ⁺	80.84%	82.77% ⁺	1.93

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.3—Multi-Year Performance Measure Results*
Anthem—Fresno County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	67.36%	67.82%	68.52%	70.11%	1.59
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	93.76%	92.76%	93.71%	92.70%	-1.01
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	83.38%	86.16%	84.73%	84.44%	-0.29
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	83.51%	85.49%	86.11%	84.71%	-1.40^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	79.14%	83.00%	82.31%	80.37%	-1.94^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	26.16%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	59.86%	59.26%	67.36%	69.66%	2.30
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	49.65%	46.30%	61.57%	64.81%	3.24
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	79.63%	76.62%	70.60%	72.68%	2.08
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	45.16%	Not Comparable
<i>Cervical Cancer Screening</i>	50.93%	52.79%	46.17%	49.42%	3.25
<i>Prenatal and Postpartum Care—Postpartum Care</i>	52.90%	56.74%	51.87%	61.34%	9.47^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	74.94%	76.98%	68.46%	78.47%	10.01^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.80%	83.15%	83.34%	85.84%	2.50^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.63%	84.60%	84.35%	85.76%	1.41
<i>Asthma Medication Ratio—Total</i>	--	--	--	55.91%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	52.44%	54.17%	58.33%	62.27%	3.94
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.89%	39.58%	47.45%	53.70%	6.25

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	36.22%	42.13%	47.22%	45.60%	-1.62
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	50.00%	51.39%	44.91%	44.21%	-0.70
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	79.33%	83.10%	84.03%	86.11%	2.08
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.22%	81.02%	89.81% ⁺	90.28%	0.47
<i>Controlling High Blood Pressure</i>	53.32%	50.47%	51.28%	52.68%	1.40
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	14.38%	21.30%	18.51%	13.26%	-5.25 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	48.83	50.04	49.25	46.66	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	236.16	232.63	221.60	221.41	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	33.76%	34.20%	35.19%	36.58%	1.39
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	82.85% ⁺	80.13%	78.42%	74.91%	-3.51

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Performance Measure Results*
Anthem—Kings County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	68.51%	66.31%	68.75%	70.90%	2.15
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	94.74%	94.85%	93.92%	91.55%	-2.37
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	83.25%	86.59%	87.25%	84.77%	-2.48^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	84.78%	83.98%	85.42%	86.22%	0.80
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	84.64%	85.98%	84.75%	85.81%	1.06
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	18.98%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	43.29%	56.25%	58.10%	65.89%	7.79^
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	38.66%	36.34%	47.22%	58.70%	11.48^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	65.05%	70.60%	65.85%	72.22%	6.37
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	48.32%	Not Comparable
<i>Cervical Cancer Screening</i>	56.05%	49.76%	46.40%	49.42%	3.02
<i>Prenatal and Postpartum Care—Postpartum Care</i>	45.70%	45.41%	52.13%	52.63%	0.50
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	80.08%	76.53%	81.56%	78.95%	-2.61
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.64%	81.16%	85.33%	86.01%	0.68
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	77.36%	78.92%	83.44%	85.67%	2.23
<i>Asthma Medication Ratio—Total</i>	--	--	--	55.69%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	54.39%	56.39%	62.96%	61.81%	-1.15
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	40.35%	37.05%	57.87%	53.94%	-3.93

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	25.73%	34.75%	44.44%	45.83%	1.39
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	64.91%	57.05%	41.90%	42.82%	0.92
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	72.51%	74.43%	85.42%	85.65%	0.23
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	77.19%	81.97%	90.74% ⁺	91.44%	0.70
<i>Controlling High Blood Pressure</i>	43.30%	49.65%	53.95%	57.08%	3.13
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	8.43%	15.63%	13.78%	11.85%	-1.93
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	68.06	64.22	58.42	56.54	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	320.37	280.75	267.79	271.12	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	32.69%	31.82%	29.79%	44.57% ⁺	14.78 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	84.30% ⁺	76.92%	75.68%	81.73% ⁺	6.05

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.5—Multi-Year Performance Measure Results*
Anthem—Madera County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	63.78%	69.38%	76.88%	72.27%	-4.61
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	98.47%	95.07%	97.08%	97.40%	0.32
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	90.94%	92.14%	93.10%⁺	91.91%	-1.19
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	90.80%	90.49%	92.61%	93.12%	0.51
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	88.72%	90.07%	89.30%	88.84%	-0.46
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	42.59%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	61.81%	82.83%⁺	78.01%	81.69%⁺	3.68
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	52.55%	69.84%⁺	70.60%	75.96%⁺	5.36
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	86.81%⁺	85.19%⁺	83.48%	84.26%⁺	0.78
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	54.47%	Not Comparable
<i>Cervical Cancer Screening</i>	60.19%	61.31%	50.47%	53.83%	3.36
<i>Prenatal and Postpartum Care—Postpartum Care</i>	59.89%	57.37%	52.16%	60.47%	8.31
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	77.47%	79.47%	71.98%	75.58%	3.60
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.36%	82.02%	82.19%	83.49%	1.30
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.64%	83.33%	79.61%	85.67%	6.06
<i>Asthma Medication Ratio—Total</i>	--	--	--	67.31%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	61.09%	62.68%	61.11%	71.30%	10.19 [^]
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	54.91%	54.35%	56.02%	62.96%	6.94 [^]

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	43.27%	42.39%	44.68%	50.93%	6.25
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	47.64%	51.81%	45.83%	37.04%	-8.79^
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	84.36%	84.06%	88.43%	88.19%	-0.24
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.73%	84.78%	90.97% ⁺	90.97%	0.00
<i>Controlling High Blood Pressure</i>	53.36%	50.71%	52.91%	54.40%	1.49
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	8.63%	21.98%	15.24%	12.42%	-2.82
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	58.44	56.13	50.58	49.89	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	293.80	288.72	287.61	267.76	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	20.00%	6.35%	13.01%	10.95%	-2.06
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	83.54% ⁺	81.91%	75.31%	80.45%	5.14

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.6—Multi-Year Performance Measure Results*
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	67.04%	67.82%	71.95%	4.13
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	96.82%	96.56%	96.13%	-0.43
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	87.27%	88.89%	88.34%	-0.55
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	92.54%	88.58%	89.13%	0.55
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	95.74% ⁺	86.28%	86.32%	0.04
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	18.29%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	46.99%	45.14%	55.32%	10.18 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	31.71%	38.19%	53.47%	15.28 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	64.35%	64.91%	68.75%	3.84
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	49.65%	Not Comparable
<i>Cervical Cancer Screening</i>	--	39.86%	43.16%	49.16%	6.00
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	64.12%	67.98%	70.65%	2.67
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	82.87%	85.15%	87.01%	1.86
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	84.36%	86.15%	85.92%	-0.23
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	86.83%	87.08%	85.92%	-1.16
<i>Asthma Medication Ratio—Total</i>	--	--	--	57.25%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	63.74%	64.35%	67.05%	2.70
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	41.76%	44.21%	51.97%	7.76 [^]

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	39.84%	49.07%	54.29%	5.22
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	50.55%	42.13%	35.50%	-6.63^
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	86.54%	84.95%	81.44%	-3.51
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	76.10%	85.42%	85.15%	-0.27
<i>Controlling High Blood Pressure</i>	--	50.93%	60.32%	60.37%	0.05
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	11.04%	15.08%	17.06%	1.98
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	46.39	50.01	49.10	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	292.88	327.81	310.92	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	20.00%	21.39%	17.85%	-3.54
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	73.46%	74.19%	74.77%	0.58

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.7—Multi-Year Performance Measure Results*
**Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo,
 Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)**

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	50.82%	56.94%	65.05%	8.11 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	93.56%	92.37%	92.22%	-0.15
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	82.95%	83.55%	81.52%	-2.03^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	92.77%	83.19%	83.11%	-0.08
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	93.40%	83.35%	81.67%	-1.68^{^^}
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	20.37%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	45.14%	51.85%	61.34%	9.49 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	35.42%	44.91%	59.72%	14.81 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	58.93%	62.50%	65.51%	3.01
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	49.20%	Not Comparable
<i>Cervical Cancer Screening</i>	--	48.24%	47.78%	55.37%	7.59 [^]
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	59.63%	59.44%	67.94%	8.50 [^]
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	85.15%	83.45%	83.73%	0.28
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	77.42%	81.21%	83.27%	2.06
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	80.41%	83.28%	82.66%	-0.62
<i>Asthma Medication Ratio—Total</i>	--	--	--	55.24%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	63.41%	64.35%	62.73%	-1.62
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	36.28%	41.90%	46.30%	4.40

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	39.43%	49.07%	50.69%	1.62
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	50.79%	39.81%	38.89%	-0.92
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	83.60%	82.41%	82.87%	0.46
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	73.19%	86.81%	87.96%	1.15
<i>Controlling High Blood Pressure</i>	--	44.65%	52.67%	55.09%	2.42
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	8.39%	12.03%	13.00%	0.97
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	54.21	52.86	52.53	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	212.47	230.38	231.95	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	22.50%	33.67%	33.43%	-0.24
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.03%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	74.30%	75.92%	73.39%	-2.53

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.8—Multi-Year Performance Measure Results*
Anthem—Sacramento County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	58.80%	66.20%	62.04%	66.67%	4.63
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	94.03%	92.27%	91.18%	91.24%	0.06
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	81.58%	81.66%	81.28%	79.09%	-2.19^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	80.92%	83.49%	84.32%	82.57%	-1.75^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	78.14%	80.93%	80.44%	79.32%	-1.12^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	23.38%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	63.43%	62.96%	67.59%	72.92%	5.33
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	47.45%	49.54%	53.24%	64.12%	10.88^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	70.83%	67.21%	65.97%	71.53%	5.56
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	54.54%	Not Comparable
<i>Cervical Cancer Screening</i>	50.70%	56.51%	46.73%	49.53%	2.80
<i>Prenatal and Postpartum Care—Postpartum Care</i>	49.88%	56.25%	61.42%	59.12%	-2.30
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	72.39%	79.86%	79.82%	84.18%	4.36
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.33%	85.37%	84.38%	84.90%	0.52
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.50%	85.13%	84.96%	85.34%	0.38
<i>Asthma Medication Ratio—Total</i>	--	--	--	53.01%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	50.11%	49.88%	56.73%	53.94%	-2.79
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	37.75%	40.60%	41.06%	46.53%	5.47

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	40.18%	46.17%	46.14%	48.38%	2.24
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	47.68%	43.85%	41.50%	38.66%	-2.84
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	75.28%	76.80%	76.82%	81.94%	5.12
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.47%	81.67%	90.07% ⁺	89.12%	-0.95
<i>Controlling High Blood Pressure</i>	48.11%	43.43%	55.24%	49.42%	-5.82
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	11.83%	16.76%	15.46%	14.01%	-1.45
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	53.51	54.99	53.84	53.99	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	216.69	198.90	200.75	196.08	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.54%	32.92%	30.61%	40.92% ⁺	10.31 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	83.20% ⁺	81.54%	77.44%	76.32%	-1.12

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.9—Multi-Year Performance Measure Results*
Anthem—San Benito County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	58.33%	67.43%	72.41%	4.98
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	93.08%	92.50%	91.89%	-0.61
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	78.21%	84.97%	83.54%	-1.43
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	NA	86.12%	84.41%	-1.71
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	NA	82.26%	78.65%	-3.61^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	14.29%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	50.46%	53.60%	61.57%	7.97^
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	23.84%	42.46%	56.71%	14.25^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	65.74%	64.35%	65.66%	1.31
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	51.46%	Not Comparable
<i>Cervical Cancer Screening</i>	--	43.06%	44.88%	50.35%	5.47
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	48.15%	38.36%	67.33%	28.97^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	77.78%	71.23%	91.09%+	19.86^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	NA	84.00%	85.95%	1.95
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	NA	84.62%	85.71%	1.09
<i>Asthma Medication Ratio—Total</i>	--	--	--	77.36%+	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	62.86%	60.58%	59.15%	-1.43
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	34.29%	52.55%	48.59%	-3.96

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	S	35.77%	44.37%	8.60
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	62.86%	54.74%	45.77%	-8.97
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	77.14%	73.72%	75.35%	1.63
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	54.29%	86.13%	81.69%	-4.44
<i>Controlling High Blood Pressure</i>	--	NA	50.38%	49.11%	-1.27
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	NA	S	18.10%	S
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	50.76	46.51	48.82	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	234.71	260.79	239.61	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	NA	37.50%	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	NA	76.67%	75.28%	-1.39

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.10—Multi-Year Performance Measure Results*
Anthem—San Francisco County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	74.70%	75.76%	72.39%	75.78%	3.39
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	96.63%	90.76%	94.26%	93.30%	-0.96
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	89.05%	84.62%	84.12%	85.28%	1.16
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	89.23%	91.20%	89.98%	89.16%	-0.82
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	88.40%	87.60%	88.06%	87.38%	-0.68
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	31.71%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	75.00%	69.91%	72.22%	77.78%	5.56
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	68.06% ⁺	61.57%	68.75%	76.16% ⁺	7.41 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	80.55%	71.46%	75.28%	76.29%	1.01
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	61.03%	Not Comparable
<i>Cervical Cancer Screening</i>	54.80%	64.32%	53.99%	60.24%	6.25
<i>Prenatal and Postpartum Care—Postpartum Care</i>	56.55%	52.59%	57.89%	63.33%	5.44
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	77.38%	71.85%	78.95%	86.00%	7.05
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.48%	80.91%	85.27%	89.47%	4.20 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.19%	83.95%	82.83%	85.94%	3.11
<i>Asthma Medication Ratio—Total</i>	--	--	--	46.15%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	56.44%	60.42%	59.49%	66.44%	6.95 [^]
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	49.78%	48.61%	58.10%	57.87%	-0.23

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	44.44%	46.30%	53.70%	55.56%	1.86
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	47.56%	46.30%	37.73%	33.10%	-4.63
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	82.00%	83.56%	89.12%	90.05%	0.93
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.67%	84.95%	92.13% ⁺	88.66%	-3.47
<i>Controlling High Blood Pressure</i>	48.45%	51.16%	58.93%	63.34%	4.41
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	16.67%	24.15%	21.12%	19.05%	-2.07
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	58.29	56.78	47.95	46.65	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	293.45	253.37	230.13	230.95	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	53.49% ⁺	47.06% ⁺	54.84% ⁺	68.18% ⁺	13.34
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	89.11% ⁺	84.38% ⁺	79.22%	85.16% ⁺	5.94

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.11—Multi-Year Performance Measure Results*
Anthem—Santa Clara County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	67.82%	69.21%	70.83%	73.77%	2.94
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.43%	94.04%	91.29%	91.43%	0.14
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	87.49%	86.01%	82.62%	82.23%	-0.39
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	89.72%	88.86%	86.48%	85.83%	-0.65
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	85.64%	86.24%	84.22%	80.77%	-3.45^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	27.55%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	46.99%	64.58%	65.51%	73.61%	8.10^
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	34.49%	52.78%	53.94%	64.12%	10.18^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	74.45%	77.08%	69.21%	75.46%	6.25^
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	55.60%	Not Comparable
<i>Cervical Cancer Screening</i>	62.56%	65.35%	47.10%	50.82%	3.72
<i>Prenatal and Postpartum Care—Postpartum Care</i>	60.65%	56.84%	64.90%	68.21%	3.31
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	80.09%	80.97%	82.56%	85.85%	3.29
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.64%	86.17%	87.37%	88.31%	0.94
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.77%	85.87%	84.68%	87.99%	3.31^
<i>Asthma Medication Ratio—Total</i>	--	--	--	56.56%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	44.15%	54.29%	56.84%	63.81%	6.97^
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	45.25%	52.44%	61.25%	59.40%	-1.85

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.03%	56.61%	56.61%	53.36%	-3.25
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	43.27%	33.41%	31.09%	32.71%	1.62
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	83.00%	84.69%	89.79%	86.54%	-3.25
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.13%	83.99%	86.77%	90.49%	3.72
<i>Controlling High Blood Pressure</i>	40.93%	49.77%	53.13%	55.32%	2.19
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.75%	17.19%	14.96%	15.11%	0.15
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	47.16	45.39	38.27	37.73	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	257.20	209.85	207.56	186.88	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	28.24%	29.49%	30.19%	33.42%	3.23
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	80.35%	80.72%	80.05%	78.64%	-1.41

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.12—Multi-Year Performance Measure Results*
Anthem—Tulare County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	72.22%	66.67%	69.74%	72.69%	2.95
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.75%	97.24%	97.29%	96.62%	-0.67
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	90.35%	91.20%	91.69%	90.61%	-1.08^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	88.21%	91.28%	91.83%	91.69%	-0.14
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	87.52%	90.62%	90.69%	90.25%	-0.44
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	29.63%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	57.18%	68.21%	74.54%	77.25%	2.71
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	47.92%	49.19%	68.75%	72.75% ⁺	4.00
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	71.93%	72.45%	75.57%	79.17%	3.60
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	58.29%	Not Comparable
<i>Cervical Cancer Screening</i>	63.43%	60.79%	62.41%	62.24%	-0.17
<i>Prenatal and Postpartum Care—Postpartum Care</i>	58.24%	59.26%	63.49%	71.04%	7.55 [^]
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	82.37%	81.25%	81.16%	88.37%	7.21 [^]
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.06%	83.04%	87.32%	87.87%	0.55
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.53%	82.83%	87.83%	86.64%	-1.19
<i>Asthma Medication Ratio—Total</i>	--	--	--	57.55%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	54.97%	64.58%	62.96%	67.36%	4.40
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	47.02%	46.30%	51.16%	59.26%	8.10 [^]

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	42.60%	42.13%	45.83%	49.31%	3.48
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	46.36%	48.38%	41.20%	39.35%	-1.85
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	83.00%	82.87%	87.50%	91.44%	3.94
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.46%	78.24%	93.98% ⁺	90.97%	-3.01
<i>Controlling High Blood Pressure</i>	52.99%	49.07%	56.25%	58.24%	1.99
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	10.59%	16.58%	15.29%	14.30%	-0.99
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	42.71	43.20	40.01	37.12	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	325.32	317.42	299.33	296.89	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	23.42%	17.08%	24.45%	30.16%	5.71 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.04%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	85.90% ⁺	82.18%	80.13%	75.63%	-4.50 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Anthem's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

Within the Preventive Screening and Children's Health domain across all reporting units, HSAG observed the following notable performance measure results:

- ◆ Within this domain in RY 2017, five of 48 rates (10 percent) were above the HPLs and no rates were below the MPLs. Anthem performed above the HPLs for the following measures within the Preventive Screening and Children's Health domain in RY 2017:
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* in Madera County
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total* in Madera, San Francisco, and Tulare counties
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County
- ◆ All nine rates within the Preventive Screening and Children's Health domain that were below the MPLs in RY 2016 improved to above the MPLs in RY 2017.

- ◆ For rates for which a comparison was made between RY 2016 and RY 2017:
 - Eighteen of 48 rates (38 percent) improved significantly from RY 2016 to RY 2017. The significant improvement resulted in the rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017 for the following measures:
 - *Childhood Immunization Status—Combination 3* in Region 2
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* in Region 1 and Region 2
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total* in Region 1 and San Benito County
 - The rates for the following measures improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017:
 - *Childhood Immunization Status—Combination 3* in Sacramento County
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Region 1, Region 2, and San Benito County

Preventive Screening and Women’s Health

Within the Preventive Screening and Women’s Health domain across all reporting units, HSAG observed the following notable performance measure results:

- ◆ In San Benito County, the rate was above the HPL in RY 2017 for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure.
- ◆ For rates for which a comparison was made between RY 2016 and RY 2017, nine of 36 rates (25 percent) improved significantly from RY 2016 to RY 2017. The following measures within the Preventive Screening and Women’s Health domain had rates that improved significantly from RY 2016 to RY 2017:
 - *Cervical Cancer Screening* in Alameda County and Region 2
 - *Prenatal and Postpartum Care—Postpartum Care* in Fresno County, Region 2, San Benito County, and Tulare County
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Fresno, San Benito, and Tulare counties
- ◆ Nineteen of the 21 rates within this domain that were below the MPLs in RY 2016 (90 percent) improved to above the MPLs in RY 2017.
- ◆ The rates for the following measures were below the MPLs in RY 2017:
 - *Cervical Cancer Screening* in Contra Costa County for all RYs displayed in Table 3.2
 - *Prenatal and Postpartum Care—Postpartum Care* in Kings County for all RYs displayed in Table 3.4

Performance measure results within the Preventive Screening and Women’s Health domain in RY 2017 show that Anthem has the opportunity to determine whether or not current strategies need to be modified or expanded to ensure that:

- ◆ Female beneficiaries ages 21 to 64 in Contra Costa County are screened for cervical cancer within the appropriate time frames.
- ◆ Female beneficiaries in Kings County who deliver a live birth complete a postpartum visit on or between 21 and 56 days after delivery.

Care for Chronic Conditions

Within the Care for Chronic Conditions domain across all reporting units, HSAG observed the following notable performance measure results:

- ◆ For rates for which a comparison was made between RY 2016 and RY 2017, 12 of 108 rates (11 percent) improved significantly from RY 2016 to RY 2017.
- ◆ Fifteen of the 22 rates within this domain that were below the MPLs in RY 2016 (68 percent) improved to above the MPLs in RY 2017.
- ◆ The following reporting units had no rates within the Care for Chronic Conditions domain that were below the MPLs in RY 2017:
 - Fresno County
 - Kings County
 - San Francisco County
 - Santa Clara County
 - Tulare County
- ◆ Within the Care for Chronic Conditions domain, 15 of 108 rates (14 percent) were below the MPLs in RY 2017, with six of these 15 rates (40 percent) being below the MPLs for at least three consecutive years.
- ◆ The rates for the following measures moved from above the MPLs in RY 2016 to below the MPLs in RY 2017:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Contra Costa County
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Contra Costa County
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Region 1
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Alameda County, Contra Costa County, Region 1, Region 2, and San Benito County

While Anthem improved its performance to above the MPLs for some measures within the Care for Chronic Conditions domain, the MCP’s performance declined to below the MPLs or remained below the MPLs for other measures within this domain. These performance measure results show that Anthem has the opportunity to determine whether or not current strategies need to be modified or expanded to ensure that beneficiaries with chronic conditions receive quality, accessible, and timely health care.

Appropriate Treatment and Utilization

The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure for San Benito County had an “NA” audit finding (i.e., denominator less than 30); therefore, HSAG does not include this measure in its analysis of Anthem’s performance within the Appropriate Treatment and Utilization domain.

Across all reporting units, HSAG observed the following notable performance measure results within the Appropriate Treatment and Utilization domain:

- ◆ Within this domain in RY 2017, nine of 23 rates (39 percent) were above the HPLs in RY 2017. Anthem performed above the HPLs for the following measures within the Appropriate Treatment and Utilization domain in RY 2017:
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Alameda, Contra Costa, Kings, Sacramento, and San Francisco counties
 - *Use of Imaging Studies for Low Back Pain* in Alameda, Contra Costa, Kings, and San Francisco counties
- ◆ For rates for which a comparison was made between RY 2016 and RY 2017 within the Appropriate Treatment and Utilization domain, four of 35 rates (11 percent) improved significantly from RY 2016 to RY 2017. The following measures had rates that improved significantly from RY 2016 to RY 2017:
 - *All-Cause Readmissions* in Fresno County
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Kings, Sacramento, and Tulare counties
- ◆ The rates were below the MPL for the third consecutive year for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Madera County and Region 1.
- ◆ In Tulare County, the rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure may be due to NCQA’s RY 2017 specification changes for this measure and therefore may not be related to Anthem’s performance.

Performance measure results show that Anthem has the opportunity to determine whether or not current strategies in Madera County and Region 1 need to be modified or expanded to ensure the appropriate use of antibiotics for beneficiaries ages 18 to 64 with primary diagnoses of acute bronchitis.

Additionally, Anthem should determine the causes for the rate in Tulare County declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Corrective Action Plan and Improvement Plans

Corrective Action Plan

Anthem's Quality of Care CAP was implemented in November 2013 for a period of three years or until the CAP goals are achieved for 12 measures in nine reporting units. The CAP was amended in September 2014 to:

- ◆ Include three additional measures with rates that were below the MPLs for multiple years.
- ◆ Revise annual milestone targets.
- ◆ Extend the timeline for completion of the CAP goals until at least MY 2016.

The following reporting units are included in the CAP:

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

The following measures are included in the CAP:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics* measures
- ◆ *Asthma Medication Ratio—Total* measure—This measure serves as a substitute for the *Medication Management for People With Asthma* measures because DHCS replaced these measures with the *Asthma Medication Ratio—Total* measure beginning MY 2016 (RY 2017).
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- ◆ *Controlling High Blood Pressure*
- ◆ *Both Prenatal and Postpartum Care* measures
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

DHCS requires Anthem to address performance related to the CAP measures through the performance improvement plan (PIP) process and through PDSA cycles. Following are the CAP PIPs that Anthem had in progress during the reporting period of July 1, 2015, through June 30, 2016:

- ◆ *Asthma Controller Medication Refill*
- ◆ *Comprehensive Diabetes Care*
- ◆ *Controlling High Blood Pressure*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*

Information regarding Anthem’s progress on the CAP PIPs is included in Section 4 of this report (“Performance Improvement Projects”).

Following are the CAP measures for which Anthem conducted PDSA cycles during the reporting period:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

DHCS requires Anthem to achieve set milestones for each year for all measures included in the CAP. Every four months during the review period for this MCP-specific evaluation report, Anthem produced and submitted to DHCS extensive CAP progress reports on the MCP’s efforts to improve its performance to above the MPLs on all measures. Following submission of the progress reports, DHCS provided feedback to Anthem on the MCP’s improvement efforts and progress.

Improvement Plan/Plan-Do-Study-Act Cycles

In addition to the measures covered under the CAP, Anthem was required to conduct PDSA cycles or submit triannual summary reports for the following measures with rates below the MPLs in RY 2016:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Cervical Cancer Screening*
- ◆ *Both Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures
- ◆ *Immunizations for Adolescents—Combination 1*— Note that in RY 2017 DHCS replaced this measure with the *Immunizations for Adolescents—Combination 2* measure; therefore, HSAG provides no information on Anthem’s PDSA cycles for this measure.

Anthem was required by DHCS to include progress on the non-CAP IP/PDSA cycles in the progress reports that the MCP submitted to DHCS every four months.

Progress on Corrective Action Plan and Improvement Plan

During the review period for this report, Anthem made progress improving the MCP's performance on CAP and non-CAP measures. For the nine reporting units included in the CAP, 24 of the 30 rates that were below the MPLs in RY 2016 (80 percent) improved to above the MPLs in RY 2017. Additionally, across all nine reporting units, 152 of 162 rates for which Anthem was held accountable to meet the MPLs in RY 2017 (94 percent) were above the MPLs.

Requirements for 2017 Corrective Action Plan and Improvement Plans

Anthem will be required to continue working on improving the MCP's performance for all existing CAP and non-CAP measures through PIPs, PDSA cycles, and other quality improvement activities. Specifically, DHCS will require the following:

- ◆ Anthem will conduct PIPs for the following measures:
 - *Asthma Medication Ratio—Total*
 - *Prenatal and Postpartum Care—Postpartum Care*
- ◆ Anthem will conduct PDSA cycles for the following measures:
 - *Both Annual Monitoring for Patients on Persistent Medications* measures
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
 - *Cervical Cancer Screening*
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- ◆ Anthem will submit triannual summary reports to DHCS for the following measures:
 - *Childhood Immunization Status—Combination 3*
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Seniors and Persons with Disabilities Performance Measure Results

Table 3.13 through Table 3.24 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.13—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Alameda County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	22.63%	11.41%	11.22^^	16.97%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	96.50	42.72	Not Tested	48.13
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	317.70	159.53	Not Tested	175.42
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.95%	85.02%	3.93^	86.62%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.31%	84.32%	2.99	85.64%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	86.86%	Not Comparable	86.91%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.06%	77.82%	11.24^	78.08%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.78%	82.50%	3.28	82.66%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	80.20%	77.12%	3.08	77.34%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.13 through Table 3.24.

Table 3.14—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Contra Costa County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	20.67%	13.22%	7.45^^	16.01%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	76.90	42.40	Not Tested	44.93
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	297.88	158.94	Not Tested	169.14
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.57%	82.60%	5.97	84.88%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.00%	77.27%	7.73	80.00%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	89.29%	Not Comparable	89.37%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	92.71%	81.97%	10.74^	82.28%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.06%	85.70%	2.36	85.82%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.51%	81.84%	-0.33	81.82%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.15—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Fresno County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.13%	10.66%	8.47^^	13.26%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	68.55	45.14	Not Tested	46.66
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	380.04	210.43	Not Tested	221.41
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.67%	85.56%	1.11	85.84%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.05%	84.94%	3.11	85.76%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	92.81%	Not Comparable	92.70%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.03%	84.40%	1.63	84.44%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.57%	84.71%	-0.14	84.71%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.50%	80.41%	-0.91	80.37%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.16—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Kings County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	17.86%	9.16%	8.70^^	11.85%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	95.87	54.27	Not Tested	56.54
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	511.02	257.27	Not Tested	271.12
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.24%	86.65%	-2.41	86.01%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.30%	83.66%	7.64	85.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.51%	Not Comparable	91.55%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.44%	84.72%	1.72	84.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	93.59%	85.95%	7.64	86.22%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	78.63%	86.14%	-7.51^^	85.81%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.17—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Madera County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.09%	11.11%	4.98	12.42%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	77.24	48.60	Not Tested	49.89
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	506.21	256.45	Not Tested	267.76
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.61%	82.73%	3.88	83.49%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.69%	85.11%	2.58	85.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	97.39%	Not Comparable	97.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.33%	92.01%	-8.68	91.91%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.06%	93.15%	-1.09	93.12%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.36%	88.88%	-1.52	88.84%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.18—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	25.98%	10.96%	15.02^^	17.06%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	101.15	44.75	Not Tested	49.10
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	574.37	288.88	Not Tested	310.92
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.53%	85.28%	2.25	85.92%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.94%	84.96%	2.98	85.92%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	96.12%	Not Comparable	96.13%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.93%	88.31%	1.62	88.34%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.77%	89.04%	3.73	89.13%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.30%	86.28%	1.02	86.32%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.19—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	18.11%	10.88%	7.23^^	13.00%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	90.22	49.94	Not Tested	52.53
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	437.37	217.86	Not Tested	231.95
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.94%	81.95%	4.99^	83.27%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.21%	80.87%	6.34^	82.66%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	92.16%	Not Comparable	92.22%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	77.58%	81.60%	-4.02	81.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.73%	82.94%	6.79^	83.11%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.48%	81.74%	-2.26	81.67%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.20—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Sacramento County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	18.88%	10.36%	8.52^^	14.01%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	90.37	50.47	Not Tested	53.99
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	362.78	179.98	Not Tested	196.08
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.44%	83.40%	4.04^	84.90%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.95%	83.66%	4.29^	85.34%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.16%	Not Comparable	91.24%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.45%	78.96%	5.49^	79.09%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.31%	82.44%	2.87	82.57%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.12%	79.05%	4.07^	79.32%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.21—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—San Benito County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	NA	16.83%	Not Comparable	18.10%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	125.79	48.29	Not Tested	48.82
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	454.40	238.13	Not Tested	239.61
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	NA	85.34%	Not Comparable	85.95%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	NA	85.07%	Not Comparable	85.71%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.72%	Not Comparable	91.89%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	NA	83.41%	Not Comparable	83.54%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	NA	84.34%	Not Comparable	84.41%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	NA	78.55%	Not Comparable	78.65%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.22—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—San Francisco County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	23.13%	12.32%	10.81^^	19.05%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	92.19	37.08	Not Tested	46.65
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	368.70	202.01	Not Tested	230.95
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.36%	88.63%	1.73	89.47%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.46%	84.15%	3.31	85.94%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	93.79%	Not Comparable	93.30%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	NA	85.45%	Not Comparable	85.28%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.00%	89.40%	-5.40	89.16%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.11%	87.62%	-3.51	87.38%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.23—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Santa Clara County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	17.90%	13.59%	4.31^^	15.11%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	57.50	36.14	Not Tested	37.73
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	332.38	175.18	Not Tested	186.88
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.07%	87.47%	2.60	88.31%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.26%	86.47%	4.79^	87.99%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.49%	Not Comparable	91.43%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	74.71%	82.36%	-7.65	82.23%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	77.51%	86.13%	-8.62^^	85.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	75.17%	81.02%	-5.85^^	80.77%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.24—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Tulare County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	21.68%	11.05%	10.63^^	14.30%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	77.86	34.96	Not Tested	37.12
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	548.38	283.51	Not Tested	296.89
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.20%	86.92%	4.28^	87.87%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.22%	85.67%	3.55	86.64%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	96.59%	Not Comparable	96.62%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	92.09%	90.58%	1.51	90.61%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	93.42%	91.64%	1.78	91.69%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	91.97%	90.18%	1.79	90.25%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.25 through Table 3.36 present the four-year trending information for the SPD population, and Table 3.37 through Table 3.48 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.25—Multi-Year SPD Performance Measure Trend Table
Anthem—Alameda County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	19.74%	25.07%	24.07%	22.63%	-1.44
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	115.98	109.49	106.54	96.50	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	294.17	279.57	290.68	317.70	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.77%	84.97%	88.14%	88.95%	0.81
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.80%	84.52%	85.96%	87.31%	1.35
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	78.70%	83.43%	85.35%	89.06%	3.71
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	79.11%	80.49%	85.32%	85.78%	0.46
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	70.43%	77.83%	81.86%	80.20%	-1.66

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.26—Multi-Year SPD Performance Measure Trend Table
Anthem—Contra Costa County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	19.78%	17.74%	17.41%	20.67%	3.26
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	97.01	98.09	87.74	76.90	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	284.86	263.60	262.12	297.88	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.38%	80.60%	86.98%	88.57%	1.59
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.77%	83.95%	82.24%	85.00%	2.76
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.36%	85.29%	92.86%	92.71%	-0.15
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.61%	85.92%	85.71%	88.06%	2.35
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.50%	86.15%	80.73%	81.51%	0.78

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.27—Multi-Year SPD Performance Measure Trend Table
Anthem—Fresno County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.18%	26.58%	27.95%	19.13%	-8.82 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.31	77.75	74.39	68.55	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	367.46	380.66	365.85	380.04	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.57%	85.24%	85.90%	86.67%	0.77
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.08%	87.22%	89.58%	88.05%	-1.53
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.85%	88.03%	81.30%	86.03%	4.73
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.70%	85.97%	87.93%	84.57%	-3.36
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.00%	84.57%	81.81%	79.50%	-2.31

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.28—Multi-Year SPD Performance Measure Trend Table
Anthem—Kings County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	17.11%	23.14%	17.86%	-5.28
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	119.47	117.00	108.86	95.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	563.40	499.29	454.05	511.02	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.43%	79.75%	82.35%	84.24%	1.89
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.70%	82.14%	85.11%	91.30%	6.19
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	80.00%	96.30%	83.61%	86.44%	2.83
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	95.92%	88.89%	92.54%	93.59%	1.05
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.93%	83.33%	83.33%	78.63%	-4.70

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.29—Multi-Year SPD Performance Measure Trend Table
Anthem—Madera County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	25.37%	26.27%	16.09%	-10.18
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	98.73	86.42	78.35	77.24	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	509.81	536.73	524.24	506.21	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.18%	87.80%	84.38%	86.61%	2.23
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.62%	85.53%	90.48%	87.69%	-2.79
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	93.62%	97.44%	100.00%	83.33%	-16.67^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	97.44%	96.67%	93.55%	92.06%	-1.49
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	92.86%	88.17%	80.68%	87.36%	6.68

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.30—Multi-Year SPD Performance Measure Trend Table
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	23.46%	25.98%	2.52
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	NA	100.99	101.15	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	NA	566.18	574.37	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	NA	89.24%	87.53%	-1.71
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	NA	89.77%	87.94%	-1.83
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	NA	93.86%	89.93%	-3.93
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	92.11%	92.77%	0.66
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	92.00%	87.30%	-4.70

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.31—Multi-Year SPD Performance Measure Trend Table
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo,
Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	19.69%	18.11%	-1.58
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	NA	91.71	90.22	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	NA	416.86	437.37	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	NA	82.32%	86.94%	4.62 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	NA	83.80%	87.21%	3.41
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	NA	85.82%	77.58%	-8.24
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	96.30%	89.73%	-6.57
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	94.92%	79.48%	-15.44 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.32—Multi-Year SPD Performance Measure Trend Table
Anthem—Sacramento County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	13.26%	20.29%	20.05%	18.88%	-1.17
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	82.77	85.62	89.43	90.37	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	356.44	340.85	349.22	362.78	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.21%	87.82%	86.64%	87.44%	0.80
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.72%	87.67%	88.17%	87.95%	-0.22
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	92.31%	NA	90.63%	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	78.10%	80.35%	80.81%	84.45%	3.64
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.31%	84.38%	85.96%	85.31%	-0.65
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.13%	80.38%	81.37%	83.12%	1.75

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.33—Multi-Year SPD Performance Measure Trend Table
Anthem—San Benito County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	NA	NA	Not Comparable
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	S	142.86	125.79	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	308.82	566.82	454.40	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	NA	NA	Not Comparable

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.34—Multi-Year SPD Performance Measure Trend Table
Anthem—San Francisco County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	17.38%	25.49%	24.63%	23.13%	-1.50
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	95.72	92.01	99.79	92.19	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	373.20	336.25	364.70	368.70	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.77%	81.41%	85.57%	90.36%	4.79 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.60%	83.44%	83.66%	87.46%	3.80
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	70.97%	68.42%	69.70%	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	77.50%	85.42%	77.78%	84.00%	6.22
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.35%	81.30%	86.84%	84.11%	-2.73

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.35—Multi-Year SPD Performance Measure Trend Table
Anthem—Santa Clara County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.33%	19.38%	16.64%	17.90%	1.26
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.19	66.24	61.69	57.50	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	374.95	311.19	326.21	332.38	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.63%	85.50%	88.35%	90.07%	1.72
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.49%	85.44%	89.70%	91.26%	1.56
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	81.45%	74.68%	75.76%	74.71%	-1.05
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.89%	84.87%	82.04%	77.51%	-4.53
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.11%	80.27%	77.13%	75.17%	-1.96

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.36—Multi-Year SPD Performance Measure Trend Table
Anthem—Tulare County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	12.83%	21.19%	20.73%	21.68%	0.95
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	83.89	92.92	81.03	77.86	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	561.54	571.12	519.48	548.38	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.94%	85.03%	86.81%	91.20%	4.39 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.12%	86.70%	92.70%	89.22%	-3.48
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.09%	93.26%	92.16%	92.09%	-0.07
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.57%	89.50%	92.25%	93.42%	1.17
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.76%	90.29%	90.32%	91.97%	1.65

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.37—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Alameda County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	10.91%	13.26%	9.79%	11.41%	1.62
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	53.18	49.70	44.63	42.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	187.84	168.72	156.02	159.53	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	71.79%	84.44%	83.87%	85.02%	1.15
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.77%	74.66%	82.12%	84.32%	2.20
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	85.30%	87.00%	88.53%	86.86%	-1.67
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	77.79%	82.86%	78.69%	77.82%	-0.87
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	78.54%	84.81%	84.53%	82.50%	-2.03^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	75.79%	80.28%	80.10%	77.12%	-2.98^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.38—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Contra Costa County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	13.75%	12.01%	13.22%	1.21
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	56.15	53.97	45.85	42.40	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	225.26	191.29	159.08	158.94	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	76.47%	79.17%	84.01%	82.60%	-1.41
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	67.35%	76.47%	86.74%	77.27%	-9.47^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	95.23%	93.82%	90.85%	89.29%	-1.56
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.31%	85.36%	83.55%	81.97%	-1.58
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.35%	88.73%	87.70%	85.70%	-2.00^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	85.16%	87.49%	84.20%	81.84%	-2.36^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.39—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Fresno County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	10.68%	9.90%	12.05%	10.66%	-1.39
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	45.59	46.64	47.35	45.14	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	219.48	214.46	210.71	210.43	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.76%	80.12%	82.25%	85.56%	3.31 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.59%	80.36%	81.87%	84.94%	3.07 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	93.86%	92.83%	93.92%	92.81%	-1.11
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.33%	86.11%	84.82%	84.40%	-0.42
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.46%	85.47%	86.04%	84.71%	-1.33 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.14%	82.88%	82.34%	80.41%	-1.93 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.40—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Kings County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	S	7.85%	9.16%	1.31
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	61.93	58.16	55.21	54.27	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	291.39	255.64	255.91	257.27	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.56%	82.84%	86.47%	86.65%	0.18
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	68.66%	73.97%	82.69%	83.66%	0.97
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.71%	94.74%	94.13%	91.51%	-2.62
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.36%	86.28%	87.35%	84.72%	-2.63^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.26%	83.64%	85.18%	85.95%	0.77
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.62%	86.26%	84.82%	86.14%	1.32

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.41—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Madera County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	17.35%	9.05%	11.11%	2.06
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	54.40	53.49	49.19	48.60	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	272.13	267.13	275.80	256.45	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.82%	75.24%	81.55%	82.73%	1.18
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	68.42%	79.55%	76.04%	85.11%	9.07 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	98.45%	95.06%	97.06%	97.39%	0.33
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.87%	92.04%	93.01%	92.01%	-1.00
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.58%	90.19%	92.58%	93.15%	0.57
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.52%	90.21%	89.60%	88.88%	-0.72

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.42—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	11.04%	10.55%	10.96%	0.41
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	46.39	45.39	44.75	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	292.88	306.19	288.88	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	84.36%	84.79%	85.28%	0.49
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	86.83%	85.73%	84.96%	-0.77
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	96.82%	96.55%	96.12%	-0.43
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	87.27%	88.79%	88.31%	-0.48
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	92.54%	88.55%	89.04%	0.49
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	95.74%	86.25%	86.28%	0.03

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.43—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo,
Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	8.39%	9.35%	10.88%	1.53
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	54.21	50.11	49.94	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	212.47	217.19	217.86	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	77.42%	80.78%	81.95%	1.17
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	80.41%	83.05%	80.87%	-2.18
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	93.56%	92.35%	92.16%	-0.19
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	82.95%	83.51%	81.60%	-1.91^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	92.77%	83.07%	82.94%	-0.13
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	93.40%	83.26%	81.74%	-1.52^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.44—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Sacramento County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.70%	7.09%	11.07%	10.36%	-0.71
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	48.19	49.78	50.06	50.47	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	191.26	174.75	185.01	179.98	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	75.38%	79.35%	82.75%	83.40%	0.65
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.27%	77.75%	82.24%	83.66%	1.42
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.06%	92.23%	91.19%	91.16%	-0.03
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	81.70%	81.71%	81.29%	78.96%	-2.33^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	80.76%	83.42%	84.22%	82.44%	-1.78^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	78.05%	80.99%	80.36%	79.05%	-1.31^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.45—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—San Benito County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	S	16.83%	S
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	50.77	46.02	48.29	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	234.43	259.25	238.13	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	NA	84.00%	85.34%	1.34
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	NA	84.31%	85.07%	0.76
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	93.08%	92.50%	91.72%	-0.78
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	78.23%	84.93%	83.41%	-1.52
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	86.05%	84.34%	-1.71
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	82.22%	78.55%	-3.67^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.46—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—San Francisco County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	S	11.89%	12.32%	0.43
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	35.87	37.25	36.13	37.08	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	245.67	207.43	199.46	202.01	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.42%	77.98%	84.92%	88.63%	3.71
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.39%	89.13%	81.55%	84.15%	2.60
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	96.95%	90.64%	94.20%	93.79%	-0.41
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.53%	85.13%	84.48%	85.45%	0.97
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.73%	91.52%	90.55%	89.40%	-1.15
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.40%	88.26%	88.15%	87.62%	-0.53

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.47—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Santa Clara County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	6.88%	11.06%	13.88%	13.59%	-0.29
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	41.56	41.49	36.18	36.14	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	232.83	190.87	196.98	175.18	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.51%	87.56%	86.83%	87.47%	0.64
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.27%	87.01%	81.72%	86.47%	4.75 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	95.97%	94.31%	91.40%	91.49%	0.09
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	87.66%	86.22%	82.75%	82.36%	-0.39
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.89%	89.02%	86.68%	86.13%	-0.55
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	85.77%	86.46%	84.60%	81.02%	-3.58 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.48—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Tulare County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.22%	9.45%	11.95%	11.05%	-0.90
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	39.20	39.08	37.55	34.96	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	305.19	296.37	286.12	283.51	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.20%	81.37%	87.51%	86.92%	-0.59
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.50%	79.21%	85.47%	85.67%	0.20
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.77%	97.22%	97.27%	96.59%	-0.68
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.38%	91.15%	91.68%	90.58%	-1.10^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.28%	91.36%	91.81%	91.64%	-0.17
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.56%	90.64%	90.71%	90.18%	-0.53

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that Anthem stratified by the SPD and non-SPD populations:

SPD Rate Changes from RY 2016 to RY 2017

For SPD rates for which a comparison was made between RY 2016 and RY 2017:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2016 SPD rates for the following measures:
 - *All-Cause Readmissions* in Fresno County
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Region 2, San Francisco County, and Tulare County
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2016 SPD rates for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Madera County
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Region 2

Non-SPD Rate Changes from RY 2016 to RY 2017

For non-SPD rates for which a comparison was made between RY 2016 and RY 2017:

- ◆ The RY 2017 non-SPD rates were significantly better than the RY 2016 non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Fresno County
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno, Madera, and Santa Clara counties
- ◆ The RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Contra Costa County
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Kings County, Region 2, Sacramento County, and Tulare County
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Alameda, Contra Costa, Fresno, and Sacramento counties
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Alameda County, Contra Costa County, Fresno County, Region 2, Sacramento County, San Benito County, and Santa Clara County

RY 2017 SPD and RY 2017 Non-SPD Rate Comparisons

For measures for which a comparison was made between the RY 2017 SPD and RY 2017 non-SPD rates:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Alameda County, Region 2, Sacramento County, and Tulare County
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Region 2, Sacramento County, and Santa Clara County
 - *Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years* in Alameda, Contra Costa, and Sacramento counties
 - *Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years* in Region 2
 - *Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years* in Sacramento County
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures:
 - *All-Cause Readmissions* in all reporting units except Madera and San Benito counties. Note that in San Benito County, HSAG could make no comparisons between RY 2017 SPD and non-SPD rates because the RY 2017 SPD rates for all measures for which HSAG makes comparisons had “NA” audit findings (i.e., denominators less than 30).
 - *Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years* in Santa Clara County
 - *Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years* in Kings and Santa Clara 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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents’ Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age categories, based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to Anthem's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in one reporting unit—Santa Clara County—DHCS required that Anthem report rates for three HEDIS measures for that reporting unit for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.49 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.49—Multi-Year MLTSSP Performance Measure Results
Anthem—Santa Clara County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	43.04	63.09	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	282.89	480.17	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	31.71%	37.84%	6.13

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from RY 2016 to RY 2017.

Strengths—Performance Measures

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

Across all domains and reporting units, 15 of 215 rates for which MCPs were held accountable to meet the MPLs in RY 2017 (7 percent) were above the HPLs in RY 2017. Additionally, 43 of the 227 rates for which comparisons were made between RY 2016 and RY 2017 (19 percent) improved significantly from RY 2016 to RY 2017. Finally, 43 of the 54 rates that were below the MPLs in RY 2016 (80 percent) improved to above the MPLs in RY 2017.

Across all domains, the following reporting units had no rates below the MPLs for measures which MCPs were held accountable to meet the MPLs in RY 2017:

- ◆ Fresno County
- ◆ San Francisco County
- ◆ Santa Clara County
- ◆ Tulare County

The MCP's PDSA and PIP activities, as described within the "Assessment of Corrective Action Plan and Improvement Plans" heading within this section of the report and Section 4 of this report ("Performance Improvement Projects"), along with Anthem's self-reported actions as described in Table 5.1, may have contributed to the MCP's improved performance across all domains and reporting units.

Opportunities for Improvement—Performance Measures

Across all domains and reporting units, 19 of 215 rates (9 percent) were below the MPLs in RY 2017. Fifteen of those 19 rates (79 percent) were within the Care for Chronic Conditions domain, two rates were within the Preventive Screening and Women's Health domain, and two rates were within the Appropriate Treatment and Utilization domain. Performance measure results show that Anthem has the most opportunities for improvement in the Care for Chronic Conditions domain. Anthem should continue to work with DHCS to prioritize areas for improvement and determine whether or not current strategies need to be modified or expanded to improve the MCP's performance to above the MPLs for all measures.

4. Performance Improvement Projects

Anthem had four CAP PIPs in progress during the reporting period of July 1, 2016, through June 30, 2017.

Controlling High Blood Pressure Performance Improvement Project

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to Anthem to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

Anthem set the SMART Aim for the *Controlling High Blood Pressure* CAP PIP as follows:

By June 30, 2017, increase the hypertensive medication compliance rate from 55.27 percent to 60.27 percent among beneficiaries diagnosed with hypertension in Kings County who have Provider Network A⁶ providers.

Failure Modes

The following, listed in priority order, are the failure modes that Anthem identified during the Intervention Determination phase of the PIP process:

- ◆ Pharmacy is unable to reach beneficiary with emergency contact information.
- ◆ Beneficiary forgets to pick up medication.
- ◆ Pharmacy does not follow up if beneficiary does not pick up medication.
- ◆ Beneficiary does not have transportation to follow-up appointment.
- ◆ Beneficiary unable to understand refill instructions.
- ◆ Provider does not renew beneficiary's medication(s).
- ◆ Beneficiary does not feel that medication is necessary.
- ◆ Beneficiary not given follow-up appointment or does not attend the appointment.

⁶ Provider network name removed for confidentiality.

- ◆ Pharmacy does not have convenient hours.
- ◆ Provider does not obtain prior authorization for non-formulary medications.
- ◆ Beneficiary does not take medication and does not want the provider to know.

Intervention Testing

During the reporting period, Anthem selected to test creating a process co-developed with a pharmacy in Kings County to follow up with beneficiaries through provider notifications if the beneficiaries do not pick up their medications. This intervention addresses the provider awareness key driver.

Although Anthem completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Anthem's 2017–18 MCP-specific evaluation report.

Prenatal and Postpartum Care Performance Improvement Project

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to Anthem to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure. HSAG also validated modules 4 and 5 for Anthem's *Prenatal and Postpartum Care* CAP PIP and provided final validation results.

SMART Aim

Anthem set the SMART Aim for the *Prenatal and Postpartum Care* CAP PIP as follows:

By June 30, 2017, increase by 5 percentage points (from 46.09 percent to 51.09 percent) the rate of timely postpartum visits among females ages 22 through 30 who recently delivered at a high-volume obstetric provider in Sacramento County.

Although the SMART Aim end date for the *Prenatal and Postpartum Care* CAP PIP was set for June 30, 2017, due to an Anthem staff member's maternity leave, DHCS approved Anthem ending the PIP on April 30, 2017.

Failure Modes

The following, listed in priority order, are the failure modes that Anthem identified during the Intervention Determination phase of the PIP process:

- ◆ Obstetrician and gynecologist (OB/GYN) attempts to provide scheduling/re-scheduling assistance, but outreach calls fail.
- ◆ OB/GYNs do not make follow-up appointment calls to schedule new appointments for all beneficiaries who miss postpartum appointments.
- ◆ Beneficiary does not have transportation.
- ◆ Educational material content is inappropriate.
- ◆ Outreach calls made by Anthem’s case management staff to provide scheduling assistance/appointment reminders fail.
- ◆ Beneficiary forgets about appointment.
- ◆ Beneficiary lacks childcare for other children at home.
- ◆ Beneficiary not provided education from OB/GYN and/or coordinator about the importance of the postpartum exam.
- ◆ Beneficiary finds the scheduling process too difficult.
- ◆ Beneficiary does not feel that the postpartum exam is necessary.
- ◆ Beneficiary not interested in understanding the information provided.
- ◆ OB/GYN does not offer convenient appointment times.
- ◆ Language, cultural, and gender barriers exist between the beneficiary and provider.

Intervention Testing

During the reporting period, Anthem selected to test the effectiveness of a health education class on improving postpartum care appointment compliance. This intervention addresses the health literacy levels that could affect understanding the importance of timely perinatal services and completion of the postpartum exam.

Anthem completed testing the intervention through April 30, 2017, and submitted modules 4 and 5 to HSAG for validation during the reporting period. The MCP met the SMART Aim and indicated that it planned to adapt the intervention.

Final Confidence Level

To determine the final confidence level in the MCP’s reported PIP findings, HSAG assessed the validity and reliability of Anthem’s *Prenatal and Postpartum Care* CAP PIP results based on CMS validation protocols. HSAG’s assessment of the validity and reliability of Anthem’s *Prenatal and Postpartum Care* CAP PIP determined that stakeholders can have confidence in the reported results. A confidence-level determination of “confident” means that the PIP was methodologically sound and achieved the SMART

Aim goal, and some quality improvement processes were clearly linked to the demonstrated improvement; however, no clear link existed between all quality improvement processes and the demonstrated improvement.

Comprehensive Diabetes Care Performance Improvement Project

Validation Findings

During the reporting period, Anthem incorporated HSAG's initial validation feedback into modules 1 and 2 of the *Comprehensive Diabetes Care CAP PIP*. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2.

Additionally, HSAG validated Module 3 for Anthem's *Comprehensive Diabetes Care CAP PIP*. Upon initial review of the module, HSAG determined that Anthem met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis (FMEA).
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, Anthem incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to Anthem on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to Anthem to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Anthem set the SMART Aim for the *Comprehensive Diabetes Care CAP PIP* as follows:

By December 31, 2017, increase from 24.07 percent to 29.07 percent the rate of diabetic retinal exam (DRE) compliance among beneficiaries in Tulare County who have Provider A⁷ as their primary care provider.

⁷ Provider name removed for confidentiality.

Failure Modes

The following, listed in priority order, are the failure modes that Anthem identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not feel DRE is necessary.
- ◆ No follow-up is made after missed appointment.
- ◆ Beneficiary does not understand the consequences of not getting the DRE.
- ◆ Beneficiary is not interested in understanding the DRE information provided.
- ◆ Scheduling process for DRE appointment is too difficult for the beneficiary.
- ◆ Limited appointment times are available.
- ◆ Beneficiary forgets about the DRE appointment.
- ◆ Beneficiary faces language barriers.
- ◆ Beneficiary does not use the available transportation assistance.
- ◆ Beneficiary fears the DRE process.

Intervention Testing

During the reporting period, Anthem selected to test providing beneficiaries with one-on-one education at DRE appointments to improve beneficiaries' understanding of the importance of an annual DRE. This intervention addresses the beneficiary education key driver.

The MCP did not progress to completing the intervention testing during the reporting period; therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Anthem's 2017–18 MCP-specific evaluation report.

Asthma Performance Improvement Project

Validation Findings

During the reporting period, HSAG validated modules 1 and 2 for Anthem's *Medication Management for People with Asthma* CAP PIP. Upon initial review of the modules, HSAG determined that Anthem met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including all required components of the SMART Aim.
- ◆ Developing the SMART Aim based on literature review, data, and/or experience.
- ◆ Aligning the Global Aim, SMART Aim, and key driver diagram with the identified problem(s).
- ◆ Including all required components of the SMART Aim data collection methodology.
- ◆ Providing the appropriate baseline measurement period and rate for the SMART Aim measure.

- ◆ Including all required components of the SMART Aim measure.
- ◆ Including the SMART Aim goal, baseline rate, and data collection interval on the run/control chart.

After receiving technical assistance from HSAG, Anthem incorporated HSAG's feedback into the PIP modules. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. However, with the retirement of the *Medication Management for People With Asthma* measures and the introduction of the *Asthma Medication Ratio* measure into the RY 2017 External Accountability Set, DHCS approved Anthem to shift the PIP topic to align with the *Asthma Medication Ratio* measure.

Therefore, HSAG validated modules 1 through 3 for Anthem's *Asthma Controller Medication Refill* CAP PIP. Upon initial review of the modules, HSAG determined that Anthem met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Supporting the topic selection with the MCP's data and expertise, and aligning it with the State's quality strategy.
- ◆ Including all required components of the SMART Aim.
- ◆ Developing the SMART Aim based on literature review, data, and/or experience.
- ◆ Aligning the Global Aim, SMART Aim, and key driver diagram with the identified problem(s).
- ◆ Including all required components of the SMART Aim data collection methodology.
- ◆ Including all required components of the SMART Aim measure.
- ◆ Including the SMART Aim goal, baseline rate, and data collection interval on the run/control chart.
- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the FMEA.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, Anthem incorporated HSAG's feedback into the *Asthma Controller Medication Refill* CAP PIP modules. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for all submitted modules.

Due to the delay in Anthem starting the *Asthma Controller Medication Refill* CAP PIP, DHCS provided approval for Anthem to close the *Asthma Controller Medication Refill* CAP PIP and use this topic for the new Disparity PIP, which will begin in November 2017. The MCP provided lessons learned from the *Asthma Controller Medication Refill* CAP PIP modules 1 through 3, and HSAG closed the PIP.

Strengths—Performance Improvement Projects

Through HSAG’s PIP validation and technical assistance, Anthem improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

Based on Anthem’s PIP progression and validation results, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Anthem’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Anthem’s self-reported actions.

Table 5.1—Anthem’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure resolution of all deficiencies from the November 2015 A&I Medical Audit.	Anthem provided all documentation required as a result of the November 2015 A&I Medical Audit. Anthem was informed on June 15, 2017, that all items had been reviewed and were found in compliance; and the CAP related to the audit was officially closed.
2. Work with DHCS to continue to prioritize areas for improvement related to performance measures showing declining performance or performance below the MPLs. HSAG recommends that Anthem focus on performance measures for which the MCP performed below the MPLs in RY 2016.	RY 2016 (MY 2015) HEDIS results showed that Anthem was below the MPL for the <i>Annual Monitoring for Patients on Persistent Medications (MPM)</i> , <i>Cervical Cancer Screening (CCS)</i> , <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i> , <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i> , <i>Prenatal and Postpartum Care (PPC)</i> , <i>Medication Management for People With Asthma (MMA)</i> , <i>Comprehensive Diabetes Care (CDC)</i> , and <i>Childhood Immunization Status (CIS)</i> measures. Anthem implemented PDSA Cycles for <i>MPM</i> , <i>CCS</i> , <i>WCC</i> , <i>W34</i> , <i>PPC-Pre</i> , and <i>CIS</i> . Each quarter Anthem submitted a PDSA cycle on these measures. Feedback from DHCS was implemented in the subsequent quarter. Anthem also implemented PIPs for the <i>Controlling High Blood Pressure</i> , <i>CDC</i> , <i>PPC-Post</i> , and <i>MMA</i> measures, meeting the deliverable timelines set forth for each of the PIPs and incorporating feedback as received.
3. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the interventions for the <i>Controlling High Blood Pressure</i> corrective action plan performance improvement plan (CAP PIP) and the	For the <i>Controlling High Blood Pressure</i> PIP Module 4, Anthem is incorporating the feedback received from HSAG. This feedback was incorporated and will be evidenced in the final Module 4 and Module 5 submissions that are due to DHCS/HSAG on August 15, 2017. For the <i>Prenatal and Postpartum Care</i> PIP, Anthem incorporated feedback for HSAG into the final Module 4

2015–16 External Quality Review Recommendations Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<i>Prenatal and Postpartum Care</i> CAP PIP.	and Module 5 submissions that were submitted to DHCS/HSAG on June 1, 2017. The <i>Prenatal and Postpartum Care</i> PIP Modules 4 and 5 were approved on June 16, 2017.
4. Incorporate HSAG’s feedback on modules 1 and 2 for the <i>Comprehensive Diabetes Care</i> CAP PIP to ensure that all validation criteria are met for a methodologically sound PIP.	Anthem received feedback on the <i>Comprehensive Diabetes Care</i> PIP Module 1 and Module 2 on June 16, 2016. Anthem made the recommended corrections and re-submitted the <i>Comprehensive Diabetes Care</i> PIP Modules 1 and 2 on June 30, 2016; and HSAG/DHCS approved the PIP modules on July 7, 2016.

2016–17 Recommendations

Based on the overall assessment of Anthem’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 resolves all deficiencies from the October 31, 2016, through November 4, 2016, SPD Medical Survey, particularly in the area of Grievances and Appeals within the Member Rights category.
- ◆ Continue to work with DHCS to prioritize areas for improvement and determine whether or not current strategies need to be modified or expanded to improve the MCP’s performance to above the MPLs for all measures. HSAG recommends that Anthem focus on the following measures for which the MCP performed below the MPLs in RY 2017:
 - Preventive Screening and Women’s Health
 - *Cervical Cancer Screening* in Contra Costa County
 - *Prenatal and Postpartum Care—Postpartum Care* in Kings County
 - Care for Chronic Conditions
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Contra Costa County, Madera County, Region 2, and Sacramento County
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Contra Costa County and Region 2
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Region 1, Region 2, Sacramento County, and San Benito County
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Alameda County, Contra Costa County, Region 1, Region 2, and San Benito County
 - Appropriate Treatment and Utilization
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Madera County and Region 1

In the next annual review, HSAG will evaluate continued successes of Anthem as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix D:
Performance Evaluation Report
California Health & Wellness Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), California Health & Wellness Plan (“CHW” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in CHW’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CHW is a full-scope MCP delivering services to beneficiaries under the Regional and Imperial models. In all counties, beneficiaries may enroll in CHW or the other commercial plan (CP).

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 CPs for each county, the number and percentage of beneficiaries enrolled in CHW for each county, and the MCP’s total number of beneficiaries as of June 30, 2017.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Jul 18, 2017.

Table 1.1—CHW Enrollment as of June 30, 2017

County	Other Commercial Plan	Enrollment as of June 30, 2017	CHW's Percentage of Beneficiaries Enrolled in the County
Alpine	Anthem Blue Cross Partnership Plan (Anthem)	104	43%
Amador	Anthem Kaiser NorCal	1,008	16%
Butte	Anthem	34,765	53%
Calaveras	Anthem	5,796	61%
Colusa	Anthem	2,488	34%
El Dorado	Anthem Kaiser NorCal	19,756	65%
Glenn	Anthem	5,842	59%
Imperial	Molina Healthcare of California Partner Plan, Inc.	15,652	21%
Inyo	Anthem	1,874	49%
Mariposa	Anthem	840	23%
Mono	Anthem	1,008	37%
Nevada	Anthem	7,794	38%
Placer	Anthem Kaiser NorCal	9,243	20%
Plumas	Anthem	2,370	47%
Sierra	Anthem	215	36%
Sutter	Anthem	10,462	32%
Tehama	Anthem	10,933	53%
Tuolumne	Anthem	5,761	53%
Yuba	Anthem	8,768	35%
Total		144,679	

For Region 1 and Region 2, DHCS allows CHW to combine data from multiple counties to make up single reporting units. 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

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

DHCS' Audits & Investigations Division (A&I) conducted Medical and State Supported Services Audits of CHW from November 7, 2016, through November 18, 2016, covering the review period of November 1, 2015, through October 31, 2016. At the time that this MCP-specific evaluation report was produced, the draft audit reports were pending. HSAG will include the results of the November 2016 audits in CHW's 2017–18 MCP-specific evaluation report.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for California Health & Wellness Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that CHW followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.3 for CHW's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.3:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
CHW—Imperial County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	61.90%	64.66%	66.05%	1.39
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	98.15%	96.89%	97.05%	0.16
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	89.84%	91.07%	90.01%	-1.06^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	NA	89.57%	88.96%	-0.61
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	NA	88.34%	86.38%	-1.96^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	24.82%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	56.01%	68.75%	70.24%	1.49
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	46.63%	58.17%	63.66%	5.49
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	71.39%	70.67%	73.28%	2.61
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	59.80%	Not Comparable
<i>Cervical Cancer Screening</i>	--	55.10%	58.60%	60.35%	1.75
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	55.37%	55.48%	63.64%	8.16^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	72.55%	76.46%	83.54%	7.08^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	93.60% ⁺	91.65%	92.98% ⁺	1.33
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	93.93% ⁺	92.57% ⁺	92.78% ⁺	0.21
<i>Asthma Medication Ratio—Total</i>	--	--	--	72.25% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	72.61%	65.74%	72.99%	7.25^
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	56.79%	65.74%	68.86% ⁺	3.12

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	32.29%	45.14%	49.15%	4.01
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	56.35%	47.22%	41.12%	-6.10
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	90.20%	88.89%	88.81%	-0.08
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	80.62%	91.20% ⁺	92.70%	1.50
<i>Controlling High Blood Pressure</i>	--	68.87%	70.69% ⁺	69.25%	-1.44
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	S	10.15%	11.80%	1.65
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	61.92	60.72	58.33	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	299.04	285.71	290.81	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	39.22% ⁺	35.18%	35.97%	0.79
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	10.63%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	59.27%	58.50%	50.92%	-7.58^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	63.94%	65.63%	68.35%	2.72
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	94.23%	95.34%	96.32%	0.98
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	88.33%	88.56%	88.54%	-0.02
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	NA	90.30%	89.40%	-0.90
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	NA	88.08%	86.58%	-1.50^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	20.92%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	39.90%	46.02%	60.58%	14.56^
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	29.33%	35.90%	52.07%	16.17^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	59.62%	63.22%	68.49%	5.27
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	49.37%	Not Comparable
<i>Cervical Cancer Screening</i>	--	44.53%	41.88%	48.66%	6.78^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	63.50%	61.14%	64.54%	3.40
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	76.40%	72.04%	83.93%	11.89^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	81.59%	84.03%	84.40%	0.37
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	81.33%	83.02%	85.43%	2.41
<i>Asthma Medication Ratio—Total</i>	--	--	--	62.13%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	70.60%	66.67%	65.94%	-0.73

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	39.20%	46.99%	54.01%	7.02 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	40.31%	45.83%	47.20%	1.37
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	44.99%	44.91%	41.36%	-3.55
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	84.63%	83.33%	83.45%	0.12
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	76.17%	84.95%	84.43%	-0.52
<i>Controlling High Blood Pressure</i>	--	54.20%	66.35%	66.58%	0.23
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	13.56%	17.54%	19.27%	1.73
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	47.61	54.37	53.99	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	331.93	348.53	341.25	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	16.15%	16.59%	20.92%	4.33 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	14.84%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	77.96%	78.05%	67.24%	-10.81^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (†), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.3—Multi-Year Performance Measure Results*
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYS 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	52.08%	53.13%	58.05%	4.92
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	91.36%	92.36%	92.30%	-0.06
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	80.61%	82.57%	82.41%	-0.16
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	NA	84.16%	83.39%	-0.77
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	NA	82.34%	81.87%	-0.47
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	17.76%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	53.13%	44.82%	61.07%	16.25 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	42.31%	36.87%	51.82%	14.95 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	59.13%	58.65%	63.34%	4.69
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	48.08%	Not Comparable
<i>Cervical Cancer Screening</i>	--	40.88%	44.55%	52.31%	7.76 [^]
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	53.28%	62.91%	69.07%	6.16
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	72.99%	73.47%	86.60%	13.13 [^]
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	81.43%	81.94%	81.93%	-0.01
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	82.69%	81.25%	82.76%	1.51
<i>Asthma Medication Ratio—Total</i>	--	--	--	54.81%	Not Comparable

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	61.20%	62.27%	62.53%	0.26
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	38.14%	41.20%	52.80%	11.60 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	40.13%	46.30%	54.99%	8.69 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	48.12%	45.14%	34.06%	-11.08 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	87.80%	83.80%	85.89%	2.09
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	83.37%	87.27%	88.56%	1.29
<i>Controlling High Blood Pressure</i>	--	51.88%	54.95%	63.33%	8.38 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	17.65%	15.31%	12.61%	-2.70 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	59.57	58.83	56.29	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	257.36	260.30	263.87	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	18.60%	27.46%	28.27%	0.81
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	17.36%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	78.98%	75.30%	66.82%	-8.48^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of CHW’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ *All four Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Across all reporting units within the Preventive Screening and Children’s Health domain, seven of nine rates that were below the MPLs in RY 2016 (78 percent) moved to above the MPLs in RY 2017.

In Region 2, the rates for the following measures in this domain were below the MPLs in RY 2017:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that CHW implemented during the review period to improve the MCP’s performance on measures within the Preventive Screening and Children’s Health domain. Information regarding the intervention that CHW tested as part of the *Immunizations of Two-Year-Olds* performance improvement project (PIP) to improve the MCP’s performance on the *Childhood Immunization Status—Combination 3* measure is included in Section 4 of this report (“Performance Improvement Projects”).

CHW has opportunities to build on strategies conducted as part of the MCP's *Immunizations of Two-Year-Olds* PIP and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* IP/PDSA cycle to ensure that in Region 2:

- ◆ Beneficiaries receive their specified immunization dosages by age 2.
- ◆ Beneficiaries 3 to 6 years of age are seen for one or more well-child visit(s) with a primary care provider (PCP) during the MY.

Preventive Screening and Women's Health

Across all reporting units within the Preventive Screening and Women's Health domain, six of nine rates (67 percent) improved significantly from RY 2016 to RY 2017, with five of the rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017. The MCP had no rates below the MPLs within the Preventive Screening and Women's Health domain in RY 2017.

Under the "Assessment of Improvement Plans" heading in this section of the report, HSAG provides a summary of the PDSA cycles that CHW implemented during the review period to improve the MCP's performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in all three reporting units. Information regarding the intervention that CHW tested as part of its *Cervical Cancer Screening* PIP to improve the MCP's performance on the *Cervical Cancer Screening* measure in regions 1 and 2 is included in Section 4 of this report ("Performance Improvement Projects"). CHW's efforts may have contributed to the rates in all three reporting units for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and the rates in regions 1 and 2 for the *Cervical Cancer Screening* measure moving from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Performance measure results show that CHW improved its performance from RY 2016 to RY 2017 for ensuring that female beneficiaries:

- ◆ Ages 21 to 64 are screened for cervical cancer within the appropriate time frames.
- ◆ Who deliver a live birth received a prenatal care visit in the first trimester or within 42 days of enrollment in CHW.
- ◆ Who deliver a live birth complete a postpartum visit on or between 21 and 56 days after delivery.

Care for Chronic Conditions

In RY 2017, Imperial County performed best within the Care for Chronic Conditions domain. This reporting unit had three of nine measures (33 percent) with rates above the HPLs and no measures with rates below the MPLs, while regions 1 and 2 each had no measures with rates above the HPLs and two of nine measures (22 percent) with rates below the MPLs. Imperial County performed above the HPLs for the following measures within the Care for Chronic Conditions domain in RY 2017:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

Across all reporting units within this domain, six of 27 rates (22 percent) improved significantly from RY 2016 to RY 2017:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Imperial County
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in regions 1 and 2, resulting in the rates in both regions moving from below the MPL in RY 2016 to above the MPL in RY 2017
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in Region 2
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Region 2
- ◆ *Controlling High Blood Pressure* in Region 2

In Region 1, the rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.

Under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that CHW implemented during the review period to improve the MCP’s performance on both *Annual Monitoring for Patients on Persistent Medications* measures and the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure in regions 1 and 2. CHW’s efforts may have contributed to the rates improving to above the MPLs for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in Region 1 and the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure in regions 1 and 2.

Across all reporting units, four of 27 rates (15 percent) in the Care for Chronic Conditions domain were below the MPLs in RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in regions 1 and 2
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Region 2
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Region 1

Performance measure results within the Care for Chronic Conditions domain show that CHW has the opportunity to explore the causes for the MCP’s performance below the MPLs to ensure that:

- ◆ In regions 1 and 2, beneficiaries ages 18 and older on angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) receive annual monitoring.
- ◆ In Region 2, beneficiaries ages 18 and older on diuretics receive annual monitoring.
- ◆ In Region 1, beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) receive a nephropathy screening or monitoring test.

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, the rates for the following measures improved significantly from RY 2016 to RY 2017:

- ◆ *All-Cause Readmissions* measure in Region 2.
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1; however, the rate for this measure remained below the MPL in RY 2017.

In all three reporting units, the rates for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. The decline resulted in the rates remaining below the MPL in Imperial County and moving from above the MPL in RY 2016 to below the MPL in RY 2017 in regions 1 and 2.

Under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the quality improvement efforts that CHW implemented during the review period to improve the MCP’s performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Region 1 and the *Use of Imaging Studies for Low Back Pain* measure in Imperial County. Note that the significant changes in the rates for these measures may not be related to CHW’s performance but instead may be due to NCQA’s RY 2017 specification changes for these measures.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, DHCS required CHW to submit IP/PDSA cycles or triannual quality improvement summaries for measures with rates below the MPLs in RY 2016.

Summary of Plan-Do-Study-Act Cycles

CHW submitted PDSA cycles for the following measures:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures in regions 1 and 2—The rate for the *Diuretics* measure in Region 1 improved to above the MPL in RY 2017; however, the rate for the *Diuretics* measure in Region 2 and the rates for the *ACE Inhibitors or ARBs* measure in both regions remained below the MPLs in RY 2017.
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in regions 1 and 2—The rates for this measure in both regions improved to above the MPL in RY 2017.
- ◆ *Immunizations for Adolescents—Combination 1* for regions 1 and 2—DHCS replaced this measure in the RY 2017 EAS with the *Immunizations for Adolescents—Combination 2* measure; therefore, HSAG is unable to assess whether or not the rates for this measure in regions 1 and 2 improved to above the MPL in RY 2017.
 - While DHCS replaced the *Immunizations for Adolescents—Combination 1* measure in RY 2017 with the *Immunizations for Adolescents—Combination 2* measure, CHW may be able to apply the lessons learned from the *Immunizations for Adolescents—Combination 1* PDSA process to ensure that the MCP’s beneficiaries receive their specified immunization dosages by age 13.

- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in all three reporting units—The rates for this measure in all three reporting units improved to above the MPL in RY 2017.
- ◆ Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in regions 1 and 2—The rates for these measures in both regions improved to above the MPLs in RY 2017.
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in regions 1 and 2—The rate for this measure in Region 1 improved to above the MPL in RY 2017; however, the rate in Region 2 remained below the MPL in RY 2017.

For all PDSA cycles, CHW targeted non-compliant beneficiaries and set SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objectives to improve the compliance rate of the non-compliant beneficiaries at select high-volume, low-performing providers. The common interventions that CHW tested across the measures were whether or not providing training and education on care gap reports and beneficiary outreach and providing lists of new beneficiaries to the high-volume, low-performing providers would result in improved compliance for non-compliant beneficiaries. Additional interventions that the MCP tested were:

- ◆ For the two *Annual Monitoring for Patients on Persistent Medications* measures, whether correcting a data feed issue with two of its contracted labs would improve the rates for these two measures.
- ◆ For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, whether correctly mapping the International Classification of Diseases (ICD)-10 Z-codes at the corporate level would improve the rates for this measure in all three reporting units.
- ◆ For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures:
 - Whether or not offering extended clinic hours would improve the rates for these measures.
 - Whether or not educating providers on the updated ICD-10 billing codes and updating educational materials within the MCP's provider toolkit would improve the rates for these measures.

CHW reported on common lessons learned through the PDSA cycle process, including:

- ◆ Partnering with providers will likely increase beneficiary compliance for completing required services because it helps increase provider awareness of non-compliant beneficiaries.
- ◆ Ongoing communication with the appropriate provider-level contacts is paramount to successfully piloting and completing an intervention.

Summary of Triannual Quality Improvement Summaries

Based on RY 2016 performance measure results, DHCS required CHW to submit triannual quality improvement summaries for the following measures:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1—The rate for this measure in Region 1 remained below the MPL in RY 2017.
- ◆ *Use of Imaging Studies for Low Back Pain* in Imperial County—The rate for this measure in Imperial County remained below the MPL in RY 2017.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

CHW identified the following barriers to the MCP performing above the MPL for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Region 1:

- ◆ Providers lack knowledge about this measure.
- ◆ Providers and beneficiaries lack knowledge about acute bronchitis treatment and recommended care.

To address the barriers, the MCP:

- ◆ Educated providers on the HEDIS specification for this measure.
- ◆ Using resources from the Centers for Disease Control and Prevention and the Alliance Working for Antibiotic Resistance Education program, educated providers and beneficiaries on appropriate antibiotic use.
- ◆ Distributed a provider toolkit that included updated “Staying Healthy” beneficiary brochures in English and Spanish.

Use of Imaging Studies for Low Back Pain

CHW identified the following barriers to the MCP performing above the MPL for the *Use of Imaging Studies for Low Back Pain* measure in Imperial County:

- ◆ Providers lack knowledge about this measure.
- ◆ Providers and beneficiaries lack knowledge about recommended care for low back pain.

To address the barriers, the MCP:

- ◆ Educated providers on the HEDIS specification for this measure.
- ◆ Shared high-volume and high-performing providers’ best practices and interventions with the low-performing providers.
- ◆ Created a provider toolkit that included patient education flyers about low back pain and recommended care.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, CHW will be required to submit IP/PDSA cycles for the following measures, presented by domain:

Preventive Screening and Children's Health

- ◆ *Childhood Immunization Status—Combination 3* in Region 2
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Region 2

Care for Chronic Conditions

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in regions 1 and 2
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Region 2
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Region 1

Appropriate Treatment and Utilization

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1
- ◆ *Use of Imaging Studies for Low Back Pain* in all three reporting units

Seniors and Persons with Disabilities Performance Measure Results

Table 3.4 through Table 3.6 present the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.4—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHW—Imperial County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	13.78%	10.66%	3.12	11.80%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	96.35	55.87	Not Tested	58.33
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	582.11	271.92	Not Tested	290.81
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	93.70%	92.86%	0.84	92.98%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	94.34%	92.46%	1.88	92.78%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	97.03%	Not Comparable	97.05%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	95.73%	89.91%	5.82 [^]	90.01%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	97.00%	88.82%	8.18 [^]	88.96%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	93.75%	86.28%	7.47 [^]	86.38%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.4 through Table 3.6.

Table 3.5—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	25.81%	13.76%	12.05^^	19.27%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	89.02	49.77	Not Tested	53.99
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	591.80	311.04	Not Tested	341.25
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.17%	82.98%	4.19^	84.40%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.69%	83.42%	5.27^	85.43%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	96.37%	Not Comparable	96.32%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	93.21%	88.44%	4.77	88.54%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.46%	89.30%	3.16	89.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.17%	86.60%	-0.43	86.58%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.6—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.73%	10.25%	6.48^^	12.61%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	87.04	53.27	Not Tested	56.29
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	443.12	246.30	Not Tested	263.87
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.64%	79.56%	8.08^	81.93%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.05%	80.85%	6.20^	82.76%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	92.27%	Not Comparable	92.30%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.91%	82.39%	1.52	82.41%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	81.55%	83.43%	-1.88	83.39%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	82.11%	81.86%	0.25	81.87%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.7 through Table 3.9 present the four-year trending information for the SPD population, and Table 3.10 through Table 3.12 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.7—Multi-Year SPD Performance Measure Trend Table
CHW—Imperial County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	11.00%	13.78%	2.78
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	94.32	101.51	96.35	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	585.22	540.67	582.11	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	97.40%	94.46%	93.70%	-0.76
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	100.00%	94.72%	94.34%	-0.38
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	97.78%	92.09%	95.73%	3.64
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	NA	97.00%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	NA	93.75%	Not Comparable

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.8—Multi-Year SPD Performance Measure Trend Table
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	21.68%	25.81%	4.13^^
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	83.85	87.91	89.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	608.59	599.31	591.80	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	82.81%	87.51%	87.17%	-0.34
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	87.50%	86.54%	88.69%	2.15
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	93.10%	91.49%	93.21%	1.72
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	95.35%	92.46%	-2.89
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	95.65%	86.17%	-9.48

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.9—Multi-Year SPD Performance Measure Trend Table
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono,
Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	18.44%	16.73%	-1.71
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	86.17	88.42	87.04	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	454.03	444.22	443.12	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	83.33%	87.08%	87.64%	0.56
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	88.89%	86.40%	87.05%	0.65
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	NA	65.38%	83.91%	18.53 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	88.24%	81.55%	-6.69
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	90.00%	82.11%	-7.89

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.10—Multi-Year Non-SPD Performance Measure Trend Table
CHW—Imperial County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	S	9.73%	10.66%	0.93
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	61.43	58.09	55.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	294.65	269.30	271.92	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	93.25%	90.61%	92.86%	2.25 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	93.32%	91.66%	92.46%	0.80
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	98.25%	96.88%	97.03%	0.15
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	89.77%	91.04%	89.91%	-1.13 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	89.53%	88.82%	-0.71
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	88.32%	86.28%	-2.04 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	12.38%	14.80%	13.76%	-1.04
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	46.76	50.39	49.77	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	325.44	318.81	311.04	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	81.51%	82.17%	82.98%	0.81
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	80.84%	80.73%	83.42%	2.69
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	94.20%	95.33%	96.37%	1.04
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	88.29%	88.51%	88.44%	-0.07
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	90.26%	89.30%	-0.96
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	88.01%	86.60%	-1.41^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.12—Multi-Year Non-SPD Performance Measure Trend Table
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono,
Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	S	13.93%	10.25%	-3.68 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	59.01	56.02	53.27	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	253.23	242.81	246.30	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	81.31%	79.79%	79.56%	-0.23
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	82.15%	78.85%	80.85%	2.00
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	91.35%	92.44%	92.27%	-0.17
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	80.58%	82.81%	82.39%	-0.42
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	84.12%	83.43%	-0.69
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	82.29%	81.86%	-0.43

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that CHW stratified by the SPD and non-SPD populations:

- ◆ In RY 2017, the SPD rates were significantly better than the non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in regions 1 and 2
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years* measures in Imperial County
- ◆ In RY 2017, the SPD rates were significantly worse than the non-SPD rates for the *All-Cause Readmissions* measure in regions 1 and 2. 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 beneficiaries.
- ◆ For SPD rates for which a comparison could be made between RY 2016 and RY 2017:
 - In Region 2, the RY 2017 SPD rate was significantly better than the RY 2016 SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* measure.
 - In Region 1, the RY 2017 SPD rate was significantly worse than the RY 2016 SPD rate for the *All-Cause Readmissions* measure.
- ◆ For non-SPD rates for which a comparison could be made between RY 2016 and RY 2017:
 - The RY 2017 non-SPD rate was significantly better than the RY 2016 non-SPD rate for the following measures:
 - *All-Cause Readmissions* in Region 2.
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Imperial County.
 - The RY 2017 non-SPD rate was significantly worse than the RY 2016 non-SPD rate for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Imperial County.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Imperial County and Region 1.

Strengths—Performance Measures

HSAG auditors determined that CHW followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Imperial County had three of nine measures (33 percent) with rates above the HPLs within the Care for Chronic Conditions domain. Across all reporting units and domains, 18 of 57 rates (32 percent) improved significantly from RY 2016 to RY 2017. Additionally, 15 of the 22 rates that were below the MPLs in RY 2016 (68 percent) moved to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

Across all domains and reporting units, 10 of 54 rates for which the MCP was held accountable to meet the MPLs (19 percent) were below the MPLs in RY 2017. Performance measure results show that CHW has opportunities for improvement for ensuring that:

- ◆ Across all reporting units, only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.
- ◆ In Region 1:
 - Beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) receive a nephropathy screening or monitoring test.
 - Antibiotics are dispensed appropriately for beneficiaries ages 18 to 64 with a primary diagnosis of bronchitis.
- ◆ In Region 2:
 - Beneficiaries receive their specified immunization dosages by age 2.
 - Beneficiaries ages 3 to 6 are seen for one or more well-child visit(s) with a PCP during the MY.
 - Beneficiaries 18 and older on diuretics receive annual monitoring.
- ◆ In regions 1 and 2, beneficiaries 18 and older on angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) receive annual monitoring.

4. Performance Improvement Projects

CHW had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

CHW selected immunizations of two-year-olds as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to CHW and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CHW set the SMART Aim for the *Immunizations of Two-Year-Olds* PIP as follows:

By June 30, 2017, increase the *Childhood Immunizations Status—Combination 3* measure administrative rate from 18.37 percent to 66.19 percent for children turning 2 years of age who are patients of Provider A⁶ and reside in Nevada County.

Failure Modes

The following, listed in priority order, are the failure modes CHW identified during the Intervention Determination phase of the PIP process:

- ◆ Parent/guardian concerns of risks associated with immunizations of beneficiary.
- ◆ Beneficiary not offered immunizations at sick visit if fever is present.
- ◆ No transportation available in order to keep the appointment.
- ◆ Parent/guardian not able to bring beneficiary to clinic during hours of operation due to work schedules.
- ◆ Parent/guardian lack of familiarity with the immunization schedule.

⁶ Provider name removed for confidentiality.

- ◆ Beneficiary does not attend immunization appointment.
- ◆ Tracking of immunizations is not current.
- ◆ Staff/provider does not have accurate immunization records to refer to at visit.
- ◆ Beneficiary is not identified as needing immunizations early enough in the process to schedule completion of the series.
- ◆ The MCP does not receive claims for immunization administration.

Intervention Testing

During the reporting period, CHW selected to test an e-messaging campaign which addresses parent/guardian lack of familiarity with the immunization schedule.

Although CHW completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CHW's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

CHW selected cervical cancer screening as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for CHW's MCP-specific PIP.

Upon initial review of the module, HSAG determined that CHW met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a narrative description of the method used to select the sub-processes
- ◆ Describing the priority-ranking process to determine potential interventions

After receiving technical assistance from HSAG, CHW incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to CHW on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG sent periodic check-in email communications to CHW and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CHW set the SMART Aim for the *Cervical Cancer Screening* PIP as follows:

By June 30, 2017, increase cervical cancer screening rates from 31.49 percent to 54.33 percent among all eligible women ages 21 to 64 years and residing in Yuba County who receive care at Provider B.⁷

Failure Modes

The following, listed in priority order, are the failure modes that CHW identified during the Intervention Determination phase of the PIP process:

- ◆ Woman is not provided with the appropriate information about the importance of cervical cancer screening.
- ◆ Woman faces barriers to attending her cervical cancer screening appointment.
- ◆ Provider does not follow up with the woman after she misses her appointment.
- ◆ Clinic does not schedule enough preventive care visits.
- ◆ Provider does not have protocols in place to make a woman's cancer screening history available at the time of her visit.
- ◆ Woman forgets about her cervical cancer screening appointment.
- ◆ Woman is not interested in understanding the information provided.
- ◆ Woman does not feel cervical cancer screening is necessary.
- ◆ Woman's medical record contains inaccurate cervical cancer screening history.

Intervention Testing

During the reporting period, CHW selected to test financial incentives for providers and beneficiaries to address access to cervical cancer screening and beneficiary engagement.

Although CHW completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CHW's 2017–18 MCP-specific evaluation report.

⁷ Provider name removed for confidentiality.

Strengths

Through HSAG's PIP validation and technical assistance, CHW improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from CHW’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of CHW’s self-reported actions.

Table 5.1—CHW’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Revise the audit report production processes to improve the MCP’s ability to provide documents to the auditor in a timely manner during the HEDIS 2017 audit process.	The HEDIS 2017 audit was conducted by a new team. This experienced group led the process, and the audit reports were produced in a timely manner that met the satisfaction of the auditor. No further concerns were identified during the HEDIS 2017 audit regarding timely production of audit reports.
2. Work closely with DHCS to identify priority areas for improvement and engage with DHCS and the EQRO for technical assistance to help increase the potential for improved performance measure outcomes. Specifically, focus efforts on the performance measures for which the MCP is required to submit IP/PDSA cycles in 2016.	In response to the 2016 reported HEDIS rates, and in collaboration with DHCS, CHW addressed the high-priority measures for PDSA work. To prioritize, PDSAs were staggered and the energy was focused on the higher-risk measures. CHW provided activity summaries on lower-priority measures. Interventions were pinpointed on areas where data issues seemed significant; then provider engagement resources and incentives were deployed to other problem areas. The interventions were led cross-departmentally to create a stronger impact in a short period of time.
3. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Immunizations of Two-Year-Olds</i> PIP to address the MCP’s performance below the MPL for the <i>Childhood Immunization Status—Combination 3</i> measure in all three reporting units.	The Module 4 intervention, provider-group-led email and texting outreach to members and the recommendations by HSAG have begun and been incorporated to address the <i>Childhood Immunization Status—Combination 3</i> measure. Technical assistance calls were held over the last year to address significant operational barriers encountered during implementation of the intervention. Final reporting of the PIP is on track.

2015–16 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
4. Work with HSAG to ensure that the MCP continues to meet all validation criteria for a methodologically sound <i>Cervical Cancer Screening</i> PIP to provide the best opportunity for the MCP to improve performance to above the MPL for the <i>Cervical Cancer Screening</i> measure in regions 1 and 2.	The <i>Cervical Cancer Screening</i> PIP has been implemented to include interventions addressing member knowledge and provider appointment availability barriers. The targeted provider group had staff turnover issues leading to miscommunication and delays, which may have impacted the success of the incentive and member education interventions. As needed, CHW engaged with HSAG to address problems as they arose. Final reporting of the PIP is on track.

2016–17 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:

- ◆ For the following measures for which CHW performed below the MPLs, identify the causes for the MCP’s performance below the MPLs and, when applicable, apply successful improvement strategies from PDSA cycles and PIPs to improve the MCP’s performance to above the MPLs:
 - Preventive Screening and Children’s Health domain
 - *Childhood Immunization Status—Combination 3* in Region 2
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Region 2
 - Care for Chronic Conditions domain
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in regions 1 and 2
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Region 2
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Region 1
 - Appropriate Treatment and Utilization domain
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1
 - *Use of Imaging Studies for Low Back Pain* in all three reporting units

In the next annual review, HSAG will evaluate continued successes of CHW as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix E:
Performance Evaluation Report
CalOptima
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), CalOptima (or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in CalOptima’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CalOptima is a full-scope MCP delivering services to beneficiaries in the County Organized Health System (COHS) model.

CalOptima became operational to provide MCMC services in Orange County effective October 1995. As of June 30, 2017, CalOptima had 766,775 beneficiaries in Orange County.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Aug 25, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CalOptima. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Department of Managed Health Care (DMHC) Seniors and Persons with Disabilities (SPD) Medical Survey of CalOptima. DMHC conducted the on-site survey from February 6, 2017, through February 10, 2017. Note that while DMHC issued the final report to the MCP on July 27, 2017, which is outside the review period for this MCP-specific evaluation report, HSAG includes the survey results and status because DMHC conducted the on-site survey during the review period for this report.

Table 2.1—DMHC SPD Medical Survey of CalOptima
Survey Review Period: November 1, 2014, through October 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review by DHCS.
Continuity of Care	Yes	CAP in process and under review by DHCS.
Availability and Accessibility	Yes	CAP in process and under review by DHCS.
Member Rights	Yes	CAP in process and under review by DHCS.
Quality Management	Yes	CAP in process and under review by DHCS.

Follow-Up on February 2016 Medical Audit

The DHCS Audits & Investigations Division (A&I) conducted a Medical Audit of CalOptima from February 8, 2016, through February 19, 2016, covering the review period of February 1, 2015, through January 31, 2016. HSAG provided a summary of the survey results and status in CalOptima’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, CalOptima’s CAP was in process and under review by DHCS. A letter from DHCS dated November 8, 2016, stated that CalOptima provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

CalOptima fully resolved all outstanding deficiencies from the February 2016 A&I Medical Audit.

Opportunities for Improvement—Compliance Reviews

CalOptima has the opportunity to work with DHCS to ensure that the MCP resolves all deficiencies from the February 2017 DMHC SPD Medical Survey.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for CalOptima* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that CalOptima followed the appropriate specifications to produce valid rates. During the audit process, the HSAG auditor recommended that, in addition to using oversight metrics to monitor provider network compliance and encounter processing, CalOptima also use oversight metrics to monitor paper claims and incoming encounters from the clearinghouses. Monitoring these data will help to ensure that capitated encounter data are complete.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. See Table 3.1 for CalOptima’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’ *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
CalOptima—Orange County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	79.40%	78.94%	71.46%	72.22%	0.76
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.42%	94.16%	93.08%	94.14%	1.06 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	91.43%	89.52%	87.29%	87.69%	0.40 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	92.30%	92.68%	90.62%	90.27%	-0.35^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	89.07%	89.96%	87.48%	86.67%	-0.81^{^^}
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	34.72%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	84.19% ⁺	83.29% ⁺	84.06% ⁺	85.48% ⁺	1.42
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	72.64% ⁺	76.10% ⁺	73.01% ⁺	80.91% ⁺	7.90 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	83.94% ⁺	85.71% ⁺	78.70%	79.21%	0.51
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	64.40%	Not Comparable
<i>Cervical Cancer Screening</i>	71.63%	62.78%	53.58%	52.93%	-0.65
<i>Prenatal and Postpartum Care—Postpartum Care</i>	58.96%	64.15%	61.02%	69.01%	7.99 [^]
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	85.07%	84.20%	80.15%	84.98%	4.83
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.55%	90.07%	86.50%	88.90%	2.40 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.62%	89.44%	87.05%	88.52%	1.47 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	66.78%	Not Comparable

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	69.30%	74.07%	71.05%	71.63%	0.58
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	67.91% ⁺	63.89%	59.37%	63.49%	4.12
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	59.07% ⁺	61.57% ⁺	54.01%	57.21%	3.20
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	32.33%	27.78% ⁺	34.31%	32.09%	-2.22
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	85.12%	89.81%	84.18%	86.98%	2.80
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.81%	82.64%	89.54% ⁺	90.93%	1.39
<i>Controlling High Blood Pressure</i>	67.25%	69.29%	72.51% ⁺	71.79% ⁺	-0.72
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	15.22%	17.60%	17.45%	15.79%	-1.66 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	34.90	35.17	33.08	32.73	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	271.66	256.82	238.83	242.24	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	20.65%	22.00%	21.64%	22.44%	0.80
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	99.70%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	3.63%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	75.25%	76.66%	76.10%	73.33%	-2.77^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of CalOptima’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures were above the HPLs for all RYs displayed in Table 3.1, with the rate for the *Physical Activity Counseling—Total* measure improving significantly from RY 2016 to RY 2017. CalOptima had no rates below the MPLs in the Preventive Screening and Children’s Health domain in RY 2017.

Preventive Screening and Women’s Health

Within the Preventive Screening and Women’s Health domain, the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure improved significantly from RY 2016 to RY 2017. Additionally, the rate for the *Cervical Cancer Screening* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017. CalOptima provided detailed information on actions that the MCP took during the review period to address the rate for the *Cervical Cancer Screening* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that CalOptima conducted during the review period to improve the MCP’s performance on this measure. CalOptima’s efforts may have contributed to the rate for the *Cervical Cancer Screening* measure improving significantly from RY 2016 to RY 2017.

Care for Chronic Conditions

Within the Care for Chronic Conditions in RY 2017, the rate for the *Controlling High Blood Pressure* measure was above the HPL and the MCP had no rates below the MPLs. Additionally, the rates for both *Annual Monitoring for Patients on Persistent Medications* measures improved significantly from RY 2016 to RY 2017.

Appropriate Treatment and Utilization

CalOptima had no measures within the Appropriate Treatment and Utilization domain with rates below the MPLs in RY 2017. The rate for the *All-Cause Readmissions* measure improved significantly from RY 2016 to RY 2017, reflecting a reduction in unplanned acute readmissions within 30 days of discharge for beneficiaries 21 years and older.

The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017. CalOptima provided detailed information on actions that the MCP took during the review period to address the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that CalOptima conducted during the review period to improve the MCP’s performance on this measure. Note that the significant improvement in the rate for this measure from RY 2016 to RY 2017 may be due to NCQA’s RY 2017 specification changes for this measure and therefore may not be related to CalOptima’s improvement efforts or performance.

The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017; however, the significant decline may be due to NCQA’s RY 2017 specifications for this measure and therefore may not be related to CalOptima’s performance.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, CalOptima was required to submit two IP/PDSA cycles—one for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and one for the *Cervical Cancer Screening* measure. The rates for both measures improved from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

During the review period for this report, CalOptima conducted two PDSA cycles to improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.

Plan-Do-Study-Act Cycle 1

For the first PDSA cycle, the MCP set the following SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective:

By January 31, 2017, complete 100 percent of provider trainings to five targeted Medi-Cal providers who have been identified as high-prescribers of antibiotics for acute bronchitis and low performers for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Orange County.

The MCP's medical director conducted the provider trainings telephonically and in person. The trainings focused on clinical practice guidelines, awareness of the providers' current *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rates, the measure's specification, appropriate coding and documentation, and supplementary education resources.

CalOptima reported that the MCP met the SMART objective and decided to adopt the intervention.

Plan-Do-Study-Act Cycle 2

For the second PDSA cycle, the MCP sought to assess whether or not the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rates improved for the providers who received the training. The MCP set the following SMART objective for this PDSA cycle:

By May 31, 2017, decrease the inappropriate antibiotic prescriptions by 5 percentage points from baseline to follow-up among the eight providers who received training during the first PDSA cycle.

CalOptima reported that it met the SMART objective; however, the MCP reported that it decided to abandon the intervention because of having noted no significant differences when comparing changes in antibiotic prescribing rates between providers who received the training with providers who did not receive the training. CalOptima concluded that more than one intervention may have contributed to the reduction in the antibiotic prescribing rates for beneficiaries with acute bronchitis.

Cervical Cancer Screening

CalOptima conducted one PDSA cycle to address the MCP's performance being below the MPL in RY 2016 for the *Cervical Cancer Screening Measure*. CalOptima set the following SMART objective for the PDSA cycle:

By July 15, 2017, two high-volume Medi-Cal provider offices will have scheduled well-woman appointments with 15 percent of the women who are due for a cervical cancer screening.

CalOptima tested whether providing a beneficiary registry list to participating providers that includes information on beneficiaries who may be due for a cervical cancer screening would result in an increase in the percentage of women scheduled to be screened for cervical cancer. The MCP offered incentives to the provider front-office personnel to support their efforts in scheduling women for their screening appointments.

CalOptima reported that it did not meet its SMART objective and that it decided to adapt the intervention. The MCP also reported on lessons learned during the PDSA process, including:

- ◆ Greater success with scheduling the appointments occurred when the providers were able to talk directly with the women.
- ◆ Electronic communication caused unnecessary delays, and using hard copies and in-person communication provided added value.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, CalOptima is not required to submit any improvement plans for RY 2017.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalOptima—Orange County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.29%	13.70%	5.59^^	15.79%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	46.55	31.53	Not Tested	32.73
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	491.25	220.63	Not Tested	242.24
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.95%	87.74%	3.21^	88.90%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	92.20%	86.41%	5.79^	88.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	86.27%	94.20%	-7.93^^	94.14%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.34%	87.77%	-3.43^^	87.69%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.99%	90.44%	-4.45^^	90.27%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.38%	86.87%	-5.49^^	86.67%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
CalOptima—Orange County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.83%	19.97%	20.48%	19.29%	-1.19
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	51.03	52.48	50.02	46.55	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	573.24	536.97	495.20	491.25	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.90%	91.07%	88.83%	90.95%	2.12 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.16%	91.12%	90.14%	92.20%	2.06 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	85.27%	75.19%	70.09%	86.27%	16.18 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.47%	87.18%	83.01%	84.34%	1.33
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.84%	88.65%	86.29%	85.99%	-0.30
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	80.71%	83.86%	79.16%	81.38%	2.22 [^]

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
CalOptima—Orange County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	10.83%	14.49%	15.45%	13.70%	-1.75 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	32.50	33.33	31.65	31.53	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	226.81	227.07	217.20	220.63	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.11%	88.91%	85.14%	87.74%	2.60 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.73%	87.62%	85.17%	86.41%	1.24 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.54%	94.33%	93.27%	94.20%	0.93 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	91.62%	89.59%	87.39%	87.77%	0.38 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.64%	92.88%	90.80%	90.44%	-0.36 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	89.52%	90.27%	87.82%	86.87%	-0.95 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures CalOptima stratified by the SPD and non-SPD populations:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures:
 - *All-Cause Readmissions*
 - All four *Children and Adolescents' Access to Primary Care Practitioners* measures

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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population, based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from a primary care practitioner.
- ◆ The SPD rates improved significantly from RY 2016 to RY 2017 for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- ◆ The non-SPD rates improved significantly from RY 2016 to RY 2017 for the following measures:
 - *All-Cause Readmissions*
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- ◆ The non-SPD rates declined significantly from RY 2016 to RY 2017 for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to CalOptima's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that CalOptima report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit. Although RY 2016 was the first year that DHCS required MLTSSPs to report rates, DHCS did not require CalOptima to report MLTSS rates in RY 2016 because CalOptima became operational as an MLTSSP in late 2015 and therefore did not have a full year of data to report. RY 2017 was the first year that DHCS required CalOptima to report MLTSSP performance measure rates.

Table 3.5 presents the rates for each required MLTSSP performance measure for RY 2017.

**Table 3.5—RY 2017 (MY 2016) MLTSSP Performance Measure Results
CalOptima—Orange County**

Measure	RY 2017 Rate ¹
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	61.81
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	806.24
<i>Medication Reconciliation Post-Discharge</i>	24.35%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

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

Strengths—Performance Measures

HSAG auditors determined that CalOptima followed the appropriate specifications to produce valid rates.

Across all domains, CalOptima performed above the HPLs for three measures and the rates for five measures improved significantly from RY 2016 to RY 2017. Additionally, the rates for the two measures with rates below the MPLs in RY 2016 improved to above the MPLs in RY 2017. Finally, the MCP had no measures with rates below the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

To help ensure that capitated encounter data are complete, CalOptima has the opportunity to expand the use of the MCP's oversight metrics to monitor paper claims and incoming encounters from the clearinghouses. Additionally, the MCP has the opportunity to identify the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

CalOptima had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

CalOptima selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to CalOptima and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CalOptima set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, increase HbA1c testing rates from 70.15 percent to 80.00 percent for CalOptima beneficiaries at Provider Office A.⁶

Failure Modes

The following, listed in priority order, are the failure modes CalOptima identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary is not provided with understandable information on the importance of HbA1c testing.
- ◆ Providers do not refer the beneficiary for HbA1c testing.
- ◆ Lab hours are inconvenient.
- ◆ Beneficiary does not have transportation to lab or provider office for HbA1c testing.
- ◆ Beneficiary is not happy with the care received from his or her current provider, who is providing the HbA1c testing referral.
- ◆ Beneficiary is unaware of the referral process to obtain HbA1c testing.

⁶ Provider office name removed for confidentiality.

- ◆ Beneficiary is unsure of whether or not additional costs are required for HbA1c testing.
- ◆ Beneficiary forgets about the referral.
- ◆ Beneficiary is not interested in understanding the HbA1c testing results.

Intervention Testing

During the reporting period, CalOptima selected to test:

- ◆ Working with Provider Office A in implementing better beneficiary educational outreach for HbA1c testing, which addresses the following key drivers:
 - Beneficiary engagement
 - Provider awareness
 - Access and availability of resources related to diabetes care management
- ◆ Sharing monthly list of beneficiaries needing their HbA1c tests with Provider Office A for outreach, which addresses the following key drivers:
 - Beneficiary engagement
 - Provider awareness
 - Identification of beneficiaries needing HbA1c testing
- ◆ Working with Provider Office A to identify a list of labs and those labs' hours to provide to beneficiaries who may not be aware of all options, which addresses the following key drivers:
 - Beneficiary engagement
 - Access and availability of resources related to diabetes care management

Although CalOptima completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CalOptima's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

CalOptima selected initial health assessment (IHA) as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for CalOptima's MCP-specific PIP.

Upon initial review of the module, HSAG determined that CalOptima met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis (FMEA).

- ◆ Describing the priority-ranking process to determine potential interventions.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, CalOptima incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to CalOptima on the Plan portion of the PDSA cycle for the interventions the MCP selected to test. HSAG sent periodic check-in email communications to CalOptima and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CalOptima set the SMART Aim for the *Initial Health Assessment* PIP as follows:

By June 30, 2017, increase the IHA completion rate from 3.4 percent to 25.0 percent for CalOptima beneficiaries assigned to Provider Office A and Provider Office B.⁷

Failure Modes

The following, listed in priority order, are the failure modes that CalOptima identified during the Intervention Determination phase of the PIP process:

- ◆ Providers are confused about the differences between the IHA and Individual Health Education Behavioral Assessment (IHEBA) requirements.
- ◆ Providers cannot identify beneficiaries who need their IHA completed to conduct outreach so that the beneficiaries complete the IHA in a timely manner.
- ◆ Beneficiaries do not feel that the IHA is necessary.
- ◆ Follow-up to complete IHAs is not conducted after beneficiaries miss their appointments.
- ◆ Providers do not consider IHA completion a priority health care service.
- ◆ Providers do not conduct outreach to beneficiaries who need their IHAs completed.
- ◆ Beneficiaries forget about their IHA completion appointments.
- ◆ Beneficiaries have challenges in getting to their IHA completion appointments.

⁷ Provider office names removed for confidentiality.

Intervention Testing

During the reporting period, CalOptima selected to test:

- ◆ Conducting an in-service to partnered providers to include quick reference guides and other supportive tools to address the key driver of provider awareness.
- ◆ Identifying administrative resources to reschedule missed IHA completion appointments to address the key driver of access and availability of resources.
- ◆ Conducting phone call reminders to new beneficiaries assigned to partnered providers to increase beneficiaries' awareness and understanding of the IHA.

Although CalOptima completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CalOptima's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, CalOptima improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from CalOptima’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of CalOptima’s self-reported actions.

Table 5.1—CalOptima’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure resolution of all deficiencies from the February 1, 2015, through January 31, 2016, A&I Medical Audit.	CalOptima notes that the CAP submitted in response to the deficiencies identified during the A&I Medical Audit covering the time period of February 1, 2015, through January 31, 2016, was closed by the DHCS on November 8, 2016.
2. Ensure that the MCP appropriately flags providers in its claims processes to ensure that services are billed with the appropriate specialty designation.	<ul style="list-style-type: none"> ◆ NCQA does not allow claims billed under a primary care clinic or group to be considered as a primary care provider (PCP) service based on HEDIS 2017 specifications. ◆ CalOptima reviewed individual providers in clinics and groups to ensure the providers are all PCPs. CalOptima received the HEDIS auditor’s approval to map these clinics and groups to PCP. ◆ CalOptima will continue to work with our auditor to get these claims to be counted for primary care services.
3. Explore the causes for the MCP’s declining performance or performance below the MPLs for the following measures: <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> b. <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> c. <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i> 	<p>For HEDIS 2016 MY, CalOptima met the MPLs for all reported measures.</p> <p>a. <i>Annual Monitoring for Patients on Persistent Medications (MPM)—ACE Inhibitors or ARBs</i></p> <p>Causes for performance declining significantly from RY 2015 to RY 2016:</p> <ul style="list-style-type: none"> ◆ Lack of staffing and resources ◆ Lack of member adherence to medication <p>The MY 2016 MPM (<i>ACE Inhibitors or ARBs</i> submeasure) rate is 88.90 percent and is above the NCQA 25th percentile of 85.63</p>

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>d. <i>Childhood Immunization Status—Combination 3</i></p> <p>e. <i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i></p> <p>f. <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i></p> <p>g. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></p>	<p>percent. This measure has improved from the previous year.</p> <ul style="list-style-type: none"> ◆ CalOptima is developing a physician fax notification process for members who have been identified with a false numerator for the <i>MPM</i> measure. These fax notifications provide information to providers regarding their members' status and assist with the monitoring of ACE inhibitors or ARBs. ◆ In Q1, 2017, ad hoc faxes were sent to physicians to inform them of their patients who are taking one or more of the drugs in this <i>MPM</i> measure and who are in need of lab tests. <p>b. Annual Monitoring for Patients on Persistent Medications—Diuretics</p> <p>Causes for performance declining significantly from RY 2015 to RY 2016:</p> <ul style="list-style-type: none"> ◆ Lack of staffing and resources ◆ Lack of member adherence to medication <p>The 2016 MY <i>MPM</i> (<i>Diuretics</i> submeasure) rate is 88.52 percent and is above the NCQA 25th percentile of 85.18 percent. This measure has improved from the previous year.</p> <ul style="list-style-type: none"> ◆ CalOptima is developing a physician fax notification process for members who have been identified with a false numerator for the <i>MPM</i> measure. These fax notifications provide information to providers regarding their members' status and assist with the monitoring of members who are on persistent medications—diuretics. ◆ In Q1, 2017, ad hoc faxes were sent to physicians to inform them of their patients who are taking one or more of the drugs in this <i>MPM</i> measure and who are in need of lab tests. <p>c. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)</p> <p>Causes for performance below the MPL in RY 2016:</p> <ul style="list-style-type: none"> ◆ Lacking adherence with clinical practice guidelines ◆ Lack of patient communication skills ◆ Giving in to patients' demands/requests for antibiotics ◆ Risking adverse member satisfaction if the providers do not prescribe antibiotics <p>The CalOptima <i>AAB</i> measure met the MPL for HEDIS 2016 MY at the rate of 22.44 percent.</p> <ul style="list-style-type: none"> ◆ Q4, 2016, the Alliance Working for Antibiotic Resistance Education (AWARE) toolkits were sent to high-prescribing CalOptima providers via the California Medical Association (CMA) Foundation. This toolkit goes over the clinical practice

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>guidelines for appropriate antibiotic prescribing.</p> <ul style="list-style-type: none"> ◆ CalOptima conducted telephonic provider trainings to targeted, high-prescribing Medi-Cal offices with low AAB HEDIS rates in January 2017. Trainings covered the following topics: clinical practice guidelines, awareness of current AAB rates, appropriate coding and documentation, and educational resources. <p>d. Childhood Immunization Status—Combination 3 (CIS)</p> <p>Causes for performance declining significantly from RY 2015 to RY 2016:</p> <ul style="list-style-type: none"> ◆ Lack of knowledge for members regarding vaccine recommendations and safety ◆ Lack of time and transportation for members ◆ Lack of resources for providers—time and outreach efforts ◆ Technical difficulty with obtaining California Immunization Registry (CAIR) data for the MCP <p>The 2016 MY CIS rate is 72.22 percent and has reached the NCQA’s 50th percentile benchmark. This measure has improved from the previous year.</p> <ul style="list-style-type: none"> ◆ CIS measure is incentivized through our Pay for Value program. ◆ CalOptima worked with CAIR to obtain a regular data feed to help close gaps in care and reduce the medical record review burden. ◆ In Q4, 2016, CalOptima conducted a continuing medical education (CME) workshop for physicians and licensed health care professionals on: “Infections in Pregnant Women and Neonates and How to Avoid Them,” which included the topic of childhood immunizations through age 1. ◆ CalOptima conducted <i>Healthy You</i> mailings that promoted immunizations and well-care visits for children 0 through 2 years of age. ◆ Child health guides were mailed to children who were recently admitted to the hospitals. ◆ CalOptima also conducted interactive voice recording (IVR) calls between September 2016 and December 2016 to targeted members who may have missed an immunization. ◆ In August 2017, CalOptima will be working with clinics to host multiple health and wellness events surrounding childhood and adolescent immunizations in the hopes of further improving rates. Members will be given an incentive for participating, and the four clinics will be provided with an incentive for hosting the event.

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>e. Comprehensive Diabetes Care (CDC) HbA1c Control (<8.0 Percent)</p> <p>Causes for performance declining significantly from RY 2015 to RY 2016:</p> <ul style="list-style-type: none"> ◆ Lack of member adherence to HbA1c testing. ◆ Lack of member knowledge regarding diabetic care. ◆ Lack of time, knowledge of lab requirements, transportation for members. ◆ Lack of resources for providers—time and outreach efforts. <p>CalOptima CDC measure met the MPL for HEDIS 2016 MY and is above the NCQA 75th percentile for the CDC HbA1c Control <8.0%. The prospective rate for this measure has increased, compared to the same time last year. With CalOptima’s growing membership, there will be an increase in the diabetic members served. Although CalOptima’s rate is well above the MPL for this submeasure, there is room for improvement when looking at diabetic members and their compliancy to HbA1c testing per provider office.</p> <ul style="list-style-type: none"> ◆ In efforts to accomplish rapid change, the focus will be on a specific provider office with a large volume of diabetic members and a rate needing improvement (HbA1c testing rate <75%). The Diabetes PIP therefore focused on HbA1c testing rates for targeted provider offices. ◆ CalOptima worked with our lab vendor to obtain lab results regularly to help close gaps in care. ◆ Diabetes management mailings are sent to targeted members. ◆ The CDC measure is also incentivized through our Pay for Value program. <p>f. Comprehensive Diabetes Care HbA1c >9.0 Percent.</p> <p>Causes for performance declining significantly from RY 2015 to RY 2016:</p> <ul style="list-style-type: none"> ◆ Lack of member adherence to HbA1c testing. ◆ Lack of member knowledge regarding diabetic care. ◆ Lack of time, knowledge of lab requirements, transportation for members. ◆ Lack of resources for providers—time and outreach efforts. <p>CalOptima CDC HbA1c Poor Control >9.0 Percent measure met the MPL and is above the NCQA 75th percentile for the CDC HbA1c Poor Control >9.0 Percent measure. The prospective rate increased in 2017, compared to the same time last year. With CalOptima’s growing membership, there will be an increase in the</p>

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>diabetic members served. CalOptima would like to ensure that the diabetic population served is able to access quality health care, where screening is important in providing comprehensive diabetic management to increase member health status.</p> <ul style="list-style-type: none"> ◆ Through the Diabetes PIP, CalOptima has started a new work team to focus on diabetic members whose HbA1c levels are less than 9.0 percent and to outreach to providers who have the largest volume of these members. These targeted providers will be receiving detailed patient-level information (e.g., labs, test results, co-morbidities) that can assist in better diabetes management. ◆ CalOptima worked with lab vendors to obtain lab results regularly to help close gaps in care. ◆ Diabetes management mailings are sent to targeted members. ◆ The <i>CDC</i> measure is also incentivized through our Pay for Value program. <p>g. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i></p> <p>Causes for performance declining significantly from RY 2015 to RY 2016:</p> <ul style="list-style-type: none"> ◆ Lack of knowledge for members regarding vaccine recommendations and safety ◆ Lack of time and transportation for members ◆ Lack of resources for providers—time and outreach efforts <p>HEDIS 2016 MY shows some improvements in the <i>W34</i> measure. CalOptima’s 2016 MY rate is 79.21 percent, which falls within the NCQA 75th percentile benchmark.</p> <ul style="list-style-type: none"> ◆ The <i>W34</i> measure is incentivized through our Pay for Value program. ◆ CalOptima conducted <i>Healthy You</i> mailings that promoted immunizations and well-care visits for children ages 3 through 12. Articles included the importance of well-care visits, immunizations, nutrition, and other health-related topics. ◆ Child health guides were mailed to children who were recently admitted to the hospitals.
<p>4. Assess whether or not changes are needed in the MCP’s ongoing improvement efforts for cervical cancer screenings to ensure that the MCP’s performance on the <i>Cervical Cancer Screening</i> measure improves to above the MPL.</p>	<p>CalOptima met the MPL for the <i>Cervical Cancer Screening (CCS)</i> measure with a rate of 52.93 percent. This is above the NCQA 25th percentile benchmark (48.18 percent).</p> <p>In July 2016, CalOptima conducted an internal barrier analysis exercise to assess cervical cancer screening barriers that may hinder members from completing this care. Based upon this feedback,</p>

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>CalOptima developed a multi-pronged approach that supports members and providers. The goal is to address those identified barriers.</p> <p>Activities:</p> <ul style="list-style-type: none"> ◆ The <i>CCS</i> measure is incentivized through our Pay for Value program. ◆ Health networks receive monthly reports of select HEDIS scores, which includes the <i>CCS</i> measure. The reports also include member-specific lists of members with gaps in care for provider outreach. The reports and member-level detail files are delivered via a secure file transfer protocol site. ◆ CalOptima worked with lab vendors to obtain lab results regularly to help close gaps in care. ◆ In Q4 2016, CalOptima mailed a cover letter and six-panel brochure, in the seven Medi-Cal threshold languages, to members who may be due for cervical cancer screenings. ◆ Development of new quality initiatives began in Q1; and, upon Board of Directors approval received in March 2017, CalOptima launched several pilot programs: <ol style="list-style-type: none"> 1. Member incentive: CalOptima offered a \$75 no-cost gift card opportunity drawing for female members due for a cervical cancer screening. Screenings must be completed between June 1, 2017, and December 31, 2017. Up to 150 members will be randomly selected each month to receive a gift card. 2. Provider incentive—extended office hours initiative: CalOptima identified lack of time as a barrier and is partnering with providers and office staff to extend office hours. This pilot program is being tested at 1 to 2 provider offices over the course of three months. Providers can earn up to \$4,800 for this incentive. 3. Provider office staff incentive: To help support provider front office/clinic personnel, CalOptima launched in Q2 an incentive opportunity to select offices for demonstrating improvement in cervical cancer screening performance. The goal is to boost 2017 performance from the 2016 baseline. Front office members will receive a \$10 gift card for each completed service over the 2016 monthly baseline value. The offices receive ongoing support from CalOptima via refreshed member registry lists, supporting documents, and monthly follow-ups. 4. Radio and print ads: In an effort to connect with traditionally hard-to-reach populations, radio messages were launched in May 2017. Ads were developed in multiple

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>languages (English, Spanish, Vietnamese, and Korean) and played by local stations whose audiences reflected at least one of these languages. To complement the radio ads, print ads were also developed; these ran in local newspapers, encouraging women and their family and friends to begin the conversation about the importance of cervical cancer screenings.</p> <p>5. Web site launch: CalOptima added a new member-centric page called “Good Health” to the company website. Here, members are encouraged to start the conversation and discuss topics, including cervical cancer screening, with providers, family, and friends. To visit the site, please follow https://www.caloptima.org/en/Members/GoodHealth.aspx. The site is currently available in English, Spanish, Vietnamese, and Korean. Other threshold languages are scheduled to follow.</p>
<p>5. To further address the MCP’s declining performance on the <i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i> measure, conduct ongoing assessment of the MCP’s <i>Diabetes</i> PIP to determine if modifications need to be made in the interventions being tested and if successful interventions can be tested in new provider sites.</p>	<p>CalOptima continues to evaluate the Diabetes PIP’s progress by (a) maintaining communication with the targeted provider office, (b) pulling quarterly data of members who need HbA1c testing, and (c) comparing the HbA1c data from the previous quarters. CalOptima has collected from the targeted provider offices feedback which has been helpful in developing new outreach strategies for both members and providers, ensuring that members obtain HbA1c testing, and promoting appropriate diabetes management. Discussion has been held internally with CalOptima’s Chronic Care Quality Initiatives (QI) work team to use best practices learned from the Diabetes PIP and to outreach to more provider offices with a high volume of members with uncontrolled diabetes. CalOptima will continue our efforts to collaborate with various internal departments to increase involvement in managing diabetic members more effectively. CalOptima worked with lab vendors to obtain lab results regularly to help close gaps in care. The prospective rate has increased for this measure in 2017, compared to the same time last year.</p>
<p>6. Incorporate HSAG’s initial feedback on the Plan portions of the Module 4 submissions prior to testing the interventions for the <i>Diabetes</i> PIP.</p>	<p>Intervention being tested: Test working with partnered provider office in implementing better member educational outreach for HbA1c testing.</p> <p>CalOptima and targeted provider office collaborated in improving the member educational outreach as recommended by HSAG. The intervention discussed for member outreach included that (1) Provider Office A would call targeted members to remind them about HbA1c testing needed, and (2) CalOptima would send a reminder letter with educational materials in the appropriate languages, depending on the demographic of the provider's member population.</p>

2015–16 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>Intervention being tested: CalOptima will obtain monthly data of Provider Office A identifying members needing their HbA1c test and share this list with Provider Office A for outreach.</p> <p>Per HSAG recommendations, CalOptima’s QI team and provider office staff members worked on proper documentation of data logs. This includes identifying, of the targeted provider office, members who need their HbA1c test bimonthly; logging member information; and tracking whether or not members obtained their HbA1c tests after outreach was completed. Information on the data logs will be evaluated by the QI Work Team and discussed with the targeted provider office staff members if any adjustments are needed for this intervention to be successful.</p> <p>Intervention being tested: CalOptima will work with Provider Office A to identify a list of labs and their hours to provide to members who may not be aware of other options.</p> <p>CalOptima worked with the targeted provider to update lab information to share with members in need of HbA1c tests. Per HSAG feedback, the QI work team and provider office staff members have been working closely to identify member feedback on how the educational materials provided were helpful/not helpful in encouraging members to obtain their HbA1c testing. Feedback received from the provider office will be reviewed for effectiveness and compared to the additional failure modes identified by the QI work team.</p>

2016–17 Recommendations

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

- ◆ Ensure resolution of all deficiencies from the February 2017 DMHC SPD Medical Survey.
- ◆ To help ensure that capitated encounter data are complete for performance measure reporting, expand use of the MCP’s oversight metrics to monitor paper claims and incoming encounters from the clearinghouses.
- ◆ Identify the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017. Identifying the causes will help CalOptima to develop strategies, as applicable, to address the MCP’s declining performance on this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix F:
Performance Evaluation Report
CalViva Health
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), CalViva Health (“CalViva” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in CalViva’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CalViva is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries in Fresno, Kings, and Madera counties may enroll in CalViva, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan (CP).

CalViva became operational in Fresno, Kings, and Madera counties to provide MCMC services effective March 2011. As of June 30, 2017, CalViva had 300,700 beneficiaries in Fresno County, 27,057 in Kings County, and 36,182 in Madera County—for a total of 363,939 beneficiaries.¹ This represents 73 percent of the beneficiaries enrolled in Fresno County, 57 percent in Kings County, and 65 percent in Madera County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Oct 11, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CalViva. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CalViva. A&I conducted the on-site audits from April 18, 2016, through April 29, 2016. While A&I conducted the audits outside the review period for this report, HSAG includes the results because DHCS issued the final reports and final CAP closeout letter during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CalViva
Audit Review Period: April 1, 2015 through March 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	Yes	Closed.
Access and Availability of Care	Yes	Closed.
Member’s Rights	No	Not applicable.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Utilization Management, Member’s Rights, Quality Management, Administrative and Organizational Capacity, or State Supported Services categories during the April 2016 Medical and State Supported Services Audits of CalViva. Additionally, CalViva’s responses to the MCP’s CAP for the deficiencies that A&I identified during the Medical Audit resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

CalViva has no outstanding deficiencies from the April 2016 Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for CalViva Health* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that CalViva followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.3 for CalViva's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.3:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
CalViva—Fresno County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	71.80%	66.96%	68.19%	65.00%	-3.19
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	96.60%	95.19%	94.29%	94.12%	-0.17
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	91.08%	89.70%	86.89%	85.65%	-1.24^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	91.42%	91.47%	89.98%	88.19%	-1.79^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	87.51%	88.04%	86.68%	84.96%	-1.72^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	27.49%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	74.94%	74.63%	73.71%	71.17%	-2.54
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	52.55%	57.80%	61.18%	60.97%	-0.21
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	82.69% ⁺	76.80%	76.39%	74.43%	-1.96
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	49.83%	Not Comparable
<i>Cervical Cancer Screening</i>	64.34%	64.74%	61.05%	61.22%	0.17
<i>Prenatal and Postpartum Care—Postpartum Care</i>	61.20%	60.46%	67.59%	68.03%	0.44
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	88.02%	86.22%	83.04%	86.89%	3.85
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.64%	84.88%	84.94%	85.74%	0.80
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.96%	84.82%	85.07%	86.24%	1.17
<i>Asthma Medication Ratio—Total</i>	--	--	--	69.38%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	54.26%	60.58%	55.72%	61.31%	5.59

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	48.42%	53.77%	54.74%	55.96%	1.22
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	38.20%	47.69%	36.74%	46.23%	9.49 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	54.74%	43.31%	55.47%	42.34%	-13.13 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	79.81%	84.67%	80.29%	84.91%	4.62
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	76.89%	82.00%	87.83% ⁺	90.51%	2.68
<i>Controlling High Blood Pressure</i>	53.12%	61.46%	47.96%	56.93%	8.97 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.10%	17.43%	17.90%	15.52%	-2.38 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	50.13	31.76	52.99	51.53	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	469.48	298.94	363.32	341.77	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	38.66% ⁺	40.38% ⁺	37.62%	35.34%	-2.28
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	7.27%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	79.90%	77.90%	76.03%	70.65%	-5.38^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
CalViva—Kings County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	70.06%	57.76%	63.03%	67.71%	4.68
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	94.68%	89.62%	92.49%	92.96%	0.47
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	83.58%	83.53%	83.71%	83.36%	-0.35
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	87.06%	86.25%	83.31%	83.45%	0.14
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	84.62%	85.55%	84.21%	82.99%	-1.22
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	15.33%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	45.99%	63.26%	56.20%	69.83%	13.63 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	36.98%	45.26%	46.23%	63.26%	17.03 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	59.29%	64.82%	66.32%	73.32%	7.00 [^]
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	55.21%	Not Comparable
<i>Cervical Cancer Screening</i>	57.18%	51.12%	54.99%	57.95%	2.96
<i>Prenatal and Postpartum Care—Postpartum Care</i>	52.84%	52.82%	50.24%	61.07%	10.83 [^]
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	82.67%	83.38%	84.39%	86.37%	1.98
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.21%	80.17%	83.07%	90.43%	7.36 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.25%	82.83%	84.26%	90.78%	6.52 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	66.29%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	45.50%	57.18%	60.34%	65.21%	4.87

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	48.42%	49.15%	55.96%	54.26%	-1.70
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	39.66%	44.28%	42.34%	47.69%	5.35
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	52.07%	46.72%	47.69%	41.85%	-5.84
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	78.59%	79.08%	76.64%	86.62%	9.98 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	78.10%	82.24%	91.97% ⁺	91.97%	0.00
<i>Controlling High Blood Pressure</i>	41.03%	56.69%	58.77%	55.61%	-3.16
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	7.92%	13.94%	12.87%	11.88%	-0.99
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	62.09	40.29	65.99	63.76	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	430.69	289.58	369.80	365.98	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	17.24%	27.37%	21.38%	29.56%	8.18
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	7.90%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	80.23%	75.11%	72.87%	75.50%	2.63

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.3—Multi-Year Performance Measure Results*
CalViva—Madera County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	66.96%	69.54%	71.19%	72.22%	1.03
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	98.08%	95.37%	97.28%	96.39%	-0.89
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	93.49%	92.02%	91.18%	90.83%	-0.35
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	92.88%	92.71%	91.71%	90.84%	-0.87
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	90.68%	90.48%	90.37%	88.54%	-1.83^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	43.07%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	68.81%	87.44% ⁺	82.08% ⁺	82.75% ⁺	0.67
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	60.82%	80.40% ⁺	73.48% ⁺	77.49% ⁺	4.01
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	87.34% ⁺	83.16% ⁺	87.08% ⁺	86.22% ⁺	-0.86
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	58.34%	Not Comparable
<i>Cervical Cancer Screening</i>	64.44%	58.68%	52.87%	57.56%	4.69
<i>Prenatal and Postpartum Care—Postpartum Care</i>	50.27%	66.67%	58.76%	64.09%	5.33
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	80.05%	87.10%	83.83%	82.29%	-1.54
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.06%	86.14%	83.98%	82.64%	-1.34
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.94%	82.97%	83.57%	82.20%	-1.37
<i>Asthma Medication Ratio—Total</i>	--	--	--	71.38% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	64.96%	67.40%	65.45%	67.15%	1.70

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	60.34%	63.02%	59.12%	66.42%	7.30 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	43.07%	50.12%	44.28%	49.39%	5.11
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	49.39%	38.44%	50.36%	43.31%	-7.05 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	88.32%	88.32%	87.10%	86.62%	-0.48
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.00%	83.45%	91.73% ⁺	90.51%	-1.22
<i>Controlling High Blood Pressure</i>	52.10%	62.93%	57.99%	59.80%	1.81
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.40%	15.51%	14.22%	13.11%	-1.11
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	52.05	30.91	49.44	50.13	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	482.26	327.12	396.51	379.96	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	16.67%	20.65%	19.69%	18.26%	-1.43
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	7.16%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	70.68%	74.24%	74.17%	66.67%	-7.50^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of CalViva's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

HSAG identified the following notable performance measure results within the Preventive Screening and Children's Health domain:

- ◆ Across all three counties, CalViva performed above the MPLs for all measures within this domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.
- ◆ Within this domain, CalViva performed best in Madera County. In this county, the rates were above the HPLs for three of the four measures for which DHCS held MCPs accountable to meet the MPLs in RY 2017 (75 percent). The rates for the following measures were above the HPLs in Madera County:
 - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures for the third consecutive year.
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for all RYs displayed in Table 3.3.
- ◆ In Kings County, the rate for the *Childhood Immunization Status—Combination 3* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.

- CalViva provided information on actions that the MCP took during the review period to address the MCP’s performance related to measures with rates below the MPLs in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that CalViva conducted during the review period to improve the MCP’s performance on the *Childhood Immunization Status—Combination 3* measure in Kings County. CalViva’s efforts may have contributed to the rate for this measure improving to above the MPL in RY 2017.
- ◆ In Fresno and Kings counties, CalViva performed between the HPLs and MPLs for all measures within the Preventive Screening and Children’s Health domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.
 - The rates improved significantly from RY 2016 to RY 2017 for the following measures in King’s County:
 - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Preventive Screening and Women’s Health

Across all three counties within the Preventive Screening and Women’s Health domain, CalViva performed between the HPLs and MPLs for all measures for which DHCS held MCPs accountable to meet the MPLs in RY 2017. The rates for the following measures within this domain moved from below the MPLs in RY 2016 to above the MPLs in RY 2017:

- ◆ *Cervical Cancer Screening* in Madera County
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kings County

CalViva provided information on actions that the MCP took during the review period to address the MCP’s performance related to measures with rates below the MPLs in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report HSAG provides a summary of the PDSA cycles that CalViva conducted during the review period to improve the MCP’s performance on the *Cervical Cancer Screening* measure in Madera County. Finally, HSAG includes information regarding CalViva’s progress on its *Postpartum Care* performance improvement project (PIP) in Section 4 of this report (“Performance Improvement Projects”). CalViva’s efforts may have contributed to the rates improving to above the MPLs for the *Cervical Cancer Screening* measure in Madera County and the *Prenatal and Postpartum Care—Postpartum Care* measure in Kings County.

Care for Chronic Conditions

HSAG identified the following notable performance measure results within the Care for Chronic Conditions domain:

- ◆ In Fresno and Kings counties, CalViva performed between the HPLs and MPLs for all measures within this domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.

- ◆ Across all counties within the Care for Chronic Conditions domain, nine of the 11 rates that were below the MPLs in RY 2016 (82 percent) moved from below the MPLs in RY 2016 to above the MPLs in RY 2017. The rates for the following measures moved from below the MPLs in RY 2016 to above the MPLs in RY 2017:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in Kings County
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Fresno County
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in Fresno County
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Fresno and Madera counties
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Fresno and Kings counties
 - *Controlling High Blood Pressure* in Fresno County
- ◆ Across all counties within the Care for Chronic Conditions domain, eight of the 27 rates for which comparisons were made between RY 2016 and RY 2017 (30 percent) improved significantly from RY 2016 to RY 2017.
- ◆ In Madera County, the rates for both *Annual Monitoring for Patients on Persistent Medications* measures were below the MPLs in RY 2017.

CalViva provided information on actions that the MCP took during the review period to address the MCP's performance related to measures with rates below the MPLs in RY 2016. (See Table 5.1.) Additionally, under the "Assessment of Improvement Plans" heading in this section of the report, HSAG provides a summary of the PDSA cycles that CalViva conducted during the review period to improve the MCP's performance on both *Annual Monitoring for Patients on Persistent Medications* measures in Kings and Madera counties and the *Controlling High Blood Pressure* measure in Fresno County. Finally, HSAG includes information regarding CalViva's progress on its *Diabetes* PIP in Section 4 of this report ("Performance Improvement Projects"). CalViva's efforts may have contributed to the rates improving to above the MPLs for both *Annual Monitoring for Patients on Persistent Medications* measures in Kings County, *Comprehensive Diabetes Care* measures in all three counties, and *Controlling High Blood Pressure* measure in Fresno County.

Performance measure results within the Care for Chronic Conditions domain show that CalViva's quality improvement strategies may have resulted in improved monitoring of the MCP's beneficiaries with chronic conditions. Performance measure results also show that CalViva has the opportunity to assess whether current strategies need to be modified or expanded to ensure that in Madera County beneficiaries ages 18 and older on angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), or diuretics receive annual monitoring.

Appropriate Treatment and Utilization

HSAG identified the following notable performance measure results within the Appropriate Treatment and Utilization domain:

- ◆ In Fresno and Kings counties, within the Appropriate Treatment domain, CalViva performed between the HPLs and MPLs for all measures for which DHCS held MCPs accountable to meet the MPLs in RY 2017.

- ◆ In Kings County, the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ In Fresno County, the rate for the *All-Cause Readmissions* measure improved significantly from RY 2016 to RY 2017, reflecting a reduction in hospital readmissions.
- ◆ The rates for the following measures in Madera County were below the MPLs in RY 2017:
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
 - *Use of Imaging Studies for Low Back Pain*
- ◆ In Fresno and Madera counties, the rates for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. The significant decline in Madera County resulted in the rate moving from above the MPL in RY 2016 to below the MPL in RY 2017.

CalViva provided information on actions that the MCP took during the review period to address the MCP's performance related to measures with rates below the MPLs in RY 2016. (See Table 5.1.) Additionally, under the "Assessment of Improvement Plans" heading in this section of the report, HSAG provides a summary of the strategies that CalViva tested to improve the MCP's performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Kings and Madera counties. CalViva's efforts may have contributed to the rate improving to above the MPL for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Kings County.

Performance measure results show that CalViva has the opportunity to:

- ◆ Assess whether current strategies need to be modified or expanded in Madera County to ensure the appropriate use of antibiotics for beneficiaries ages 18 to 64 with a primary diagnosis of bronchitis.
- ◆ Identify the causes for the rates declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure in Fresno and Madera counties to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Note that the MCP's declining performance or performance below the MPLs for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures may be due to NCQA's RY 2017 specification changes for these measures and therefore may not be related to CalViva's performance.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, the MCP was required to submit IP/PDSA cycles for the following measures:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures in Kings and Madera counties
- ◆ *Cervical Cancer Screening* in Madera County

- ◆ *Childhood Immunization Status—Combination 3* in Kings County
- ◆ *Controlling High Blood Pressure* in Fresno County

CalViva also was required to submit triannual quality improvement summaries for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Kings and Madera counties.

In lieu of IP/PDSA cycles, DHCS allowed CalViva to conduct PIPs to help improve the MCP's performance on the *Comprehensive Diabetes Care* measures in Fresno, Madera, and Kings counties and *Prenatal and Postpartum Care—Postpartum Care* measure in Kings County.

Annual Monitoring for Patients on Persistent Medications

CalViva conducted two PDSA cycles to improve the MCP's performance on the *Annual Monitoring for Patients on Persistent Medications* measures in Kings and Madera counties.

Plan-Do-Study-Act Cycle 1

For the first PDSA cycle, CalViva set the following SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective:

By February 28, 2017, and after the clinic partner in Kings County receives the gaps in care list, at least 3 percent (up from 0 percent) of targeted beneficiaries will have completed their annual laboratory monitoring tests at the clinic partner in Kings County.

CalViva tested whether or not distributing gaps in care lists to the clinic partner would result in the clinic staff members contacting beneficiaries regarding obtaining their required lab testing or scheduling their appointments. CalViva reported that it met the SMART objective and that the MCP decided to adapt the intervention. Additionally, CalViva reported on lessons learned through the PDSA cycle process, including:

- ◆ When producing the gaps in care list at the end of the calendar year, claims lag or lag time between running the gaps in care list may result in beneficiaries from the previous year appearing on the list again.
- ◆ Supplementing the clinic partner gaps in care list with a provider profile was a moderately effective method for increasing the number of beneficiaries identified who needed laboratory testing during the shift from one calendar year to the next.

Plan-Do-Study-Act Cycle 2

For the second PDSA cycle, CalViva set the following SMART objective:

By June 30, 2017, and after the clinic partner in Kings County receives the quarterly provider profile, at least 10 percent (up from 0 percent) of targeted beneficiaries will have completed their annual laboratory monitoring tests at the clinic partner in Kings County.

CalViva tested whether or not distributing quarterly provider profiles to the clinic partner would result in the clinic staff members contacting beneficiaries regarding obtaining their required lab testing or scheduling their appointments. CalViva reported that it met the SMART objective and that the MCP decided to adopt the intervention. Additionally, CalViva reported on lessons learned through the PDSA cycle process, including:

- ◆ Reconciling the list of beneficiaries using claims data resulted in the MCP accurately identifying beneficiaries who needed testing.
- ◆ Obtaining staff members' feedback is crucial to successful intervention implementation.

In RY 2017, the rates improved to above the MPLs for both *Annual Monitoring for Patients on Persistent Medications* measures in Kings County; however, the rates remained below the MPLs for these measures in Madera County.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

CalViva submitted triannual quality improvement summaries to DHCS that described the activities that the MCP conducted to improve its performance for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Kings and Madera counties. The MCP's activities focused on provider and beneficiary education and included the following interventions:

- ◆ Distributed monthly report cards to providers that indicated the providers' levels of compliance with the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.
- ◆ Participated in Alliance Working for Antibiotic Resistance Education (AWARE) and promoted the AWARE toolkit.
- ◆ Conducted data analysis to identify high-volume, high-performing providers and best practices that providers have implemented that resulted in high rates; then shared the best practices with high-volume, low-performing providers.
- ◆ Partnered with the MCP's pharmacy benefits provider to include on prescription bags educational messages regarding the appropriate use of antibiotics and care tips for adults with acute bronchitis.
- ◆ Conducted lunch-and-learn events at clinics to educate providers on the appropriate use of antibiotics.
- ◆ Sent faxes to 65 provider offices, informing the providers about an online simulator resource tool which includes virtual simulations to help providers practice real-life conversations about use of antibiotics.

In RY 2017, the rate improved to above the MPL for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Kings County; however, the rate remained below the MPL for this measure in Madera County.

Cervical Cancer Screening

CalViva conducted two PDSA cycles to improve the MCP's performance on the *Cervical Cancer Screening* measure in Madera County.

Plan-Do-Study-Act Cycle 1

For the first PDSA cycle, CalViva set the following SMART objective:

By February 17, 2017, at least 30 percent of beneficiaries in need of their cervical cancer screenings from a high-volume, low-compliance clinic in Madera County will have their Pap smear test appointments scheduled.

CalViva tested whether or not distributing to the clinic partner a provider profile of beneficiaries who needed their cervical cancer screening would result in the clinic partner scheduling Pap smear test appointments for those beneficiaries. CalViva reported that it met the SMART objective and that the MCP decided to adapt the intervention. Additionally, CalViva reported on lessons learned through the PDSA cycle process, including:

- ◆ Conducting periodic reviews of the data collection process and clinical staff feedback during the PDSA cycle process allowed for the MCP to address any critical questions or issues that arose.
- ◆ When indicated, it is important for the clinic partner staff members to use eligibility lists as one way for determining whether or not a beneficiary is assigned to the clinic and therefore should be contacted by the clinic for an appointment.

Plan-Do-Study-Act Cycle 2

For the second PDSA cycle, CalViva set the following SMART objective:

By June 30, 2017, at least 30 percent of beneficiaries with appointments scheduled from the first PDSA cycle at the high-volume, low-compliance clinic in Madera County will have completed their appointments due to being offered an incentive to be delivered at the time of their appointments.

CalViva tested whether or not offering a beneficiary incentive at the Pap smear test appointment would increase the cervical cancer screening appointment completion rate. CalViva reported that it met the SMART objective and that the MCP decided to adopt the intervention. Additionally, CalViva reported on lessons learned through the PDSA cycle process, including:

- ◆ Offering incentives at the point of care may have led to more beneficiaries completing their appointments than if the beneficiaries had several steps to complete following their appointments to receive the incentives.
- ◆ Reminding beneficiaries that they would be receiving an incentive at the point of care may have resulted in fewer beneficiaries missing appointments.

The rate for the *Cervical Cancer Screening* measure improved to above the MPL in RY 2017 in Madera County.

Childhood Immunization Status—Combination 3

CalViva conducted two PDSA cycles to improve the MCP's performance on the *Childhood Immunization Status—Combination 3* measure in Kings County.

Plan-Do-Study-Act Cycle 1

For the first PDSA cycle CalViva set the following SMART objective:

By December 31, 2016, at least 30 percent of beneficiaries at a high-volume provider group in Kings County will have completed their immunization appointments due to receiving outreach and beneficiary incentives.

CalViva tested whether or not distributing provider profile lists to five targeted clinics and offering a beneficiary incentive at the point of care would increase the provider group's immunization appointment completion rate. CalViva was unable to determine if the SMART objective was met because the provider group did not use the provider profiles and therefore collected variables other than those included in the SMART objective. CalViva decided to adapt the intervention and continue to offer appointments at times outside of usual clinic hours to better align appointment times with parents' schedules.

Plan-Do-Study-Act Cycle 2

For the second PDSA cycle, CalViva set the following SMART objective:

By May 31, 2017, at least 30 percent of beneficiaries at a high-volume, low-compliance clinic in Kings County will have completed their immunization appointments due to receiving outreach and beneficiary incentives.

CalViva tested the same intervention that the MCP tested during the first PDSA cycle. CalViva reported that it met the SMART objective and that the MCP decided to adopt the intervention. Additionally, CalViva indicated that incorporating use of the California Immunization Registry 2 (CAIR 2) into the workflow allowed MCP staff members to more accurately identify and outreach to non-compliant beneficiaries.

The rate for the *Childhood Immunization Status—Combination 3* measure improved to above the MPL in RY 2017 in Kings County.

Controlling High Blood Pressure

CalViva conducted two PDSA cycles to improve the MCP's performance on the *Controlling High Blood Pressure* measure in Fresno County.

Plan-Do-Study-Act Cycle 1

For the first PDSA cycle, CalViva set the following SMART objective:

By March 15, 2017, and after the clinic partner in Fresno County receives the provider profile, at least 30 percent (32 out of 107) of beneficiaries who need blood pressure monitoring will have an appointment scheduled by the clinic partner in Fresno County.

CalViva tested whether or not distributing to the clinic partner a provider profile of beneficiaries who needed to have their blood pressure monitored would result in the clinic partner conducting outreach and scheduling beneficiaries for their blood pressure monitoring appointments. CalViva reported that it met the SMART objective and that the MCP decided to adapt the intervention. Additionally, CalViva reported on lessons learned through the PDSA cycle process, including:

- ◆ Providing clinics with a provider profile list may not be necessary if clinics are able to produce their own lists. This will reduce the amount of MCP resources needed to sustain the intervention.
- ◆ Obtaining staff members' feedback is crucial to successful intervention implementation.

Plan-Do-Study-Act Cycle 2

For the second PDSA cycle, CalViva set the following SMART objective:

By July 15, 2017, and after the clinic partner in Fresno County receives the modified quarterly provider profile, at least 30 percent (33 out of 110) of beneficiaries who need blood pressure monitoring will have attended at least one blood pressure monitoring appointment.

CalViva tested the same intervention that the MCP tested during the first PDSA cycle. CalViva reported that it met the SMART objective and that the MCP decided to adopt the intervention. Additionally, CalViva reported on lessons learned through the PDSA cycle process, including:

- ◆ Using the clinic partner's internal beneficiary list in conjunction with the MCP's provider profile yielded a high number of beneficiaries who attended appointments. This approach may be useful for hybrid HEDIS measures for which the MCP identifies an issue, but the clinic's data may be more current for identifying the beneficiaries in need of the services.

The rate for the *Controlling High Blood Pressure* measure improved to above the MPL in RY 2017 in Fresno County.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, CalViva will be required to submit IP/PDSA cycles or triannual quality improvement summaries for the following measures for Madera County:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Seniors and Persons with Disabilities Performance Measure Results

Table 3.4 through Table 3.6 present the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.4—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Fresno County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	22.54%	12.10%	10.44^^	15.52%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	76.74	50.03	Not Tested	51.53
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	522.46	331.07	Not Tested	341.77
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.62%	85.07%	2.55^	85.74%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.20%	85.47%	2.73^	86.24%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	91.67%	94.13%	-2.46	94.12%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.73%	85.65%	0.08	85.65%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	91.24%	88.09%	3.15^	88.19%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.18%	84.84%	3.34^	84.96%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.4 through Table 3.6.

Table 3.5—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Kings County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.11%	10.19%	5.92	11.88%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	111.77	60.94	Not Tested	63.76
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	629.67	350.49	Not Tested	365.98
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.70%	90.06%	1.64	90.43%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	95.04%	89.55%	5.49 [^]	90.78%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	93.11%	Not Comparable	92.96%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	78.08%	83.48%	-5.40	83.36%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.50%	83.25%	5.25	83.45%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.27%	82.73%	5.54	82.99%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.6—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Madera County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.77%	11.96%	4.81	13.11%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	67.31	49.37	Not Tested	50.13
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	661.97	367.48	Not Tested	379.96
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.79%	80.99%	8.80 [^]	82.64%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.69%	80.68%	7.01	82.20%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	96.36%	Not Comparable	96.39%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	91.11%	90.83%	0.28	90.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	97.50%	90.66%	6.84 [^]	90.84%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.93%	88.58%	-1.65	88.54%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.7 through Table 3.9 present the four-year trending information for the SPD population, and Table 3.10 through Table 3.12 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.7—Multi-Year SPD Performance Measure Trend Table
CalViva—Fresno County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	15.39%	20.99%	25.64%	22.54%	-3.10 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	70.05	40.72	81.25	76.74	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	555.25	336.48	560.97	522.46	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.27%	86.47%	87.15%	87.62%	0.47
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.97%	87.20%	88.96%	88.20%	-0.76
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	100.00%	80.95%	92.86%	91.67%	-1.19
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	91.65%	89.91%	86.16%	85.73%	-0.43
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	93.33%	93.95%	91.31%	91.24%	-0.07
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.51%	89.10%	88.95%	88.18%	-0.77

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.8—Multi-Year SPD Performance Measure Trend Table
CalViva—Kings County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.57%	18.91%	13.79%	16.11%	2.32
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	113.80	57.15	111.00	111.77	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	651.69	399.51	654.22	629.67	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.32%	85.09%	86.88%	91.70%	4.82
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	92.14%	90.30%	85.82%	95.04%	9.22 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	87.65%	81.82%	83.95%	78.08%	-5.87
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.00%	91.11%	82.69%	88.50%	5.81
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	85.71%	88.24%	86.79%	88.27%	1.48

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.9—Multi-Year SPD Performance Measure Trend Table
CalViva—Madera County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.36%	20.61%	22.71%	16.77%	-5.94
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	78.44	40.34	75.78	67.31	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	665.45	406.08	705.32	661.97	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.77%	88.84%	89.52%	89.79%	0.27
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.71%	85.00%	89.60%	87.69%	-1.91
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	97.17%	94.64%	94.23%	91.11%	-3.12
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	94.29%	93.33%	94.69%	97.50%	2.81
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.42%	87.07%	88.10%	86.93%	-1.17

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.10—Multi-Year Non-SPD Performance Measure Trend Table
CalViva—Fresno County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	7.78%	11.20%	12.61%	12.10%	-0.51
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	47.62	30.78	51.09	50.03	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	458.67	294.85	350.06	331.07	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.64%	82.74%	83.91%	85.07%	1.16
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.23%	81.37%	83.06%	85.47%	2.41 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	96.57%	95.28%	94.30%	94.13%	-0.17
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	91.06%	89.69%	86.90%	85.65%	-1.25 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	91.33%	91.36%	89.94%	88.09%	-1.85 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.45%	87.98%	86.58%	84.84%	-1.74 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
CalViva—Kings County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	9.13%	12.50%	10.19%	-2.31
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	55.66	38.54	63.09	60.94	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	403.24	278.19	351.49	350.49	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.71%	77.15%	81.68%	90.06%	8.38 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	74.56%	78.54%	83.68%	89.55%	5.87 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.85%	89.65%	92.75%	93.11%	0.36
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.44%	83.59%	83.70%	83.48%	-0.22
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.92%	86.01%	83.33%	83.25%	-0.08
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.55%	85.35%	84.05%	82.73%	-1.32

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.12—Multi-Year Non-SPD Performance Measure Trend Table
CalViva—Madera County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	9.80%	10.23%	11.96%	1.73
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	49.54	30.13	48.14	49.37	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	464.83	320.60	381.28	367.48	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.41%	84.62%	82.44%	80.99%	-1.45
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.42%	81.77%	81.49%	80.68%	-0.81
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	98.06%	95.30%	97.26%	96.36%	-0.90
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	93.38%	91.95%	91.11%	90.83%	-0.28
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.84%	92.69%	91.62%	90.66%	-0.96
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	90.76%	90.64%	90.46%	88.58%	-1.88^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures CalViva stratified by the SPD and non-SPD populations:

SPD Rate Changes from RY 2016 to RY 2017

For SPD rates for which a comparison could be made from RY 2016 to RY 2017:

- ◆ No statistically significant changes occurred for any SPD rates between RY 2016 and RY 2017 in Madera County.
- ◆ The RY 2017 SPD rates were significantly better than the RY 2016 SPD rates for the following measures:
 - *All-Cause Readmissions* in Fresno County.
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Kings County.

Non-SPD Rate Changes from RY 2016 to RY 2017

For non-SPD rates for which a comparison was made from RY 2016 to RY 2017:

- ◆ The RY 2017 non-SPD rates were significantly better than the RY 2016 non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Kings County
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno and Kings counties
- ◆ The RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Fresno County
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Fresno County
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Fresno and Madera counties

RY 2017 SPD and RY 2017 Non-SPD Rate Comparisons

For measures for which HSAG could compare the SPD rates to the non-SPD rates in 2017:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Fresno and Madera counties

- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno and Kings counties
- *Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years* in Fresno and Madera counties
- *Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years* in Fresno County
- ◆ The RY 2017 SPD rate was significantly worse than the RY 2017 non-SPD rate for the *All-Cause Readmissions* measure in Fresno 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 beneficiaries.

Strengths—Performance Measures

HSAG auditors determined that CalViva followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all domains and counties:

- ◆ In RY 2017, within the Preventive Screening and Children’s Health domain, three of 12 rates (25 percent) were above the HPLs for at least three consecutive years. All three rates were in Madera County.
- ◆ For rates for which a comparison could be made between RY 2016 and RY 2017, 13 of 57 rates (23 percent) improved significantly from RY 2016 to RY 2017.
 - The Care for Chronic Conditions domain had the highest percentage of rates that improved significantly from RY 2016 to RY 2017, with eight of 27 rates (30 percent) improving significantly.
- ◆ Of the 16 rates below the MPLs in RY 2016, 13 rates (81 percent) improved from below the MPLs in RY 2016 to above the MPLs in RY 2017.
 - The Care for Chronic Conditions domain had the highest percentage of rates that improved from below the MPLs in RY 2016 to above the MPLs in RY 2017, with nine of 11 rates (82 percent) within this domain improving from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

Across all domains and counties, four of 54 rates (7 percent) were below the MPLs in RY 2017. Based on HSAG’s assessment of CalViva’s performance measure results, the MCP has the opportunity to:

- ◆ Assess whether current strategies need to be modified or expanded to ensure:
 - That in Madera County beneficiaries ages 18 and older on angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), or diuretics receive annual monitoring.
 - The appropriate use of antibiotics in Madera County for beneficiaries ages 18 to 64 with a primary diagnosis of bronchitis.

- ◆ Identify the causes for the rates declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure in Fresno and Madera counties and the MCP's performance being below the MPL for this measure in Madera County, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

CalViva had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

CalViva selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG reviewed and provided feedback to CalViva on the Plan portion of the PDSA cycle for the second intervention the MCP selected to test. HSAG sent periodic check-in email communications to CalViva to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CalViva set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, increase from 55 percent to 65 percent the postpartum visit rate among CalViva Health beneficiaries who belong to the selected high-volume clinic.

Failure Modes

The following, listed in priority order, are the failure modes that CalViva identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not have a scheduled postpartum visit appointment after delivery.
- ◆ Provider is unable to contact the beneficiary after delivery.
- ◆ Beneficiary forgets about the postpartum visit appointment.
- ◆ Beneficiary does not understand the importance of the postpartum visit appointment.
- ◆ Beneficiary does not have transportation to the postpartum visit appointment.
- ◆ Beneficiary returns to her primary care provider immediately after delivery.

Intervention Testing

During the reporting period, CalViva selected to test the following interventions:

- ◆ Collecting contact information specific to the postpartum recovery period (the two months after delivery) while the beneficiaries are hospitalized to improve the ability to provide postpartum visit appointment reminders to the beneficiaries. This intervention addresses lack of reminders for beneficiaries to attend postpartum visits and postpartum visits occurring out of the specified time frame.
- ◆ Offering a \$25 gift card incentive to beneficiaries at the time of their postpartum visits between 21 and 56 days post delivery. This intervention addresses beneficiaries' lack of understanding of the difference between the first or second week visit and the postpartum visit, the latter of which is to occur between 21 and 56 days postpartum.

Although CalViva completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CalViva's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

CalViva selected diabetes care as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for CalViva's MCP-specific PIP and determined that the MCP met all validation criteria for the module in its initial submission.

HSAG also reviewed and provided feedback to CalViva on the Plan portion of the PDSA cycle for the two interventions the MCP selected to test. HSAG sent periodic check-in email communications to CalViva and conducted technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CalViva set the SMART Aim for the *Diabetes Care* PIP as follows:

By June 30, 2017, increase from 76.00 percent to 83.19 percent the rate of HbA1c testing among CalViva beneficiaries diagnosed with diabetes at Provider A.⁶

⁶ Provider name removed for confidentiality.

Failure Modes

The following, listed in priority order, are the failure modes that CalViva identified during the Intervention Determination phase of the PIP process:

- ◆ Provider does not have accurate contact information for the beneficiary.
- ◆ Beneficiary is not responsive to provider's outreach call.
- ◆ Beneficiary may have lifestyle barriers that prevent keeping the appointment, such as work conflicts.
- ◆ Beneficiary may believe that HbA1c testing is not necessary.
- ◆ Beneficiary lacks transportation and/or may be unaware of transportation options available.

Intervention Testing

During the reporting period, CalViva selected to test whether or not the provider collecting information on the “best time to call” and confirming the “best phone number” would improve the ability for the provider to contact beneficiaries and provide reminders for HbA1c tests. However, after a couple months of implementation, the MCP abandoned the intervention testing due to the MCP not being able to gather an adequate number of beneficiaries' contact information.

Instead, CalViva selected to test whether or not the MCP supplying the provider with a list of beneficiaries who need HbA1c tests to verify against its database would improve the ability of the provider to contact beneficiaries and provide reminders for HbA1c tests.

Although CalViva completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CalViva's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, CalViva improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from CalViva’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of CalViva’s self-reported actions.

Table 5.1—CalViva’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. Assess whether or not current improvement strategies need to be modified or expanded for measures with rates below the MPLs in RY 2016.</p>	<p>During the 2016–17 intervention period, CalViva examined the barriers to specific HEDIS measures performing below the MPL. Barrier analysis was completed and measures were prioritized to facilitate successful improvement in rates for RY 2017.</p> <p>In addition, PIPs and frequent PDSA reports were completed to assess progress with interventions and modify these activities when needed. Some of these interventions/activities included, but were not limited to:</p> <ul style="list-style-type: none"> ◆ Offering a member incentive at the point of care. ◆ Supplying provider profiles to the clinics and providers to support efforts to contact patients and schedule appointments for preventive services. ◆ Offering health education classes. ◆ Offering same-day appointment clinics for cervical cancer screenings. ◆ Facilitating and providing reminders to members to attend scheduled appointments/events. ◆ Clinics using the provider profile to gather data to communicate results to the health plan. <p>These interventions were reviewed frequently throughout the year to assess whether the designed improvement strategies were successful as planned or required modifications or expansion to promote optimal success in reaching goals.</p>

2015–16 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>2. Work with HSAG to ensure that the MCP continues to meet all validation criteria for a methodologically sound <i>Diabetes Care</i> PIP to provide the best opportunity for the MCP to improve performance to above the MPL for the <i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i> measure in Fresno and Kings counties.</p>	<p>Between July 2016 and June 2017, CalViva Medical Management staff worked with HSAG on the <i>Diabetes Care</i> PIP to initiate improvement strategies likely to improve HbA1c testing compliance in Fresno and Kings counties. Milestones were met throughout this phase of the project.</p> <p>Upon receipt of validation criteria from HSAG, CalViva medical management staff members addressed opportunities to adjust and clarify interventions. All validation criteria were met after adjusting the interventions in partnership with the targeted high-volume, low-performing provider group. CalViva medical management met regularly with the <i>Diabetes Care</i> PIP improvement team to ensure that data were collected and interventions and activities were moving forward. Some of those activities/interventions included:</p> <ul style="list-style-type: none"> ◆ Improving data integrity. ◆ Providing member education and booklets to record screening history. ◆ Distributing provider and member incentives. ◆ Distributing provider profiles to the seven participating clinics in Fresno and Kings counties to track scheduled and completed appointments. <p>The final data were collected through June 30, 2017. Final analysis and completion of the PIP is in progress and due for submission to HSAG on August 15, 2017.</p>
<p>3. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Postpartum Care</i> PIP to address the MCP’s performance below the MPL for the <i>Prenatal and Postpartum Care—Postpartum Care</i> measure in Kings County.</p>	<p>Three of the five modules for the <i>Postpartum Care</i> PIP were submitted to HSAG during the July 1, 2016, through June 30, 2017, review period. This included the proposal for Module 4 Intervention #2, which was submitted to HSAG for review and feedback on November 30, 2016. CalViva Health then received feedback from HSAG on December 19, 2016. This feedback was incorporated into the implementation plan prior to fully implementing the intervention in Kings County.</p> <p>CalViva medical management staff members collaborated with its selected high-volume, low-performing provider group to implement and evaluate interventions, including member incentives at the point of care, postpartum visit scheduling support, and collaborative data collection with a stakeholder hospital. Final analysis of these interventions is in progress and will be provided to HSAG by August 15, 2017.</p>

2016–17 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:

- ◆ Assess whether current strategies need to be modified or expanded to address the MCP’s performance below the MPLs in RY 2017 for the following measures in Madera County:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ Identify the causes for the rates declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure in Fresno and Madera counties and the MCP’s performance below the MPL for this measure in Madera County. Identifying the causes will help CalViva to develop strategies, as applicable, to address the MCP’s declining performance for this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix G:
Performance Evaluation Report
Care1st Partner Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Care1st Partner Plan (“Care1st” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Care1st’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Care1st is a full-scope MCP delivering services to beneficiaries 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 Care1st, San Diego County’s beneficiaries may select from the following MCPs:

- ◆ Community Health Group Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser SoCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

Care1st became operational in San Diego County to provide MCMC services effective February 2006. As of June 30, 2017, Care1st had 84,192 beneficiaries.¹ This represents 12 percent of the beneficiaries enrolled in San Diego County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 22, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Care1st. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Care1st. A&I conducted the on-site audits from February 27, 2017, through March 2, 2017. A&I only reviewed categories in which A&I identified deficiencies during the 2016 audits of Care1st. Note that while DHCS issued the audit reports on July 6, 2017, and the final closeout letter on August 8, 2017, which are outside the review period for this MCP-specific evaluation report, HSAG includes the audit results and status 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 Care1st
 Audit Review Period: February 1, 2016, through January 31, 2017**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Administrative and Organizational Capacity	Yes	Closed.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member’s Rights, or State Supported Services categories during the February 27, 2017, through March 2, 2017 Medical and State Supported Services Audits of Care1st.

Opportunities for Improvement—Compliance Reviews

Care1st fully resolved the deficiency from the February 27, 2017, through March 2, 2017, A&I Medical Audit in the Administrative and Organizational Capacity category; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Care1st Partner Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance AuditTM.³ HSAG auditors determined that Care1st followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for Care1st's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Care1st—San Diego County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	65.45%	69.34%	66.18%	70.07%	3.89
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	89.27%	85.60%	82.07%	81.38%	-0.69
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	80.91%	77.82%	73.77%	72.10%	-1.67
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	80.88%	80.73%	77.72%	74.91%	-2.81^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	78.71%	76.16%	73.59%	68.67%	-4.92^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	18.68%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	62.29%	75.67%	76.64%	79.23%	2.59
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	37.96%	64.96%	66.67%	69.40%	2.73
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	67.34%	66.18%	61.99%	63.66%	1.67
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	54.02%	Not Comparable
<i>Cervical Cancer Screening</i>	43.31%	49.64%	47.45%	58.39%	10.94^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	60.58%	64.96%	64.72%	69.21%	4.49
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	81.02%	79.08%	81.51%	78.42%	-3.09
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.72%	85.47%	88.41%	91.52%	3.11^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.96%	87.37%	88.75%	89.43%	0.68
<i>Asthma Medication Ratio—Total</i>	--	--	--	21.84%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	46.72%	48.66%	60.10%	69.10%	9.00^

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	37.71%	53.53%	46.47%	56.69%	10.22 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	42.58%	48.42%	50.61%	53.53%	2.92
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	51.82%	39.42%	40.63%	35.77%	-4.86
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	81.27%	87.59%	83.45%	89.29%	5.84 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.24%	84.18%	89.78% ⁺	91.48%	1.70
<i>Controlling High Blood Pressure</i>	42.82%	59.37%	54.02%	67.73%	13.71 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	15.57%	16.89%	19.00%	17.72%	-1.28
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	51.00	53.48	46.25	42.99	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	279.31	366.29	341.22	350.69	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.41%	25.20%	25.14%	30.83%	5.69
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	100.0%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	13.15%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	72.11%	76.85%	66.59%	64.19%	-2.40

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Care1st’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Within the Preventive Screening and Children’s Health domain, the rate for the *Childhood Immunization Status—Combination 3* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for the measure moving from below the MPL in RY 2016 to above the MPL in RY 2017. Care1st provided information on actions that the MCP took during the review period to address the rate for the *Childhood Immunization Status—Combination 3* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that Care1st conducted during the review period to improve the MCP’s performance on this measure. Care1st’s efforts may have contributed to the rate for the *Childhood Immunization Status—Combination 3* measure improving to above the MPL in RY 2017.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was below the MPL in RY 2017. Care1st provided information on actions that the MCP took during the review period to address the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that Care1st conducted during the review period to improve the MCP’s performance on this measure. Performance measure results show that Care1st has the opportunity to determine whether or not current improvement efforts need to be modified or new interventions need to be identified to ensure

that the MCP's beneficiaries 3 to 6 years of age are seen for one or more well-child visit(s) with a primary care provider (PCP) during the MY.

Preventive Screening and Women's Health

Care1st performed between the HPLs and MPLs for the three measures within the Preventive Screening and Women's Health domain for which MCPs were held accountable to meet the MPLs in RY 2017. The rate for the *Cervical Cancer Screening* measure improved significantly from RY 2016 to RY 2017, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017. Care1st provided information on actions that the MCP took during the review period to address the rate for the *Cervical Cancer Screening* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, Care1st conducted a performance improvement project (PIP) to address the MCP's performance being below the MPL for the *Cervical Cancer Screening* measure. Information regarding the *Cervical Cancer Screening* PIP is included in Section 4 of this report ("Performance Improvement Projects").

Care for Chronic Conditions

Care1st performed between the HPLs and MPLs for all measures within the Care for Chronic Conditions domain for which MCPs were held accountable to meet the MPLs in RY 2017. The rates for the following five of nine measures for which comparisons could be made between RY 2016 and RY 2017 (56 percent) improved significantly from RY 2016 to RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs.*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg).*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HBA1c) Testing.*
- ◆ *Controlling High Blood Pressure.*

Care1st provided information on actions that the MCP took during the review period to address the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the "Assessment of Improvement Plans" heading in this section of the report, HSAG provides a summary of the PDSA cycles that Care1st conducted during the review period to improve the MCP's performance on this measure. Care1st's efforts may have contributed to the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure improving to above the MPL in RY 2017.

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain in RY 2017, the rate for the *Use of Imaging Studies for Low Back Pain* measure was below the MPL. Care1st provided information on actions that the MCP took during the review period to address the rate for the *Use of Imaging Studies* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the strategies that Care1st implemented to improve the MCP’s performance on this measure.

Performance measure results within the Appropriate Treatment and Utilization domain show that Care1st has the opportunity to determine whether or not current improvement efforts need to be modified or new interventions need to be identified to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, DHCS required Care1st to submit triannual quality improvement summary on strategies that the MCP implemented to improve the MCP’s performance to above the MPL for the *Use of Imaging Studies for Low Back Pain* measure. DHCS also required Care1st to submit IP/PDSA cycles for the following measures with rates below the MPLs in RY 2016:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the *Childhood Immunization Status—Combination 3* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measures improved to above the MPLs in RY 2017; however, the rates remained below the MPLs for the *Use of Imaging Studies for Low Back Pain* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures.

Use of Imaging Studies for Low Back Pain

To improve the MCP’s performance for the *Use of Imaging Studies for Low Back Pain* measure, Care1st implemented the following strategies:

- ◆ Trained providers on the criteria for appropriate ordering of imaging studies for beneficiaries presenting with low back pain.
- ◆ Mailed educational materials to providers about conservative treatment options.
- ◆ Added a beneficiary health and wellness program portal to the MCP’s website that included back pain self-management health topics.
 - To improve beneficiary use of the educational information, Care1st offered incentives to beneficiaries who completed the online program, including the back pain self-management module.

Childhood Immunization Status—Combination 3

Care1st conducted two PDSA cycles to help improve the MCP's performance for the *Childhood Immunization Status—Combination 3* measure to above the MPL.

Plan-Do-Study-Act Cycle 1

For the first PDSA cycle, Care1st set the following SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective:

By December 31, 2016, improve the *Childhood Immunization Status—Combination 3* rate from 58.6 percent to 75.0 percent for eligible beneficiaries who were identified through the MCP's Web portal to be overdue for their immunizations.

Care1st tested whether or not educating the MCP's providers and medical groups on the value of immunizations and use of the MCP's web-based gap in care reports would increase the percentage of beneficiaries receiving their recommended immunization dosages. Care1st reported that it did not meet the SMART objective and indicated that the MCP decided to abandon the intervention. The MCP indicated that although an improvement in the immunization rate occurred, the MCP could not associate the improvement with the tested intervention. Care1st also indicated that modifying the data elements for collection is valuable to allow for a more thoughtful analysis regarding whether or not the intervention was effective in influencing the outcomes.

Plan-Do-Study-Act Cycle 2

For the second PDSA cycle, Care1st set the following SMART objective:

By May 31, 2017, improve the *Childhood Immunization Status—Combination 3* rate from 66.18 percent to 75.00 percent for beneficiaries who were overdue for their immunizations and who received the outreach interventions at a designated federally qualified health center (FQHC).

Care1st tested whether or not having clinic staff members conducting telephonic beneficiary outreach would increase the percentage of beneficiaries receiving their recommended immunization dosages. The MCP reported that it did not meet the SMART objective and indicated the following lessons learned:

- ◆ To avoid inaccurate and misguided conclusions, adding more interventions to an existing PDSA plan design during the testing period requires careful planning, collaboration, strategic communication, and coordination with provider partners.
- ◆ To assess progress and proactively address barriers, it is important to conduct regular quality improvement follow-up visits and have frequent communication with the provider partners during the intervention testing process.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Care1st planned to conduct two PDSA cycles to help improve the MCP's performance to above the MPL for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure. The MCP partnered with the same provider for both PDSA cycles to test whether or not the provider conducting

beneficiary outreach based on gap in care reports would increase the percentage of eligible beneficiaries completing their retinal eye exams.

At the end of the first PDSA cycle, Care1st learned that the provider partner did not initiate the planned intervention. The provider partner did not follow through with intervention testing; therefore, Care1st indicated that the MCP recognized that obtaining buy-in from the provider partner, developing a process for follow-up and monitoring, and establishing a shared goal with the provider partner are important to the success of quality improvement efforts.

Following the second PDSA cycle, Care1st indicated that the MCP did not meet the SMART objective of increasing the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* rate from 46.47 percent to 55.00 percent at the provider partner for beneficiaries overdue for retinal eye exams and who received outreach by the provider partner. Care1st indicated that the MCP recognized that communicating clear expectations with the provider partner is important to the success of quality improvement efforts.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Care1st planned to conduct two PDSA cycles to help improve the MCP's performance to being above the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The MCP partnered with the same provider for both PDSA cycles to test whether or not having a vendor conduct telephonic outreach, coupled with the MCP sending reminder letters in English and Spanish to beneficiaries, would increase the percentage of beneficiaries being seen for well-child visits.

At the end of the first PDSA cycle, Care1st learned that the provider partner did not initiate the planned intervention. Based on the provider partner not following through with the intervention testing, Care1st indicated that the MCP recognized the importance of consistent follow-up, communication, and engagement with the provider partner's lead staff member. Additionally, Care1st identified the beneficiary face-to-face encounter with the provider partner as an opportunity for beneficiary education and scheduling of follow-up appointments.

Following the second PDSA cycle, Care1st indicated that the MCP did not meet the SMART aim goal of increasing the percentage of scheduled well-child visits from 61.99 percent to 70.00 percent for eligible members assigned to the provider partner. Care1st indicated that the MCP recognized the importance of defining the role of the MCP's provider liaison and educating the provider partner staff members on the importance of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure and the measure's implications on beneficiaries' health.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, Care1st will be required to conduct a PIP or submit IP/PDSA cycles to address the MCP's performance below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. Additionally, Care1st will be required to submit to DHCS quality improvement summaries describing strategies and efforts performed related to the *Use of Imaging Studies for Low Back Pain* measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Care1st—San Diego County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	22.75%	15.49%	7.26^^	17.72%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	84.98	39.68	Not Tested	42.99
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	653.93	326.81	Not Tested	350.69
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	93.96%	90.70%	3.26^	91.52%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	93.82%	87.83%	5.99^	89.43%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	81.47%	Not Comparable	81.38%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	72.16%	72.10%	0.06	72.10%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	70.68%	75.08%	-4.40	74.91%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	58.46%	69.15%	-10.69^^	68.67%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
Care1st—San Diego County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.90%	19.22%	23.89%	22.75%	-1.14
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	68.85	74.91	90.10	84.98	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	399.63	478.22	587.62	653.93	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.13%	85.97%	91.55%	93.96%	2.41
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.98%	87.10%	91.68%	93.82%	2.14
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	69.03%	59.63%	68.87%	72.16%	3.29
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	62.64%	64.66%	59.70%	70.68%	10.98
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	70.67%	58.79%	55.83%	58.46%	2.63

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
Care1st—San Diego County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.64%	13.92%	16.32%	15.49%	-0.83
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	44.72	49.57	42.14	39.68	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	237.00	345.87	318.11	326.81	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	76.14%	84.75%	87.21%	90.70%	3.49 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	72.65%	87.75%	87.53%	87.83%	0.30
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	89.78%	86.15%	82.06%	81.47%	-0.59
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	81.31%	78.31%	73.89%	72.10%	-1.79
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	81.93%	81.66%	78.58%	75.08%	-3.50 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.34%	77.52%	74.69%	69.15%	-5.54 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that Care1st stratified by the SPD and non-SPD populations:

SPD Rate Changes from RY 2016 to RY 2017

- Care1st had no variation in SPD rates from RY 2016 to RY 2017 for SPD rates for which a comparison could be made from RY 2016 to RY 2017.

Non-SPD Rate Changes from RY 2016 to RY 2017

- ◆ For rates for which comparisons were made between RY 2016 and RY 2017:
 - The RY 2017 non-SPD rate was significantly better than the RY 2016 non-SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure.
 - The RY 2017 non-SPD rate was significantly worse than the RY 2016 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures.

Differences between RY 2017 SPD and RY 2017 Non-SPD Rates

- ◆ For measures for which HSAG could compare the RY 2017 SPD rates to the RY 2017 non-SPD rates:
 - The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.
 - The RY 2017 SPD rate was significantly worse than the RY 2017 non-SPD rate for the following measures:
 - *All-Cause Readmissions*.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*.

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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* measure may be attributed to children and adolescents in the SPD population in the 12 to 19 years age group, based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to Care1st's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Care1st report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.5 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.5—Multi-Year MLTSSP Performance Measure Results
Care1st—San Diego County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	70.17	98.21	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	756.33	1,061.99	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	22.49%	29.50%	7.01

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from RY 2016 to RY 2017.

Strengths—Performance Measures

HSAG auditors determined that Care1st followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all domains, for measures for which a comparison could be made between RY 2016 and RY 2017, the rates improved significantly from RY 2016 to RY 2017 for six of 19 measures (32 percent). Five of the measures with rates that improved significantly from RY 2016 to RY 2017 were within the Care for Chronic Conditions domain and one measure was within the Preventive Screening and Women's Health domain. Three of the five rates that were below the MPLs in RY 2016 (60 percent) improved to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

Care1st has the opportunity to determine whether or not current improvement efforts need to be modified or new interventions need to be identified to ensure that the MCP's beneficiaries 3 to 6 years of age are seen for one or more well-child visit(s) with a PCP during the MY and that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

Care1st had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

Care1st selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG reviewed and provided feedback to Care1st on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to Care1st to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Care1st set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, increase from 50.84 to 53.53 percent the rate of *Comprehensive Diabetes Care—Blood Pressure Monitoring* among beneficiaries ages 18 to 75 with type 1 or type 2 diabetes with hypertension.

Failure Modes

The following, listed in priority order, are the failure modes that Care1st identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary living with diabetes and hypertension is not provided with information about the importance of having blood pressure measured at every routine diabetes visit and about adhering to medication and treatment regimens.
- ◆ Appointment scheduling process is too difficult for the beneficiary living with diabetes and hypertension.
- ◆ Beneficiary living with diabetes and hypertension does not feel a routine diabetes visit and blood pressure screening are necessary.
- ◆ PCP does not offer scheduling assistance.

- ◆ Beneficiary living with diabetes and hypertension does not have transportation to keep the appointment.
- ◆ PCP does not follow up with the beneficiary living with diabetes and hypertension after a missed appointment to schedule a new time.
- ◆ Beneficiary living with diabetes and hypertension forgets about the diabetes visit appointment.
- ◆ Beneficiary living with diabetes and hypertension is not interested in understanding the importance of regular diabetes visits and blood pressure screening at every visit.

Intervention Testing

During the reporting period, Care1st selected to test actively engaging beneficiaries with diabetes in controlling their blood pressure by providing education about hypertension medication, treatment adherence support, and tools and resources for self-management. This intervention addresses the key driver of beneficiary engagement.

Although Care1st completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Care1st's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

Care1st selected cervical cancer screening as its MCP-specific PIP topic.

Validation Findings

During the reporting period, Care1st incorporated HSAG's initial validation feedback into modules 1 and 2 of the MCP-specific PIP. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. Additionally, HSAG validated Module 3 for Care1st's MCP-specific PIP during the reporting period and determined that the MCP met all validation criteria for Module 3 in its initial submission.

HSAG also reviewed and provided feedback to Care1st on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to Care1st to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Care1st set the SMART Aim for the *Cervical Cancer Screening* PIP as follows:

By June 30, 2017, increase the cervical cancer screening rate from 37.29 percent to 41.02 percent among women ages 21 to 64 who had cervical cytology within the last three years or women ages 30 to 64 who had cervical cytology/human papillomavirus co-testing within the last five years.

Failure Modes

The following, listed in priority order, are the failure modes that Care1st identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary either never had a Pap test or had her last Pap test so long ago that she is not aware that female nurse practitioners may be available to perform the cervical cancer screening.
- ◆ Provider office does not offer convenient hours.
- ◆ Beneficiary is not interested or she has a misunderstanding about the information provided on the importance of getting cervical cancer screening.
- ◆ Beneficiary does not feel cervical cancer screening is necessary because she believes her sexual activity (or lack of) reduces her risk of developing cervical cancer. Also, beneficiary is not exhibiting symptoms of sexually transmitted diseases, infections, or cancer.
- ◆ Beneficiary is embarrassed lying on her back undressed in front of a clinician, feels uncomfortable having a clinician touch her in her vaginal area, has heard a Pap and pelvic exam could be quite uncomfortable and painful, or is embarrassed about her body size and that the gown would not cover enough of her body.
- ◆ PCP does not provide cervical cancer screening appointment scheduling assistance.
- ◆ Beneficiary forgets about the cervical cancer screening appointment.
- ◆ Beneficiary is not provided with information about the importance of cervical cancer screening.

Intervention Testing

During the reporting period, Care1st selected to test engaging beneficiaries to provide education on the importance of cervical cancer screenings and assist with appointment scheduling. This intervention addresses the key driver of beneficiary awareness.

Although Care1st completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Care1st's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG’s PIP validation and technical assistance, Care1st improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

Based on Care1st’s PIP progression, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Care1st’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Care1st’s self-reported actions.

Table 5.1—Care1st’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Care1st	Self-Reported Actions Taken by Care1st during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. Identify the causes for the MCP’s performance below the MPLs in RY 2016 for the following measures:</p> <ul style="list-style-type: none"> a. <i>Childhood Immunization Status—Combination 3</i> b. <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i> c. <i>Use of Imaging Studies for Low Back Pain</i> d. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> e. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> 	<p>Care1st implemented several actions to improve these measures and achieve the goal of exceeding the MPLs. For all HEDIS measures, Care1st conducts monthly tracking, comparing monthly results and producing gap lists to disseminate to providers, independent practice associations (IPAs)/medical groups, and internal HEDIS staff members for outreach to members and follow-up. Specific interventions include:</p> <p><i>Childhood Immunization Status</i></p> <ul style="list-style-type: none"> ◆ Causes for performance below the MPL: <ul style="list-style-type: none"> ■ Registry data were not pulled regularly. ■ Parents are not willing to have their children immunized. ◆ Care1st continues to send parents and guardians brochures on the importance of childhood immunizations. ◆ Care1st continues to work with the FQHCs in its efforts to conduct member outreach, calling and educating the members regarding the importance of completing the recommended childhood immunizations and assisting the members with setting appointments with the PCPs to have the services rendered. ◆ Care1st continues to utilize a vendor to make outreach calls to members, with the goal of proactively promoting the benefits of childhood immunization and encouraging members to schedule appointments with their PCPs.

2015–16 External Quality Review Recommendations Directed to Care1st	Self-Reported Actions Taken by Care1st during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p><i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i></p> <ul style="list-style-type: none"> ◆ Causes for performance below the MPL: <ul style="list-style-type: none"> ■ Care1st could not get full data on members who had the eye screening. ■ Outreach program was not established with the vendor. ◆ Care1st switched vendors to ensure the MCP receives a full report of members who received the services. ◆ Care1st sends the vendor a regular list of diabetic members eligible for the eye exams. <p><i>Use of Imaging Studies for Low Back Pain</i></p> <ul style="list-style-type: none"> ◆ Cause for performance below the MPL: <ul style="list-style-type: none"> ■ Members registered for the Healthy Back Program available on Care1st’s member portal but did not complete the program. ◆ When members note on their personal health assessments that they have had or have back pain, they are automatically enrolled in a back pain workshop. Upon automatic enrollment, members now get a message informing them that they were automatically enrolled in the workshop because of their responses. The message gives them a description of the workshop, encourages them to complete the workshop, and reminds them about our incentive program. ◆ We also identified those members who had been automatically enrolled in the workshop prior to us activating the automatic enrollment message. We sent them a similar message through the coaching portal. ◆ Additionally, now we have attached a satisfaction survey at the end of the workshop. The survey is listed as a task that members need to complete as part of the workshop. Members’ feedback will help guide future improvements to the workshops. <p><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></p> <ul style="list-style-type: none"> ◆ Causes for performance below the MPL: <ul style="list-style-type: none"> ■ Parents are not available to bring their children for well-child visits during clinic hours. ◆ Care1st continues to send parents and guardians reminders about scheduling appointments with PCPs for their children’s wellness exams at the recommended stages of life.

2015–16 External Quality Review Recommendations Directed to Care1st	Self-Reported Actions Taken by Care1st during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<ul style="list-style-type: none"> ◆ Care1st continues to work with the FQHCs in their efforts to do member outreach, calling and educating the members regarding the importance of completing the recommended childhood immunizations, and assisting the members to set up appointments with the PCPs to have services rendered. ◆ Care1st continues to utilize a vendor to make outreach calls to members, with the goal of proactively promoting the benefits of childhood immunizations and encouraging members to schedule appointments with their PCPs.
<p>2. Incorporate HSAG’s feedback on modules 1 and 2 for the <i>Cervical Cancer Screening</i> PIP to ensure that all validation criteria are met for a methodologically sound PIP to address the MCP’s performance below the MPL for the <i>Cervical Cancer Screening</i> measure.</p>	<ul style="list-style-type: none"> ◆ Care1st continues to utilize a vendor to make outreach calls to members, with the goal of proactively promoting the benefits of cervical cancer screening and encouraging members to schedule appointments with their PCPs. ◆ Care1st continues to work with the FQHCs in their efforts to do member outreach, calling and educating the members regarding the importance of completing the recommended cervical cancer screening and assisting the members to set up appointments with the PCPs to have the services rendered. ◆ The member data and performance results include those reports specific to only one provider in San Diego. ◆ Continue with the incentive program for this FQHC facility.
	<p>Early review of HEDIS for reporting year 2016 shows improvement in each of the target areas, and we will continue to do root cause analysis to ensure we are making the right efforts for continued quality improvement activities around all areas identified.</p>

2016–17 Recommendations

Based on the overall assessment of Care1st’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:

- ◆ Determine whether or not current improvement efforts need to be modified or new interventions need to be identified to improve the MCP’s performance to above the MPLs for the *Use of Imaging Studies for Low Back Pain* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures. Making this determination will help Care1st to develop appropriate strategies to address the MCP’s performance being below the MPLs for these measures.

In the next annual review, HSAG will evaluate continued successes of Care1st as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix H:
Performance Evaluation Report
CenCal Health
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), CenCal Health (“CenCal” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in CenCal’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CenCal is a full-scope MCP delivering services to beneficiaries in the County Organized Health System (COHS) model.

CenCal became operational to provide MCMC services in Santa Barbara County effective September 1983 and San Luis Obispo in March 2008. As of June 30, 2017, CenCal had 123,528 beneficiaries in Santa Barbara County and 54,409 in San Luis Obispo County—for a total of 177,937 beneficiaries.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 08, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CenCal. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CenCal. A&I conducted the on-site audits from October 18, 2016, through October 20, 2016.

**Table 2.1—DHCS A&I Medical and State Supported Services Audits of CenCal
 Audit Review Period: October 1, 2015, through September 30, 2016**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

A&I identified no deficiencies during the October 2016 Medical and State Supported Services Audits of CenCal.

Opportunities for Improvement—Compliance Reviews

CenCal had no deficiencies from the October 2016 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for CenCal Health* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that CenCal followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 and Table 3.2 for CenCal's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 and Table 3.2:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
CenCal—San Luis Obispo County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	77.43%	79.73%	70.25%	69.54%	-0.71
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	96.78%	93.11%	94.22%	95.37%	1.15
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	89.60%	84.30%	86.99%	85.97%	-1.02
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	90.47%	89.84%	89.63%	89.86%	0.23
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	86.83%	88.33%	88.92%	88.58%	-0.34
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	37.38%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	60.10%	63.75%	73.09%	79.69% ⁺	6.60 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	51.82%	56.45%	63.21%	73.70% ⁺	10.49 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	72.95%	66.87%	68.46%	69.44%	0.98
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	58.10%	Not Comparable
<i>Cervical Cancer Screening</i>	62.77%	61.34%	54.85%	58.68%	3.83
<i>Prenatal and Postpartum Care—Postpartum Care</i>	70.47%	67.82%	64.75%	66.84%	2.09
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	87.13%	88.79%	86.61%	92.11% ⁺	5.50 [^]
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.16%	83.99%	87.48%	84.29%	-3.19^{^^}
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.92%	85.09%	86.82%	83.54%	-3.28
<i>Asthma Medication Ratio—Total</i>	--	--	--	69.06%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.94%	68.33%	68.95%	72.57%	3.62

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	59.12%	65.59%	59.41%	70.57% ⁺	11.16 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	58.15%	54.61%	58.68% ⁺	60.85% ⁺	2.17
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	30.90% ⁺	34.66%	25.92% ⁺	28.18% ⁺	2.26
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	84.18%	84.29%	90.71%	88.03%	-2.68
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.40%	83.29%	89.98% ⁺	90.52%	0.54
<i>Controlling High Blood Pressure</i>	54.43%	59.90%	61.81%	66.58%	4.77
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	12.28%	12.36%	13.78%	11.21%	-2.57
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	58.78	57.39	56.49	57.18	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	334.76	341.47	336.94	325.37	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	17.24%	28.85%	26.88%	33.48%	6.60
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	11.15%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	80.89%	86.51% ⁺	80.43%	69.88%	-10.55^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
CenCal—Santa Barbara County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	83.56% ⁺	81.25% ⁺	78.46%	77.08%	-1.38
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	98.49% ⁺	96.79%	94.87%	91.56%	-3.31^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	93.58%	91.58%	89.86%	81.00%	-8.86^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	92.88%	93.73%	93.82%	84.52%	-9.30^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	90.59%	90.59%	90.96%	79.07%	-11.89^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	34.43%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	72.99%	77.92% ⁺	74.86%	80.93% ⁺	6.07 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	57.66%	67.49%	62.02%	72.94% ⁺	10.92 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	80.65%	74.07%	68.85%	74.17%	5.32
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	61.00%	Not Comparable
<i>Cervical Cancer Screening</i>	74.45%	70.40%	63.22%	66.41%	3.19
<i>Prenatal and Postpartum Care—Postpartum Care</i>	76.83% ⁺	74.10% ⁺	76.32% ⁺	74.75% ⁺	-1.57
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	85.98%	84.92%	89.72%	93.11% ⁺	3.39
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.79%	86.43%	88.58%	86.45%	-2.13^^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.74%	87.26%	87.42%	85.93%	-1.49
<i>Asthma Medication Ratio—Total</i>	--	--	--	72.30% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	72.02%	70.60%	70.66%	67.29%	-3.37

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	68.61% ⁺	71.36% ⁺	71.68% ⁺	69.68% ⁺	-2.00
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	59.37% ⁺	61.06% ⁺	65.05% ⁺	63.03% ⁺	-2.02
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	31.87%	29.15% ⁺	25.77% ⁺	26.33% ⁺	0.56
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	86.37%	90.95%	91.07%	90.43%	-0.64
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.91%	85.18%	90.82% ⁺	88.56%	-2.26
<i>Controlling High Blood Pressure</i>	60.25%	62.03%	58.51%	61.10%	2.59
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.15%	13.80%	14.25%	11.97%	-2.28 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	51.43	51.03	50.83	48.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	301.90	302.48	296.77	305.58	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	22.62%	28.93%	28.44%	28.61%	0.17
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	8.90%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	81.72%	83.26%	80.81%	73.34%	-7.47 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of CenCal’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ *All four Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Within the Preventive Screening and Children’s Health domain, the rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in both reporting units improved significantly from RY 2016 to RY 2017 and were above the HPLs in RY 2017. The MCP had no measures with rates below the MPLs within this domain in RY 2017.

Preventive Screening and Women’s Health

Within the Preventive Screening and Women’s Health domain, CenCal performed above the HPL in Santa Barbara County for the *Prenatal and Postpartum Care—Postpartum Care* measure for all RYs in Table 3.2. The rates were above the HPL in both reporting units for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in RY 2017. Additionally, the rate for the *Timeliness of Prenatal Care* measure improved significantly from RY 2016 to RY 2017 in San Luis Obispo County. The MCP had no rates below the MPLs within this domain in RY 2017.

Performance measure results within this domain show that in Santa Barbara County CenCal consistently exceeded DHCS’ HPLs for ensuring that female beneficiaries who deliver a live birth complete a postpartum visit on or between 21 and 56 days after delivery.

Care for Chronic Conditions

In RY 2017, within the Care for Chronic Conditions domain, CenCal performed above the HPLs in both reporting units for the following measures:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
 - The MCP performed above the HPL in Santa Barbara County for all RYs in Table 3.2.
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
 - The MCP performed above the HPL in Santa Barbara County for all RYs in Table 3.2.
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
 - RY 2017 was the third consecutive year that the rate was above the HPL in Santa Barbara County.

The rates declined significantly from RY 2016 to RY 2017 for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in both reporting units. The significant decline in the rate in San Luis Obispo County resulted in the rate moving from above the MPL in RY 2016 to below the MPL in RY 2017. Additionally, the rate was below the MPL in RY 2017 for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in San Luis Obispo County.

Performance measure results within this domain show that in Santa Barbara County, CenCal consistently exceeded DHCS' HPLs for ensuring that beneficiaries ages 18 to 75 with diabetes (type 1 and type 2):

- ◆ Receive a retinal eye exam.
- ◆ Have controlled HbA1c levels documented.

Additionally, performance measure results within this domain show that the MCP has the opportunity to identify the causes for the MCP's declining performance or performance below the MPLs for the *Annual Monitoring for Patients on Persistent Medications* measures, to ensure that beneficiaries ages 18 and older on angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), and diuretics receive annual monitoring.

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, the rate improved significantly from RY 2016 to RY 2017 for the *All-Cause Readmissions* measure in Santa Barbara County. The MCP had no measures with rates below the MPLs within this domain.

The rates declined significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure in both reporting units. Note that the significant decline in the rates from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to CenCal's performance.

Assessment of Improvement Plans

CenCal was not required to submit any improvement plans in RY 2016.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, CenCal will be required to submit IP/PDSA cycles for both *Annual Monitoring for Patients on Persistent Medications* measures in San Luis Obispo County.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.3 and Table 3.4 present the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.3—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CenCal—San Luis Obispo County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	12.23%	10.88%	1.35	11.21%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	108.28	54.11	Not Tested	57.18
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	591.41	309.39	Not Tested	325.37
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.67%	83.63%	3.04	84.29%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.00%	82.22%	5.78	83.54%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	95.45%	Not Comparable	95.37%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.29%	86.00%	-1.71	85.97%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.91%	90.03%	-5.12^^	89.86%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.66%	88.85%	-7.19^^	88.58%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.3 and Table 3.4.

Table 3.4—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CenCal—Santa Barbara County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	15.36%	10.67%	4.69^^	11.97%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	107.10	45.86	Not Tested	48.72
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	611.80	290.59	Not Tested	305.58
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.43%	85.27%	5.16^	86.45%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.23%	84.17%	7.06^	85.93%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.55%	Not Comparable	91.56%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	79.25%	81.02%	-1.77	81.00%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.67%	84.49%	1.18	84.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.32%	79.06%	0.26	79.07%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.5 and Table 3.6 present the four-year trending information for the SPD population, and Table 3.7 and Table 3.8 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.5—Multi-Year SPD Performance Measure Trend Table
CenCal—San Luis Obispo County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	14.96%	12.70%	20.05%	12.23%	-7.82 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	95.46	100.46	96.76	108.28	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	598.85	646.84	618.97	591.41	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.97%	84.97%	92.21%	86.67%	-5.54 ^{^^}
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.28%	85.96%	90.91%	88.00%	-2.91
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	76.07%	78.76%	79.80%	84.29%	4.49
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.22%	83.87%	83.52%	84.91%	1.39
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.72%	77.16%	77.62%	81.66%	4.04

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.6—Multi-Year SPD Performance Measure Trend Table
CenCal—Santa Barbara County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.41%	17.34%	18.76%	15.36%	-3.40
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	102.10	104.75	100.61	107.10	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	596.56	595.81	598.50	611.80	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.25%	88.66%	90.60%	90.43%	-0.17
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.19%	90.32%	91.28%	91.23%	-0.05
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.99%	92.95%	93.94%	79.25%	-14.69^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.32%	91.17%	93.71%	85.67%	-8.04^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	89.52%	90.43%	90.62%	79.32%	-11.30^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.7—Multi-Year Non-SPD Performance Measure Trend Table
CenCal—San Luis Obispo County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	6.71%	12.06%	10.92%	10.88%	-0.04
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	53.41	53.41	53.77	54.11	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	296.02	313.29	317.85	309.39	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	71.79%	83.10%	85.95%	83.63%	-2.32
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	72.97%	84.36%	85.27%	82.22%	-3.05
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	96.86%	93.18%	94.19%	95.45%	1.26
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.04%	84.43%	87.12%	86.00%	-1.12
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.91%	90.17%	89.87%	90.03%	0.16
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.41%	89.19%	89.39%	88.85%	-0.54

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.8—Multi-Year Non-SPD Performance Measure Trend Table
CenCal—Santa Barbara County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	7.29%	9.81%	12.02%	10.67%	-1.35
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	46.42	47.04	48.01	45.86	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	272.79	280.68	279.72	290.59	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.54%	83.97%	87.83%	85.27%	-2.56^^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.53%	83.57%	85.76%	84.17%	-1.59
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	98.48%	96.80%	94.85%	91.55%	-3.30^^
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	93.63%	91.56%	89.80%	81.02%	-8.78^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.99%	93.82%	93.82%	84.49%	-9.33^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	90.65%	90.60%	90.97%	79.06%	-11.91^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that CenCal stratified by the SPD and non-SPD populations:

- ◆ For SPD rates for which a comparison could be made between RY 2016 and RY 2017:
 - The SPD rate in San Luis Obispo County improved significantly from RY 2016 to RY 2017 for the *All-Cause Readmissions* measure.
 - The SPD rate in San Luis Obispo County declined significantly from RY 2016 to RY 2017 for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure.
 - The SPD rates in Santa Barbara County declined significantly from RY 2016 to RY 2017 for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years, 7–11 Years, and 12–19 Years* measures.
- ◆ For non-SPD rates for which a comparison could be made between RY 2016 and RY 2017:
 - No statistically significant changes occurred in San Luis Obispo County between RY 2016 and RY 2017.
 - In Santa Barbara County, the non-SPD rates declined significantly from RY 2016 to RY 2017 for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* in Santa Barbara County.
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures:
 - *All-Cause Readmissions* in Santa Barbara County
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years and 12–19 Years* in San Luis Obispo 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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age categories (i.e., *7–11 Years* and *12–19 Years*), based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Strengths—Performance Measures

HSAG auditors determined that CenCal followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all domains and reporting units, 13 of 36 rates (36 percent) were above the HPLs in RY 2017. For rates for which a comparison could be made from RY 2016 to RY 2017, seven of 38 rates (18 percent) improved significantly from RY 2016 to RY 2017.

Opportunities for Improvement—Performance Measures

CenCal has the opportunity to identify the causes for the MCP's declining performance or performance below the MPLs for both *Annual Monitoring for Patients on Persistent Medications* measures, to ensure that beneficiaries ages 18 and older on angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), or diuretics receive annual monitoring. The MCP also has the opportunity to identify the causes for the MCP's declining performance in both reporting units for the *Use of Imaging Studies for Low Back Pain* measure, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

CenCal had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

CenCal selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to CenCal to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

CenCal set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, increase the rate of diabetic retinal eye exams from 56.0 percent to 60.4 percent among San Luis Obispo Health Initiative (SLOHI) beneficiaries living with diabetes (as per HEDIS definition and specifications) assigned to Provider A.⁶

Failure Modes

The following, listed in priority order, are the failure modes that CenCal identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not have transportation to the appointment.
- ◆ Beneficiary is unable to take time off work for the appointment.
- ◆ Specialist submits the claim incorrectly.
- ◆ Beneficiary forgets about the appointment.
- ◆ Specialist fails to schedule the appointment.
- ◆ Primary care provider (PCP) is unaware that the appointment is not scheduled.
- ◆ PCP is unaware that the appointment is not kept.

⁶ Provider name removed for confidentiality.

- ◆ Specialist does not send the exam report to the PCP.
- ◆ Beneficiary is not interested in the exam.
- ◆ Provider is unable to reach the beneficiary.

Intervention Testing

During the reporting period, CenCal selected to test the coordination of beneficiary outreach and appointment scheduling assistance. This intervention addresses the access to diabetic eye exam key driver.

Although CenCal completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CenCal's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

CenCal selected initial health assessment (IHA) as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for CenCal's MCP-specific PIP.

Upon initial review of the module, HSAG determined that CenCal met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including all required components of the failure modes and effects analysis (FMEA).
- ◆ Describing the priority-ranking process to determine potential interventions.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, CenCal incorporated HSAG's feedback into the PIP modules. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to CenCal on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to CenCal and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CenCal set the SMART Aim for the *Provision of Initial Health Assessment* PIP as follows:

By June 30, 2017, increase the rate of completed IHAs of beneficiary enrollment from 10.8 percent to 19.7 percent among adult Santa Barbara Health Initiative beneficiaries ages 21 years or older assigned to Provider B.⁷

Failure Modes

The following, listed in priority order, are the failure modes that CenCal identified during the Intervention Determination phase of the PIP process:

- ◆ Provider does not schedule appointments with newly assigned beneficiaries to complete their IHAs.
- ◆ Provider does not reschedule missed IHA appointments within the 120-day time frame.
- ◆ Beneficiary is unclear about the importance of completing the IHA.
- ◆ Beneficiary does not call the provider to schedule the IHA appointment.
- ◆ Beneficiary does not keep the IHA appointment.
- ◆ Provider submits the claim incorrectly to the MCP.

Intervention Testing

During the reporting period, CenCal selected to test providing a list of new beneficiaries assigned to Provider B at the beginning of each month, including specific timelines that indicate when a beneficiary is due for his or her IHA. Provider B will receive an incentive for completion of IHAs with beneficiaries on the list. This intervention addresses the key driver of identification of beneficiaries who are due for IHAs.

Although CenCal completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CenCal's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, CenCal improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

⁷ Provider name removed for confidentiality.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from CenCal’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of CenCal’s self-reported actions.

Table 5.1—CenCal’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. To prevent further decline in performance, identify the causes for the rates declining significantly from RY 2015 to RY 2016 for the following measures:</p> <ul style="list-style-type: none"> a. <i>Cervical Cancer Screening</i> in Santa Barbara County b. <i>Childhood Immunization Status—Combination 3</i> in San Luis Obispo County c. <i>Use of Imaging Studies for Low Back Pain</i> in San Luis Obispo County 	<ul style="list-style-type: none"> a. Declining performance in Santa Barbara County was due to introduction of the previously uninsured Accountable Care Act (ACA) population to Medi-Cal. Cervical cancer screening has since improved by 3 percentage points, surpassing the NCQA Medicaid 75th percentile at 66.41 percent. To increase awareness of the importance of the screening, CenCal completed outreach to 26,709 households with members due for cervical cancer screenings, encouraging them to follow up with their primary care provider (PCP). Twenty-four percent of members who received the mailing completed a screening within the following year. An article in CenCal’s provider bulletin included information on the mailing, clinical guidelines, and importance of the screenings. A new women’s health page, which includes information on cervical cancer screenings, was added to CenCal’s website. b. In San Luis Obispo County, there is a larger proportion of members for whom vaccinations were refused by their parent and or guardian. Legislative changes that mandate immunization completeness prior to admission to public schools should help to mitigate parent refusals, but this measure remains statistically equal to the prior year. A new immunizations page, which includes age-appropriate vaccination guidelines and links to information such as the Centers for Disease Control and Prevention (CDC) and HealthyChildren.org, was added to CenCal’s website. CenCal also hosted a Keeping Kids Healthy provider training, which focused on childhood and adolescent immunizations,

2015–16 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>improvement strategies addressing late pneumococcal series, messaging, and strategies for vaccine-hesitant parents. Best practices were shared from high-performing practices to address common barriers among providers.</p> <p>c. NCQA advised plans that trending of <i>Use of Imaging Studies for Low Back Pain</i> measurement results between 2017 and prior years should be considered with caution due to specifications changes that could impact the rate. In November, an analysis was performed to identify practices with high imaging utilization and CenCal intervened to improve practice workflow with a single high-utilizing provider in CenCal’s network.</p>
<p>2. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Diabetes</i> PIP.</p>	<p>Pre-validation feedback from HSAG on the Plan portion of Module 4 has been incorporated into revisions to the Module 4 documentation. The test cycle objective was changed from a date to a description of the intervention being tested, and the highest-ranked top three failure modes are now integrated into the intervention justification. The FMEA now matches the intervention, and the intervention methodology and predicted results were improved based on initial feedback.</p>

2016–17 Recommendations

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

- ◆ Identify the causes for the MCP’s declining performance or performance below the MPLs for the *Annual Monitoring for Patients on Persistent Medications* measures. Identifying the causes will help the MCP to develop strategies to address the MCP’s declining performance in both reporting units for the *ACE Inhibitors or ARBs* measure and performance below the MPLs in San Luis Obispo County for both the *ACE Inhibitors or ARBs* and *Diuretics* measures.
- ◆ Identify the causes for the MCP’s declining performance in both reporting units for the *Use of Imaging Studies for Low Back Pain* measure to assist the MCP in developing strategies, as applicable, to address the MCP’s declining performance for this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix I:
Performance Evaluation Report
Central California Alliance for Health
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Central California Alliance for Health (“CCAH” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in CCAH’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CCAH is a full-scope MCP delivering services to beneficiaries in the County Organized Health System (COHS) model.

CCAH became operational to provide MCMC services in Santa Cruz County effective January 1996, in Monterey County effective October 1999, and in Merced County effective October 2009. As of June 30, 2017, CCAH had 127,474 beneficiaries in Merced County, 157,517 in Merced County, and 68,867 in Santa Cruz County—for a total of 353,858 beneficiaries.¹

DHCS allows CCAH to combine data for Monterey and Santa Cruz counties for reporting purposes. For this report, Monterey and Santa Cruz counties are considered a single reporting unit.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 12, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CCAH. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CCAH. A&I conducted the on-site audits from November 7, 2016, through November 18, 2016.

**Table 2.1—DHCS A&I Medical and State Supported Services Audits of CCAH
 Audit Review Period: November 1, 2015, through October 31, 2016**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

A&I identified no deficiencies during the November 2016 Medical and State Supported Services Audits of CCAH.

Opportunities for Improvement—Compliance Reviews

CCAHA had no deficiencies from the November 2016 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Central California Alliance for Health* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that CCAH followed the appropriate specifications to produce valid rates.

During the audit, the auditors identified several extreme lab values in the MCP’s data warehouse. The auditors noted that some of these extreme lab values may have been entered incorrectly and, had the errors been identified and corrected, those values could have contributed to the MCP’s rates. HSAG auditors recommended that CCAH conduct data integrity reviews throughout the year and, if possible, implement system edits that will result in warnings for extreme lab values upon receipt from the MCP’s vendor and/or providers so that the MCP can research with the vendor and/or providers whether or not any identified extreme lab values are accurate.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. See Table 3.1 and Table 3.2 for CCAH’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 and Table 3.2:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’ *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
CCAH—Merced County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYS 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	68.68%	67.88%	68.03%	66.67%	-1.36
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.63%	95.28%	94.50%	93.96%	-0.54
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	91.65%	89.48%	87.30%	87.24%	-0.06
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	90.31%	90.80%	89.60%	90.31%	0.71
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	88.46%	88.98%	87.78%	87.88%	0.10
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	20.44%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	68.13%	66.91%	62.77%	74.45%	11.68 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	43.07%	47.20%	45.74%	51.82%	6.08
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	76.32%	73.97%	72.56%	71.34%	-1.22
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	55.84%	Not Comparable
<i>Cervical Cancer Screening</i>	65.63%	64.96%	51.58%	56.20%	4.62
<i>Prenatal and Postpartum Care—Postpartum Care</i>	60.35%	57.91%	57.07%	62.77%	5.70
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	82.79%	83.45%	80.15%	81.27%	1.12
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.87%	87.32%	87.20%	86.91%	-0.29
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.43%	84.93%	87.37%	87.06%	-0.31
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.75%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	62.53%	66.18%	59.85%	56.20%	-3.65

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	53.53%	52.31%	53.28%	52.80%	-0.48
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	44.28%	45.99%	47.93%	44.04%	-3.89
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	45.74%	43.80%	40.63%	44.77%	4.14
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	83.94%	86.37%	85.64%	88.56%	2.92
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.27%	84.91%	89.29% ⁺	91.73%	2.44
<i>Controlling High Blood Pressure</i>	53.66%	62.04%	54.38%	53.53%	-0.85
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	12.78%	18.49%	14.74%	14.48%	-0.26
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	52.70	50.58	51.37	53.37	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	321.41	297.12	288.32	303.35	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	18.62%	25.14%	21.87%	22.57%	0.70
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	9.91%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	82.49% ⁺	78.62%	77.09%	70.49%	-6.60^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
CCAH—Monterey/Santa Cruz Counties

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	Ry 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	82.48%	77.62%	78.72%	79.86% ⁺	1.14
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	98.31%	95.99%	94.77%	96.31%	1.54 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	92.11%	90.19%	88.12%	90.32%	2.20 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	93.18%	92.44%	91.31%	92.30%	0.99 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	90.94%	89.95%	88.67%	89.02%	0.35
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	29.20%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	78.59% ⁺	78.35% ⁺	79.52%	88.30% ⁺	8.78 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	65.21% ⁺	65.21%	65.43%	74.73% ⁺	9.30 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	80.29%	81.27%	78.46%	82.29%	3.83
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	61.01%	Not Comparable
<i>Cervical Cancer Screening</i>	72.22%	65.45%	54.79%	54.50%	-0.29
<i>Prenatal and Postpartum Care—Postpartum Care</i>	69.83%	70.07%	72.99% ⁺	75.52% ⁺	2.53
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	93.10% ⁺	86.13%	83.62%	84.78%	1.16
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.34%	88.16%	84.93%	86.99%	2.06 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.02%	88.70%	86.64%	87.34%	0.70
<i>Asthma Medication Ratio—Total</i>	--	--	--	70.78% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	75.18% ⁺	67.40%	63.75%	63.26%	-0.49

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	56.45%	59.85%	60.34%	59.12%	-1.22
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	51.82%	46.96%	53.77%	50.12%	-3.65
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	38.20%	43.80%	38.44%	38.93%	0.49
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	86.86%	87.83%	90.27%	86.86%	-3.41
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.32%	82.00%	89.78% ⁺	88.81%	-0.97
<i>Controlling High Blood Pressure</i>	59.46%	64.72%	56.58%	53.04%	-3.54
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	11.58%	14.30%	13.61%	14.27%	0.66
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	46.64	45.17	44.44	49.40	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	303.75	290.72	270.16	313.45	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	28.07%	25.24%	29.24%	37.15%	7.91 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	12.79%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	85.20% ⁺	86.47% ⁺	84.47% ⁺	75.79%	-8.68 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of CCAH's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ *All four Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

Within the Preventive Screening and Children's Health domain, the MCP had no rates below the MPLs in RY 2017 across both reporting units. CCAH performed best in Monterey/Santa Cruz counties, with the rates for three of four measures within this domain in the reporting unit (75 percent) being above the HPLs in RY 2017. The rates for the following measures were above the HPLs in Monterey/Santa Cruz counties:

- ◆ *Childhood Immunization Status—Combination 3.*
- ◆ *Both Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures, with the rates for both measures improving significantly from RY 2016 to RY 2017.

In Merced County, the rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* measure improved significantly from RY 2016 to RY 2017.

Preventive Screening and Women’s Health

Within the Preventive Screening and Women’s Health domain, the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was above the HPL in RY 2017 in Monterey/Santa Cruz counties. Across both reporting units in RY 2017 no rates were below the MPLs within this domain.

In Merced County, the rate for the *Cervical Cancer Screening* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017. CCAH provided information on actions that the MCP took during the review period to address the rates for (1) the *Cervical Cancer Screening* measure in both reporting units declining significantly from RY 2015 to RY 2016, and (2) the rate for this measure in Merced County being below the MPL in RY 2016. (See Table 5.1.)

Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that CCAH conducted during the review period to ensure that female beneficiaries ages 21 to 64 in Merced County are screened for cervical cancer within the appropriate time frames. CCAH’s efforts may have contributed to the rate for the *Cervical Cancer Screening* measure in Merced County improving from RY 2016 to RY 2017.

Care for Chronic Conditions

Across both reporting units in RY 2017, all rates were between the HPLs and MPLs within the Care for Chronic Conditions domain. In Monterey/Santa Cruz counties, the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure improved significantly from RY 2016 to RY 2017. CCAH provided information on actions that the MCP took during the review period to address the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in Monterey/Santa Cruz counties declining significantly from RY 2015 to RY 2016. (See Table 5.1.) CCAH’s efforts may have contributed to the significant improvement in the rate for this measure in Monterey/Santa Cruz counties from RY 2016 to RY 2017.

Appropriate Treatment and Utilization

Across both reporting units in RY 2017, all rates were between the HPLs and MPLs within the Appropriate Treatment and Utilization domain. In Monterey/Santa Cruz counties, the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved significantly from RY 2016 to RY 2017. In Merced County, the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure in Merced County moving from below the MPL in RY 2016 to above the MPL in RY 2017.

Under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that CCAH conducted during the review period to ensure the appropriate use of antibiotics for beneficiaries ages 18 to 64 with a primary diagnosis of bronchitis in Merced County. Note that the improvement in the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in both reporting units from RY 2016 to RY 2017 may be due to NCQA’s RY 2017 specification changes for this measure and therefore may not be related to CCAH’s performance.

In both reporting units, the rates for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. CCAH has the opportunity to assess the causes for the significant decline in the rates, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study. Note that the significant decline in the MCP's rates for this measure may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to CCAH's performance.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, CCAH was required to submit IP/PDSA cycles for the following measures in Merced County:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Cervical Cancer Screening*
- ◆ *Immunizations for Adolescents—Combination 1*—Note that in RY 2017 DHCS replaced this measure with the *Immunizations for Adolescents—Combination 2* measure; therefore, HSAG provides no information on CCAH's PDSA cycles for this measure.

In Merced County, the rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Cervical Cancer Screening* measures improved from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

CCAH conducted two PDSA cycles to improve the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Merced County. The MCP partnered with two medical centers—one for each PDSA cycle. CCAH's SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objectives focused on increasing the rate of appropriately prescribed antibiotics for adult beneficiaries with acute bronchitis and decreasing the rate of inappropriately prescribed antibiotics for this population.

For both PDSA cycles, CCAH tested whether or not sending individual provider reports and educating medical staff members on the Centers for Disease Control and Prevention (CDC) antibiotic prescribing guidelines would improve the partnered medical centers' appropriate prescription of antibiotics for adult beneficiaries with acute bronchitis. CCAH reported that it met the SMART objectives and that the MCP decided to adopt the intervention. The MCP reported on lessons learned through the PDSA cycle process, including:

- ◆ The cost of conducting educational seminars and disseminating provider trending analyses is low, and the effect on compliance with antibiotic prescribing guidelines is substantial.
- ◆ Providing clarification of the CDC antibiotic prescribing guidelines contributed to the intervention's success.

Cervical Cancer Screening

CCAH conducted two PDSA cycles to improve the rate for the *Cervical Cancer Screening* measure in Merced County. The MCP partnered with two medical centers—one for each PDSA cycle. CCAH’s SMART objectives focused on increasing the cervical cancer screening rate for eligible beneficiaries linked to the two medical centers.

For both PDSA cycles, CCAH tested whether or not conducting provider education about a care-based incentive for providers who perform cervical cancer screening on eligible beneficiaries would improve the percentage of beneficiaries screened for cervical cancer at the two medical center partners. CCAH reported that it met the SMART objectives and that the MCP decided to adopt the intervention. The MCP indicated that the incentive program was well received by the partnered medical centers and resulted in the medical center staff members feeling encouraged to advocate that beneficiaries due for their cervical cancer screenings have the screening completed.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, CCAH will not be required to submit any IP/PDSA cycles.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.3 and Table 3.4 present the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.3—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCAH—Merced County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	21.38%	10.49%	10.89^^	14.48%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	91.55	50.91	Not Tested	53.37
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	515.31	289.74	Not Tested	303.35
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.81%	85.93%	3.88^	86.91%

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.3 and 3.4.

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.44%	85.38%	6.06 [^]	87.06%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	93.98%	Not Comparable	93.96%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.12%	87.20%	1.92	87.24%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	94.70%	90.17%	4.53 [^]	90.31%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.30%	87.95%	-1.65	87.88%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.4—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCAH—Monterey/Santa Cruz Counties

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.03%	12.07%	6.96^^	14.27%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	85.20	47.49	Not Tested	49.40
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	575.95	299.44	Not Tested	313.45
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.20%	85.52%	5.68^	86.99%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.34%	85.74%	5.60^	87.34%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	90.24%	96.36%	-6.12^^	96.31%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	94.78%	90.25%	4.53^	90.32%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	95.21%	92.23%	2.98^	92.30%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	93.67%	88.90%	4.77^	89.02%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

Table 3.5 and Table 3.6 present the four-year trending information for the SPD population, and Table 3.7 and Table 3.8 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.5—Multi-Year SPD Performance Measure Trend Table
 CCAH—Merced County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	15.78%	22.57%	18.51%	21.38%	2.87
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	76.83	79.54	80.83	91.55	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	539.90	509.74	490.67	515.31	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.10%	88.89%	88.82%	89.81%	0.99
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.17%	86.44%	88.79%	91.44%	2.65
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	91.03%	90.30%	89.44%	89.12%	-0.32
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	94.07%	93.41%	90.45%	94.70%	4.25 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.86%	84.97%	86.10%	86.30%	0.20

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.6—Multi-Year SPD Performance Measure Trend Table
 CCAH—Monterey/Santa Cruz Counties**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	13.89%	17.51%	20.62%	19.03%	-1.59
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.76	75.65	74.49	85.20	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	549.69	520.95	492.08	575.95	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.63%	91.91%	88.62%	91.20%	2.58 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.06%	91.83%	91.51%	91.34%	-0.17
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	84.38%	91.49%	90.24%	-1.25
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	95.29%	93.44%	94.34%	94.78%	0.44
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.34%	93.24%	93.18%	95.21%	2.03
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.52%	89.19%	90.02%	93.67%	3.65 [^]

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.7—Multi-Year Non-SPD Performance Measure Trend Table
 CCAH—Merced County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.00%	14.39%	12.31%	10.49%	-1.82
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	50.05	48.28	49.26	50.91	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	297.38	280.19	273.80	289.74	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.92%	86.14%	86.61%	85.93%	-0.68
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.91%	83.73%	86.77%	85.38%	-1.39
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.66%	95.35%	94.55%	93.98%	-0.57
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	91.67%	89.46%	87.25%	87.20%	-0.05
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.11%	90.67%	89.57%	90.17%	0.60
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.58%	89.23%	87.86%	87.95%	0.09

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.8—Multi-Year Non-SPD Performance Measure Trend Table
 CCAH—Monterey/Santa Cruz Counties**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	7.69%	11.32%	9.26%	12.07%	2.81^^
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	44.17	43.18	42.67	47.49	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	282.10	275.69	257.14	299.44	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.28%	85.21%	83.47%	85.52%	2.05^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.85%	85.83%	84.45%	85.74%	1.29
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	98.32%	96.05%	94.79%	96.36%	1.57^
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	92.06%	90.14%	88.02%	90.25%	2.23^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	93.21%	92.42%	91.25%	92.23%	0.98^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	91.08%	89.98%	88.62%	88.90%	0.28

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in RY 2017 for measures that CCAH stratified by the SPD and non-SPD populations:

SPD Rate Changes from RY 2016 to RY 2017

For SPD rates for which a comparison could be made between RY 2016 and RY 2017, the SPD rates improved significantly from RY 2016 to RY 2017 for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Merced County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Monterey/Santa Cruz counties

Non-SPD Rate Changes from RY 2016 to RY 2017

For non-SPD rates for which a comparison was made between RY 2016 and RY 2017:

- ◆ No significant changes occurred for any non-SPD rates in Merced County between RY 2016 and RY 2017.
- ◆ The non-SPD rates for the following measures improved significantly from RY 2016 to RY 2017 in Monterey/Santa Cruz counties:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, and 7–11 Years*
- ◆ The non-SPD rate for the *All-Cause Readmissions* measure declined significantly from RY 2016 to RY 2017 in Monterey/Santa Cruz counties.

Differences Between RY 2017 SPD and RY 2017 Non-SPD Rates

In RY 2017, for rates for which a comparison could be made between the SPD and non-SPD rates:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in both reporting units
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Monterey/Santa Cruz counties
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in both reporting units
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Monterey/Santa Cruz counties

- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures:
 - *All-Cause Readmissions* in both reporting units
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* in Monterey/Santa Cruz 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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* measure may be attributed to children and adolescents ages 12 to 24 months in the SPD population, based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Strengths—Performance Measures

HSAG auditors determined that CCAH followed the appropriate specifications to produce valid rates.

In Monterey/Santa Cruz counties, the rates for four measures were above the HPLs in RY 2017, and the rates for four of 19 measures for which a comparison could be made between RY 2016 and RY 2017 (21 percent) improved significantly from RY 2016 to RY 2017. Merced County had one rate that improved significantly from RY 2016 to RY 2017. The rates for the *Cervical Cancer Screening* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measures in Merced County improved from below the MPLs in RY 2016 to above the MPLs in RY 2017. CCAH had no measures with rates below the MPLs in RY 2017 in either of the reporting units.

Opportunities for Improvement—Performance Measures

CCAH has the opportunity to implement data integrity reviews throughout the year and, if possible, system edits that will result in warnings for extreme lab values upon receipt from the MCP's vendor and/or providers so that the MCP can research with the vendor and/or providers whether or not the extreme lab values are accurate.

CCAH has the opportunity to identify the causes for the MCP's declining performance in both reporting units for the *Use of Imaging Studies for Low Back Pain* measure, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study. Identifying the causes will help CCAH to develop strategies, as applicable, to address the MCP's declining performance for this measure.

4. Performance Improvement Projects

CCAH had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

CCAH selected immunizations of two-year-olds as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG reviewed and provided feedback to CCAH on the Plan portion of the PDSA cycle for a second intervention the MCP selected to test. HSAG sent periodic check-in email communications to CCAH to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CCAH set the SMART Aim for the *Immunizations of Two-Year-Olds* PIP as follows:

By June 30, 2017, increase the *Childhood Immunization Status—Combination 3* measure rate from 48.42 percent to 70.00 percent for two-year-olds who have Clinic A⁶ as their primary care provider (PCP).

Failure Modes

The following, listed in priority order, are the failure modes that CCAH identified during the Intervention Determination phase of the PIP process:

- ◆ Insufficient/ineffective outreach to the parent/guardian when the beneficiary is behind on immunizations.
- ◆ Clinic staff are unaware of the immunization schedules (including catch-up schedules).
- ◆ Parent/guardian does not understand the importance of vaccinations.
- ◆ Immunization registry data are inaccurate or incomplete.

⁶ Clinic name removed for confidentiality.

- ◆ Parent/guardian does not know when the beneficiary should be immunized.
- ◆ Parent/guardian believes immunizations are harmful or dangerous.
- ◆ Beneficiary does not have transportation to attend appointment.
- ◆ Parent/guardian is not aware that immunizations should be scheduled with the beneficiary's PCP.
- ◆ Parent/guardian does not have an immunization record for the beneficiary.
- ◆ Parent/guardian forgets to take the beneficiary to the appointment.
- ◆ Beneficiary has moved and/or received vaccinations from multiple providers.

Intervention Testing

During the reporting period, CCAH selected to test the following interventions:

- ◆ Monthly telephone reminder calls by an immunization champion for beneficiaries who have turned 9 months of age in the previous calendar month and are past due on immunizations. This intervention addresses the key driver of collaboration and local partnerships.
- ◆ Postcard reminders for immunizations sent to beneficiaries at 1 and 5 months of age. This intervention addresses the key driver of identification of beneficiaries who need or are past due for immunizations.

Although CCAH completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CCAH's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

CCAH selected improving health outcomes of persons living with asthma in Merced County as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for CCAH's MCP-specific PIP.

Upon initial review of the module, HSAG determined that CCAH met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, CCAH incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to CCAH on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to CCAH and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CCAHA set the SMART Aim for the *Improving Health Outcomes of Persons Living With Asthma in Merced County* PIP as follows:

By June 30, 2017, increase the percentage of completed current asthma action plans (AAPs) from 7 percent to 10 percent for beneficiaries ages 5 to 18 years, with a diagnosis of persistent asthma, and who are linked to Provider A.⁷

Failure Modes

The following, listed in priority order, are the failure modes that CCAH identified during the Intervention Determination phase of the PIP process:

- ◆ Provider office does not conduct outreach to remind the beneficiary of the need for a preventive appointment.
- ◆ Provider does not have time to create and explain the AAP and does not have assistance from clinic staff.
- ◆ Beneficiary does not complete an asthma severity assessment.
- ◆ Provider is not prompted by the electronic medical record system to complete an AAP.
- ◆ Medical assistant does not complete the peak flow test or measure oxygen saturation at intake.
- ◆ Beneficiary and beneficiary's guardians are not aware that the beneficiary needs to complete an AAP and update the AAP annually.

Intervention Testing

During the reporting period, CCAH selected to test a train-the-trainer intervention to increase the confidence and competence level of Provider A staff regarding understanding the importance and implementation of the AAP and methods of beneficiary engagement. This intervention addresses the key driver of creating partnerships with provider staff.

Although CCAH completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the

⁷ Provider name removed for confidentiality.

reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CCAH's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, CCAH improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from CCAH’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of CCAH’s self-reported actions.

Table 5.1—CCAH’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. Identify the causes for the MCP’s declining performance or performance below the MPLs for the following measures:</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> in Monterey/Santa Cruz counties b. <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> in Monterey/Santa Cruz counties c. <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i> in Merced County d. <i>Cervical Cancer Screening</i> in both reporting units e. <i>Controlling High Blood Pressure</i> in both reporting units f. <i>Immunizations for Adolescents—Combination 1</i> in Merced County g. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total</i> in Merced County 	<ul style="list-style-type: none"> a. Completed two PDSA cycle interventions in MY 2015 and initiated provider communication on the <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> measure. Past intervention performance was monitored, and performance was carried into MY 2016. Activities aligned with EQRO recommendations and were carried into the July 1, 2016, through June 30, 2017, review period. b. Completed two PDSA cycle interventions in MY 2015, and initiated provider communication on the <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> measure. Past intervention performance was monitored, and performance was carried into MY 2016. Activities aligned with EQRO recommendations and were carried into the July 1, 2016, through June 30, 2017, review period. c. Completed two PDSA cycle interventions that focused on physician-centric training of two provider sites for <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>. The rate was above the MPL in Merced County for HEDIS 2017. d. The national cervical cancer screening average for health maintenance organizations (HMOs) dropped from 60.22 percent to 55.84 percent (4.38 percentage points) between MY 2014 and MY 2015. In accordance with the rate drop, CCAH’s rate drop in both reporting units is reflective of a MY 2015 downward trend shown across the nation and across many MCPs. To address this, pay-for-performance (P4P) incentives were extended into MY 2016 and a fee-for-service incentive included in MY 2017 along with provider messaging. The rates were above the MPL in both reporting units in RY 2017.

2015–16 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>e. CCAH elected to abstract medical records for the <i>Controlling High Blood Pressure</i> measure to meet and exceed the MPL; and the rate should therefore not be compared to previous reporting periods, due to this being a hybrid-only measure. Written physician educational materials are in development and scheduled for distribution during Fall 2017.</p> <p>f. Partnered with Merced County Public Health to offer core vaccine administration training to local PCPs on August 16, 2016. Designed and delivered webinar to Merced County providers on how to use the local immunization registry, Regional Immunization Data Exchange (RIDE), including reporting and electronic medical record set-up. The webinar was recorded and is available on the CCAH’s website. Completed two PDSA cycle interventions at the largest Merced County provider site, which makes up roughly 25 percent of Merced County’s eligible population. Created recall method for adolescent vaccines during the July 1, 2016, through June 30, 2017, review period.</p> <p>g. Continued to promote well-child exams through our P4P program. A complementary P4P program for overweight and obese children (2 to 18 years of age), which requires documentation of the child’s body mass index (BMI) for a complete referral, is also promoted by health programs.</p>
<p>2. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Immunizations of Two-Year-Olds</i> PIP.</p>	<p>CCAH incorporated the feedback for the Plan portion of Module 4 and sought technical assistance from HSAG.</p>

2016–17 Recommendations

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

- ◆ To allow for the MCP to research with its vendor and/or providers whether or not extreme lab values are accurate, implement data integrity reviews throughout the year and, if possible, system edits that will result in warnings for extreme lab values upon receipt from the vendor and/or providers.
- ◆ Identify the causes for the MCP’s declining performance in both reporting units for the *Use of Imaging Studies for Low Back Pain* measure. Identifying the causes will help CCAH to develop strategies, as applicable, to address the MCP’s declining performance for this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix J:
Performance Evaluation Report
Community Health Group Partnership Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Community Health Group Partnership Plan (“CHG” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in CHG’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CHG is a full-scope MCP delivering services to beneficiaries 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 CHG, San Diego County’s beneficiaries may select from the following MCPs:

- ◆ Care1st Partner Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser SoCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

CHG became operational in San Diego County to provide MCMC services effective August 1998. As of June 30, 2017, CHG had 283,227 beneficiaries.¹ This represents 39 percent of the beneficiaries enrolled in San Diego County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 22, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CHG. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the most recent Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CHG. A&I conducted the on-site audits from June 26, 2017, through June 28, 2017. Note that while DHCS issued the final audit reports on September 5, 2017, which is outside the review period for this MCP-specific evaluation report, HSAG includes the audit results and status because A&I conducted the on-site audits during the review period. The purpose of the audit was to confirm that CHG acted upon prior findings and that the MCP revised its policies and procedures.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CHG
Audit Review Period: June 1, 2016, through May 31, 2017

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Table 2.2 summarizes the results and status of the 2016 A&I Medical and State Supported Services Audits of CHG. A&I conducted the on-site audits from June 13, 2016, through June 21, 2016. While A&I conducted the audits outside the review period for this report, HSAG includes the results because DHCS issued the final reports on October 28, 2016, and the closeout letter on January 30, 2017, which were during the review period for this report.

Table 2.2—DHCS A&I Medical and State Supported Services Audits of CHG
Audit Review Period: June 1, 2015, through May 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	Yes	Closed.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	Yes	Closed.

Table 2.3 summarizes the results and status of the Department of Managed Health Care (DMHC) Seniors and Persons with Disabilities (SPD) Medical Survey of CHG. DMHC conducted the on-site survey from June 13, 2016, through June 16, 2016. While DMHC conducted the survey outside the review period for this report, HSAG includes the results and status because DHCS issued the final report and closeout letter during the review period for this report.

Table 2.3—DMHC SPD Medical Survey of CHG
Survey Review Period: June 1, 2015, through May 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Continuity of Care	Yes	Closed.
Availability and Accessibility	Yes	Closed.
Member Rights	Yes	Closed.
Quality Management	Yes	Closed.

Strengths—Compliance Reviews

A&I identified no deficiencies during the June 2017 Medical and State Supported Services Audits of CHG. Additionally, CHG fully resolved all deficiencies from the June 2016 A&I Medical and State Supported Services Audits and June 2016 DMHC SPD Medical Survey.

Opportunities for Improvement—Compliance Reviews

CHG has no outstanding deficiencies from the June 2016 A&I Medical and State Supported Services Audits and June 2016 DMHC SPD Medical Survey; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Community Health Group Partnership Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that CHG followed the appropriate specifications to produce valid rates. Brief summaries of the notable findings and opportunities for improvement are included below.

- ◆ The auditors noted that it was commendable that CHG had initiated an annual HEDIS data analysis report; however, based on data variances that occurred during the audit process, the auditors recommended that the MCP update the report to reflect, by product line, data used for HEDIS measure production.
- ◆ During the on-site visit, the auditors observed that CHG did not track in the MCP's system the Medi-Cal beneficiaries who are receiving hospice services; however, the MCP did use transaction reply codes for Medicare beneficiaries receiving hospice benefits. The auditors recommended that CHG implement a mechanism to identify across all lines of business beneficiaries receiving hospice benefits.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for CHG's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
CHG—San Diego County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	70.07%	75.91%	66.91%	68.37%	1.46
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.95%	93.48%	91.40%	93.13%	1.73 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	89.92%	87.21%	83.16%	84.47%	1.31 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	89.41%	90.19%	88.90%	88.02%	-0.88^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	85.47%	85.92%	85.48%	84.59%	-0.89^{^^}
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	29.20%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	75.43% ⁺	69.34%	75.67%	80.29% ⁺	4.62
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	70.32% ⁺	66.42%	76.16% ⁺	78.83% ⁺	2.67
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	78.10%	73.24%	70.32%	71.05%	0.73
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	64.15%	Not Comparable
<i>Cervical Cancer Screening</i>	65.21%	59.37%	54.78%	55.23%	0.45
<i>Prenatal and Postpartum Care—Postpartum Care</i>	57.91%	57.66%	56.93%	58.15%	1.22
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	80.29%	77.86%	78.83%	79.32%	0.49
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.41%	84.37%	87.62%	91.28%	3.66 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.16%	85.87%	87.44%	92.01%	4.57 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	81.98% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	45.99%	56.45%	57.18%	63.50%	6.32

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	55.47%	54.74%	51.82%	60.34%	8.52 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.01%	54.26%	50.61%	59.12% ⁺	8.51 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	40.88%	36.01%	38.44%	29.93%	-8.51 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	86.13%	91.00%	89.54%	90.02%	0.48
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.27%	89.29% ⁺	90.51% ⁺	93.67% ⁺	3.16
<i>Controlling High Blood Pressure</i>	52.07%	50.86%	51.82%	56.69%	4.87
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.28%	18.76%	15.66%	14.73%	-0.93
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	36.42	46.22	43.83	42.05	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	293.39	288.23	281.00	274.02	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	39.69% ⁺	44.60% ⁺	41.67% ⁺	50.74% ⁺	9.07 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	100.00%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	12.94%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	77.32%	72.17%	70.98%	63.95%	-7.03^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of CHG’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Within the Preventive Screening and Children’s Health domain in RY 2017, the rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures were above the HPLs, and the MCP had no measures within this domain with rates below the MPLs.

Preventive Screening and Women’s Health

CHG performed between the HPLs and MPLs for all measures within the Preventive Screening and Women’s Health domain, with no statistically significant variation in rates from RY 2016 to RY 2017 for measures for which a comparison could be made from RY 2016 to RY 2017.

Care for Chronic Conditions

CHG had no measures with rates below the MPLs in RY 2017 within the Care for Chronic Conditions domain. The rates for the following measures for which DHCS held MCPs accountable to meet the MPLs in RY 2017 were above the HPLs in RY 2017:

- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* for the third consecutive year

Within the Care for Chronic Conditions domain, the following five of nine measures for which a comparison could be made between RY 2016 and RY 2017 (56 percent) improved significantly from RY 2016 to RY 2017:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved significantly from RY 2016 to RY 2017, and CHG performed above the HPL for this measure for all RYs displayed in Table 3.1.

The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 and RY 2017, and the rate remained below the MPL in RY 2017. CHG provided information on actions that the MCP took during the review period to address the rate for the *Use of Imaging Studies* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the strategies that CHG implemented to improve the MCP’s performance on this measure. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure may be due to NCQA’s RY 2017 specification changes for this measure and therefore may not be related to CHG’s performance.

Performance measures results within the Appropriate Treatment and Utilization domain show that CHG has the opportunity to determine whether or not current improvement efforts need to be modified or new interventions need to be identified to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, DHCS required CHG to continue submitting IP/PDSA cycles for the *Cervical Cancer Screening* measure due to the rates for this measure consistently declining since RY 2015. DHCS also required CHG to submit an annual quality improvement summary on strategies that the MCP implemented during the measurement year to improve the MCP’s performance for the *Use of Imaging Studies for Low Back Pain* measure.

Cervical Cancer Screening

CHG conducted two PDSA cycles to address the MCP’s consistent declining performance for the *Cervical Cancer Screening* measure. The MCP tested the same intervention for both PDSA cycles; however, the MCP partnered with two different federally qualified health centers (FQHCs)—one for

each PDSA cycle. CHG tested whether or not health educators conducting telephonic or in-person cervical cancer screening-related health education sessions would increase the number of health education encounters and cervical cancer screening appointments. The SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective for both PDSA cycles was to increase the rate of cervical cancer screening at the partnered FQHC by 5 percentage points.

For both PDSA cycles, CHG reported that it met the SMART objective and that the MCP decided to adopt the intervention. The MCP noted lessons learned from the PDSA cycle process, including:

- ◆ The mode of delivering the health education sessions (i.e., telephonic or in-person) did not significantly affect the number of screenings completed.
- ◆ A positive correlation exists between increasing outreach and prevention counseling efforts and cervical cancer screening rates.
- ◆ Opportunities exist to align the MCP's health education activities and pertinent health topics across chronic disease measures.

Use of Imaging Studies for Low Back Pain

CHG identified the following challenges to improving the MCP's performance on the *Use of Imaging Studies for Low Back Pain* measure:

- ◆ Emergency room (ER) physicians feeling the need to order imaging studies to justify prescribing narcotic medications for patients with lower back pain.
- ◆ Increased regulatory scrutiny of opioid prescribing, resulting in physicians ordering imaging studies to justify prescribing the medication.

CHG implemented the following interventions to address the identified challenges:

- ◆ Collaborated with the Independent Emergency Physicians Consortium (IEPC), which resulted in CHG adding non-narcotic alternatives to the MCP's Medi-Cal formulary.
- ◆ Released a provider newsletter in 2016 that included information on appropriate ordering of imaging studies.
- ◆ Used gap in care reports and conducted data mining and analyses of inappropriate imaging utilization.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, CHG will be required to submit IP/PDSA cycles rather than the annual quality improvement summary for the *Use of Imaging Studies for Low Back Pain* measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHG—San Diego County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	18.41%	12.82%	5.59^^	14.73%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	72.47	39.88	Not Tested	42.05
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	544.84	254.62	Not Tested	274.02
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	93.42%	90.44%	2.98^	91.28%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	93.67%	91.27%	2.40^	92.01%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	93.11%	Not Comparable	93.13%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.31%	84.34%	5.97^	84.47%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.65%	87.93%	2.72^	88.02%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	85.08%	84.57%	0.51	84.59%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
CHG—San Diego County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	14.88%	22.31%	19.45%	18.41%	-1.04
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	46.05	65.87	68.38	72.47	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	384.72	488.98	494.40	544.84	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.03%	86.30%	89.34%	93.42%	4.08 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.33%	88.70%	90.66%	93.67%	3.01 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.37%	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.30%	87.44%	86.56%	90.31%	3.75 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.97%	88.08%	87.76%	90.65%	2.89
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.81%	84.25%	82.57%	85.08%	2.51

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
CHG—San Diego County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	10.38%	15.62%	12.94%	12.82%	-0.12
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	35.06	44.00	41.69	39.88	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	280.48	265.64	262.42	254.62	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.18%	82.85%	86.78%	90.44%	3.66 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.92%	83.57%	85.66%	91.27%	5.61 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	95.94%	93.46%	91.36%	93.11%	1.75 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	89.97%	87.21%	83.07%	84.34%	1.27 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.39%	90.27%	88.94%	87.93%	-1.01 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	85.50%	85.99%	85.60%	84.57%	-1.03 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that CHG stratified by the SPD and non-SPD populations:

SPD Rate Changes from RY 2016 to RY 2017

- ◆ For rates for which comparisons could be made between RY 2016 and RY 2017, the RY 2017 SPD rates were significantly better than the RY 2016 SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*

Non-SPD Rate Changes from RY 2016 to RY 2017

- ◆ For rates for which comparisons were made between RY 2016 and RY 2017:
 - The RY 2017 non-SPD rates were significantly better than the RY 2016 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *25 Months–6 Years* measures.
 - The RY 2017 non-SPD rate was significantly worse than the RY 2016 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures.

Differences between RY 2017 SPD and RY 2017 Non-SPD Rates

- ◆ For measures for which HSAG could compare the RY 2017 SPD rates to the RY 2017 non-SPD rates:
 - The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures.
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *7–11 Years* measures.
 - The RY 2017 SPD rate for the *All-Cause Readmissions* measure was significantly worse than the RY 2017 non-SPD rate. 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 beneficiaries.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to CHG's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that CHG report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.5 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.5—Multi-Year MLTSSP Performance Measure Results
CHG—San Diego County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	49.17	13.28	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	325.92	100.06	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	5.60%	5.35%	-0.25

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from RY 2016 to RY 2017.

Strengths—Performance Measures

HSAG auditors determined that CHG followed the appropriate specifications to produce valid rates.

Table 3.1 shows that, across all domains in RY 2017, CHG performed above the HPLs for five of 18 measures (28 percent) and that the MCP performed above the HPLs for at least three consecutive years for two of the measures. For measures for which a comparison could be made between RY 2016 and RY 2017, the rates improved significantly from RY 2016 to RY 2017 for six of 19 measures (32 percent). Five of the measures with rates that improved significantly from RY 2016 to RY 2017 were within the Care for Chronic Conditions domain and one measure was within the Appropriate Treatment and Utilization domain.

Opportunities for Improvement—Performance Measures

CHG has the opportunity to update the MCP's annual HEDIS data analysis report to reflect, by product line, data used for HEDIS measure production. Additionally, CHG has the opportunity to implement a mechanism to identify beneficiaries receiving hospice benefits across all lines of business.

CHG has the opportunity to assess whether or not current improvement efforts need to be modified or new interventions need to be identified, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

CHG had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

CHG selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for CHG’s DHCS-priority PIP.

Upon initial review of the module, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including a narrative description of the method used to select the sub-processes.
- ◆ Supporting the sub-processes selection with the MCP’s data and/or experiences.
- ◆ Including all required components of the failure modes and effects analysis (FMEA).
- ◆ Describing the priority-ranking process to determine potential interventions.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions’ reliability and sustainability.

After receiving technical assistance from HSAG, CHG incorporated HSAG’s feedback into the PIP module. Upon HSAG’s final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to CHG on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to CHG to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CHG set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, increase the rate of diabetic eye exams among the Medi-Cal population from 18.63 percent to 37.00 percent for beneficiaries assigned to Provider A.⁶

Failure Modes

The following, listed in priority order, are the failure modes that CHG identified during the Intervention Determination phase of the PIP process:

- ◆ Primary care provider (PCP) does not communicate with beneficiaries regarding retinal eye exams due.
- ◆ Beneficiaries do not receive reminders and encouragement to schedule retinal eye exam appointments.
- ◆ Vision vendor (VSP) does not offer convenient or timely appointments.
- ◆ PCP desires that beneficiaries receive their retinal eye exams via Center vision providers, none of whom are considered preferred providers by VSP.

Intervention Testing

During the reporting period, CHG selected to test sending to PCPs lists of their respective beneficiaries due for retinal eye exams along with a pre-prepared written reminder which PCPs are to send to their beneficiaries, followed by telephonic outreach. This intervention addresses the failure mode of PCPs not communicating with beneficiaries regarding retinal eye exams.

Although CHG completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CHG's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

CHG selected annual monitoring of patients on persistent medication—ACE inhibitors or ARBs as its MCP-specific PIP topic.

⁶ Provider name removed for confidentiality.

Validation Findings

During the reporting period, CHG incorporated HSAG’s initial validation feedback into modules 1 and 2 of the MCP-specific PIP. Upon HSAG’s final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2.

Additionally, HSAG validated Module 3 for CHG’s MCP-specific PIP. Upon initial review of the module, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including a narrative description of the method used to select the sub-processes.
- ◆ Supporting the sub-processes selection with the MCP’s data and/or experiences.
- ◆ Including all required components of the FMEA.
- ◆ Describing the priority-ranking process to determine potential interventions.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions’ reliability and sustainability.

After receiving technical assistance from HSAG, CHG incorporated HSAG’s feedback into the PIP module. Upon HSAG’s final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to CHG on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to CHG to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CHG set the SMART Aim for the *Annual Monitoring of Patients on Persistent Medication—ACE Inhibitors or ARBs* PIP as follows:

By June 30, 2017, increase the rate of lab monitoring from 60 percent to 75 percent for beneficiaries ages 18 years and older assigned to provider B.⁷

⁷ Provider name removed for confidentiality.

Failure Modes

The following, listed in priority order, are the failure modes that CHG identified during the Intervention Determination phase of the PIP process:

- ◆ PCP does not communicate with beneficiaries regarding lab monitoring due.
- ◆ Beneficiaries do not have standing orders for lab monitoring.
- ◆ Beneficiaries do not have transportation for lab monitoring appointments.
- ◆ Beneficiaries do not receive reminders and encouragement to schedule lab monitoring appointments.
- ◆ Beneficiaries do not receive follow-up after missed lab monitoring appointments.

Intervention Testing

During the reporting period, CHG selected to test conducting outreach calls to beneficiaries to: assist with making lab monitoring appointments, educate on the importance of lab monitoring, and address potential barriers. This intervention addresses the key driver of member engagement.

Although CHG completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CHG's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, CHG improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from CHG’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of CHG’s self-reported actions.

Table 5.1—CHG’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. Identify the causes for the MCP’s performance below the MPL for the <i>Use of Imaging Studies for Low Back Pain</i> measure.</p>	<p>CHG conducted a barrier analysis to determine the causes for the MCP’s performance below the MPL for the <i>Use of Imaging Studies for Low Back Pain</i> measure. The change in the specifications of the measure negatively impacted our performance. We also know that the use of imaging by the emergency rooms caused frustration on the part of PCP sites. This was discovered when our HEDIS team worked with the PCP sites to drill down on specific cases where the sites implied that our data were incorrect because there was no evidence in the members’ medical record of imaging being ordered. We discovered that the triggering imaging claim in several instances was generated by the ER. The underlying factor contributing to the increase in the use of imaging studies was likely the increased focus on appropriate prescribing of narcotic analgesics. With the increased regulatory scrutiny over physicians’ documentation of their assessments and evaluations of pain, imaging studies were ordered to justify treatment with narcotics. Additionally, as some doctors became less willing to prescribe long-term or large quantities of narcotics, members began to frequent the ER.</p> <p>Interventions:</p> <p>To address the ordering of imaging studies by ER physicians, we had a conversation with a local ER physician who is the president and founder of the IEPC, an organization providing collaboration and services to over 30 independent emergency departments in California. CHG met with IEPC to discuss the issue of safe narcotic prescribing and how to collaborate to address our high ER utilizers, many of whom are drug-seeking. To provide options for physicians to treat members who go to the ER with chronic pain, the physician</p>

2015–16 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>has asked CHG to add some non-narcotic alternatives to the formulary. We made some changes to our Medi-Cal formulary in 2016 as a result.</p> <p>Primary care sites were also provided with their gap reports; although with this measure, by the time the site receives this as a “negative hit” on its report it is too late to intervene on a case-by-case basis.</p> <p>CHG developed reference materials to bring awareness of this HEDIS measure. The goal of the reference materials is to increase the use of conservative methods of treatment prior to ordering imaging studies, such as non-narcotic medications, physical therapy, and chiropractic and acupuncture services.</p> <p>In addition, CHG had monthly calls with FQHCs, which represent greater than 50 percent of our membership. During these calls, we addressed the inappropriate use of imaging studies, valid exclusions, and conservative methods.</p>
<p>2. To prevent further decline in performance, identify the causes for the rate declining significantly from RY 2015 to RY 2016 for the <i>Childhood Immunization Status—Combination 3</i> measure.</p>	<p>Greater than 50 percent of CHG’s membership receive primary care services at an FQHC. A significant barrier for FQHC compliance with the <i>Childhood Immunization Status—Combination 3</i> measure was the fact that the Uniform Data System (UDS) age criteria specification that FQHCs are held to was not in alignment with NCQA’s standards (3 years of age versus 2 years of age).</p> <p>Interventions:</p> <p>CHG addressed our immunization rate with all contracted pediatricians and shared the NCQA standards. In 2016, we encouraged all providers to transcribe all immunizations and enter them into the San Diego Immunization Registry. Additionally, UDS guidelines regarding immunization age criteria came into alignment with NCQA. A significant increase in this measure is expected for calendar year 2017 as our mid-year preliminary rates are almost 20 percent greater than same time last year.</p>
<p>3. Incorporate HSAG’s feedback on Module 3 for the <i>Diabetes</i> PIP to ensure that all validation criteria are met for a methodologically sound PIP.</p>	<p>HSAG feedback was incorporated for Module 3 of the <i>Increasing Diabetic Eye Exams</i> PIP. On July 13, 2016, CHG received HSAG’s review of our resubmission of the <i>Increasing Diabetic Eye Exams</i> PIP; all requirements for Module 3 were successfully achieved.</p>
<p>4. Incorporate HSAG’s feedback on modules 1 and 2 for the <i>Annual Monitoring of Patients on Persistent Medication—ACE Inhibitors or ARBs</i> to ensure that all validation criteria are met for a methodologically sound PIP.</p>	<p>HSAG feedback was incorporated for modules 1 and 2 of the <i>Annual Monitoring of Patients on Persistent Medication—ACE Inhibitors or ARBs</i> PIP. On July 13, 2016, CHG received HSAG’s review of our resubmission of the <i>Annual Monitoring of Patients on Persistent Medication—ACE Inhibitors or ARBs</i> PIP; all requirements for modules 1 and 2 were successfully achieved.</p>

2016–17 Recommendations

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

- ◆ Update the MCP’s annual HEDIS data analysis report to reflect, by product line, data used for HEDIS measure production.
- ◆ Implement a mechanism to identify beneficiaries receiving hospice benefits across all lines of business.
- ◆ To improve the MCP’s performance to above the MPL for the *Use of Imaging Studies for Low Back Pain* measure, determine whether or not current improvement efforts need to be modified or new interventions need to be identified. Making this determination will help CHG to develop appropriate strategies to address the MCP’s performance being below the MPL for this measure.

In the next annual review, HSAG will evaluate continued successes of CHG as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix K:
Performance Evaluation Report
Contra Costa Health Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Contra Costa Health Plan (“CCHP” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in CCHP’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CCHP is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in CCHP, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan (CP).

CCHP became operational in Contra Costa County to provide MCMC services effective February 1997. As of June 30, 2017, CCHP had 182,406 beneficiaries in Contra Costa County.¹ This represents 87 percent of the beneficiaries enrolled in Contra Costa County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 22, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CCHP. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CCHP. A&I conducted the on-site audits from May 9, 2016, through May 19, 2016. While A&I conducted the audits outside the review period for this report, HSAG includes the results because DHCS issued the final reports and closeout letter during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CCHP
Audit Review Period: May 1, 2015, through April 30, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Case Management and Coordination of Care	Yes	Closed.
Access and Availability of Care	Yes	Closed.
Member’s Rights	No	Not applicable.
Quality Management	Yes	Closed.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Table 2.2 summarizes the results and status of the Department of Managed Health Care (DMHC) Seniors and Persons with Disabilities (SPD) Medical Survey of CCHP. DMHC conducted the on-site survey from May 9, 2016, through May 13, 2016. While DMHC conducted the survey outside the review period for this report, HSAG includes the results because DHCS issued the final report and closeout letter during the review period for this report.

Table 2.2—DMHC SPD Medical Survey of CCHP
Survey Review Period: May 1, 2015, through April 30, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Continuity of Care	No	Not applicable.
Availability and Accessibility	No	Not applicable.
Member Rights	Yes	Closed.
Quality Management	Yes	Closed.

Follow-Up on June 2015 Medical Audit

A&I conducted a Medical Audit of CCHP from June 1, 2015, through June 12, 2015, covering the review period of March 1, 2014, through February 28, 2015. HSAG provided a summary of the survey results and status in CCHP’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, DHCS had issued a provisional closeout letter which indicated that two deficiencies were provisionally closed. The deficiencies were in the Case Management and Coordination of Care and Access and Availability of Care categories. A letter from DHCS dated March 10, 2017, stated that CCHP provided DHCS with additional information regarding the provisionally closed deficiencies and that DHCS had found all items in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Member’s Rights, Administrative and Organizational Capacity, and State Supported Services categories during the May 2016 Medical and State Supported Services Audits of CCHP. Additionally, DMHC identified no deficiencies in the Continuity of Care and Availability and Accessibility categories during the May 2016 SPD Medical Survey of CCHP. Finally, the MCP fully resolved all identified deficiencies from the June 2015 and May 2016 A&I Medical Audits and the May 2016 DMHC SPD Medical Survey.

Opportunities for Improvement—Compliance Reviews

CCHP has no outstanding deficiencies from the most recent A&I Medical and State Supported Services Audits or DMHC SPD Medical Survey; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Contra Costa Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that CCHP followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for CCHP's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
CCHP—Contra Costa County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	74.70%	77.86%	73.97%	76.67%	2.70
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	94.62%	93.94%	94.42%	94.00%	-0.42
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.07%	84.21%	83.56%	81.25%	-2.31^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	86.71%	86.56%	86.20%	84.93%	-1.27^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	83.44%	83.80%	83.95%	80.84%	-3.11^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	27.93%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	59.37%	67.64%	72.68%	72.93%	0.25
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	50.85%	66.67%	71.58% ⁺	71.71% ⁺	0.13
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	74.45%	79.81%	78.14%	71.57%	-6.57
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	58.96%	Not Comparable
<i>Cervical Cancer Screening</i>	54.99%	55.47%	58.15%	58.48%	0.33
<i>Prenatal and Postpartum Care—Postpartum Care</i>	60.34%	67.15%	68.13%	75.43% ⁺	7.30 [^]
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	83.45%	85.89%	86.13%	91.24% ⁺	5.11 [^]
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.52%	85.55%	86.96%	88.54%	1.58 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.11%	84.60%	86.26%	87.39%	1.13
<i>Asthma Medication Ratio—Total</i>	--	--	--	46.73%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	61.31%	60.44%	60.44%	63.13%	2.69

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	51.34%	55.10%	51.94%	48.74%	-3.20
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.18%	44.17%	50.24%	55.56%	5.32
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	41.61%	41.26%	41.50%	31.82%	-9.68 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	84.43%	83.98%	86.17%	90.91%	4.74 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	83.94%	82.52%	88.83% ⁺	88.13%	-0.70
<i>Controlling High Blood Pressure</i>	53.28%	64.23%	57.11%	58.87%	1.76
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	12.95%	17.35%	15.52%	13.95%	-1.57 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	53.25	56.21	55.65	53.05	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	246.81	257.12	339.74	287.22	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	44.09% ⁺	47.06% ⁺	41.08% ⁺	46.60% ⁺	5.52 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	100.00%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	17.33%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	87.85% ⁺	87.31% ⁺	82.30%	76.18%	-6.12^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of CCHP's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

The rate for one measure within the Preventive Screening and Children's Health domain—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total*—was above the HPL in RY 2017. CCHP had no measures within this domain with rates below the MPLs in RY 2017.

Preventive Screening and Women's Health

Within the Preventive Screening and Women's Health domain, the rates for both *Prenatal and Postpartum Care* measures improved significantly from RY 2016 to RY 2017, and the rates for both measures were above the HPLs in RY 2017. CCHP had no measures within this domain with rates below the MPLs in RY 2017.

Care for Chronic Conditions

The rates for the following measures within the Care for Chronic Conditions domain improved significantly from RY 2016 to RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*

The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure declined from RY 2016 to RY 2017. Although the decline was not statistically significant, the change resulted in the rate moving from above the HPL in RY 2016 to below the MPL in RY 2017. The MCP has the opportunity to identify the causes for the decline in the MCP's performance to below the MPL. Identifying the causes will help CCHP to identify strategies to ensure that beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) receive a nephropathy screening or monitoring test.

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved significantly from RY 2016 to RY 2017 and CCHP performed above the HPL for this measure for all RYs displayed in Table 3.1. Additionally, the rate for the *All-Cause Readmissions* measure improved significantly from RY 2016 to RY 2017, reflecting a reduction in hospital readmissions. CCHP had no measures within this domain with rates below the MPLs in RY 2017.

The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to CCHP's performance.

Assessment of Improvement Plans

CCHP was not required to submit any improvement plans in RY 2016.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, CCHP will be required to conduct a performance improvement project (PIP) in lieu of IP/PDSA cycles for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCHP—Contra Costa County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	17.22%	11.04%	6.18^^	13.95%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	75.17	49.88	Not Tested	53.05
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	434.09	266.21	Not Tested	287.22
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.37%	87.44%	2.93^	88.54%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.49%	86.08%	3.41^	87.39%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	94.06%	Not Comparable	94.00%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.37%	81.17%	4.20	81.25%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.16%	84.92%	0.24	84.93%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	80.22%	80.87%	-0.65	80.84%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
CCHP—Contra Costa County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	14.13%	23.03%	19.70%	17.22%	-2.48 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.83	78.73	75.35	75.17	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	342.49	338.92	439.82	434.09	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.41%	87.44%	89.00%	90.37%	1.37
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.24%	87.23%	89.19%	89.49%	0.30
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	96.77%	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	87.47%	83.71%	86.65%	85.37%	-1.28
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.49%	87.52%	85.54%	85.16%	-0.38
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	82.72%	81.82%	82.65%	80.22%	-2.43

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
CCHP—Contra Costa County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	9.53%	10.62%	12.22%	11.04%	-1.18
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	48.06	52.20	52.66	49.88	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	223.77	242.58	324.58	266.21	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.51%	83.66%	85.53%	87.44%	1.91 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.67%	82.04%	84.19%	86.08%	1.89 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.62%	94.03%	94.39%	94.06%	-0.33
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.03%	84.22%	83.50%	81.17%	-2.33 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.72%	86.51%	86.23%	84.92%	-1.31 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.50%	83.96%	84.02%	80.87%	-3.15 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that CCHP stratified by the SPD and non-SPD populations:

- ◆ The SPD rate for the *All-Cause Readmissions* measure improved significantly from RY 2016 to RY 2017, reflecting a reduction in hospital readmissions for the SPD population.
- ◆ The non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures improved significantly from RY 2016 to RY 2017.
- ◆ The non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years* measures declined significantly from RY 2016 to RY 2017.
- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.
- ◆ The RY 2017 SPD rate for the *All-Cause Readmissions* measure was significantly worse than the RY 2017 non-SPD rate for this measure. 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 beneficiaries.

Strengths—Performance Measures

HSAG auditors determined that CCHP followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all domains, four of 18 rates (22 percent) were above the HPLs and seven of 19 rates for which a comparison could be made (37 percent) improved significantly from RY 2016 to RY 2017.

Opportunities for Improvement—Performance Measures

To assist CCHP in identifying strategies to ensure that beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) receive a nephropathy screening or monitoring test, the MCP has the opportunity to identify the causes for the MCP's performance below the MPL in RY 2017 for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. Additionally, CCHP has the opportunity to identify the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017 to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

CCHP had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

CCHP selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to CCHP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

CCHP set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, increase from 56.83 percent to 61.29 percent the rate of postpartum visits among CCHP Medi-Cal beneficiaries ages 16 to 45 years in Contra Costa County who have prenatal care at Provider A.⁶

Failure Modes

The following, listed in priority order, are the failure modes that CCHP identified during the Intervention Determination phase of the PIP process:

- ◆ No follow-up is conducted after a postpartum visit appointment is missed.
- ◆ Beneficiary does not have transportation to get to the postpartum visit appointment.
- ◆ Beneficiary is not given information about the importance of a postpartum visit.
- ◆ Beneficiary forgets about the postpartum visit appointment.
- ◆ Outside hospitals do not schedule postpartum visits for CCHP beneficiaries.
- ◆ Beneficiary is not interested in postpartum information.

⁶ Provider name removed for confidentiality.

- ◆ Appointment time that is scheduled during the hospital discharge process may not be convenient for the beneficiary.
- ◆ Beneficiary has difficulty scheduling the postpartum visit appointment.
- ◆ Beneficiary does not feel that the postpartum visit is important.
- ◆ Beneficiary is educated about the postpartum visit at an inappropriate time.
- ◆ Beneficiary does not have childcare for other children during the postpartum visit appointment.

Intervention Testing

During the reporting period, CCHP selected to test utilizing public health nurses to assist with postpartum visit education and scheduling. This intervention addresses the key driver of access to health care system

Although CCHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CCHP's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

CCHP selected medication management for people with asthma as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for CCHP's MCP-specific PIP.

Upon initial review of the module, HSAG determined that CCHP met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, CCHP incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to CCHP on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to CCHP and conducted technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

CCHP set the SMART Aim for the *Medication Management for People With Asthma—Medication Compliance 75% PIP* as follows:

By June 30, 2017, increase the rate of asthma medication compliance from 58.42 percent to 63.44 percent among CCHP beneficiaries ages 5 to 18 years who receive care at Provider B.⁷

Failure Modes

The following, listed in priority order, are the failure modes that CCHP identified during the Intervention Determination phase of the PIP process:

- ◆ Asthma medications are not filled in a timely manner.
- ◆ Family members do not fill the prescriptions for beneficiaries 5 to 18 years of age.
- ◆ Provider does not update the asthma action plan.
- ◆ Provider does not create the asthma action plan.
- ◆ Family members do not understand the asthma action plan.
- ◆ Family members do not understand the asthma education that is provided.
- ◆ Beneficiary does not attend asthma appointments.
- ◆ Scheduling asthma appointment is difficult.
- ◆ Family members do not receive any asthma education materials.
- ◆ Family members do not read asthma education materials provided.
- ◆ Appointment times are often during work or school hours.

Intervention Testing

During the reporting period, CCHP selected to test mailing asthma education materials to parents of beneficiaries 5 to 18 years of age who have asthma. This intervention addresses the beneficiary and family lacking education to support asthma self-management skills.

Although CCHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in CCHP's 2017–18 MCP-specific evaluation report.

⁷ Provider name removed for confidentiality.

Strengths—Performance Improvement Projects

Through HSAG’s PIP validation and technical assistance, CCHP improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

Based on CCHP’s PIP progression, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from CCHP’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of CCHP’s self-reported actions.

Table 5.1—CCHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. To prevent further decline in performance, identify the causes for the rates declining significantly from RY 2015 to RY 2016 for the following measures: <ul style="list-style-type: none"> a. <i>Controlling High Blood Pressure</i> b. <i>Medication Management for People With Asthma—Medication Compliance 50%—Total</i> c. <i>Medication Management for People With Asthma—Medication Compliance 75%—Total</i> d. <i>Use of Imaging Studies for Low Back Pain</i> 	a—2015 appears to be an anomalous year. We were unable to determine why there was a large increase for that year or why it went back down. Looking at 2013–17 without 2015, we see a steady improvement. b/c—We cannot be certain why these rates declined, but we believe the deterioration is a result of losing the Asthma Action Plan when our largest network adopted an electronic health record (EHR). We launched an asthma PIP to work on these issues and added a smart set and action plan for asthma to the EHR. d—We reeducated providers about our clinical guidelines and the details of this measure in particular.
2. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Postpartum Care</i> PIP.	Feedback was incorporated into our September 2016 submission.

2016–17 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:

- ◆ To assist the MCP with developing relevant quality improvement strategies:
 - Identify the causes for the MCP’s performance below the MPL in RY 2017 for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure.
 - Identify the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix L:
Performance Evaluation Report
Family Mosaic Project
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care specialty health plan (SHP), Family Mosaic Project (“FMP” or “the SHP”). The purpose of this appendix is to provide SHP-specific results of each activity and an assessment of FMP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this SHP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in FMP’s 2017–18 SHP-specific evaluation report. This SHP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all Medi-Cal full-scope managed care health plan (MCP)- and SHP-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Specialty Health Plan Overview

FMP is an SHP which provides intensive case management and wraparound services for MCMC children and adolescents at risk of out-of-home placement in San Francisco County. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health (SFDPH) Community Behavioral Health Services. To receive services from FMP, a beneficiary must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. FMP submits qualifying clients to DHCS for approval to be enrolled in FMP’s MCMC. Once a client is approved and included under FMP’s contract with DHCS, the SHP receives a per-beneficiary, 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 30, 2017, FMP had 19 beneficiaries.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Nov 6, 2017.

2. Specialty Health Plan Compliance

Compliance Reviews Conducted

DHCS' Mental Health Services Division (MHSD) conducts triennial oversight reviews of 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 DHCS determines that the MHP is out of compliance. After the review, DHCS identifies strength-based practices of the MHP and 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, a description of any corrective action(s) needed, and the time frames in which the MHP is required to become compliant. For all items that DHCS determines to be out of compliance, MHPs are required to submit a plan of correction (POC) to DHCS within 60 days of the MHP's receipt of the final report of findings. If an urgent issue is identified, the issue is addressed immediately.

DHCS conducted its triennial on-site review of the San Francisco County MHP on April 24, 2017. FMP is part of the Child, Youth, and Family System of Care operated by SFDPH Community Behavioral Health Services; therefore, HSAG provides a high-level summary of the results and status of DHCS' triennial on-site review of the San Francisco County MHP in FMP's SHP-specific evaluation report.

DHCS submitted the final report to the San Francisco County MHP on June 23, 2017. The report indicated that the MHP was fully compliant with the requirements within the following system review areas:

- ◆ Attestations Related to Compliance with Regulatory and/or Contractual Requirements
- ◆ Network Adequacy and Array of Services
- ◆ Interface with Physical Health Care
- ◆ Program Integrity
- ◆ Quality Improvement
- ◆ Mental Health Services Act

DHCS determined that the San Francisco County MHP was out of compliance with the requirements within the following system review areas:

- ◆ Access
- ◆ Authorization
- ◆ Beneficiary Protection
- ◆ Provider Relations

DHCS stated in the report that the San Francisco County MHP was required to submit a POC within 60 days of the MHP receiving the final triennial on-site review report. As part of the process for producing this SHP-specific evaluation report, DHCS provided HSAG with a copy of the POC that the MHP submitted to DHCS. In the POC, the MHP documented detailed plans related to each finding from the on-site review.

Strengths—Compliance Reviews

During the April 24, 2017, triennial on-site review of the San Francisco County MHP, DHCS determined that the MHP was fully compliant with the requirements within the following system review areas:

- ◆ Attestations Related to Compliance with Regulatory and/or Contractual Requirements
- ◆ Network Adequacy and Array of Services
- ◆ Interface with Physical Health Care
- ◆ Program Integrity
- ◆ Quality Improvement
- ◆ Mental Health Services Act

Additionally, the MHP submitted to DHCS a POC for all findings that DHCS identified during the on-site review.

Opportunities for Improvement—Compliance Reviews

Based on information that DHCS sent to HSAG, FMP has no outstanding findings from the April 24, 2017, triennial on-site review of the San Francisco County MHP; therefore, HSAG has no recommendations for FMP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

For reporting year (RY) 2017, FMP was required to report two performance measures—*Promotion of Positive Pro-Social Activity* and *School Attendance*. Neither is a HEDIS^{®2} measure; therefore, HSAG conducted performance measure validation for the two performance measures selected, calculated, and reported by the SHP. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services' (CMS') publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012³ (i.e., CMS' performance measure validation protocol).

The *2017 Performance Measure Validation Final Report of Findings for Family Mosaic Project* contains the detailed findings and recommendations from HSAG's performance measure validation of the two measures that FMP reported. HSAG auditors determined that each performance measure was fully compliant with the written specifications and that FMP accurately calculated the rates. Additionally, the auditors identified no issues of concern.

Performance Measure Results

After validating the SHP's performance measure rates, HSAG assessed the results. See Table 3.1 for FMP's performance measure results for RYs 2014 through 2017. The RY is the year in which the SHP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Dec 6, 2017.

Table 3.1—Multi-Year Performance Measure Results*
FMP—San Francisco County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Promotion of Positive Pro-Social Activity</i>	--	--	--	NA	Not Comparable
<i>School Attendance**</i>	NA	S	S	NA	Not Comparable

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Measure results were not compared to high-performance level (HPL) or minimum-performance level (MPL) benchmarks.

** For this measure, a lower rate indicates better performance.

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

S = Fewer than 11 cases exist in the numerator for 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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2016 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2016 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Performance Measure Findings

RY 2017 was the first year that FMP reported a rate for the *Promotion of Positive Pro-Social Activity* measure. The denominator for the measure was less than 30, resulting in a *Not Applicable* audit finding. Additionally, the audit finding for the *School Attendance* measure was *Not Applicable*; therefore, HSAG could make no comparison between the RY 2016 rate and the RY 2017 rate for this measure.

Strengths—Performance Measures

HSAG auditors determined that both of FMP’s required performance measures were fully compliant with the written specifications and that FMP accurately calculated the rates. Additionally, the auditors identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on performance measure results, HSAG has no recommendations for FMP in the area of performance measures.

4. Performance Improvement Projects

FMP had two performance improvement projects (PIP) in progress during the reporting period of July 1, 2016, through June 30, 2017.

Promoting Caregiver Engagement and Participation Performance Improvement Project

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to FMP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

FMP set the SMART Aim for the *Promoting Caregiver Engagement and Participation* PIP as follows:

By June 30, 2017, increase from 53.8 percent to 80.0 percent the rate of caregiver attendance at care coordination meetings among enrolled families.

Failure Modes

The following, listed in priority order, are the failure modes that FMP identified during the Intervention Determination phase of the PIP process:

- ◆ Care coordination assignment is not a good match based on personality, culture, and/or language of the caregivers.
- ◆ Demands on caregivers due to an unusually high number of crises.
- ◆ Presence of many stressors on caregivers during treatment process.
- ◆ Care coordinator misunderstands caregivers' priorities

Intervention Testing

During the reporting period, FMP selected to test scheduling the initial care team meeting immediately after beneficiary enrollment and before the assessment period begins. This intervention addresses the competing demands, stressors, and perceived crises that the caregiver may be experiencing at the time of service.

Although FMP completed testing the intervention through the SMART Aim end date of June 30, 2017, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in FMP's 2017–18 SHP-specific evaluation report.

Ensuring Primary Care Connections Performance Improvement Project

Validation Findings

During the reporting period, HSAG validated Module 3 for FMP's the *Ensuring Primary Care Connections* PIP. Upon initial review of the module, HSAG determined that FMP met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including all required components of the failure modes and effects analysis.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, FMP incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the SHP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to FMP on the Plan portion of the PDSA cycle for the intervention the SHP selected to test. HSAG sent periodic check-in email communications to FMP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

FMP set the SMART Aim for the *Ensuring Primary Care Connections* PIP as follows:

By June 30, 2017, increase the rate of primary care connections for FMP beneficiaries from 71 percent to 90 percent.

Failure Modes

The following, listed in priority order, are the failure modes that FMP identified during the Intervention Determination phase of the PIP process:

- ◆ Standardized procedures are not currently in place for care coordinators to refer beneficiaries and families to primary care providers.
- ◆ Standardized procedures are not currently in place for care coordinators to involve primary care providers in the care planning process.
- ◆ Care coordinators forget to assess whether or not primary care providers are actively in place for beneficiaries.

Intervention Testing

During the reporting period, FMP selected to test developing clear written procedures for care coordinators to connect beneficiaries and families to primary care providers. This intervention addresses the key driver of caregiver's interest and ability to make and attend the beneficiary's primary care appointments.

Although FMP completed testing the intervention through the SMART Aim end date of June 30, 2017, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in FMP's 2017–18 SHP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, FMP improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the SHP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 SHP-specific evaluation report. Table 5.1 provides EQR recommendations from FMP’s July 1, 2015, through June 30, 2016, SHP-specific evaluation report, along with the SHP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of FMP’s self-reported actions.

Table 5.1—FMP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, SHP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to FMP	Self-Reported Actions Taken by FMP during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Promoting Caregiver Engagement and Participation</i> PIP.	<ul style="list-style-type: none"> ◆ HSAG feedback included the recommendation that intervention testing occur with more than one new enrollee assigned to the trained care coordinator. The care coordinator initially assigned to this intervention was not available to test the intervention with a second enrollee because that care coordinator left FMP in January 2017. However, FMP addressed this recommendation by having a second care coordinator trained in the intervention. The second care coordinator did complete a test of the intervention with a new enrollee in spring 2017. ◆ HSAG requested that documentation of the results of qualitative questions (from care coordinators and family members) be included in Module 4. FMP addressed this by including the results of these questions in the “Study” section of the most recently completed Module 4.

2016–17 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 continued successes of FMP.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix M:
Performance Evaluation Report
Gold Coast Health Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Gold Coast Health Plan (“Gold Coast” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Gold Coast’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Gold Coast is a full-scope MCP delivering services to beneficiaries in the County Organized Health System (COHS) model.

Gold Coast became operational to provide MCMC services in Ventura County effective July 2011. As of June 30, 2017, Gold Coast had 202,822 beneficiaries.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Jul 18, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Gold Coast. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Gold Coast. A&I conducted the on-site audits from April 25, 2016, through May 6, 2016.

**Table 2.1—DHCS A&I Medical and State Supported Services Audits of Gold Coast
 Audit Review Period: April 1, 2015, through March 31, 2016**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Quality Management	Yes	Closed.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

During the April 25, 2016, through May 6, 2016, A&I Medical and State Supported Services Audits, DHCS identified no deficiencies in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member’s Rights, Administrative and Organizational Capacity, or State Supported Services categories. Additionally, Gold Coast’s responses to the MCP’s CAP for the deficiency that A&I identified in the category of Quality Management during the Medical Audit resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

Gold Coast has no outstanding deficiencies from the MCP's most recent A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Gold Coast Health Plan* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance AuditTM.³ HSAG auditors determined that Gold Coast followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. See Table 3.1 for Gold Coast’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’ *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Gold Coast—Ventura County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	75.43%	69.97%	75.43%	64.96%	-10.47^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.37%	95.42%	94.65%	93.86%	-0.79
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.27%	83.12%	84.87%	85.52%	0.65
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	82.26%	83.31%	85.62%	84.54%	-1.08^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	79.18%	82.01%	84.14%	82.32%	-1.82^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	23.11%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	43.31%	54.26%	55.96%	54.50%	-1.46
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	28.71%	41.85%	49.88%	48.66%	-1.22
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	64.23%	67.11%	64.72%	66.18%	1.46
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	59.34%	Not Comparable
<i>Cervical Cancer Screening</i>	60.58%	61.77%	50.61%	54.50%	3.89
<i>Prenatal and Postpartum Care—Postpartum Care</i>	59.37%	62.81%	59.12%	65.45%	6.33
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	83.94%	85.68%	82.24%	84.18%	1.94
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.47%	82.14%	86.94%	85.09%	-1.85^^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.51%	83.27%	87.37%	85.14%	-2.23^^
<i>Asthma Medication Ratio—Total</i>	--	--	--	51.24%	Not Comparable

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	61.31%	63.75%	65.69%	48.66%	-17.03^^
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	45.74%	60.10%	81.51% ⁺	50.61%	-30.90^^
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.50%	57.91%	54.50%	36.98%	-17.52^^
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	45.50%	32.85%	37.71%	54.50%	16.79^^
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	85.16%	90.51%	88.56%	86.86%	-1.70
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	78.10%	83.70%	91.24% ⁺	89.05%	-2.19
<i>Controlling High Blood Pressure</i>	54.01%	55.01%	64.72%	44.77%	-19.95^^
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.08%	17.87%	15.77%	14.33%	-1.44
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	38.12	39.21	41.05	40.20	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	205.78	209.28	246.05	263.85	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	18.24%	21.15%	25.58%	29.27%	3.69
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	100.00%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.10%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	77.07%	75.71%	73.51%	73.89%	0.38

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Gold Coast’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Within the Preventive Screening and Children’s Health domain, the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017. Gold Coast provided information on actions that the MCP took during the review period to address the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that Gold Coast implemented to improve the MCP’s performance on this measure. Gold Coast’s efforts may have contributed to the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure improving from below the MPL in RY 2016 to above the MPL in RY 2017.

The rate for the *Childhood Immunization Status—Combination 3* measure declined significantly from RY 2016 to RY 2017, reflecting an opportunity for Gold Coast to assess the cause for the decline to ensure that the MCP’s beneficiaries receive their specified immunization dosages by age 2.

Preventive Screening and Women's Health

The rate for the *Cervical Cancer Screening* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for the measure moving from below the MPL in RY 2016 to above the MPL in RY 2017. Gold Coast provided information on actions that the MCP took during the review period to address the rate for the *Cervical Cancer Screening* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the "Assessment of Improvement Plans" heading in this section of the report, HSAG provides a summary of the PDSA cycles that Gold Coast implemented during the review period to improve the MCP's performance on this measure. Gold Coast's efforts may have contributed to the rate for the *Cervical Cancer Screening* measure improving from below the MPL in RY 2016 to above the MPL in RY 2017.

Care for Chronic Conditions

Within the Care for Chronic Conditions domain, the RY 2017 rates were significantly worse than the RY 2016 rates for seven of nine measures (78 percent), resulting in Gold Coast's performance moving from above the MPLs in RY 2016 to below the MPLs in RY 2017 for six of these measures. The MCP performed below the MPLs in RY 2017 on the following measures:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Controlling High Blood Pressure*

The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure declined significantly from RY 2016 to RY 2017; however, the rate remained above the MPL.

Performance measure results show that Gold Coast has the opportunity to explore the causes for the MCP's decline in performance on 78 percent of the measures within the Care for Chronic Conditions domain to ensure that:

- ◆ Beneficiaries ages 18 and older on angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), and diuretics receive annual monitoring.
- ◆ Beneficiaries ages 18 to 75 with diabetes (type 1 and type 2):
 - Have controlled blood pressure.
 - Have controlled HbA1c levels.
 - Receive a retinal eye exam.
- ◆ Beneficiaries 18 to 75 with hypertension have controlled blood pressure.

Appropriate Treatment and Utilization

The rates for all measures within the Appropriate Treatment and Utilization domain remained stable from RY 2016 to RY 2017, and all rates within the domain were above the MPLs in RY 2017.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, Gold Coast was required to submit two IP/PDSA cycles—one for the *Cervical Cancer Screening* measure and one for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The rates for both measures moved from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Cervical Cancer Screening

Gold Coast conducted two PDSA cycles to address the MCP's performance being below the MPL for the *Cervical Cancer Screening* measure. For each PDSA cycle, the MCP set a SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective to increase cervical cancer screening by 5 percentage points for women enrolled in a targeted medical group.

For both PDSA cycles, Gold Coast tested whether or not a member outreach program consisting of mailing Pap test reminder letters, followed by telephone calls to verify receipt of the letters and assist with scheduling appointments, would result in women completing their cervical cancer screenings. The MCP did not meet the SMART objective for either cycle and decided to adapt the intervention following both cycles. Gold Coast reported on lessons learned from the PDSA cycle process, including:

- ◆ It is important for the MCP to inform partner clinics about planned interventions and designate a clinic contact prior to intervention initiation to ensure that the clinic staff members are aware of the purpose of the intervention.
- ◆ Beneficiaries and providers tend to have limited availability for appointments during holiday months.
- ◆ Telephonic outreach is time-intensive, and making direct contact with beneficiaries did not result in an increase in the percentage of women who completed their cervical cancer screening exams.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Gold Coast conducted two PDSA cycles to address the MCP's performance being below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The MCP set the following SMART objective for the first PDSA cycle:

By December 31, 2016, increase the rate of well-child exams by 5 percentage points for children ages 3 to 6 who are enrolled in two low-performing clinics in Ventura County.

Gold Coast tested whether sending a performance feedback report to the low-performing clinics would assist the clinics in scheduling well-child exams with beneficiaries ages 3 to 6. The MCP met the SMART objective and decided to adapt the intervention. Gold Coast identified the following lessons learned through the first PDSA cycle:

- ◆ To prevent delays in the clinics beginning outreach to schedule well-child exam appointments, it is important for the MCP to contact the clinics to verify receipt of the reports.

- ◆ Missing claims data creates false negatives on the performance feedback reports. Identifying this lesson learned reinforced the MCP's commitment to promote timely claims submissions by providers.

Gold Coast partnered with two different clinics for the second PDSA cycle and set the following SMART objective:

By April 30, 2017, increase the rate of well-child exams by 10 percentage points for children ages 3 to 6 who are enrolled in two low-performing clinics in Ventura County.

The MCP tested the same intervention as tested in the first PDSA cycle and reported that it did not meet the SMART objective. The MCP decided to adopt the intervention and identified lessons learned through the second PDSA cycle, including:

- ◆ Lack of outreach to schedule well-child exams may be the most significant barrier to beneficiaries ages 3 to 6 being seen for their exams.
- ◆ Having buy-in from management regarding the importance of performance feedback reports and allocating staff to use the reports may improve the outcomes of this type of intervention.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, Gold Coast will be required to submit IP/PDSA cycles for the following measures, all of which are in the Care for Chronic Conditions domain:

- ◆ *Both Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Controlling High Blood Pressure*

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Gold Coast—Ventura County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	21.08%	11.88%	9.20^^	14.33%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	71.60	38.63	Not Tested	40.20
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	470.59	253.54	Not Tested	263.85
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.12%	84.07%	5.05^	85.09%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.36%	83.75%	6.61^	85.14%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	85.00%	93.96%	-8.96^^	93.86%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.14%	85.46%	2.68	85.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.21%	84.37%	5.84^	84.54%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.54%	82.18%	4.36^	82.32%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
Gold Coast—Ventura County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	15.06%	22.83%	20.71%	21.08%	0.37
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	64.02	70.45	71.34	71.60	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	361.16	397.29	440.50	470.59	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.11%	86.29%	89.21%	89.12%	-0.09
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.10%	88.34%	90.47%	90.36%	-0.11
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	89.74%	84.21%	88.64%	85.00%	-3.64
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.61%	86.37%	87.59%	88.14%	0.55
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	77.69%	89.29%	89.55%	90.21%	0.66
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	72.72%	83.31%	86.58%	86.54%	-0.04

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
Gold Coast—Ventura County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	9.53%	12.80%	13.62%	11.88%	-1.74
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	35.36	37.05	39.38	38.63	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	189.20	196.26	235.33	253.54	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.52%	79.63%	86.29%	84.07%	-2.22^^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.58%	80.29%	86.40%	83.75%	-2.65^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.46%	95.54%	94.72%	93.96%	-0.76
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.35%	83.04%	84.81%	85.46%	0.65
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	82.53%	83.01%	85.49%	84.37%	-1.12^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.68%	81.92%	84.04%	82.18%	-1.86^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that Gold Coast stratified by the SPD and non-SPD populations:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- ◆ For SPD rates for which a comparison was made between RY 2016 and RY 2017, no statistically significant changes occurred for any SPD rates between RY 2016 and RY 2017.
- ◆ For non-SPD rates for which a comparison was made between RY 2016 and RY 2017, the RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*

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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* measure may be attributed to children and adolescents in the SPD population in the specified age group (i.e., *12–24 Months*), based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Strengths—Performance Measures

HSAG auditors determined that Gold Coast followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Gold Coast's performance on two measures—*Cervical Cancer Screening* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*—improved from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

Gold Coast has the opportunity to identify the causes for the MCP's declining performance and performance being below the MPLs in RY 2017 for the following measures:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Controlling High Blood Pressure*

4. Performance Improvement Projects

Gold Coast had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

Gold Coast selected immunizations of two-year-olds as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to Gold Coast to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Gold Coast set the SMART Aim for the *Immunizations of Two-Year-Olds* PIP as follows:

By June 30, 2017, increase childhood immunizations for beneficiaries ages two years and younger, at Provider Group A,⁶ from 67.66 percent to 77.66 percent.

Failure Modes

The following, listed in priority order, are the failure modes Gold Coast identified during the Intervention Determination phase of the PIP process:

- ◆ Parent/guardian prefers to see a specific provider.
- ◆ Advance physician scheduling limited to three months.
- ◆ Missed opportunity to provide care due to no physical exam or no doctor order for immunizations.
- ◆ Parent/guardian instructed to call clinic 30 days before beneficiary's immunization(s) are due to schedule appointment but does not do so.

⁶ Provider group name removed for confidentiality.

Intervention Testing

During the reporting period, Gold Coast selected to test using reports from electronic health records (EHRs), Comprehensive Clinic Assessment Software Application (CoCASA), and California Immunization Registry (CAIR) to identify beneficiaries (younger than or equal to 24 months of age) with incomplete immunizations and to contact the parents of these beneficiaries to schedule appointments for immunizations. This intervention addresses the key driver of provider follow-up with parent/guardian.

Although Gold Coast completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Gold Coast's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

Gold Coast selected developmental screening for children as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG revalidated modules 1 through 3 for Gold Coast's MCP-specific PIP, which the MCP revised due to the MCP having to change its provider partner for the PIP.

Upon initial review of the revised modules, HSAG determined that Gold Coast met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including all required components of the SMART Aim.
- ◆ Including all required components of the SMART Aim measure.
- ◆ Including the SMART Aim goal, baseline rate, and data collection interval on the run/control chart.
- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure mode and effects analysis (FMEA).
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, Gold Coast incorporated HSAG's feedback into the PIP modules. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for all submitted modules.

During the reporting period, HSAG also reviewed and provided feedback to Gold Coast on the Plan portion of the PDSA cycle for the interventions that the MCP selected to test. HSAG sent periodic check-in email communications to Gold Coast and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Gold Coast set the SMART Aim for the *Increase Developmental Screening for Children* PIP as follows:

By June 30, 2017, increase from 45.82 percent to 55.82 percent the percentage of standardized, child developmental screening tools completed for those children 8 to 11 months who are due for the developmental screening and enrolled at Provider A.⁷

Failure Modes

The following, listed in priority order, are the failure modes that Gold Coast identified during the Intervention Determination phase of the PIP process:

- ◆ Parent/guardian does not have enough time to complete the child developmental screening questionnaire form.
- ◆ Parent/guardian does not receive the questionnaire to complete, or the parent is given the wrong age-specific questionnaire.
- ◆ Parent/guardian does not want to or is not interested in completing the questionnaire.
- ◆ Clinic staff does not instruct the parent/guardian on how to complete the form.

Intervention Testing

During the reporting period, Gold Coast selected to test training its first provider partner's clinic staff on using a screening tool during well-child exams. However, due to competing priorities, the first provider partner could not continue testing the training program at its site and Gold Coast had to abandon the intervention. To continue to increase the percentage of children who receive developmental screenings, Gold Coast partnered with another provider to test staff training on using the screening tool during well-child exams.

Although Gold Coast completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Gold Coast's 2017–18 MCP-specific evaluation report.

⁷ Provider name removed for confidentiality.

Strengths—Performance Improvement Projects

Through HSAG’s PIP validation and technical assistance, Gold Coast improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

Based on Gold Coast’s PIP progression, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Gold Coast’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Gold Coast’s self-reported actions.

Table 5.1—Gold Coast’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations								
<p>1. In tandem with the MCP’s providers, explore the causes for the significant decline in the documentation of BMI during outpatient visits with beneficiaries ages 3 to 17 and determine whether any strategies leading to the significant improvement in the documentation of physical activity counseling may be replicated to improve the BMI documentation.</p>	<p><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)</i></p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="background-color: #0056b3; color: white;">Measure</th> <th style="background-color: #0056b3; color: white;">RY 2015 Rate</th> <th style="background-color: #0056b3; color: white;">RY 2016 Rate</th> <th style="background-color: #0056b3; color: white;">RY 2017 Rate</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">WCC-BMI</td> <td style="text-align: center;">80.05</td> <td style="text-align: center;">72.51</td> <td style="text-align: center;">65.69</td> </tr> </tbody> </table> <p><i>Analysis</i></p> <p>The decline in <i>the WCC-BMI</i> hybrid rate from 80.05 in RY 2015 to 72.51 in RY 2016 was attributed to changes in the MCP’s overread and secondary pursuit strategy. In 2015, Gold Coast overread both compliant and non-compliant records and attempted secondary pursuit for missing documentation and non-compliant records that enabled the MCP to find documentation for BMI percentiles. Due to delays with initiating chart retrieval in 2016 and 2017, overreads were focused primarily on compliant records and there was a reduction in secondary pursuits due to time limitations. Additionally, medical record retrieval was problematic in 2017 for the following reasons:</p> <ul style="list-style-type: none"> • Gold Coast sent the HEDIS vendor a provider file that contained errors, which caused a three-week delay in sending providers their medical record requests and reduced the vendor’s timeline for retrieving and abstracting medical records. • The MCP delayed assisting the HEDIS vendor with coordinating retrieval of medical records from a problematic provider that had the highest volume of medical record requests until two weeks before the retrieval/abstraction project ended on May 15. 	Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	WCC-BMI	80.05	72.51	65.69
Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate						
WCC-BMI	80.05	72.51	65.69						

2015–16 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations								
	<ul style="list-style-type: none"> Technical challenges with the HEDIS vendor’s new retrieval system made it difficult for the vendor and MCP to monitor retrieval and abstraction status. <p>Clinical care practice was not a factor that contributed to the rate decline for the BMI assessments. Reviews of medical records did not show deficiencies in BMI documentation; and most EMRs calculate the BMI when the patient’s age, height, and weight are documented. Plus, reviews of claims data show that providers have increased coding for BMI assessments. Data analysis demonstrates that, beginning in August 2014, providers increased using medical codes on claims and encounter data to document completed BMI assessments for children and adolescents. This indicates that providers are completing BMI assessments and validates that the <i>WCC-BMI</i> rate decrease from 80.05 in RY 2015 to 72.51 RY 2016 was not due to a decrease in provider BMI assessments.</p> <p><i>MCP Actions</i> The Quality Improvement Department will improve management of retrieval and pursuit of medical records for the HEDIS audit by:</p> <ul style="list-style-type: none"> Implementing a validation process to ensure that the provider file sent to the HEDIS vendor is correct. Starting retrieval and pursuit earlier in the year. Increasing oversight of the vendor’s retrieval and pursuit status. Overreading compliant and non-compliant records. Including secondary pursuit of non-compliant records. 								
<p>2. To improve performance for the following measures to above the MPLs, identify the causes for the rates moving from above the MPLs in RY 2015 to below the MPLs in RY 2016:</p> <ol style="list-style-type: none"> <i>Cervical Cancer Screening</i> <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> 	<p><i>Cervical Cancer Screening (CCS)</i></p> <table border="1" data-bbox="784 1310 1362 1430"> <thead> <tr> <th>Measure</th> <th>RY 2015 Rate</th> <th>RY 2016 Rate</th> <th>RY 2017 Rate</th> </tr> </thead> <tbody> <tr> <td><i>CCS</i></td> <td>61.77</td> <td>50.61</td> <td>54.74</td> </tr> </tbody> </table> <p><i>Analysis</i> The eligible population increased from 12,900 in 2014 to 25,498 in 2015. The count of non-compliant women reported for the 2016 RY administrative rate was 14,640 women; 73 percent (10,743/14,640) of the non-compliant women were part of the Medicaid expansion program and 13 percent (1,951/14,640) had no visits with their primary care providers (PCPs). Consequently, the following factors contributed to the decreased 2016 RY rate:</p> <ul style="list-style-type: none"> Women in the Medicaid expansion category may have not had preventive care due to lack of health care coverage in the past. Many women had no PCP visits. 	Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	<i>CCS</i>	61.77	50.61	54.74
Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate						
<i>CCS</i>	61.77	50.61	54.74						

2015–16 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p><i>Health Plan Actions</i></p> <ol style="list-style-type: none"> 1. To improve the <i>CCS</i> rates, the Quality Improvement and Health Education/Cultural Linguistics departments collaborated on testing a bundled member outreach program: to increase member engagement along with members completing a Pap test. The outreach consisted of mailing a packet that included a Pap reminder letter and <i>CCS</i> educational material in English and Spanish, followed by a telephone call by a health navigator to verify receipt of the mailed packet and to assist with scheduling a Pap exam with the member’s PCP. This intervention was tested using the PDSA methodology, and two three-month PDSA cycles were completed between October 2016 and May 2017. Each PDSA cycle targeted the non-compliant members assigned to one high-volume/low-performing clinic, and the goal of each PDSA was to increase cervical cancer screenings by 5 percent. We were close to meeting our goals for each PDSA; and some of the barriers identified were: <ul style="list-style-type: none"> • Telephonic outreach was a time-intensive process, and direct contact with members did not increase member engagement with completing cervical cancer screening exams. • Some of the challenges with direct outreach to members included the inability to reach all members and disinterested members. Additionally, some members were hesitant to discuss cervical cancer screenings because it was a sensitive or personal topic. <p>Although we did not meet our goal for the two PDSAs, our <i>CCS</i> rate for the 2017 RY did improve by 4.13 percentage points, from 50.61 to 54.74. We will continue the member outreach program with the following modifications:</p> <ul style="list-style-type: none"> • We will discontinue the telephonic outreach program. • We will continue the annual <i>CCS</i> mailers that consist of the cervical cancer screening letter and educational material. 2. On July 25, 2016, the MCP distributed HEDIS reports to clinics, which included the following: (1) HEDIS rates for the 2015 measurement year; (2) performance feedback reports, which listed those Gold Coast members assigned to each clinic who are non-compliant for specific screenings and services. 3. On August 31, 2016, the MCP sent providers a women’s health memorandum to: (1) notify providers of the decreased <i>CCS</i> rates; (2) advise providers how they can improve their <i>CCS</i> rates; (3) provide information on the MCP’s initiatives to improve this measure.

2015–16 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations								
	<p data-bbox="654 369 1487 436"><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i></p> <table border="1" data-bbox="790 443 1357 562"> <thead> <tr> <th data-bbox="790 443 927 516">Measure</th> <th data-bbox="927 443 1070 516">RY 2015 Rate</th> <th data-bbox="1070 443 1213 516">RY 2016 Rate</th> <th data-bbox="1213 443 1357 516">RY 2017 Rate</th> </tr> </thead> <tbody> <tr> <td data-bbox="790 516 927 562">W34</td> <td data-bbox="927 516 1070 562">67.11</td> <td data-bbox="1070 516 1213 562">64.72</td> <td data-bbox="1213 516 1357 562">66.18</td> </tr> </tbody> </table> <p data-bbox="654 606 756 638"><i>Analysis</i></p> <p data-bbox="654 648 1487 747">Analysis of the 145 non-compliant members in the 411 sample records for the MY 2015 W34 measure showed the following reasons for non-compliance with well-child exams:</p> <ul data-bbox="654 758 1425 995" style="list-style-type: none"> • Opportunities to provide or schedule well-child exams were missed while patients were at the office for acute care visits. • Provider continued to follow an outdated Child Health and Disability Prevention (CHDP) periodicity schedule that recommended well-child exams every two years. • Incomplete well-child exams that did not include all elements required for the W34 measure well-child exam. <p data-bbox="654 1041 813 1073"><i>MCP Actions</i></p> <ol data-bbox="654 1083 1487 1619" style="list-style-type: none"> 1. To improve the W34 rate, the Quality Improvement Department tested a provider awareness program to assist providers with scheduling well-child exams. The intervention consisted of sending the targeted clinics: (1) performance feedback reports that listed 3-to-6-year-old children enrolled at the targeted clinics who need well-child exams; and (2) provider tips sheets that provided coding, documentation, and HEDIS specifications guidelines on the W34 measure. This intervention was tested using the PDSA methodology, and two three-month PDSA cycles were completed between October 2016 and May 2017. Each PDSA cycle targeted two high-volume/low-performing clinics, and the goal was to increase well-child exams by 5 percentage points in PDSA #1 and by 10 percentage points in PDSA #2. We surpassed our goal in PDSA #1, and we almost met our goal in PDSA #2. Additionally, the final HEDIS rate for the RY 2017 increased by 1.46 percentage points, from 64.72 to 66.18. <p data-bbox="703 1646 1487 1873">The MCP will adopt this intervention and expand it to other clinics because the results of both PDSA #1 and PDSA #2 demonstrated that performance feedback reports helped clinics schedule well-child exams. The expanded outreach to the clinics conducted by the quality improvement registered nurse (RN) in PDSA #2 demonstrated the value of having a designated contact within the Quality Improvement Department to build relationships with the</p>	Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	W34	67.11	64.72	66.18
Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate						
W34	67.11	64.72	66.18						

2015–16 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>clinics and to provide education on the HEDIS measures and the benefits of using the performance feedback report.</p> <ol style="list-style-type: none"> 2. On July 25, 2016, the MCP distributed HEDIS reports to clinics, which included the following: (1) HEDIS rates for the 2015 measurement year; and (2) performance feedback reports, which listed those Gold Coast members assigned to each clinic who are non-compliant for specific screenings and services. 3. The July 2016 <i>Provider Operations Bulletin</i> contained information on the W34 measure to: (1) notify providers of the decreased W34 rates, (2) advise providers how they can improve their W34 rates, and (3) provide information on the MCP’s initiatives to improve this measure. 4. The January 2017 <i>Provider Operations Bulletin</i> re-published the July 2016 article that contained information on the W34 measure to: (1) notify providers of the decreased W34 rates, (2) advise providers how they can improve their W34 rates, and (3) provide information on the MCP’s initiatives to improve this measure.
<ol style="list-style-type: none"> 3. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Immunizations of Two-Year-Olds</i> PIP. 	<p>HSAG’s Feedback and Recommendation for Module 4</p> <p><i>HSAG’s Pre-Validation Review, June 13, 2016</i></p> <p>HSAG provided the following recommendation for testing the effectiveness of the intervention studied in the <i>Immunizations of Two-Year-Olds</i> PIP: “The MCP indicated the data collection methodology to link the intervention being tested to immunization appointments scheduled. HSAG recommends also linking the intervention to immunization appointments kept.”</p> <p>Gold Coast incorporated all feedback from HSAG into modules for our PIPs.</p> <p><i>MCP Actions</i></p> <p>The Quality Improvement Department collaborated with the clinic partner to integrate HSAG’s recommendation into the data collection tool. Each month, the clinic tracked the number of immunization appointments scheduled and kept. These monthly rates are reported on the following three run charts in Module 4:</p> <ul style="list-style-type: none"> • Run Chart 1: Appointments Scheduled (Current and Future Months) • Run Chart 2: Appointments Scheduled (Current Month) • Run Chart 3: Appointments Kept (Current Month)

2016–17 Recommendations

Based on the overall assessment of Gold Coast’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:

- ◆ Identify the causes for the MCP’s declining performance and performance being below the MPLs in RY 2017 for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Childhood Immunization Status—Combination 3*
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
 - *Controlling High Blood Pressure*

Identifying the causes will help Gold Coast to develop strategies to address the MCP’s declining performance and performance being below the MPLs for these measures.

In the next annual review, HSAG will evaluate continued successes of Gold Coast as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix N:
Performance Evaluation Report
Health Net Community Solutions, Inc.
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Health Net Community Solutions, Inc. (“Health Net” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Health Net’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Health Net is a full-scope MCP delivering services to beneficiaries as a commercial MCP under the Two-Plan Model (TPM) and also under a Geographic Managed Care (GMC) model.

Table 1.1 shows the counties in which Health Net provided services to beneficiaries under the TPM and denotes which MCP is the “Local Initiative” (LI). Beneficiaries may enroll in Health Net, the commercial MCP; or in the alternative LI.

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 Family Health Care
Los Angeles	L.A. Care Health Plan
San Joaquin	Health Plan of San Joaquin
Stanislaus	Health Plan of San Joaquin
Tulare	Anthem Blue Cross Partnership Plan

Health Net operates under a GMC model in the counties of Sacramento and San Diego. 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:

- ◆ Anthem Blue Cross Partnership Plan
- ◆ Kaiser NorCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

In addition to Health Net, San Diego County’s beneficiaries may select from the following MCPs:

- ◆ Care1st Partner Plan
- ◆ Community Health Group Partnership Plan
- ◆ Kaiser SoCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

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. Table 1.2 shows the number of beneficiaries enrolled in Health Net for each county, Health Net’s percentage of beneficiaries enrolled in each county, and the MCP’s total number of beneficiaries as of June 30, 2017.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 25, 2017.

Table 1.2—Health Net Enrollment as of June 30, 2017

County	Enrollment as of June 30, 2017	Health Net's Percentage of Beneficiaries Enrolled in the County
Kern	78,117	24%
Los Angeles	1,009,193	33%
Sacramento	116,767	26%
San Diego	76,221	11%
San Joaquin	22,852	9%
Stanislaus	75,381	37%
Tulare	113,190	54%
Total	1,491,721	

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Health Net. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Health Net. A&I conducted the on-site reviews from May 23, 2016, through June 3, 2016. While A&I conducted the audits outside the review period for this report, HSAG includes the results because DHCS issued the final reports on March 22, 2017, which is within the review period for this report. Additionally, DHCS issued the final closeout letter on August 31, 2017, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of all deficiencies from the May 23, 2016, through June 3, 2016, A&I Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Health Net
Audit Review Period: May 1, 2015, through April 30, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Case Management and Coordination of Care	Yes	Closed.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	Yes	Closed.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Table 2.2 summarizes the results and status of the Department of Managed Health Care (DMHC) Seniors and Persons with Disabilities (SPD) Medical Survey of Health Net. DMHC conducted the on-site survey from May 23, 2016, through May 27, 2016. While DMHC conducted the on-site review outside the review period for this report, HSAG includes the survey results and status because DMHC issued the final report on December 21, 2016, and the CAP closeout letter on May 9, 2017, which are within the review period for this report.

**Table 2.2—DMHC SPD Medical Survey of Health Net
Survey Review Period: May 1, 2015, through February 29, 2016**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Continuity of Care	Yes	Closed.
Availability and Accessibility	No	Not applicable.
Member Rights	Yes	Closed.
Quality Management	Yes	Closed.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Administrative and Organizational Capacity and State Supported Services categories during the May 23, 2016, through June 3, 2016, Medical and State Supported Services Audits of Health Net. Additionally, DMHC identified no deficiencies in the Availability and Accessibility category during the May 2016 SPD Medical Survey of Health Net. Finally, Health Net’s responses to the MCP’s CAP for the deficiencies that A&I identified during the May 23, 2016, through June 3, 2016, Medical Audit and that DMHC identified during the SPD Medical Survey resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

Health Net has no outstanding deficiencies from the May 23, 2016, through June 3, 2016, A&I Medical Audit or the May 2016 DMHC SPD Medical Survey; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Health Net Community Solutions, Inc.* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that Health Net followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.7 for Health Net's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.7:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Health Net—Kern County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	65.28%	67.29%	61.48%	58.93%	-2.55
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	92.95%	90.50%	87.95%	89.96%	2.01
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	79.16%	79.39%	78.86%	78.46%	-0.40
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	67.96%	72.20%	75.28%	75.39%	0.11
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	67.50%	71.83%	75.39%	75.71%	0.32
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	20.44%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	86.98% ⁺	81.42% ⁺	76.15%	82.53% ⁺	6.38 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	77.86% ⁺	72.97% ⁺	68.68%	75.95% ⁺	7.27 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	71.54%	68.13%	67.22%	70.77%	3.55
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	48.30%	Not Comparable
<i>Cervical Cancer Screening</i>	49.64%	49.64%	43.55%	43.31%	-0.24
<i>Prenatal and Postpartum Care—Postpartum Care</i>	54.15%	60.15%	58.99%	63.34%	4.35
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	71.71%	72.13%	77.97%	79.05%	1.08
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.19%	87.74%	86.62%	87.62%	1.00
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.82%	88.10%	85.49%	86.62%	1.13
<i>Asthma Medication Ratio—Total</i>	--	--	--	50.82%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	50.36%	55.72%	57.18%	54.99%	-2.19

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	42.34%	47.93%	46.72%	47.69%	0.97
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	33.33%	42.82%	43.80%	43.07%	-0.73
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	60.10%	45.74%	44.04%	45.26%	1.22
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	76.89%	83.21%	82.48%	84.43%	1.95
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.32%	86.13%	89.54% ⁺	89.05%	-0.49
<i>Controlling High Blood Pressure</i>	47.20%	64.48%	56.05%	53.58%	-2.47
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	11.50%	15.94%	14.54%	12.66%	-1.88
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	54.16	36.06	51.76	49.76	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	350.94	229.06	295.85	257.95	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	23.14%	21.77%	26.28%	28.15%	1.87
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	7.66%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	74.70%	75.47%	71.52%	61.09%	-10.43^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
Health Net—Los Angeles County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	Ry 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	76.15%	75.74%	80.51%	75.93%	-4.58
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	94.47%	91.83%	88.04%	89.65%	1.61^
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	81.18%	80.84%	78.36%	79.66%	1.30^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	81.99%	84.33%	84.13%	84.53%	0.40^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	77.41%	79.54%	79.55%	80.22%	0.67^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	24.82%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	75.47% ⁺	74.86%	77.49%	82.50% ⁺	5.01
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	67.65% ⁺	71.31% ⁺	70.18%	75.00% ⁺	4.82
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	69.26%	70.90%	72.13%	71.34%	-0.79
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	56.76%	Not Comparable
<i>Cervical Cancer Screening</i>	61.80%	51.53%	50.61%	48.66%	-1.95
<i>Prenatal and Postpartum Care—Postpartum Care</i>	45.01%	51.82%	55.72%	56.02%	0.30
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	68.37%	73.97%	77.86%	78.62%	0.76
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.35%	84.62%	86.83%	87.65%	0.82^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.78%	84.19%	86.16%	86.87%	0.71
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.65%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	59.61%	59.85%	58.64%	61.31%	2.67

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.36%	55.72%	55.23%	63.02%	7.79 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.26%	45.74%	50.36%	50.36%	0.00
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	48.66%	38.20%	37.47%	40.15%	2.68
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	79.81%	86.37%	85.64%	84.91%	-0.73
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.27%	86.13%	91.48% ⁺	90.51%	-0.97
<i>Controlling High Blood Pressure</i>	56.33%	63.46%	60.16%	65.06%	4.90
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	11.64%	17.29%	16.00%	14.40%	-1.60 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	35.29	22.52	33.98	35.36	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	274.97	170.14	246.76	239.27	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.72%	31.32%	32.06%	29.99%	-2.07 ^{^^}
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	100.00%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	7.84%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	76.76%	76.71%	75.62%	68.94%	-6.68 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.3—Multi-Year Performance Measure Results*
Health Net—Sacramento County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	59.57%	62.31%	60.82%	62.28%	1.46
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	92.57%	88.84%	88.46%	88.76%	0.30
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	81.06%	80.16%	76.60%	76.68%	0.08
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	79.43%	80.97%	80.90%	79.85%	-1.05
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	75.02%	76.97%	77.23%	77.18%	-0.05
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	27.49%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	72.95%	70.32%	69.27%	73.66%	4.39
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	58.81%	63.84%	56.25%	67.80%	11.55^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	67.54%	68.58%	61.67%	64.80%	3.13
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	50.29%	Not Comparable
<i>Cervical Cancer Screening</i>	48.91%	51.34%	40.63%	44.28%	3.65
<i>Prenatal and Postpartum Care—Postpartum Care</i>	49.02%	58.15%	57.11%	60.30%	3.19
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	77.07%	82.00%	82.29%	81.39%	-0.90
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	72.60%	79.88%	85.68%	82.87%	-2.81^^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.56%	79.52%	84.46%	81.46%	-3.00^^
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.98%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	45.99%	59.12%	57.18%	57.42%	0.24

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	37.96%	39.90%	35.04%	40.88%	5.84
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.18%	47.69%	49.39%	45.26%	-4.13
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	46.23%	40.15%	39.90%	41.12%	1.22
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	77.62%	78.59%	81.51%	78.35%	-3.16
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.29%	84.67%	90.27% ⁺	89.54%	-0.73
<i>Controlling High Blood Pressure</i>	45.72%	58.88%	59.35%	54.77%	-4.58
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	12.69%	17.19%	15.62%	15.97%	0.35
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	44.04	30.09	50.27	50.46	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	305.99	172.89	206.66	217.25	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.62%	30.96%	30.57%	38.79%	8.22 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	8.81%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	85.49% ⁺	78.12%	76.96%	70.46%	-6.50^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Performance Measure Results*
Health Net—San Diego County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	67.46%	74.32%	72.27%	75.52%	3.25
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.87%	92.46%	92.41%	90.95%	-1.46
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	87.67%	84.80%	81.86%	83.01%	1.15^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	86.20%	87.52%	86.81%	86.87%	0.06
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	82.09%	81.01%	83.38%	82.75%	-0.63
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	16.79%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	74.59%	74.14%	69.85%	67.01%	-2.84
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	70.77% ⁺	73.56% ⁺	65.67%	62.11%	-3.56
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	76.64%	69.18%	71.75%	73.10%	1.35
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	42.44%	Not Comparable
<i>Cervical Cancer Screening</i>	39.66%	41.12%	38.44%	42.58%	4.14
<i>Prenatal and Postpartum Care—Postpartum Care</i>	41.11%	44.12%	56.30%	68.03%	11.73
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	62.78%	60.29%	75.63%	76.23%	0.60
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.08%	83.46%	82.48%	86.18%	3.70^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.33%	84.51%	82.83%	85.40%	2.57
<i>Asthma Medication Ratio—Total</i>	--	--	--	64.15%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	46.23%	57.91%	62.77%	65.69%	2.92

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.77%	49.15%	46.72%	57.91%	11.19 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	38.69%	47.20%	47.93%	49.64%	1.71
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	54.01%	43.31%	44.28%	37.23%	-7.05 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	77.13%	77.62%	77.37%	83.45%	6.08 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	78.10%	80.54%	87.83% ⁺	90.75%	2.92
<i>Controlling High Blood Pressure</i>	44.72%	61.56%	64.29%	64.47%	0.18
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	15.90%	24.12%	22.11%	20.85%	-1.26
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	46.66	25.76	37.53	34.92	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	354.48	207.58	243.95	224.56	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	28.18%	33.82%	29.82%	34.15%	4.33
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	7.90%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	64.79%	74.80%	76.96%	62.77%	-14.19^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.5—Multi-Year Performance Measure Results*
Health Net—San Joaquin County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYS 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	NA	57.59%	54.89%	55.26%	0.37
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	92.11%	86.51%	83.15%	85.17%	2.02
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	76.97%	69.64%	66.95%	72.98%	6.03^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	NA	77.40%	74.38%	71.12%	-3.26
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	NA	75.12%	72.92%	71.70%	-1.22
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	11.75%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	68.37%	73.22%	64.09%	59.37%	-4.72
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	55.72%	63.39%	51.37%	54.26%	2.89
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	59.12%	66.08%	56.87%	59.75%	2.88
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	46.97%	Not Comparable
<i>Cervical Cancer Screening</i>	20.92%	36.25%	36.74%	37.71%	0.97
<i>Prenatal and Postpartum Care—Postpartum Care</i>	46.38%	49.12%	57.97%	58.88%	0.91
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	71.01%	78.95%	72.95%	77.66%	4.71
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	67.00%	74.48%	83.81%	80.54%	-3.27
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	65.45%	79.21%	82.93%	81.45%	-1.48
<i>Asthma Medication Ratio—Total</i>	--	--	--	46.55%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	34.96%	54.39%	47.45%	52.31%	4.86

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	39.02%	53.82%	53.28%	54.50%	1.22
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	29.27%	45.33%	39.90%	41.12%	1.22
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	65.04%	41.08%	50.85%	49.39%	-1.46
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	73.17%	81.87%	77.86%	73.97%	-3.89
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.30%	84.70%	89.05% ⁺	83.21%	-5.84^^
<i>Controlling High Blood Pressure</i>	30.86%	54.38%	38.88%	54.50%	15.62^
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	18.60%	21.67%	15.15%	21.87%	6.72^^
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	53.47	31.01	50.08	46.76	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	266.70	143.82	184.62	178.79	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	NA	26.32%	25.81%	19.47%	-6.34
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	8.20%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	NA	80.72%	75.60%	70.97%	-4.63

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.6—Multi-Year Performance Measure Results*
Health Net—Stanislaus County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	70.18%	65.52%	61.44%	58.42%	-3.02
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.59%	92.99%	90.02%	89.98%	-0.04
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	85.89%	84.31%	81.60%	79.67%	-1.93^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	86.39%	86.38%	84.68%	81.68%	-3.00^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	83.84%	82.60%	80.73%	78.19%	-2.54^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	16.79%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	62.59%	67.53%	67.35%	68.11%	0.76
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	66.08% ⁺	67.01%	66.84%	68.62%	1.78
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	70.11%	71.26%	63.74%	69.01%	5.27
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	47.46%	Not Comparable
<i>Cervical Cancer Screening</i>	48.18%	54.99%	42.79%	48.91%	6.12
<i>Prenatal and Postpartum Care—Postpartum Care</i>	55.61%	58.72%	62.34%	63.92%	1.58
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	83.29%	83.78%	82.29%	81.96%	-0.33
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.17%	80.74%	84.19%	83.64%	-0.55
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.38%	85.11%	83.98%	83.07%	-0.91
<i>Asthma Medication Ratio—Total</i>	--	--	--	60.33%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	58.64%	63.75%	59.61%	63.99%	4.38

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	41.36%	46.47%	44.28%	39.66%	-4.62
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	51.82%	47.20%	41.85%	52.31%	10.46 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	37.23%	41.36%	45.74%	38.93%	-6.81 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	87.10%	80.29%	82.97%	81.75%	-1.22
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	78.35%	75.43%	88.08% ⁺	88.32%	0.24
<i>Controlling High Blood Pressure</i>	56.30%	63.46%	57.55%	61.29%	3.74
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	10.97%	15.37%	16.21%	15.62%	-0.59
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	62.40	41.14	58.30	56.01	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	392.65	230.36	279.85	256.42	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	22.19%	30.69%	29.04%	26.64%	-2.40
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	10.96%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	77.33%	80.41%	78.74%	70.98%	-7.76^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.7—Multi-Year Performance Measure Results*
Health Net—Tulare County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	Ry 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	75.69%	74.44%	73.21%	74.39%	1.18
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.60%	95.94%	94.80%	94.67%	-0.13
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	91.99%	89.77%	87.27%	88.40%	1.13 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	91.23%	90.35%	89.82%	89.76%	-0.06
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	89.42%	88.53%	87.55%	87.52%	-0.03
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	31.39%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	65.69%	75.67%	81.11% ⁺	80.83% ⁺	-0.28
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	49.88%	69.10%	76.94% ⁺	75.40% ⁺	-1.54
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	80.18%	78.89%	73.96%	75.61%	1.65
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	55.34%	Not Comparable
<i>Cervical Cancer Screening</i>	59.85%	63.32%	56.51%	63.46%	6.95 [^]
<i>Prenatal and Postpartum Care—Postpartum Care</i>	57.98%	63.03%	62.50%	66.75%	4.25
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	88.56%	88.34%	88.02%	87.63%	-0.39
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.77%	84.34%	84.52%	86.31%	1.79 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.10%	85.51%	83.68%	85.20%	1.52
<i>Asthma Medication Ratio—Total</i>	--	--	--	68.54%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	55.96%	61.80%	69.34%	66.67%	-2.67

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.12%	50.61%	51.09%	52.80%	1.71
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.26%	49.39%	44.04%	48.91%	4.87
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	47.45%	40.88%	43.80%	41.36%	-2.44
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	79.56%	84.18%	87.35%	85.40%	-1.95
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.56%	87.83% ⁺	91.73% ⁺	89.29%	-2.44
<i>Controlling High Blood Pressure</i>	49.39%	64.72%	60.79%	61.52%	0.73
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	11.74%	12.75%	13.02%	13.95%	0.93
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	42.27	27.13	42.97	38.78	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	505.10	311.82	355.23	364.25	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	24.05%	23.25%	23.27%	26.71%	3.44
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	7.92%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	83.22% ⁺	81.70%	81.41%	74.37%	-7.04^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Health Net’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Within the Preventive Screening and Children’s Health domain, HSAG observed the following notable performance measure results:

- ◆ Across all counties for rates within this domain for which MCPs were held accountable to meet the MPLs in RY 2017:
 - Six of 28 rates (21 percent) were above the HPLs in RY 2017, three rates (11 percent) improved significantly from RY 2016 to RY 2017, and no rates declined significantly from RY 2016 to RY 2017.
 - Five of 28 rates (18 percent) were below the MPLs in RY 2017, with three of these rates being below the MPLs for at least the third consecutive year.
- ◆ The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in Kern, Los Angeles, and Tulare counties were above the HPLs in RY 2017.
 - The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* measure in Kern County improved significantly from RY 2016 to RY 2017.

- The rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling —Total* measure in Kern and Sacramento counties improved significantly from RY 2016 to RY 2017.
- ◆ The rates for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Sacramento and Stanislaus counties improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rates for this measure in both counties moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ In RY 2017, Health Net performed above the MPLs in Los Angeles, San Diego, and Tulare counties for all measures within this domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.
- ◆ The rates were below the MPLs in RY 2017 for the following measures within this domain for which MCPs were held accountable to meet the MPLs in RY 2017:
 - *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Joaquin, and Stanislaus counties, with the rates in Sacramento, San Joaquin, and Stanislaus counties being below the MPL for at least the third consecutive year.
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin County.

Performance measure results within the Preventive Screening and Children’s Health domain show that Health Net has the opportunity to assess whether current strategies need to be modified or expanded to ensure that:

- ◆ Beneficiaries in Kern, Sacramento, San Joaquin, and Stanislaus counties receive their specified immunization dosages by age 2.
- ◆ Beneficiaries 3 to 6 years of age in San Joaquin County are seen for one or more well-child visit(s) with a primary care provider (PCP) during the MY.

Preventive Screening and Women’s Health

Within the Preventive Screening and Women’s Health domain, HSAG observed the following notable performance measure results:

- ◆ The rate for the *Cervical Cancer Screening* measure in Tulare County improved significantly from RY 2016 to RY 2017.
- ◆ In RY 2017, Health Net performed above the MPLs in Los Angeles, Stanislaus, and Tulare counties for all measures within this domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.
- ◆ Health Net’s performance improved from below the MPLs in RY 2016 to above the MPLs in RY 2017 for the following measures:
 - *Cervical Cancer Screening* in Los Angeles and Stanislaus counties.
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in San Diego and San Joaquin counties.

- ◆ The rates for the *Cervical Cancer Screening* measure in Kern, Sacramento, San Diego, and San Joaquin counties were below the MPLs for all RYs displayed in Table 3.1, Table 3.3, Table 3.4, and Table 3.5.

Performance measure results within the Preventive Screening and Women’s Health domain show that Health Net has the opportunity to assess whether current strategies need to be modified or expanded to ensure that female beneficiaries ages 21 to 64 in Kern, Sacramento, San Diego, and San Joaquin counties are screened for cervical cancer within the appropriate time frames.

Care for Chronic Conditions

Within the Care for Chronic Conditions domain, HSAG observed the following notable performance measure results:

- ◆ Across all counties for rates within this domain for which MCPs were held accountable to meet the MPLs in RY 2017:
 - Ten of 63 rates (16 percent) improved significantly from RY 2016 to RY 2017.
 - Twelve of the 22 rates that were below the MPLs in RY 2016 (55 percent) improved to above the MPLs in RY 2017.
 - Twelve of 63 rates (19 percent) were below the MPLs in RY 2017, with seven of these twelve rates (58 percent) being below the MPLs for at least the third consecutive year.
- ◆ In RY 2017, Health Net performed above the MPLs in Kern, Los Angeles, San Diego, and Tulare counties for all measures within this domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.
- ◆ The rates declined significantly from RY 2016 to RY 2017 for the following measures within this domain:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in Sacramento County, resulting in the rate for the *ACE Inhibitors or ARBs* measure moving from above the MPL in RY 2016 to below the MPL in RY 2017 and the rate for the *Diuretics* measure remaining below the MPL for at least the fourth consecutive year.
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in San Joaquin County, resulting in the rate for this measure moving from above the HPL in RY 2016 to below the MPL in RY 2017.

Performance measure results in the Care for Chronic Conditions domain show that Health Net has the opportunity to assess whether strategies need to be modified or expanded to ensure that beneficiaries with chronic conditions and in Sacramento, San Joaquin, and Stanislaus counties receive quality, accessible, and timely health care.

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, HSAG observed the following notable performance measure results:

- ◆ In RY 2017, Health Net performed above the MPLs in Sacramento, Stanislaus, and Tulare counties for all measures within this domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.
- ◆ The rates were below the MPLs in RY 2017 for the following measures:
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Joaquin County.
 - *Use of Imaging Studies for Low Back Pain* in Kern, Los Angeles, and San Diego counties.
- ◆ For measures for which a comparison was made between RY 2016 and RY2017:
 - The rates improved significantly from RY 2016 to RY 2017 for the following measures:
 - *All-Cause Readmissions* in Los Angeles County.
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Sacramento County.
 - The RY 2017 rates were significantly worse than the RY 2016 rates for the following measures:
 - *All-Cause Readmissions* in San Joaquin County.
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Los Angeles County.
 - *Use of Imaging Studies for Low Back Pain* in all counties but San Joaquin, resulting in the rate moving from above the MPL in RY 2016 to below the MPL in RY 2017 for Los Angeles and San Diego counties.
 - The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in San Joaquin County declined from RY 2016 to RY 2017. Although the decline was not statistically significant, the change resulted in the rate for this measure moving from above the MPL in RY 2016 to below the MPL in RY 2017.

Note that the changes in the rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for these measures and therefore may not be related to Health Net's performance.

Performance measure results within the Appropriate Treatment and Utilization domain show that Health Net has the opportunity to assess the causes for the MCP's declining performance or performance below the MPLs to help the MCP develop strategies to:

- ◆ Prevent, to the highest degree possible, unplanned acute readmissions within 30 days of discharge for beneficiaries 21 years and older in San Joaquin County.
- ◆ Ensure the appropriate use of antibiotics for beneficiaries ages 18 to 64 with a primary diagnosis of bronchitis in Los Angeles and San Joaquin counties.
- ◆ Ensure that in Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties, only beneficiaries with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Corrective Action Plan

Health Net's Quality of Care CAP was implemented in December 2015 for a period of four or more years and until the CAP goals are achieved. The CAP outlines the overall goals for Health Net along with yearly CAP milestones. Health Net's CAP covers 10 measures across three reporting units.

- ◆ In Los Angeles County, Health Net is required to address performance related to the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - Both *Prenatal and Postpartum Care* measures
- ◆ In Sacramento County, Health Net is required to address performance related to the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*
- ◆ In San Diego County, Health Net is required to address performance related to both *Prenatal and Postpartum Care* measures.

Health Net's *Postpartum Care* and *Comprehensive Diabetes Care* performance improvement projects (PIPs) are also included in the MCP's CAP. Information regarding Health Net's progress on these PIPs is included in Section 4 of this report ("Performance Improvement Projects").

DHCS requires Health Net to achieve set milestones for each year of the CAP for all measures included in the CAP. During the review period for this report, Health Net conducted quarterly PDSA cycles on all CAP measures and produced extensive quarterly CAP progress reports. As part of the quarterly CAP progress reports, Health Net was required to provide summaries of the MCP's PDSA cycles and progress on improving the MCP's performance on the following seven indicators:

- ◆ *Cervical Cancer Screening*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- ◆ *Medication Management for People With Asthma—Medication Compliance 75%—Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Note that in RY 2017 DHCS replaced the *Immunizations for Adolescents—Combination 1* measure with the *Immunizations for Adolescents—Combination 2* measure and the *Medication Management for People With Asthma* measures with the *Asthma Medication Ratio—Total* measure.

DHCS and the EQRO provided Health Net with feedback on CAP activities each quarter through a technical assistance conference call. Health Net's quality improvement director met monthly with the DHCS nurse consultant assigned to the MCP to provide updates on all CAP areas. As required, Health Net met with DHCS leadership quarterly to provide CAP updates and updates on overall progress.

Progress on Corrective Action Plan

During the review period for this report, Health Net’s interventions and PDSA cycles focused on activities at the data, provider, and beneficiary levels to improve performance on the measures included in the MCP’s CAP. The following is a summary of the status of the measures included in the CAP at the conclusion of the second year of the CAP:

- ◆ Los Angeles County:
 - The rates for both *Annual Monitoring for Patients on Persistent Medications* measures were above the MPLs in RY 2016 and RY 2017.
 - The rate for the *ACE Inhibitors or ARBs* measure improved significantly from RY 2016 to RY 2017.
 - The rates for both *Prenatal and Postpartum Care* measures were above the MPLs in RY 2016 and RY 2017.
- ◆ Sacramento County:
 - The rates for both *Annual Monitoring for Patients on Persistent Medications* measures declined significantly from RY 2016 to RY 2017.
 - The significant decline in the rate for the *ACE Inhibitors or ARBs* measure resulted in the rate moving from above the MPL in RY 2016 to below the MPL in RY 2017.
 - The rate for the *Diuretics* measure remained below the MPL for the fifth consecutive year.
 - The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure remained below the MPL for the fifth consecutive year.
 - The rate for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure remained below the MPL for the fifth consecutive year.
- ◆ San Diego County:
 - The rates for both *Prenatal and Postpartum Care* measures were above the MPLs in RY 2017.
 - The rate for the *Postpartum Care* measure was above the MPL in both RY 2016 and RY 2017.
 - The rate for the *Timeliness of Prenatal Care* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.

Corrective Action Plan Requirements for RY 2017

While Health Net improved its performance during the review period, across all counties 25 of 126 rates for which MCPs were held accountable to meet the MPLs in RY 2017 (20 percent) were below the MPLs in RY 2017. For RY 2017, Stanislaus County met DHCS’ criteria for a CAP based on the rates for the following three measures being below the MPLs for three consecutive years:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures
- ◆ *Childhood Immunization Status—Combination 3*

At the time of this report, DHCS and Health Net were in discussions regarding requirements for Year 3 of the MCP’s CAP.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.8 through Table 3.14 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.8—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Kern County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	15.71%	11.01%	4.70^^	12.66%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	90.57	46.43	Not Tested	49.76
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	415.79	245.08	Not Tested	257.95
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.57%	88.03%	-1.46	87.62%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.26%	86.80%	-0.54	86.62%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	89.87%	Not Comparable	89.96%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	80.50%	78.43%	2.07	78.46%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	80.92%	75.19%	5.73^	75.39%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	74.23%	75.77%	-1.54	75.71%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.8 through Table 3.14.

Table 3.9—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Los Angeles County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.60%	12.10%	7.50^^	14.40%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	63.41	33.51	Not Tested	35.36
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	370.61	230.62	Not Tested	239.27
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.37%	87.07%	2.30^	87.65%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.29%	85.94%	3.35^	86.87%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	89.66%	Not Comparable	89.65%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	81.32%	79.62%	1.70	79.66%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.29%	84.54%	-0.25	84.53%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	77.22%	80.38%	-3.16^^	80.22%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.10—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Sacramento County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	22.30%	11.23%	11.07^^	15.97%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	86.01	47.02	Not Tested	50.46
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	348.23	204.57	Not Tested	217.25
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.63%	81.14%	4.49^	82.87%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.21%	78.41%	7.80^	81.46%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	88.86%	Not Comparable	88.76%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	75.75%	76.70%	-0.95	76.68%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.19%	79.66%	5.53^	79.85%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	76.12%	77.24%	-1.12	77.18%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.11—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—San Diego County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	29.18%	12.71%	16.47^^	20.85%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	71.66	32.75	Not Tested	34.92
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	306.41	219.72	Not Tested	224.56
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.82%	84.46%	5.36^	86.18%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.53%	82.68%	7.85^	85.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	90.95%	Not Comparable	90.95%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.80%	82.97%	1.83	83.01%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	80.20%	87.13%	-6.93^^	86.87%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	70.83%	83.29%	-12.46^^	82.75%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.12—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—San Joaquin County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	33.81%	17.56%	16.25^^	21.87%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	93.07	44.44	Not Tested	46.76
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	277.60	173.84	Not Tested	178.79
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.15%	80.42%	0.73	80.54%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.35%	81.25%	1.10	81.45%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	85.49%	Not Comparable	85.17%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	51.52%	73.35%	-21.83^^	72.98%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	78.13%	70.95%	7.18	71.12%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	75.36%	71.57%	3.79	71.70%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.13—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Stanislaus County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	21.03%	12.08%	8.95^^	15.62%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	96.15	52.72	Not Tested	56.01
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	392.14	245.27	Not Tested	256.42
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.16%	82.48%	3.68^	83.64%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.45%	80.65%	6.80^	83.07%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	90.06%	Not Comparable	89.98%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.76%	79.58%	4.18	79.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.88%	81.51%	4.37^	81.68%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.18%	77.85%	6.33^	78.19%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.14—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Tulare County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.94%	11.44%	8.50^^	13.95%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	70.51	36.97	Not Tested	38.78
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	556.77	353.22	Not Tested	364.25
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.65%	85.02%	5.63^	86.31%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.80%	83.75%	6.05^	85.20%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	94.68%	Not Comparable	94.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.92%	88.39%	0.53	88.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	92.26%	89.66%	2.60	89.76%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	90.41%	87.39%	3.02^	87.52%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.15 through Table 3.21 present the four-year trending information for the SPD population, and Table 3.22 through Table 3.28 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.15—Multi-Year SPD Performance Measure Trend Table
Health Net—Kern County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	12.18%	17.40%	18.50%	15.71%	-2.79
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	83.64	55.00	92.60	90.57	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	302.99	248.74	434.17	415.79	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.38%	87.92%	87.91%	86.57%	-1.34
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.49%	89.45%	85.69%	86.26%	0.57
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	73.87%	75.34%	84.69%	80.50%	-4.19
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	70.16%	76.60%	81.37%	80.92%	-0.45
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	63.26%	69.12%	73.61%	74.23%	0.62

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.16—Multi-Year SPD Performance Measure Trend Table
Health Net—Los Angeles County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	13.40%	20.98%	20.94%	19.60%	-1.34
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	52.60	28.53	58.87	63.41	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	262.13	150.49	354.75	370.61	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.62%	84.74%	87.81%	89.37%	1.56 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.59%	84.98%	88.30%	89.29%	0.99
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	73.01%	69.34%	89.80%	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	78.05%	77.43%	75.80%	81.32%	5.52 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	81.11%	82.75%	82.05%	84.29%	2.24 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	73.04%	75.34%	74.12%	77.22%	3.10 [^]

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.17—Multi-Year SPD Performance Measure Trend Table
Health Net—Sacramento County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	13.70%	19.25%	19.55%	22.30%	2.75
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	64.11	39.16	81.39	86.01	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	358.78	191.02	307.81	348.23	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.02%	81.51%	88.86%	85.63%	-3.23^^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	72.64%	82.32%	89.27%	86.21%	-3.06^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.22%	73.17%	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	79.88%	81.67%	76.47%	75.75%	-0.72
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.38%	84.02%	84.21%	85.19%	0.98
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	73.71%	77.37%	74.77%	76.12%	1.35

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.18—Multi-Year SPD Performance Measure Trend Table
Health Net—San Diego County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	17.37%	26.64%	29.17%	29.18%	0.01
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	69.30	29.69	70.36	71.66	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	319.25	155.22	297.18	306.41	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.18%	86.09%	84.19%	89.82%	5.63 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.62%	86.53%	88.73%	90.53%	1.80
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	75.61%	75.36%	74.31%	84.80%	10.49 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	81.54%	80.08%	76.25%	80.20%	3.95
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	77.03%	75.00%	71.03%	70.83%	-0.20

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.19—Multi-Year SPD Performance Measure Trend Table
Health Net—San Joaquin County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	25.00%	27.18%	14.97%	33.81%	18.84^^
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	104.16	51.30	96.83	93.07	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	344.91	153.04	285.19	277.60	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	75.47%	74.47%	89.57%	81.15%	-8.42
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	NA	81.48%	84.21%	82.35%	-1.86
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	NA	NA	71.43%	51.52%	-19.91
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	NA	NA	NA	78.13%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	NA	NA	71.15%	75.36%	4.21

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.20—Multi-Year SPD Performance Measure Trend Table
Health Net—Stanislaus County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	13.24%	17.13%	20.21%	21.03%	0.82
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	93.41	60.78	92.88	96.15	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	470.09	261.19	404.61	392.14	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.15%	82.29%	87.13%	86.16%	-0.97
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.17%	86.23%	87.78%	87.45%	-0.33
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.32%	86.89%	83.27%	83.76%	0.49
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.57%	87.26%	85.75%	85.88%	0.13
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.08%	84.42%	84.66%	84.18%	-0.48

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.21—Multi-Year SPD Performance Measure Trend Table
Health Net—Tulare County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	12.77%	14.81%	17.11%	19.94%	2.83
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	70.74	42.48	73.69	70.51	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	651.79	375.32	523.29	556.77	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.40%	85.33%	88.04%	90.65%	2.61
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.63%	87.97%	85.99%	89.80%	3.81
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.20%	90.75%	88.43%	88.92%	0.49
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	94.23%	91.46%	91.86%	92.26%	0.40
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	90.40%	88.97%	88.04%	90.41%	2.37

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.22—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Kern County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	9.35%	13.78%	11.67%	11.01%	-0.66
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	48.90	33.30	48.03	46.43	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	359.51	226.19	283.20	245.08	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.73%	87.59%	86.02%	88.03%	2.01
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.89%	86.56%	85.38%	86.80%	1.42
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	93.14%	90.57%	87.97%	89.87%	1.90
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	79.32%	79.49%	78.73%	78.43%	-0.30
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	67.84%	71.93%	75.03%	75.19%	0.16
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	67.83%	72.05%	75.49%	75.77%	0.28

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.23—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Los Angeles County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	6.53%	12.52%	12.72%	12.10%	-0.62
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	32.38	21.65	32.07	33.51	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	277.13	173.02	238.49	230.62	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.70%	84.53%	86.43%	87.07%	0.64 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	76.55%	83.58%	85.18%	85.94%	0.76
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.70%	92.03%	88.03%	89.66%	1.63 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	81.27%	80.93%	78.42%	79.62%	1.20 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	82.04%	84.42%	84.24%	84.54%	0.30
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	77.67%	79.84%	79.88%	80.38%	0.50 [^]

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.24—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Sacramento County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	9.16%	12.34%	12.00%	11.23%	-0.77
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	39.23	28.31	46.88	47.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	293.32	169.33	195.65	204.57	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	67.61%	76.78%	83.21%	81.14%	-2.07
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	63.48%	74.42%	80.65%	78.41%	-2.24
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	92.50%	89.13%	88.58%	88.86%	0.28
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	81.11%	80.12%	76.60%	76.70%	0.10
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	79.18%	80.76%	80.76%	79.66%	-1.10^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	75.14%	76.93%	77.39%	77.24%	-0.15

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.25—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—San Diego County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	7.87%	13.39%	10.75%	12.71%	1.96
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	41.81	24.93	34.85	32.75	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	362.03	218.65	239.61	219.72	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.47%	74.66%	81.12%	84.46%	3.34
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.26%	77.67%	78.24%	82.68%	4.44
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	96.17%	92.45%	92.37%	90.95%	-1.42
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.28%	85.13%	82.06%	82.97%	0.91
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.55%	88.08%	87.32%	87.13%	-0.19
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	82.56%	81.69%	84.07%	83.29%	-0.78

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.26—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—San Joaquin County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	NA	15.96%	15.21%	17.56%	2.35
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	46.94	29.20	47.73	44.44	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	256.64	142.99	179.55	173.84	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	57.45%	74.48%	82.53%	80.42%	-2.11
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	NA	78.23%	82.61%	81.25%	-1.36
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	91.89%	86.67%	83.08%	85.49%	2.41
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	76.48%	69.42%	66.85%	73.35%	6.50 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	NA	76.98%	74.74%	70.95%	-3.79
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	NA	75.17%	73.00%	71.57%	-1.43

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.27—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Stanislaus County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	S	12.35%	13.45%	12.08%	-1.37
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	56.78	38.34	55.19	52.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	378.60	225.96	268.61	245.27	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.05%	78.65%	82.66%	82.48%	-0.18
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.47%	83.29%	81.47%	80.65%	-0.82
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	95.53%	93.01%	90.13%	90.06%	-0.07
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.74%	84.22%	81.56%	79.58%	-1.98^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.32%	86.31%	84.61%	81.51%	-3.10^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.89%	82.44%	80.47%	77.85%	-2.62^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.28—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Tulare County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	9.62%	10.34%	10.76%	11.44%	0.68
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	38.64	25.50	40.93	36.97	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	486.43	305.08	344.08	353.22	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.29%	83.43%	83.21%	85.02%	1.81
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.40%	83.07%	82.75%	83.75%	1.00
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.57%	95.95%	94.78%	94.68%	-0.10
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	92.05%	89.74%	87.24%	88.39%	1.15 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	91.06%	90.28%	89.72%	89.66%	-0.06
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	89.35%	88.49%	87.52%	87.39%	-0.13

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures Health Net stratified by the SPD and non-SPD populations:

SPD Rate Changes from RY 2016 to RY 2017

For SPD rates for which a comparison could be made between RY 2016 and RY 2017:

- ◆ No statistically significant changes occurred for any SPD rates between RY 2016 and RY 2017 in Kern, Stanislaus, and Tulare counties.
- ◆ The RY 2017 SPD rates were significantly better than the RY 2016 SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Los Angeles and San Diego counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Los Angeles and San Diego counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years and 12–19 Years* in Los Angeles County.
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2016 SPD rates for the following measures:
 - *All-Cause Readmissions* in San Joaquin County.
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in Sacramento County.

Non-SPD Rate Changes from RY 2016 to RY 2017

For non-SPD rates for which a comparison could be made between RY 2016 and RY 2017:

- ◆ No statistically significant changes occurred for any non-SPD rates between RY 2016 and RY 2017 in Kern and San Diego Counties.
- ◆ The RY 2017 non-SPD rates were significantly better than the RY 2016 non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Los Angeles County.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* in Los Angeles County.
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Los Angeles, San Joaquin, and Tulare counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Los Angeles County.

- ◆ The RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Stanislaus County.
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Sacramento and Stanislaus counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Stanislaus County.

Comparisons of RY 2017 SPD and RY 2017 Non-SPD Rates

For measures for which a comparison could be made between the RY 2017 SPD and RY 2017 non-SPD rates:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Kern, Sacramento, and Stanislaus counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Stanislaus and Tulare counties.
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures:
 - *All-Cause Readmissions* in all seven counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in San Joaquin County.
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in San Diego County.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Los Angeles 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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age categories, based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Managed Long-Term Services and Supports Plan Performance Measure Results

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 three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.29 and Table 3.30 present the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.29—Multi-Year MLTSSP Performance Measure Results
Health Net—Los Angeles County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	68.53	79.59	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	549.24	671.23	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	3.41%	8.03%	4.62 [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member’s “contribution” to the total yearly membership.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.30—Multi-Year MLTSSP Performance Measure Results
Health Net—San Diego County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	87.67	91.57	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	635.00	570.74	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	S	9.21%	S [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member’s “contribution” to the total yearly membership.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases 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 an RY 2016 or RY 2017 rate is suppressed, then HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rates for the *Medication Reconciliation Post-Discharge* measure in both Los Angeles and San Diego counties improved significantly from RY 2016 to RY 2017.

Strengths—Performance Measures

HSAG auditors determined that Health Net followed the appropriate specifications to produce valid rates, and identified no issues of concern.

In Table 3.1 through Table 3.7 across all domains, six rates were above the HPLs in RY 2017, all of which were within the Preventive Screening and Children’s Health domain. Additionally, 16 of 133 rates (12 percent) improved significantly from RY 2016 to RY 2017. Finally, 18 of the 38 rates that were below the MPLs in RY 2016 (47 percent) improved from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

While Health Net’s performance improved across all domains as displayed in Table 3.1 through Table 3.7, the MCP has continued opportunities for improvement. In RY 2017, 25 of 126 rates (20 percent) were below the MPLs. For rates for which comparisons were made between RY 2016 and RY 2017, three of 63 rates within the Care for Chronic Conditions domain (5 percent) and eight of 21 rates within the Appropriate Treatment and Utilization domain (38 percent) declined significantly from RY 2016 to RY 2017.

Performance measure results displayed in Table 3.1 through Table 3.7 show that San Joaquin, Sacramento, and Stanislaus counties have the greatest opportunities for improvement based on these counties having the highest percentages of rates below the MPLs in RY 2017—eight of 18 (44 percent), six of 18 (33 percent), and five of 18 (28 percent), respectively. To provide the best opportunity for success, Health Net should work with DHCS to identify priority areas for improvement based on RY 2017 performance measure results. Additionally, Health Net should expand strategies that the MCP determined contributed to performance above the MPLs in RY 2017 and to improved performance from RY 2016 to RY 2017.

4. Performance Improvement Projects

Health Net had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

Health Net selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG reviewed and provided feedback to Health Net on the Plan portion of the PDSA cycle for the second intervention the MCP selected to test. HSAG sent periodic check-in email communications to Health Net to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

Health Net set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, increase from 39.00 percent to 55.47 percent the rate of postpartum visits among obstetrics/primary care providers in the Provider Group A⁶ in San Diego County.

Failure Modes

The following, listed in priority order, are the failure modes that Health Net identified during the Intervention Determination phase of the PIP process:

- ◆ Encounter data are rejected by MCP.
- ◆ Beneficiaries do not know that they need postpartum care visits.
- ◆ Some accepted encounter data do not count toward a positive HEDIS administrative hit.
- ◆ Beneficiaries do not have childcare for their children.
- ◆ Beneficiaries do not have transportation to the postpartum care visits.

⁶ Provider group name removed for confidentiality.

- ◆ Providers do not document the postpartum visits per HEDIS specifications in medical charts or in claims.
- ◆ Beneficiaries cannot schedule postpartum visit appointments between 21 and 56 days after they deliver their babies.
- ◆ Providers use wrong codes for obstetric specialty or primary care services.
- ◆ Encounter data are not submitted in a timely manner.

Intervention Testing

During the reporting period, Health Net selected to test the following:

- ◆ Use of a Postpartum Care Notification Form that collects necessary administrative data required for a positive HEDIS administrative hit for a postpartum care visit. This intervention addresses the issue of providers not including the postpartum visit date in encounter data due to global billing.
- ◆ Offering incentives to beneficiaries who completed timely postpartum care visits. This intervention addresses failure modes of beneficiaries being too busy, not having childcare and transportation, and not knowing that they need postpartum care visits.

Although Health Net completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Health Net's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

Health Net selected comprehensive diabetes care as its MCP-specific PIP topic.

Validation Findings

During the reporting period, Health Net incorporated HSAG's initial validation feedback into Module 3 of the MCP-specific PIP. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for the module.

HSAG also reviewed and provided feedback to Health Net on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to Health Net to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Health Net set the SMART Aim for the *Comprehensive Diabetes Care* PIP as follows:

By June 30, 2017, increase from 65.00 percent to 70.00 percent the rate of hemoglobin A1c (HbA1c) testing among Health Net Medi-Cal beneficiaries receiving care at Provider Group B.⁷

Failure Modes

The following, listed in priority order, are the failure modes that Health Net identified during the Intervention Determination phase of the PIP process:

- ◆ Providers have no protocols in place for beneficiary outreach.
- ◆ Beneficiaries may not know their newly assigned providers; therefore, beneficiaries do not call to set up appointments for their comprehensive diabetes care appointments.
- ◆ Beneficiaries do not complete their HbA1c testing.
- ◆ Beneficiaries lack transportation and/or may be unaware of transportation options available to them.
- ◆ Beneficiaries' time with the providers or the health educators is minimal.
- ◆ Providers have incorrect beneficiary contact information.

Intervention Testing

During the reporting period, Health Net selected to test beneficiary outreach calls for appointment reminders and appointment scheduling. This intervention addresses the failure mode of providers not having protocols in place for beneficiary outreach.

Although Health Net completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Health Net's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, Health Net improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

⁷ Provider group name removed for confidentiality.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Health Net’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Health Net’s self-reported actions.

Table 5.1—Health Net’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Work with DHCS to prioritize areas for improvement related to performance measures showing declining performance or performance below the MPLs. HSAG recommends that Health Net focus on performance measures for which the MCP performed below the MPLs in RY 2016.	Health Net continues to prioritize measures in partnership with DHCS and HSAG. While working on priority measures, we have identified priority groups, clinics, and physicians to engage in PDSA and PIP projects. These relationships have identified barriers and opportunities such as member appointment no-shows; providers unaware that patients are assigned to them; communication issues among the management services organization (MSO), the provider group, and physician; member access issues; and financial incentives, to name a few. Internal monitoring tools also gave us the information we needed to engage the groups, clinics, and physicians to address members’ gaps in care. This monitoring and barrier identification led to several amendments and adoption of interventions.
2. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Postpartum Care</i> PIP.	During PIP review and implementation, we have collaborated closely with HSAG. Module 4 updates were submitted as requested, and comments from HSAG were reviewed for implementation. Throughout the process, we have encountered various challenges in collecting data, engaging the providers at the right level for implementation, and changing operations. Closure of the PIP is in progress.
3. Incorporate HSAG’s feedback on Module 3 for the <i>Comprehensive Diabetes Care</i> PIP to ensure that all validation criteria are met for a methodologically sound PIP.	Upon receiving HSAG’s review and feedback, and during the additional follow-up for Module 4 check-ins, Health Net engaged in technical assistance calls and sent updates and clarifications to strengthen the PIP interventions and documentation. The PIP interventions moved forward, and successes and challenges will be reported during the final PIP submission.

2016–17 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 identify priority areas for improvement based on RY 2017 performance measure results, and expand strategies that the MCP determined contributed to performance above the MPLs in RY 2017 and to improved performance from RY 2016 to RY 2017. Based on RY 2017 results, Health Net may want to focus improvement efforts on San Joaquin, Sacramento, and Stanislaus counties, which had the highest percentages of rates below the MPLs in RY 2017 (44 percent, 33 percent, and 28 percent, respectively). Across all reporting units, Health Net performed below the MPLs for the following measures in RY 2017:
 - Preventive Screening and Children’s Health
 - *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Joaquin, and Stanislaus counties.
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin County.
 - Preventive Screening and Women’s Health
 - *Cervical Cancer Screening* in Kern, Sacramento, San Diego, and San Joaquin counties.
 - Care for Chronic Conditions
 - *Both Annual Monitoring for Patients on Persistent Medications* measures in Sacramento, San Joaquin, and Stanislaus counties.
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Sacramento and Stanislaus counties.
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Sacramento, San Joaquin, and Stanislaus counties.
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in San Joaquin County.
 - Appropriate Treatment and Utilization
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Joaquin County.
 - *Use of Imaging Studies for Low Back Pain* in Kern, Los Angeles, and San Diego counties.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix O:
Performance Evaluation Report
Health Plan of San Joaquin
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Health Plan of San Joaquin (“HPSJ” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in HPSJ’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

HPSJ is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in HPSJ, the LI MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan (CP).

HPSJ became operational in San Joaquin County to provide MCMC services effective February 1996 and in Stanislaus County effective January 2013. As of June 30, 2017, HPSJ had 219,648 beneficiaries in San Joaquin County and 127,764 in Stanislaus County—for a total of 347,412 beneficiaries.¹ This represents 91 percent of the beneficiaries enrolled in San Joaquin County and 63 percent in Stanislaus County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 02, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for HPSJ. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of HPSJ. A&I conducted the on-site audits from July 11, 2016, through July 22, 2016.

**Table 2.1—DHCS A&I Medical and State Supported Services Audits of HPSJ
 Audit Review Period: July 1, 2015, through June 30, 2016**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

A&I identified no deficiencies during the July 2016 Medical and State Supported Services Audits of HPSJ.

Opportunities for Improvement—Compliance Reviews

HPSJ had no identified deficiencies from the July 2016 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Health Plan of San Joaquin* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that HPSJ followed the appropriate specifications to produce valid rates; however, the auditors noted during the audit that a small percentage of beneficiaries had retroactive eligibility. The auditors recommended that HPSJ determine the percentage of retroactive enrollment that occurs; determine the impact on the rates; and consider removing these beneficiaries for future HEDIS reporting, as allowed by NCQA.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 and Table 3.2 for HPSJ's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 and Table 3.2:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
HPSJ—San Joaquin County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	75.91%	69.59%	67.40%	60.58%	-6.82^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.04%	96.17%	95.39%	95.10%	-0.29
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	87.79%	85.04%	84.62%	84.89%	0.27
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	86.70%	86.27%	86.87%	86.09%	-0.78^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	83.23%	82.56%	83.70%	81.94%	-1.76^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	21.65%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	68.37%	70.56%	54.01%	60.10%	6.09
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	55.96%	61.31%	53.28%	55.23%	1.95
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	76.89%	76.40%	70.56%	72.51%	1.95
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	51.67%	Not Comparable
<i>Cervical Cancer Screening</i>	61.12%	57.18%	49.39%	47.20%	-2.19
<i>Prenatal and Postpartum Care—Postpartum Care</i>	60.83%	59.61%	45.99%	61.80%	15.81^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	82.24%	80.78%	56.69%	75.91%	19.22^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.80%	80.51%	83.66%	83.83%	0.17
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.29%	81.60%	83.75%	82.42%	-1.33
<i>Asthma Medication Ratio—Total</i>	--	--	--	57.59%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.69%	70.56%	51.34%	54.99%	3.65

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.77%	47.20%	41.85%	40.88%	-0.97
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	51.82%	46.72%	46.96%	45.26%	-1.70
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	40.15%	42.09%	45.01%	46.23%	1.22
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	79.08%	79.32%	76.89%	81.51%	4.62
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.08%	81.75%	87.10%	90.27%	3.17
<i>Controlling High Blood Pressure</i>	65.45%	61.80%	48.42%	54.99%	6.57
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	11.06%	12.78%	13.03%	12.73%	-0.30
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	45.89	45.82	48.82	49.82	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	249.11	241.84	244.43	234.67	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	25.10%	29.46%	26.08%	18.23%	-7.85^^
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	9.48%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	84.03% ⁺	82.67%	81.04%	71.57%	-9.47^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading⁺ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
HPSJ—Stanislaus County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	64.96%	60.58%	62.53%	57.18%	-5.35
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.23%	92.46%	92.75%	92.37%	-0.38
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	88.43%	84.31%	83.11%	82.62%	-0.49
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	88.90%	87.59%	86.63%	84.48%	-2.15^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	86.60%	84.54%	83.32%	80.09%	-3.23^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	19.46%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	41.85%	56.45%	48.18%	54.26%	6.08
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	39.17%	44.77%	43.07%	47.45%	4.38
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	68.61%	65.21%	57.18%	60.83%	3.65
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	55.82%	Not Comparable
<i>Cervical Cancer Screening</i>	41.08%	50.12%	45.74%	50.36%	4.62
<i>Prenatal and Postpartum Care—Postpartum Care</i>	54.99%	57.18%	47.07%	60.58%	13.51^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	73.24%	79.81%	64.15%	75.67%	11.52^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.64%	85.88%	84.86%	84.58%	-0.28
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.39%	86.26%	85.22%	85.14%	-0.08
<i>Asthma Medication Ratio—Total</i>	--	--	--	62.36%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	67.88%	72.26%	72.26%	66.67%	-5.59

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	37.23%	36.25%	44.53%	26.52%	-18.01^{^^}
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	52.31%	51.82%	50.12%	54.74%	4.62
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	36.98%	39.90%	39.90%	35.04%	-4.86
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	85.40%	80.78%	81.02%	84.18%	3.16
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.29%	77.13%	87.35%	85.16%	-2.19
<i>Controlling High Blood Pressure</i>	56.20%	67.64%	60.34%	60.10%	-0.24
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.11%	14.29%	14.25%	13.41%	-0.84
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	56.07	60.36	59.55	55.89	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	272.99	274.08	262.80	257.58	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	16.95%	18.65%	23.07%	26.25%	3.18
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	12.31%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	76.51%	78.90%	78.15%	70.31%	-7.84^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of HPSJ's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ *All four Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in Stanislaus County improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in both rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017 and reflects improved documentation by providers in Stanislaus County of counseling for nutrition and counseling for physical activity during outpatient visits with beneficiaries 3 to 17 years of age.

The rates were below the MPLs in RY 2017 for the following measures within the Preventive Screening and Children's Health domain:

- ◆ *Childhood Immunization Status—Combination 3* in both reporting units
 - The rate in San Joaquin County declined significantly from RY 2016 to RY 2017, resulting in the rate moving from above the MPL in RY 2016 to below the MPL in RY 2017.
 - The rates in Stanislaus County were below the MPL for all RYs displayed in Table 3.2.
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County for the third consecutive year

Performance measure results show that HPSJ has the opportunity to build on the MCP's strategies described in Table 5.1 to ensure that:

- ◆ Beneficiaries in San Joaquin and Stanislaus counties receive their specified immunization doses by age 2.
- ◆ Beneficiaries ages 3 to 6 in Stanislaus County are seen for one or more well-child visit(s) with a primary care provider (PCP) during the MY.

Preventive Screening and Women's Health

Stanislaus County had no rates below the MPLs in RY 2017 within the Preventive Screening and Women's Health domain. In both reporting units, the rates for both *Prenatal and Postpartum Care* measures improved significantly from RY 2016 to RY 2017, resulting in all four rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017. Additionally, the rate for the *Cervical Cancer Screening* measure in Stanislaus County improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.

The rate for the *Cervical Cancer Screening* measure in San Joaquin County was below the MPL in RY 2017, reflecting the MCP's opportunity for improvement related to ensuring that female beneficiaries ages 21 to 64 in this county are screened for cervical cancer within the appropriate time frames.

Care for Chronic Conditions

The rates for the following measures within the Care for Chronic Conditions domain improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in San Joaquin County
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Stanislaus County
- ◆ *Controlling High Blood Pressure* in San Joaquin County

Across both reporting units, eight of 18 rates within the Care for Chronic Conditions domain (44 percent) were below the MPLs in RY 2017. The rates for the following measures were below the MPLs:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures in both reporting units
 - In San Joaquin County, the rate was below the MPL for all RYs displayed in Table 3.1.
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in both reporting units
 - In Stanislaus County, the rate for this measure declined significantly from RY 2016 to RY 2017, and the rates were below the MPL for all RYs displayed in Table 3.2.
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in San Joaquin County for all RYs displayed in Table 3.1
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Stanislaus County

Performance measure results show that HPSJ has the opportunity to build on the MCP's strategies described in Table 5.1 to ensure that beneficiaries in:

- ◆ San Joaquin and Stanislaus counties ages 18 and older on angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) and diuretics receive annual monitoring.
- ◆ San Joaquin and Stanislaus counties ages 18 to 75 with diabetes (type 1 and type 2) have performance of a retinal eye exam documented during the MY.
- ◆ San Joaquin County ages 18 to 75 with diabetes (type 1 and type 2) have an HbA1c test documented during the MY.
- ◆ Stanislaus County ages 18 to 75 with diabetes (type 1 and type 2) receive a nephropathy screening or monitoring test.

Appropriate Treatment and Utilization

In RY 2017, Stanislaus County had no rates below the MPLs within the Appropriate Treatment and Utilization domain.

In San Joaquin County, the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure declined significantly from RY 2016 to RY 2017, resulting in the rate moving from above the MPL in RY 2016 to below the MPL in RY 2017. Note that the significant decline in the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to HPSJ's performance.

In both reporting units, the rates for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to HPSJ's performance.

HPSJ has the opportunity to explore the causes for the MCP's performance below the MPL in San Joaquin County for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and declining performance in both counties for the *Use of Imaging Studies for Low Back Pain* measure to ensure:

- ◆ The appropriate use of antibiotics for beneficiaries ages 18 to 64 with a primary diagnosis of acute bronchitis.
- ◆ That only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Corrective Action Plan and Improvement Plans

Corrective Action Plan

HPSJ's Quality of Care CAP was initiated in September 2016 for a period of four years or until HPSJ achieves the CAP goals. The CAP outlines the overall goals that HPSJ must achieve, along with yearly CAP milestones. HPSJ's CAP requires the MCP to address performance below the MPLs for the following three measures in San Joaquin County:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*
- ◆ *Medication Management for People With Asthma*—Note that in RY 2017 DHCS replaced this measure with the *Asthma Medication Ratio—Total* measure.

To address performance below the MPLs for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Medication Management for People With Asthma* measures, DHCS required HPSJ to submit two PDSA cycles.

DHCS required HPSJ to address performance related to the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure through the MCP's *Diabetes* performance improvement project (PIP). Information regarding HPSJ's progress on its *Diabetes* PIP is included in Section 4 of this report ("Performance Improvement Projects").

Improvement Plan/Plan-Do-Study-Act Cycles

In addition to the measures covered under the CAP, DHCS required HPSJ to conduct IP/PDSA cycles for the following measures with rates below the MPLs in RY 2016:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Joaquin County
- ◆ *Childhood Immunization Status—Combination 3* in Stanislaus County
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in San Joaquin County
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in San Joaquin and Stanislaus counties
- ◆ *Controlling High Blood Pressure* in San Joaquin County
- ◆ *Immunizations for Adolescents—Combination 1* in Stanislaus County—Note that in RY 2017 DHCS replaced this measure with the *Immunizations for Adolescents—Combination 2* measure.
- ◆ Both *Prenatal and Postpartum Care* measures in San Joaquin and Stanislaus counties
- ◆ Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures in Stanislaus County
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County

Progress on Corrective Action Plan and Improvement Plans

HPSJ's CAP and IP/PDSA cycles focused on activities at the beneficiary-, provider-, and MCP-levels, with strategies addressing opportunities for improvement related to the MCP's operational infrastructure, MCP resources, data, and staff.

At the conclusion of the first year of the CAP, DHCS indicated that HPSJ met the initial CAP milestones established for RY 2017. HSAG observed the following notable results for the measures included in the MCP's CAP:

- ◆ The rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure remained below the MPL in San Joaquin County.
- ◆ The rate for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure remained below the MPL in San Joaquin County.
- ◆ The rate for the *Asthma Medication Ratio—Total* measure exceeded the MPL in San Joaquin County. Please note the following:
 - As indicated previously, in RY 2017 this measure replaced the *Medication Management for People With Asthma* measure.
 - DHCS did not hold MCPs accountable to meet the MPL for the *Asthma Medication Ratio—Total* measure in RY 2017; however, DHCS evaluated HPSJ's performance on this measure in RY 2017 as part of DHCS' assessment of the MCP's progress on its CAP goals.
 - DHCS indicated that, in May 2018, DHCS will require HPSJ to submit an end-of-year summary of the MCP's progress on the *Asthma Medication Ratio—Total* measure.

HSAG observed the following notable results in RY 2017 for measures for which DHCS required HPSJ to conduct IP/PDSA cycles, excluding results for the *Immunizations for Adolescents—Combination 1* measure because, as indicated previously, DHCS replaced this measure with the *Immunizations for Adolescents—Combination 2* measure in RY 2017:

- ◆ Eight of 13 rates for measures for which DHCS required HPSJ to conduct IP/PDSA cycles in both reporting units (62 percent) moved from below the MPLs in RY 2016 to above the MPLs in RY 2017. The rates for the following measures addressed by the IP/PDSA cycles were above the MPLs in RY 2017:
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in San Joaquin County
 - *Controlling High Blood Pressure* in San Joaquin County
 - Both *Prenatal and Postpartum Care* measures in both reporting units
 - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures in Stanislaus County
- ◆ The rates for the following measures addressed by the IP/PDSA cycles remained below the MPLs in RY 2017:
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Joaquin County

- *Childhood Immunization Status—Combination 3* in Stanislaus County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in both reporting units
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County

Corrective Action Plan Requirements for RY 2017

In all, 13 of 36 rates for which DHCS held the MCP accountable to meet the MPLs in RY 2017 (36 percent) were below the MPLs. DHCS will require HPSJ to conduct and submit IP/PDSA cycles or quality improvement summaries indicating strategies and efforts for selected measures with rates that were below the MPLs in RY 2017. The following are the measures, by domain, with rates below the MPLs in RY 2017:

- ◆ Preventive Screening and Children’s Health
 - *Childhood Immunization Status—Combination 3* in both reporting units
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County
- ◆ Preventive Screening and Women’s Health
 - *Cervical Cancer Screening* in San Joaquin County
- ◆ Care for Chronic Conditions
 - *Both Annual Monitoring for Patients on Persistent Medications* measures in both reporting units
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in both reporting units
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in San Joaquin County
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Stanislaus County
- ◆ Appropriate Treatment and Utilization
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Joaquin County

Seniors and Persons with Disabilities Performance Measure Results

Table 3.3 and Table 3.4 present the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.3—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSJ—San Joaquin County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	17.79%	9.74%	8.05^^	12.73%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	81.78	47.11	Not Tested	49.82
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	414.33	219.42	Not Tested	234.67
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.24%	83.16%	2.08^	83.83%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.68%	80.70%	4.98^	82.42%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	95.35%	95.10%	0.25	95.10%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.26%	84.79%	3.47^	84.89%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.15%	86.05%	1.10	86.09%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	82.97%	81.89%	1.08	81.94%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.3 and Table 3.4.

Table 3.4—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSJ—Stanislaus County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/ Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.62%	10.79%	8.83^^	13.41%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	105.98	52.86	Not Tested	55.89
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	513.61	242.12	Not Tested	257.58
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.69%	82.92%	6.77^	84.58%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.81%	83.45%	6.36^	85.14%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	92.35%	Not Comparable	92.37%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.71%	82.55%	3.16	82.62%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.27%	84.36%	3.91	84.48%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.45%	79.95%	4.50^	80.09%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.5 and Table 3.6 present the four-year trending information for the SPD population, and Table 3.7 and Table 3.8 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

Table 3.5—Multi-Year SPD Performance Measure Trend Table
HPSJ—San Joaquin County

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	13.65%	16.82%	17.73%	17.79%	0.06
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	71.99	70.82	76.82	81.78	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	438.00	401.82	410.40	414.33	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.07%	81.04%	85.39%	85.24%	-0.15
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.24%	84.20%	86.99%	85.68%	-1.31
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	100.00%	100.00%	94.12%	95.35%	1.23
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.09%	83.28%	86.07%	88.26%	2.19
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.37%	87.42%	87.47%	87.15%	-0.32
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	85.91%	84.27%	84.42%	82.97%	-1.45

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.6—Multi-Year SPD Performance Measure Trend Table
HPSJ—Stanislaus County

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	15.88%	20.55%	22.96%	19.62%	-3.34
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	105.58	105.69	109.30	105.98	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	585.69	535.60	508.87	513.61	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.72%	89.02%	87.73%	89.69%	1.96
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.27%	88.44%	88.32%	89.81%	1.49
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	93.20%	82.25%	81.71%	85.71%	4.00
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	NA	92.06%	89.30%	88.27%	-1.03
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	NA	89.64%	84.66%	84.45%	-0.21

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.7—Multi-Year Non-SPD Performance Measure Trend Table
HPSJ—San Joaquin County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	6.86%	7.91%	10.48%	9.74%	-0.74
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	42.34	43.63	46.52	47.11	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	223.43	225.18	230.79	219.42	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.28%	79.93%	82.81%	83.16%	0.35
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.14%	78.50%	81.94%	80.70%	-1.24
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.00%	96.14%	95.40%	95.10%	-0.30
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	87.86%	85.08%	84.59%	84.79%	0.20
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.67%	86.21%	86.84%	86.05%	-0.79^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.07%	82.44%	83.66%	81.89%	-1.77^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.8—Multi-Year Non-SPD Performance Measure Trend Table
HPSJ—Stanislaus County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.67%	8.95%	10.82%	10.79%	-0.03
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	51.51	56.92	56.58	52.86	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	244.19	254.18	248.12	242.12	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.48%	82.84%	83.93%	82.92%	-1.01
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.05%	83.86%	84.01%	83.45%	-0.56
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.21%	92.42%	92.72%	92.35%	-0.37
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.33%	84.35%	83.13%	82.55%	-0.58
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.87%	87.48%	86.55%	84.36%	-2.19^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.62%	84.41%	83.28%	79.95%	-3.33^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in RY 2017 for measures that HPSJ stratified by the SPD and non-SPD populations:

- ◆ For both reporting units, HPSJ had no significant variation in the SPD rates from RY 2016 to RY 2017 for SPD rates for which a comparison could be made.

- ◆ For both reporting units, the RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures.
- ◆ For measures for which HSAG could compare the SPD rates to the non-SPD rates in RY 2017:
 - The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in both reporting units
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in San Joaquin County
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Stanislaus County
 - The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the *All-Cause Readmissions* measure in 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 beneficiaries.

Strengths—Performance Measures

HSAG auditors determined that HPSJ followed the appropriate specifications to produce valid rates.

Across both reporting units, four of six comparable rates within the Preventive Screening and Women's Health domain (67 percent) improved significantly from RY 2016 to RY 2017, and the improvement resulted in all four of those rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017. Across all domains and reporting units, 10 of the 19 rates that were below the MPLs in RY 2016 (53 percent) improved to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

HPSJ has the opportunity to determine the percentage of retroactive enrollment that occurs for the MCP; determine the impact on the rates; and consider removing these beneficiaries for future HEDIS reporting, as allowed by NCQA.

Across all domains and reporting units, 13 of 36 rates for which DHCS held the MCP accountable to meet the MPLs in RY 2017 (36 percent) were below the MPLs. Most opportunities for improvement for HPSJ are within the Care for Chronic Conditions domain, based on eight of 18 rates within this domain (44 percent) being below the MPLs in RY 2017, with four of the eight rates (50 percent) being below the MPLs for at least three consecutive years. HPSJ's RY 2017 performance measure results demonstrate opportunities for improvement in the areas of quality and timeliness of, and access to health care.

4. Performance Improvement Projects

HPSJ had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

HPSJ selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG reviewed and provided feedback to HPSJ on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to HPSJ and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

HPSJ set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, increase from 72 percent to 75 percent the rate of HbA1c testing for HPSJ beneficiaries assigned to Provider A⁶.

Failure Modes

The following, listed in priority order, are the failure modes that HPSJ identified during the Intervention Determination phase of the PIP process:

- ◆ MCP/provider does not have accurate demographic data for the beneficiary.
- ◆ Beneficiary does not understand the importance of HbA1c testing.
- ◆ Beneficiary does not receive the HbA1c lab slip in the mail.
- ◆ Beneficiary does not have transportation to the lab.
- ◆ Beneficiary frequently changes PCPs.
- ◆ MCP/provider does not have an accurate phone number for the beneficiary.

⁶ Provider name removed for confidentiality.

- ◆ Beneficiary's Medi-Cal eligibility changes from month to month.
- ◆ Beneficiary is assigned to the provider, but does not seek care.

Intervention Testing

During the reporting period, HPSJ selected to test the effectiveness of a mass mailing campaign to provide beneficiaries with diabetes education sheets, incentive brochures, and lab order slips. This intervention addresses the failure mode of beneficiaries' lack of understanding of the importance of HbA1c testing.

Although HPSJ completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in HPSJ's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

HPSJ selected cervical cancer screening as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for HPSJ's MCP-specific PIP.

Upon initial review of the module, HSAG determined that HPSJ met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis (FMEA).
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, HPSJ incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to HPSJ on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to HPSJ to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

HPSJ set the SMART Aim for the *Cervical Cancer Screening* PIP as follows:

By June 30, 2017, increase the rate of cervical cancer screenings from 31 percent to 35 percent among female beneficiaries ages 24 to 64 years residing in Stanislaus County who have Provider B⁷ as their PCP.

Failure Modes

The following, listed in priority order, are the failure modes that HPSJ identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary is unaware to schedule a cervical cancer screening.
- ◆ Beneficiary forgets about the cervical cancer screening appointment.
- ◆ Provider does not follow-up with beneficiary after a missed appointment to schedule a new appointment.
- ◆ Beneficiary is not provided with information about the importance of cervical cancer screening.
- ◆ Beneficiary does not have transportation to keep the cervical cancer screening appointment.

Intervention Testing

During the reporting period, HPSJ selected to test outreach calls to remind beneficiaries to schedule and complete their cervical cancer screenings. This intervention addresses the failure mode of beneficiaries being unaware about the need to schedule a cervical cancer screening.

Although HPSJ completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in HPSJ's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, HPSJ improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

⁷ Provider name removed for confidentiality.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from HPSJ’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of HPSJ’s self-reported actions.

Table 5.1—HPSJ’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Work with the MCP’s delegated plan partner in San Joaquin County to obtain more complete monthly encounter files from the plan partner or to obtain the fourth quarter data file more timely.	HPSJ utilized its Provider Partnership Program to educate the provider regarding timely claims submission. The IT teams from both entities worked to ensure that all codes submitted to San Joaquin can fully integrate within our system. This allowed HPSJ to capture services being performed. The MCP was also able to work with the provider group to capture point-of-care tests of HbA1c tests and to capture eye exams being performed by an outside vendor. Gaps in care reports to the provider are available monthly, and now contain the most accurate data to date.
2. To address the significant decline in some of the MCP’s hybrid measure rates, the MCP should consider reinstating provision of beneficiary incentives and educating providers on inclusion of appropriate data and codes for all provided services on the claims forms.	The MCP member incentive program has been expanded to target members throughout the year, not to place the focus on members who only received services during the end of the year. The Provider Partnership Program also educated providers regarding timely claims submission. The team also included training providers regarding the use of codes recognized by NCQA and HEDIS. The MCP provided a tip sheet as a reference guide for providers.
3. Assess whether or not current improvement strategies need to be modified or expanded for performance measures for which the MCP performed below the MPLs in RY 2016.	Although the MCP had a significant increase in measures with rates below the MPLs, there are still significant opportunities to both maintain and increase the number of compliant measures. Current activities will be expanded in order to target both a larger provider and member group. The MCP’s provider partnership has expanded, and a HEDIS workgroup has been developed. This workgroup includes a multidisciplinary team which meets every two weeks to discuss and develop HEDIS interventions.

2016–17 Recommendations

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

- ◆ Determine the percentage of retroactive enrollment that occurs for the MCP; determine the impact on the rates; and consider removing these beneficiaries for future HEDIS reporting, as allowed by NCQA.
- ◆ Continue to work with DHCS to identify the causes for the rates for the following measures being below the MPLs:
 - Preventive Screening and Children’s Health
 - *Childhood Immunization Status—Combination 3* in both reporting units
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County
 - Preventive Screening and Women’s Health
 - *Cervical Cancer Screening* in San Joaquin County
 - Care for Chronic Conditions
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in both reporting units
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in both reporting units
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in San Joaquin County
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Stanislaus County
 - Appropriate Treatment and Utilization
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Joaquin County

Identifying the causes will help HPSJ to determine whether current improvement strategies implemented through the MCP’s CAP and IP/PDSA cycles need to be modified or expanded to ensure that the MCP performs above the MPLs for required measures. For measures not already included in the MCP’s CAP and IP/PDSA requirements, identifying the causes will help the MCP to develop and conduct strategies to address the MCP’s performance below the MPLs for these measures.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix P:
Performance Evaluation Report
Health Plan of San Mateo
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Health Plan of San Mateo (“HPSM” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in HPSM’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

HPSM is a full-scope MCP delivering services to beneficiaries in the County Organized Health System (COHS) model.

HPSM became operational to provide MCMC services in San Mateo County effective December 1987. As of June 30, 2017, HPSM had 111,465 beneficiaries in San Mateo County.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 05, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for HPSM. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical Audit of HPSM. A&I conducted the on-site audit from November 28, 2016, through December 2, 2016. A&I examined documentation for compliance and to determine to what extent HPSM had operationalized the MCP’s CAP from the November 2015 A&I Medical Audit. A&I did not review the Case Management and Coordination of Care and Administrative and Organizational Capacity categories during the November 28, 2016, through December 2, 2016, audits and indicated that A&I will review these categories in a future audit. DHCS sent HPSM the final response to the MCP’s CAP on August 11, 2017, which is outside the review period for this report; however, HSAG includes the information because it reflects full resolution of all deficiencies from the audit.

Note that A&I generally conducts a State Supported Services Audit in tandem with the Medical Audit; however, in 2016 A&I did not conduct a State Supported Services Audit of HPSM.

Table 2.1—DHCS A&I Medical Audit of HPSM
Audit Review Period: November 1, 2015, through October 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	No	Not applicable.

Follow-Up on Previous Reviews

Audits & Investigations Division Medical Audit

DHCS conducted an A&I Medical Audit of HPSM from November 2, 2015, through November 13, 2015, covering the review period of November 1, 2014, through October 31, 2015. HSAG provided a summary of the audit results and status in HPSM’s 2015–16 MCP-specific evaluation report. At the time

of the 2015–16 MCP-specific report publication, HPSM’s CAP was in process and under review by DHCS. A letter from DHCS dated February 27, 2017, stated that HPSM provided DHCS with additional information regarding the CAP, that DHCS had either closed or provisionally closed all deficiencies, and that DHCS had closed the CAP. DHCS also indicated that it will continue to monitor and/or follow-up with HPSM on provisionally-closed deficiencies.

Department of Managed Health Care Seniors and Persons with Disabilities Medical Survey

The Department of Managed Health Care (DMHC) conducted a Seniors and Persons with Disabilities (SPD) Medical Survey of HPSM from November 3, 2014, through November 6, 2014, covering the review period of January 1, 2014, through July 31, 2014. HSAG provided a summary of the survey results and status in HPSM’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, HPSM’s CAP was in process and under review by DHCS. A letter from DHCS dated March 8, 2017, stated that HPSM provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Quality Management category during the November 28, 2016, through December 2, 2016, Medical Audit of HPSM. Based on HPSM’s responses to the MCP’s CAP, DHCS closed all deficiencies from this audit. Additionally, based on HPSM’s responses to the MCP’s CAP, DHCS closed or provisionally closed all deficiencies from the November 2015 A&I Medical Audit and the November 2014 SPD Medical Survey.

Opportunities for Improvement—Compliance Reviews

HPSM has no outstanding deficiencies from the November 28, 2016, through December 2, 2016, A&I Medical Audit; November 2015 A&I Medical Audit; or November 2014 DMHC SPD Medical Survey; therefore, HSAG has no recommendations for the MCP in the area of compliance review.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Health Plan of San Mateo* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that HPSM followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for HPSM's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
HPSM—San Mateo County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	Ry 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	82.11%	81.60% ⁺	78.08%	82.99% ⁺	4.91
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.13%	93.89%	92.20%	93.74%	1.54
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	90.40%	89.21%	86.45%	85.91%	-0.54
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	89.74%	91.49%	90.97%	89.52%	-1.45^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	85.34%	87.36%	87.89%	86.17%	-1.72^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	38.93%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	73.90%	75.00%	79.08%	77.22%	-1.86
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	63.66%	61.98%	68.62%	65.00%	-3.62
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	75.68%	73.16%	71.34%	76.61%	5.27
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	65.77%	Not Comparable
<i>Cervical Cancer Screening</i>	61.80%	55.10%	54.79%	55.26%	0.47
<i>Prenatal and Postpartum Care—Postpartum Care</i>	59.55%	63.07%	64.84%	67.11%	2.27
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	82.66%	77.89%	79.95%	82.63%	2.68
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.97%	89.51%	89.92%	90.90%	0.98 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.85% ⁺	90.03%	89.69%	90.54%	0.85
<i>Asthma Medication Ratio—Total</i>	--	--	--	54.89%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	46.72%	60.10%	61.12%	61.80%	0.68

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	60.83%	63.75%	58.92%	64.48%	5.56
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	54.01%	54.99%	48.90%	54.26%	5.36
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	38.69%	38.20%	43.52%	36.01%	-7.51 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	87.10%	89.29%	86.55%	85.40%	-1.15
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	90.02% ⁺	83.94%	87.29%	89.78%	2.49
<i>Controlling High Blood Pressure</i>	29.93%	61.80%	68.88%	66.39%	-2.49
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	15.68%	16.99%	15.19%	14.14%	-1.05
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	48.80	49.73	48.44	46.37	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	445.65	438.97	403.76	381.24	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	37.13% ⁺	35.50%	36.05%	48.67% ⁺	12.62 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	100.00%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	14.72%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	79.18%	83.47%	84.38% ⁺	78.93%	-5.45^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of HPSM's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

Within the Preventive Screening and Children's Health domain in RY 2017, the rate for the *Childhood Immunization Status—Combination 3* measure was above the HPL. HPSM had no measures with rates below the MPLs within this domain.

Preventive Screening and Women's Health

In RY 2017, HPSM performed between the HPLs and MPLs for all measures within the Preventive Screening and Women's Health domain.

Care for Chronic Conditions

In RY 2017, HPSM performed between the HPLs and MPLs for all measures within the Care for Chronic Conditions domain. The rates improved significantly from RY 2016 to RY 2017 for the following measures within this domain:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved significantly from RY 2016 to RY 2017, resulting in the rate moving to above the HPL in RY 2017. HPSM had no measures with rates below the MPLs within the Appropriate Treatment and Utilization domain in RY 2017.

The rate declined significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure; however, the significant decline in the rate for this measure may be due to NCQA's RY 2017 specification changes for this measures and therefore may not be related to HPSM's performance.

Assessment of Improvement Plans

HPSM was not required to submit any improvement plans for RY 2016. Based on RY 2017 performance measure results, the MCP is not required to submit any improvement plans for RY 2017.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSM—San Mateo County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	15.04%	12.48%	2.56^^	14.14%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	60.02	44.04	Not Tested	46.37
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	826.61	305.27	Not Tested	381.24
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	92.15%	88.87%	3.28^	90.90%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	92.66%	86.99%	5.67^	90.54%

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.2.

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	93.81%	Not Comparable	93.74%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	72.57%	86.19%	-13.62^^	85.91%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	75.30%	90.01%	-14.71^^	89.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	69.98%	86.79%	-16.81^^	86.17%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
HPSM—San Mateo County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.78%	20.91%	16.77%	15.04%	-1.73
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	60.39	60.26	62.09	60.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	797.31	803.65	814.59	826.61	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.58%	90.60%	91.36%	92.15%	0.79
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	92.65%	91.55%	92.35%	92.66%	0.31

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	77.57%	77.54%	78.42%	72.57%	-5.85
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	72.88%	72.75%	73.24%	75.30%	2.06
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	68.15%	69.49%	71.23%	69.98%	-1.25

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
HPSM—San Mateo County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	11.52%	11.64%	11.85%	12.48%	0.63
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	44.87	47.21	45.75	44.04	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	326.37	351.81	322.75	305.27	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.57%	86.99%	87.26%	88.87%	1.61
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.05%	86.47%	84.58%	86.99%	2.41
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.15%	93.94%	92.21%	93.81%	1.60 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.80%	89.51%	86.63%	86.19%	-0.44
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.92%	92.37%	91.70%	90.01%	-1.69 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.89%	88.43%	88.65%	86.79%	-1.86 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in RY 2017 for measures that HPSM stratified by the SPD and non-SPD populations:

- ◆ For SPD rates for which a comparison could be made from RY 2016 to RY 2017, HPSM had no statistically significant variation in SPD rates from RY 2016 to RY 2017.
- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.
- ◆ The RY 2017 non-SPD rate was significantly better than the RY 2016 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* measure.
- ◆ The RY 2017 non-SPD rate was significantly worse than the RY 2016 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures.
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures for which comparisons could be made between RY 2017 SPD and RY 2017 non-SPD rates:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years*

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 beneficiaries. Additionally, the significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age categories (i.e., *25 Months–6 Years, 7–11 Years, and 12–19 Years*) relying on specialist providers as their care sources rather than accessing care from primary care practitioners for their complicated health care needs.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to HPSM's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that HPSM report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.5 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.5—Multi-Year MLTSSP Performance Measure Results
HPSM—San Mateo County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	76.52	73.62	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	630.77	627.79	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	21.41%	30.41%	9.00 [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure improved significantly from RY 2016 to RY 2017.

Strengths—Performance Measures

HSAG auditors determined that HPSM followed the appropriate specifications to produce valid rates, and identified no issues of concern.

In Table 3.1 across all domains, the rates for three measures improved significantly from RY 2016 to RY 2017 and the rates were above the HPLs in RY 2017 for the *Childhood Immunization Status—Combination 3* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measures.

Opportunities for Improvement—Performance Measures

HPSM has the opportunity to identify the causes for the MCP's decline in performance for the *Use of Imaging Studies for Low Back Pain* measure. Identifying the causes will help the MCP to identify strategies to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

HPSM had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

HPSM selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to HPSM to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

HPSM set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, improve timely (21–56 day post-delivery) postpartum care from 66.46 percent to 75.00 percent for all HPSM beneficiaries who had a live birth delivery and received obstetric care from Provider A.⁶

Failure Modes

The following, listed in priority order, are the failure modes that HPSM identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary is unaware of the significance of postpartum care after delivery.
- ◆ Beneficiary does not think that the postpartum care visit is a covered benefit.
- ◆ Appointment is not within the postpartum time frame after delivery (3 to 8 weeks).
- ◆ Beneficiary forgets about the postpartum care visit appointment.
- ◆ Provider does not have a procedure in place to follow up after the missed appointment to reschedule the postpartum care visit.

⁶ Provider name removed for confidentiality.

- ◆ Beneficiary has more than 10 minutes of call wait time to schedule an appointment.
- ◆ Scheduling process is too complicated for the beneficiary.
- ◆ Beneficiary does not have childcare to attend the postpartum care visit appointment.
- ◆ Beneficiary does not have reliable transportation to attend the postpartum care visit appointment.
- ◆ Beneficiary is not motivated to understand the prenatal information provided.

Intervention Testing

During the reporting period, HPSM selected to test the impact of a text messaging reminder campaign by measuring the number of HPSM beneficiaries who successfully receive a text message through the CareMessage portal and attend their postpartum appointment on or between 21–56 days after delivery. This intervention addresses the beneficiaries' lack of:

- ◆ Understanding and value of the postpartum care appointment.
- ◆ Knowledge that the postpartum care visit is a covered Medi-Cal benefit.
- ◆ Knowledge of the 21–56-day post-delivery time frame for postpartum care visit.

Although HPSM completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in HPSM's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

HPSM selected cervical cancer screening as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 2 for HPSM's MCP-specific PIP, which the MCP revised due to changes to the SMART Aim measure denominator description. Upon review, HSAG determined that HPSM met all validation criteria for Module 2.

Additionally, HSAG validated Module 3 for HPSM's MCP-specific PIP. Upon initial review of the module, HSAG determined that HPSM met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, HPSM incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to HPSM on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to HPSM to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

HPSM set the SMART Aim for the *Cervical Cancer Screening* PIP as follows:

By June 30, 2017, increase the cervical cancer screening compliance rate among beneficiaries ages 24 to 64 years assigned to Provider B⁷ from baseline measurement of 69 percent to goal of 77 percent.

Failure Modes

The following, listed in priority order, are the failure modes that HPSM identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary is not captured by report parameters for Pap test reminder call because the clinic does not have documentation for the prior primary care provider (PCP) visit.
- ◆ Beneficiary is not motivated to schedule a Pap text due to lack of awareness of gynecological health needs and/or has low perception of risk for cervical cancer.
- ◆ Older beneficiary does not believe that a routine Pap test is necessary in mid-life.
- ◆ Beneficiary does not attend the scheduled cervical cancer screening appointment.
- ◆ Provider is unaware of beneficiary's assignment to the clinic.
- ◆ Beneficiary forgets about her scheduled appointment.

Intervention Testing

During the reporting period, HPSM selected to test a new process to identify and outreach to beneficiaries who are overdue for cervical cancer screenings and were previously excluded in Provider B's Pap test reminder call report due to the clinic not having documentation for the beneficiaries' prior PCP visits. This intervention addresses the infrastructure for providing health reminders to beneficiaries who have not had previous PCP visits.

Although HPSM completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in HPSM's 2017–18 MCP-specific evaluation report.

⁷ Provider name removed for confidentiality.

Strengths—Performance Improvement Projects

Through HSAG’s PIP validation and technical assistance, HPSM improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

Based on HPSM’s PIP progression, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from HPSM’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of HPSM’s self-reported actions.

Table 5.1—HPSM’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure resolution of all deficiencies from the November 2015 A&I medical audit.	HPSM has submitted to DHCS a formal CAP response with corrective actions described for all identified deficiencies. HPSM continues to communicate with DHCS regarding corrective actions in progress or which had prospective compliance dates or were identified as repeat issues in the subsequent 2016 A&I Medical Audit.
2. Ensure oversight of the MCP’s plan partner and work to obtain complete monthly encounter files from the plan partner, proactively identifying missing or problematic data.	HPSM has actively monitored the plan partner’s submitted encounters. HPSM and the plan partner have held monthly meetings, and HPSM has experienced good and ongoing success with the partnership. The plan partner is implementing its CAP and HPSM benefits from this as the plan partner moves forward.
3. Ensure full implementation of the MCP’s policies and procedures for conducting at least annual reconciliation between the MCP’s credentialing and provider databases as well as implementation of a monitoring/audit process of data entry accuracy into both systems to be conducted before the formal, annual reconciliation.	Ongoing, any discrepancies that are discovered between PRIME and HealthSuite are corrected with HPSM’s internal process by completing a “data correction form.” The form is forwarded to HPSM’s IT department to make any necessary updates. Also, a “Provider Update” form is mailed to all providers in HPSM’s network to notify HPSM of updates or changes. Providers are instructed to fax those changes to HPSM’s provider services department, and those changes are updated in both the PRIME and HealthSuite systems. HPSM is also in the process of implementing a provider portal, which includes an online provider directory search. Part of the process for the implementation is to compare provider data in both systems and reconcile any discrepancies.

2015–16 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>4. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Postpartum Care</i> PIP.</p>	<p>HSAG has reviewed HPSM’s Module 4 progress update for the <i>Postpartum Care</i> PIP. HSAG noted that HPSM had made appropriate progress with intervention testing. HPSM identified a lesson learned and, as a result, initiated a new process. HPSM provided results to demonstrate that the intervention has shown success, and HPSM is considering testing at different times and days as well as expanding to additional provider groups.</p>

2016–17 Recommendations

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

- ◆ Identify the causes for the decline in performance for the *Use of Imaging Studies for Low Back Pain* measure. Identifying the causes will help the MCP to develop strategies, as applicable, to address the MCP’s declining performance for this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix Q:
Performance Evaluation Report
Inland Empire Health Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Inland Empire Health Plan (“IEHP” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in IEHP’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

IEHP is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in IEHP, the LI MCP; or in Molina Healthcare of California Partner Plan, Inc., the alternative commercial plan (CP).

IEHP became operational in Riverside and San Bernardino counties to provide MCMC services effective September 1996. As of June 30, 2017, IEHP had 602,888 beneficiaries in Riverside County and 630,912 in San Bernardino County—for a total of 1,233,800 beneficiaries.¹ This represents 87 percent of the beneficiaries enrolled in Riverside County and 89 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 are considered a single reporting unit.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 13, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for IEHP. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of IEHP. A&I conducted the on-site audits from October 17, 2016, through October 21, 2016.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of IEHP
Audit Review Period: October 1, 2015, through September 30, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	No	Not applicable.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	Yes	Closed.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member’s Rights, Quality Management, and State Supported Services categories during the October 2016 Medical and State Supported Services Audits of IEHP. Additionally, IEHP fully resolved the deficiency in the Administrative and Organizational Capacity category.

Opportunities for Improvement—Compliance Reviews

IEHP has no outstanding deficiencies from the October 2016 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Inland Empire Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{™3}. HSAG auditors determined that IEHP followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for IEHP's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
IEHP—Riverside/San Bernardino Counties

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYS 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	76.85%	75.46%	70.83%	72.45%	1.62
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	96.67%	94.72%	91.90%	93.72%	1.82 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.77%	84.75%	82.89%	83.28%	0.39 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	84.55%	84.36%	83.43%	82.59%	-0.84^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	83.97%	83.06%	82.35%	81.72%	-0.63^{^^}
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	23.61%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	73.84%	76.39%	80.09% ⁺	80.09% ⁺	0.00
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	53.01%	65.05%	65.74%	68.06%	2.32
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	71.53%	71.06%	68.06%	73.15%	5.09
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	64.17%	Not Comparable
<i>Cervical Cancer Screening</i>	70.47%	68.00%	54.12%	58.59%	4.47
<i>Prenatal and Postpartum Care—Postpartum Care</i>	59.02%	61.03%	59.67%	64.19%	4.52
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	86.42%	86.38%	83.68%	83.49%	-0.19
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.33%	87.85%	87.11%	87.67%	0.56 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.42%	86.93%	86.40%	86.94%	0.54
<i>Asthma Medication Ratio—Total</i>	--	--	--	49.22%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	62.88%	64.35%	59.16%	66.82%	7.66 [^]

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	51.74%	57.41%	55.68%	60.56%	4.88
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.87%	50.23%	51.04%	52.90%	1.86
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	39.44%	36.57%	38.75%	37.12%	-1.63
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	84.69%	86.11%	86.77%	87.24%	0.47
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.13%	84.49%	92.58%⁺	90.49%	-2.09
<i>Controlling High Blood Pressure</i>	67.56%	69.25%	58.85%	58.85%	0.00
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	14.73%	17.89%	18.12%	15.87%	-2.25 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	48.50	49.83	47.36	46.08	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	288.05	244.43	230.67	238.56	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	21.52%	21.75%	23.13%	27.30%	4.17 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	97.67%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.03%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	75.14%	75.34%	73.96%	72.31%	-1.65^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (⁺), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of IEHP’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Within the Preventive Screening and Children’s Health domain in RY 2017, IEHP performed above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* measure. This measure reports documentation of counseling for nutrition during outpatient visits with beneficiaries ages 3 to 17. The MCP had no measures with rates below the MPLs within this domain in RY 2017.

Preventive Screening and Women’s Health

Within the Preventive Screening and Women’s Health domain in RY 2017, the rates for the three measures for which DHCS held MCPs accountable to meet the MPLs were between the HPLs and MPLs. The rate for the *Cervical Cancer Screening* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017. IEHP provided information on actions that the MCP took during the review period to address the rate for the *Cervical Cancer Screening* measure being below the MPL in RY 2016. (See Table 5.1). Additionally, HSAG includes information on IEHP’s *Cervical Cancer Screening* performance improvement project (PIP) in Section 4 of this report (“Performance Improvement Projects”). IEHP’s efforts may have contributed to the rate for the *Cervical Cancer Screening* measure improving from below the MPL in RY 2016 to above the MPL in RY 2017.

Care for Chronic Conditions

Within the Care for Chronic Conditions domain in RY 2017, the rates for the nine measures for which DHCS held MCPs accountable to meet the MPLs were between the HPLs and MPLs. The rates for the following measures improved significantly from RY 2016 to RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain in RY 2017, the rates for the two measures for which DHCS held MCPs accountable to meet the MPLs were between the HPLs and MPLs. The rate for the *All-Cause Readmissions* measure improved significantly from RY 2016 to RY 2017, reflecting a reduction in hospital readmissions.

The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. IEHP has the opportunity to explore the causes for the MCP's decline in performance for this measure to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to IEHP's performance.

Assessment of Improvement Plans

While the rate for the *Cervical Cancer Screening* measure was below the MPL in RY 2016, DHCS did not require IEHP to submit IP/PDSA cycles because the MCP was conducting a PIP to improve the rate for this measure. The rate improved to above the MPL in RY 2017; therefore, the MCP will not be required to submit an IP/PDSA cycle for the *Cervical Cancer Screening* measure.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, IEHP will not be required to submit any IP/PDSA cycles for RY 2017.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for IEHP—Riverside/San Bernardino Counties

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	20.79%	13.01%	7.78^^	15.87%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	78.53	43.67	Not Tested	46.08
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	508.82	218.45	Not Tested	238.56
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.51%	85.77%	5.74^	87.67%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.58%	84.48%	7.10^	86.94%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	98.39%	93.68%	4.71^	93.72%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.92%	83.20%	3.72^	83.28%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.13%	82.42%	4.71^	82.59%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	82.90%	81.67%	1.23^	81.72%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
IEHP—Riverside/San Bernardino Counties**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	17.37%	21.77%	23.99%	20.79%	-3.20^
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	82.89	83.70	81.09	78.53	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	632.06	452.07	472.31	508.82	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.35%	89.54%	90.24%	91.51%	1.27^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.55%	88.93%	89.68%	91.58%	1.90^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.61%	93.81%	97.81%	98.39%	0.58
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.58%	86.10%	86.27%	86.92%	0.65
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	86.46%	86.29%	86.53%	87.13%	0.60
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	82.45%	82.37%	81.53%	82.90%	1.37^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
IEHP—Riverside/San Bernardino Counties

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	9.67%	13.43%	13.87%	13.01%	-0.86 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	44.44	46.76	44.57	43.67	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	247.47	225.61	210.73	218.45	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.43%	86.53%	85.47%	85.77%	0.30
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.92%	85.29%	84.52%	84.48%	-0.04
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	96.70%	94.73%	91.86%	93.68%	1.82 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.81%	84.71%	82.81%	83.20%	0.39 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.46%	84.26%	83.30%	82.42%	-0.88 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.06%	83.10%	82.39%	81.67%	-0.72 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in RY 2017 for measures that IEHP stratified by the SPD and non-SPD populations:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- ◆ The RY 2017 SPD rates were significantly better than the RY 2016 SPD rates for the following measures:
 - *All-Cause Readmissions*
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- ◆ The RY 2017 non-SPD rates were significantly better than the RY 2016 non-SPD rates for the following measures:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months and 25 Months–6 Years* measures
- ◆ The RY 2017 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures were significantly worse than the RY 2016 non-SPD rates for these measures.
- ◆ The RY 2017 SPD rate for the *All-Cause Readmissions* measure was significantly worse than the RY 2017 non-SPD rate for this measure. 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 beneficiaries.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to IEHP's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that IEHP report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.5 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.5—Multi-Year MLTSSP Performance Measure Results
IEHP— Riverside/San Bernardino Counties**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	93.97	99.38	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	573.50	689.51	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	15.44%	41.94%	26.50 [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure improved significantly from RY 2016 to RY 2017.

Strengths—Performance Measures

HSAG auditors determined that IEHP followed the appropriate specifications to produce valid rates, and identified no issues of concern.

IEHP performed above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* measure. In Table 3.1 across all domains, IEHP had no rates below the MPLs in RY 2017; and the rates for four measures improved significantly from RY 2016 to RY 2017. Additionally, the rate for the *Cervical Cancer Screening* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.

Opportunities for Improvement—Performance Measures

IEHP has the opportunity to explore the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

IEHP had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

IEHP selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG validated modules 1 and 3 and the Plan portion of Module 4 for IEHP's DHCS-priority PIP, which the MCP revised due to the MCP encountering changes that affected the entire PIP process. Upon review, HSAG determined that IEHP met all validation criteria for modules 1 and 3 and provided feedback on the Plan portion of Module 4 for the MCP to consider prior to intervention testing.

HSAG also sent periodic check-in email communications to IEHP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

IEHP set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, among eligible beneficiaries with diabetes, providers A, B, and C will increase HbA1c testing compliance from 40.49 percent to 45.49 percent, 40.35 percent to 45.35 percent, and 55.81 percent to 60.81 percent, respectively.⁶

Failure Modes

The following, listed in priority order, are the failure modes that IEHP identified during the Intervention Determination phase of the PIP process:

- ◆ Provider does not inform beneficiaries of the on-site phlebotomist; therefore, beneficiaries are not aware that an HbA1c test can be completed in the provider office.

⁶ Provider names removed for confidentiality.

- ◆ Provider does not identify beneficiaries who are due for an HbA1c test.
- ◆ Beneficiaries complete visits, but no HbA1c tests are ordered.
- ◆ Provider orders the HbA1c tests, but beneficiaries do not complete the blood draws for HbA1c tests.
- ◆ Beneficiaries do not understand how HbA1c levels can affect their health.
- ◆ Beneficiaries do not understand their HbA1c test results and their goals.
- ◆ Beneficiaries are not provided with instructions on how often HbA1c testing should be completed.
- ◆ Provider is unable to contact beneficiaries to schedule appointments.
- ◆ Beneficiaries are unable to schedule appointments with their assigned primary care providers (PCPs).
- ◆ Appointment time slots are too short to address all of the beneficiaries' concerns.
- ◆ Provider does not follow up with beneficiaries after missed appointments.
- ◆ Beneficiaries forget their appointments or have scheduling conflicts.
- ◆ Beneficiaries are scheduled for multiple referrals at a time.
- ◆ Beneficiaries are unable to get time off work or are unable to arrange personal time.
- ◆ Beneficiaries do not feel that an HbA1c test is important.
- ◆ Beneficiaries face language and/or cultural barriers at the clinic site.
- ◆ Beneficiaries are not provided with culturally and linguistically appropriate information about the importance of controlling diabetes.

Intervention Testing

During the reporting period, IEHP selected to test a standardized workflow for in-office HbA1c testing at providers A, B, and C. This intervention addresses the key driver of standardizing the diabetes care process.

Although IEHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in IEHP's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

IEHP selected cervical cancer screening as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for IEHP's MCP-specific PIP. Upon initial review of the module, HSAG determined that IEHP met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis (FMEA).
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, IEHP incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to IEHP on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to IEHP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

IEHP set the SMART Aim for the *Cervical Cancer Screening* PIP as follows:

By June 30, 2017, Provider A⁷ will increase its Pap smear testing rate from 64.29 percent to 71.00 percent among eligible female beneficiaries.

Failure Modes

The following, listed in priority order, are the failure modes that IEHP identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiaries do not receive any educational messaging about Pap tests.
- ◆ Provider does not give beneficiaries instructions on how often they should be tested, provide information of disease transmission and prevention, or explain the importance of Pap tests.
- ◆ Provider office lacks a tracking and/or reminder system that prompts staff members to outreach to beneficiaries due for Pap tests.
- ◆ Provider does not give beneficiaries culturally and linguistically appropriate information about the importance of Pap tests.
- ◆ Beneficiaries are not interested in understanding the information provided.
- ◆ Provider office is unable to contact beneficiaries to schedule appointments.
- ◆ Beneficiaries are unable to attend their original appointments.
- ◆ Provider does not follow up with beneficiaries after missed appointments.
- ◆ Beneficiaries are unable to schedule appointments with their assigned PCPs.

⁷ Provider name removed for confidentiality.

- ◆ Beneficiaries have multiple appointment referrals with other specialty providers.
- ◆ Walk-ins are welcome, but beneficiaries are unable to wait.
- ◆ Beneficiaries forget their appointments.
- ◆ Beneficiaries feel scared or embarrassed about a physical exam and testing.

Intervention Testing

During the reporting period, IEHP selected to test developing a protocol for provider and support staff members to identify beneficiaries who are due for Pap tests. This intervention addresses the key driver of identification of beneficiaries who need screening and treatment.

Although IEHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in IEHP's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, IEHP improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from IEHP’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of IEHP’s self-reported actions.

Table 5.1—IEHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Identify the causes for the MCP’s declining performance or performance below the MPLs for the following measures: <ol style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> b. <i>Cervical Cancer Screening</i> c. <i>Controlling High Blood Pressure</i> 	<p>Actions taken:</p> <ul style="list-style-type: none"> ◆ Implemented IEHP’s Global Quality Pay for Performance (GQP4P) program, which provides financial incentives for Independent Physician Associations (IPAs) and physicians to monitor, track, and improve performance on <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> and <i>Cervical Cancer Screening</i> measures. ◆ Implemented member outreach activities and provided incentives to members to complete their cervical cancer screenings. ◆ Hypertension clinical practice guidelines were reviewed and approved in 2016, and recommendations are being used for medication therapy management. Use of recommended guidelines will be included in future physician and staff education to improve clinical care and standards of practice.

2016–17 Recommendations

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

- ◆ Explore the causes for the rate for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017. Identifying the causes will help IEHP to develop strategies, as applicable, to address the MCP’s declining performance for this measure.

In the next annual review, HSAG will evaluate continued successes of IEHP as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix R:
Performance Evaluation Report
Kern Family Health Care
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Kern Family Health Care (“KFHC” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in KFHC’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

KFHC is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in KFHC, the LI MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan (CP).

KFHC became operational in Kern County to provide MCMC services effective July 1996. As of June 30, 2017, KFHC had 248,913 beneficiaries in Kern County.¹ This represents 76 percent of the beneficiaries enrolled in Kern County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Jul 10, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for KFHC. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of KFHC. A&I conducted the on-site audits from August 30, 2016, through September 2, 2016.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of KFHC
Audit Review Period: August 1, 2015, through July 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Table 2.2 summarizes the results and status of the Department of Managed Health Care (DMHC) Seniors and Persons with Disabilities (SPD) Medical Survey of KFHC. DMHC conducted the on-site survey from August 29, 2016, through September 1, 2016.

Table 2.2—DMHC SPD Medical Survey of KFHC
Survey Review Period: August 1, 2015, through July 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Continuity of Care	No	Not applicable.
Availability and Accessibility	Yes	Closed.

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Member Rights	Yes	Closed.
Quality Management	No	Not applicable.

Strengths—Compliance Reviews

During the August 30, 2016, through September 2, 2016, A&I Medical and State Supported Services Audits, DHCS identified no deficiencies in the Utilization Management, Case Management and Coordination of Care, Quality Management, Administrative and Organizational Capacity, and State Supported Services categories. Additionally, during the August 29, 2016, through September 1, 2016, SPD Medical Survey, DMHC identified no deficiencies in the Utilization Management, Continuity of Care, and Quality Management categories. Finally, KFHC's responses to the MCP's CAPs for the deficiencies that A&I identified during the Medical Audit and that DMHC identified in the SPD Medical Survey resulted in DHCS closing the CAPs.

Opportunities for Improvement—Compliance Reviews

KFHC has no outstanding deficiencies from the MCP's most recent A&I Medical and State Supported Services Audits and DMHC SPD Medical Survey; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS*^{®2} 2017 Compliance Audit Final Report of Findings for Kern Family Health Care contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance AuditTM.³ HSAG auditors determined that KFHC followed the appropriate specifications to produce valid rates. During the audit process, HSAG recommended that the MCP:

- ◆ Expand its use of electronic medical record (EMR) data for future HEDIS reporting.
- ◆ Investigate use of the Child Health and Disability Prevention Program *Confidential Screening/Billing Report* (PM 160) claim form to determine if it would be beneficial for HEDIS reporting.
 - Note that this is the third year that HSAG has made this recommendation to KFHC. In response to HSAG's recommendation in the MCP's 2015–16 MCP-specific evaluation report, the MCP indicated that it contracted with a vendor to electronically enter the PM 160 claim form data received from providers (see Table 5.1); however, HSAG has no documentation of the vendor or of this process being discussed during the HEDIS 2017 audit process.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for KFHC's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
KFHC—Kern County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	66.67%	60.10%	66.91%	64.96%	-1.95
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	93.24%	92.78%	92.64%	89.65%	-2.99^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	84.37%	82.90%	82.43%	80.61%	-1.82^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	81.39%	82.59%	82.70%	81.49%	-1.21^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	80.60%	81.10%	81.16%	80.21%	-0.95^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	21.65%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	66.91%	64.72%	66.67%	67.40%	0.73
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	56.20%	52.80%	57.91%	61.56%	3.65
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	66.18%	67.64%	67.15%	69.83%	2.68
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	50.48%	Not Comparable
<i>Cervical Cancer Screening</i>	59.37%	57.91%	52.07%	58.39%	6.32
<i>Prenatal and Postpartum Care—Postpartum Care</i>	61.07%	60.10%	56.45%	63.50%	7.05^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	81.02%	79.81%	79.08%	75.43%	-3.65
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.95%	88.78%	89.26%	88.40%	-0.86
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.62%	87.85%	88.72%	87.61%	-1.11
<i>Asthma Medication Ratio—Total</i>	--	--	--	48.38%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	75.67% ⁺	65.88%	61.86%	63.87%	2.01

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	45.01%	49.45%	49.82%	48.36%	-1.46
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	44.53%	39.78%	40.88%	51.09%	10.21 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	46.96%	51.64%	47.99%	39.60%	-8.39 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	80.05%	83.03%	84.31%	84.49%	0.18
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.48%	81.57%	90.51% ⁺	88.87%	-1.64
<i>Controlling High Blood Pressure</i>	68.37%	53.53%	50.85%	57.91%	7.06 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	14.94%	17.71%	14.74%	13.76%	-0.98
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	50.26	50.65	48.07	47.03	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	263.68	272.48	256.00	286.04	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	26.35%	21.54%	21.22%	29.47%	8.25 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	9.29%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	75.41%	79.35%	76.04%	66.25%	-9.79^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of KFHC's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

KFHC performed between the MPLs and HPLs for all measures within the Preventive Screening and Children's Health domain in RY 2017, and no significant changes in rates for the measures within this domain occurred between RY 2016 and RY 2017.

Preventive Screening and Women's Health

KFHC performed between the MPLs and HPLs for all measures within the Preventive Screening and Women's Health domain in RY 2017. The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure improved significantly from RY 2016 to RY 2017. The rate for the *Cervical Cancer Screening* measure improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017. KFHC provided information on actions that the MCP took during the review period to address the rate for the *Cervical Cancer Screening* measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the Assessment of Improvement Plans heading in this section of the report, HSAG provides a summary of the PDSA cycles that KFHC implemented during the review period to improve the MCP's performance on this measure. KFHC's efforts may have contributed to the rate for the *Cervical Cancer Screening* measure improving significantly from RY 2016 to RY 2017.

Care for Chronic Conditions

KFHC performed between the MPLs and HPLs for all measures within the Care for Chronic Conditions domain in RY 2017. Three of nine measures (33 percent) within this domain improved significantly from RY 2016 to RY 2017:

- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Controlling High Blood Pressure*

Appropriate Treatment and Utilization

The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved significantly from RY 2016 to RY 2017, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017. KFHC provided information on actions that the MCP took to address the rate for this measure being below the MPL in RY 2016. (See Table 5.1.) Additionally, under the Assessment of Improvement Plans heading in this section of the report, HSAG provides a summary of the PDSA cycles that KFHC implemented during the reporting year to improve the MCP's performance on this measure. Based on NCQA making changes to the specifications for this measure for RY 2017, HSAG is unable to assess whether or not the significant improvement in KFHC's performance on this measure is related to the MCP's quality improvement efforts or the specification changes.

The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017, resulting in the rate moving from above the MPL in RY 2016 to below the MPL in RY 2017. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to KFHC's performance.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, KFHC was required to submit IP/PDSA cycles for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Cervical Cancer Screening* measures. The rates for both measures moved from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

KFHC planned to conduct two PDSA cycles to help improve the MCP's performance related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.

For the first PDSA cycle, the MCP set the following SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective:

By January 31, 2017, 80 beneficiaries ages 18 to 64 who have been diagnosed with acute bronchitis and are assigned to a specific medical group will demonstrate an increase in knowledge in the post-test survey compared to the pre-test baseline knowledge on “Appropriate Antibiotic Use.”

KFHC planned to test whether eligible beneficiaries receiving educational modalities including telephonic health messaging, informational flyers, and magnet paraphernalia on the appropriate use of antibiotics would result in increased beneficiary knowledge of symptom recognition and self-management, and reduce provider visits. The MCP planned to conduct a telephonic eight-item pre-test survey on appropriate antibiotic use prior to the intervention, followed by a telephonic post-test survey two weeks after the intervention to determine knowledge improvement. KFHC was unable to initiate the intervention due to the MCP not receiving the complete educational materials from its vendor in the expected time frame and a delay in receiving internal approval for releasing the educational materials.

For the second PDSA cycle, the MCP set the following SMART objective:

By May 31, 2017, 66 beneficiaries ages 18 to 64 who have been diagnosed with acute bronchitis and are assigned to a specific medical group will demonstrate an increase in knowledge in the post-test survey compared to the pre-test baseline knowledge on “Appropriate Antibiotic Use.”

KFHC tested the intervention originally planned for the first cycle; however, the MCP reduced the number of questions in the pre- and post-test surveys from eight to five. KFHC reported that it met the SMART objective and planned to adopt the intervention. Additionally, the MCP reported the following lessons learned during the PDSA process:

- ◆ Beneficiaries sometimes have chronic respiratory conditions that can complicate the beneficiaries’ recognition of bronchitis symptoms and trigger the beneficiaries to seek further treatment rather than self-managing their bronchitis.
- ◆ Improving the messaging on the magnet may result in increased beneficiary interest in the health information.

The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved to above the MPL in RY 2017. Therefore, KFHC will not be required to continue to conduct IP/PDSA cycles for this measure in RY 2017.

Cervical Cancer Screening

KFHC conducted two PDSA cycles to help improve the MCP’s performance on the *Cervical Cancer Screening* measure.

For both PDSA cycles, KFHC set SMART objectives to increase the *Cervical Cancer Screening* rate across 16 provider office clinics operating under one designated federally qualified health center (FQHC) which provides services to 23 percent of KFHC’s beneficiaries.

For the first PDSA cycle, the MCP tested whether patient navigators conducting telephonic member outreach would increase female beneficiaries' compliance with cervical cancer screening. The MCP promoted competition among the patient navigators by providing incentives for the provider office and patient navigator with the greatest number of completed screenings. KFHC met its SMART objective, which was to increase the cervical cancer screening rate by 2 percentage points at the FQHC, and decided to adopt the intervention. The MCP identified the following lessons learned during the first PDSA cycle:

- ◆ Mailing reminder letters to the women following the telephonic outreach call increased the number of women completing the scheduled cervical cancer screenings.
- ◆ Scheduling preventive health screenings during the office visits allowed the elimination of additional unnecessary and highly unsuccessful contacts.

For the second PDSA cycle, the MCP tested the same telephonic outreach intervention with the addition of the mailed reminder letters following successful contacts with beneficiaries. KFHC met its SMART objective, which was to complete 527 cervical cancer screenings, and determined that the MCP would adopt the intervention. KFHC indicated that the second PDSA cycle did not result in as large an increase in screening as the first PDSA cycle and determined that, as ways of improving performance, the MCP has opportunity to consider modifying the duration of the intervention testing, evaluation periods, and variability of the incentives.

The rate for the *Cervical Cancer Screening* measure improved to above the MPL in RY 2017. Therefore, KFHC will not be required to continue to conduct IP/PDSA cycles for this measure in RY 2017.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, KFHC will be required to submit IP/PDSA cycles for the *Use of Imaging for Low Back Pain* measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for KFHC—Kern County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	22.85%	9.49%	13.36^^	13.76%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	86.90	44.70	Not Tested	47.03
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	547.55	270.75	Not Tested	286.04
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.81%	87.35%	4.46^	88.40%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.03%	86.24%	4.79^	87.61%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	89.36%	89.65%	-0.29	89.65%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.85%	80.55%	3.30	80.61%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.86%	81.35%	4.51^	81.49%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.61%	80.15%	1.46	80.21%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

Table 3.3—Multi-Year SPD Performance Measure Trend Table
KFHC—Kern County

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	18.74%	23.45%	21.04%	22.85%	1.81
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	99.42	97.43	49.74	86.90	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	492.89	488.71	248.86	547.55	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.14%	89.60%	91.03%	91.81%	0.78
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.41%	89.09%	91.40%	91.03%	-0.37
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	92.59%	95.92%	95.56%	89.36%	-6.20
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.46%	85.39%	85.04%	83.85%	-1.19
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	79.50%	81.69%	86.93%	85.86%	-1.07
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	78.43%	79.74%	78.65%	81.61%	2.96

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
KFHC—Kern County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	11.62%	13.32%	10.46%	9.49%	-0.97
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	46.93	47.95	47.96	44.70	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	248.15	259.98	256.47	270.75	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.05%	88.39%	88.57%	87.35%	-1.22
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.03%	87.18%	87.39%	86.24%	-1.15
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	93.25%	92.75%	92.62%	89.65%	-2.97^^
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.37%	82.85%	82.38%	80.55%	-1.83^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	81.42%	82.61%	82.54%	81.35%	-1.19^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	80.64%	81.14%	81.29%	80.15%	-1.14^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that KFHC stratified by the SPD and non-SPD populations:

- ◆ The RY 2017 SPD rate was significantly better than the RY 2017 non-SPD rate for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- ◆ No statistically significant changes occurred for any SPD rates between RY 2016 and RY 2017.
- ◆ The RY 2017 SPD rate was significantly worse than the RY 2016 non-SPD rate for the *All-Cause Readmissions* measure. 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 beneficiaries.
- ◆ The RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures.

Strengths—Performance Measures

HSAG auditors determined that KFHC followed the appropriate specifications to produce valid rates. Across all domains, the rates for two measures moved from below the MPLs in RY 2016 to above the MPLs in RY 2017 and the rates for five measures improved significantly from RY 2016 to RY 2017.

Opportunities for Improvement—Performance Measures

KFHC has the opportunity to identify ways to expand its use of EMR data and investigate use of the PM 160 claim form for future HEDIS reporting until DHCS phases out the form. Additionally, KFHC has the opportunity to identify the causes for the MCP's performance being below the MPL in RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

KFHC had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

KFHC selected immunizations of two-year-olds as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to KFHC regarding the MCP's progress on intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

KFHC set the SMART Aim for the *Immunizations of Two-Year-Olds* PIP as follows:

By June 30, 2017, KFHC will increase the 12-month rolling average for Provider A's⁶ practice by 5 percentage points when compared to the June 2015 12-month rolling average rate of 21.23 percent (21.23 percent to 26.23 percent).

Failure Modes

The following, listed in priority order, are the failure modes KFHC identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary only goes in to the provider's office when ill.
- ◆ Parent/guardian forgets the yellow card.
- ◆ Provider unwilling to give immunizations during sick-child visits.
- ◆ Parent/guardian does not understand importance of immunizations and/or refuses immunizations for the beneficiary.

⁶ Provider name removed for confidentiality.

Intervention Testing

During the reporting period, KFHC selected to test using Modifier 25 to capture immunizations given during appropriate sick-child visits. This intervention addresses providers' lack of considering immunizations during sick-child visits.

Although KFHC completed intervention testing through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in KFHC's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

KFHC selected medication management for beneficiaries with asthma as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for KFHC's MCP-specific PIP.

Upon initial review of the module, HSAG determined that KFHC met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including team members responsible for completing the process mapping and the failure mode and effects analysis (FMEA).
- ◆ Including a narrative description of the method used to select the sub-processes.
- ◆ Supporting the sub-processes selection with the MCP's data and/or experiences.
- ◆ Including all required components of the FMEA.
- ◆ Describing the priority-ranking process to determine potential interventions.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, KFHC incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to KFHC on the Plan portion of the PDSA cycle for the interventions that the MCP selected to test. HSAG sent periodic check-in email communications to KFHC and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

KFHC set the SMART Aim for the *Medication Management for People With Asthma* PIP as follows:

By June 30, 2017, KFHC will increase the 12-month rolling average of Provider Group A⁷ beneficiaries living with asthma receiving 75 percent of their maintenance medications by 15 percent compared to the June 30, 2015, baseline of 16.11 percent. The numeric goal is 18.53 percent.

Failure Modes

The following, listed in priority order, are the failure modes that KFHC identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not understand the importance of asthma education and the role of medication.
- ◆ Provider does not provide to the beneficiary adequate information about asthma.
- ◆ Beneficiary does not consistently refill medication.
- ◆ Beneficiary does not keep appointments with the provider.
- ◆ Beneficiary does not correctly use aero chamber or nebulizer.
- ◆ Beneficiary uses, for asthma exacerbations, the emergency room in place of regular provider visits and/or medications.
- ◆ Beneficiary chooses to only fill as-needed inhaler.
- ◆ Provider writes script for as-needed inhaler only.
- ◆ Provider does not update beneficiary's need for medication refills during visit.
- ◆ Beneficiary under- or overuses inhalers.

Intervention Testing

During the reporting period, KFHC selected to test compliance with asthma controller medication through the patient education component of the Asthma Action Plan. This intervention addressed providers' lack of patient education on asthma management and the importance of taking daily asthma controller medication. However, during the first three months of testing, KFHC assessed that only 4 percent of beneficiaries successfully received the intervention as intended. Therefore, the MCP decided to abandon the intervention due to its ineffectiveness.

For the second intervention, KFHC selected to test increasing referrals to the MCP's Health Education Department's asthma management classes by offering incentives to qualified beneficiaries. This intervention addresses providers' inability to inform patients about acute asthma management and the importance of daily maintenance medication due to limited time spent with patients during office visits.

⁷ Provider group name removed for confidentiality.

Although KFHC completed intervention testing through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in KFHC's 2017–18 MCP-specific evaluation report.

Strengths

Through HSAG's PIP validation and technical assistance, KFHC improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from KFHC’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of KFHC’s self-reported actions.

Table 5.1—KFHC’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Once the MCP’s new provider portal has been completed, move forward with implementing the electronic PM 160 claim form submission process to ensure that KFHC is experiencing no gaps in data that may impact the rates for children’s wellness-related measures.	Pended. The provider portal is not complete, so KFHC is unable to go forward until the go-live date, tentatively near the end of fourth quarter 2017. In the meantime, KFHC has contracted with a vendor to electronically enter the data from PM 160 claim forms received from providers.
2. To improve performance and to prevent further decline in performance, identify the causes for poor or declining performance for the following measures: <ul style="list-style-type: none"> a. <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)</i> b. <i>Cervical Cancer Screening (CCS)</i> c. <i>Use of Imaging Studies for Low Back Pain (LBP)</i> 	<p>AAB Data analysis showed that most prescriptions were from urgent care centers. KFHC developed an intervention to provide AAB posters for use in contracted urgent care centers, for the reception areas and patient rooms. Ongoing data analysis shows an 8 percentage point increase for HEDIS 2017 over HEDIS 2016.</p> <p>CCS Data analysis identified the cause of declining performance related to poor performance of a high-volume provider. Partnership with this large clinic was very successful, and the methodology will be spread to others. HEDIS 2017 CCS rates improved 5 percentage points over 2016.</p> <p>LBP Data analysis showed software vendor coding change related to anchor date, using non-clinical vendor’s diagnosis not validated by emergency room (ER) physician or midlevel provider. Performance continued to decline during 2017. This will be a PIP topic.</p>

2015–16 External Quality Review Recommendations Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
3. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Immunizations of Two-Year-Olds</i> PIP.	Completed. Per instructions from HSAG, failure modes were identified, along with the failure causes and effects of this intervention. We also updated Module 3 to include the intervention in the intervention determination table. Follow-through was added to the Plan’s intervention methodology.

2016–17 Recommendations

Based on the overall assessment of KFHC’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:

- ◆ Identify opportunities to expand use of EMR data for future HEDIS reporting.
- ◆ Investigate use of the PM 160 claim form, until DHCS phases out the form, to determine if data from the report would be beneficial for HEDIS reporting.
- ◆ Identify the causes for the MCP’s performance below the MPL in RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure. Identifying the causes will help KFHC to develop strategies, as applicable, to address the MCP’s performance being below the MPL for this measure.

In the next annual review, HSAG will evaluate continued successes of KFHC 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, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento counties (commonly known as “Kaiser Permanente North” and referred to in this report as “Kaiser NorCal” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Kaiser NorCal’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Kaiser NorCal is a full-scope MCP delivering services to beneficiaries under two health care models. In Sacramento County, Kaiser NorCal serves beneficiaries 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 Kaiser NorCal, Sacramento County’s beneficiaries may select from the following MCPs:

- ◆ Anthem Blue Cross Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Molina Healthcare of California Partner Plan, Inc.

In Amador, El Dorado, and Placer counties, Kaiser NorCal delivers services to its beneficiaries under the Regional Model. In all three counties, beneficiaries may enroll in Kaiser NorCal or in 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 to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013. As of June 30, 2017, Kaiser NorCal had 84,345 beneficiaries in Sacramento County, 85 in Amador County, 1,844 in El Dorado County, and 6,501 in Placer County.¹ This represents 19 percent of the beneficiaries enrolled in Sacramento County, 1 percent in Amador County, 6 percent in El Dorado County, and 14 percent in Placer County.

DHCS allows Kaiser NorCal to combine the data from Sacramento, Amador, El Dorado, and Placer counties for reporting purposes. For this report, these four counties are considered a single reporting unit (KP North).

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Aug 23, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Kaiser NorCal. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Kaiser NorCal. A&I conducted the on-site audits from September 26, 2016, through October 7, 2016.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Kaiser NorCal
Audit Review Period: September 1, 2015, through August 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	No	Not applicable.
Case Management and Coordination of Care	Yes	CAP in process and under review by DHCS.
Access and Availability of Care	Yes	CAP in process and under review by DHCS.
Member’s Rights	Yes	CAP in process and under review by DHCS.
Quality Management	Yes	CAP in process and under review by DHCS.
Administrative and Organizational Capacity	Yes	CAP in process and under review by DHCS.
State Supported Services	Yes	CAP in process and under review by DHCS.

Follow-Up on 2015 Seniors and Persons with Disabilities Medical Survey

The Department of Managed Health Care (DMHC) conducted a Seniors and Persons with Disabilities (SPD) Medical Survey of Kaiser NorCal from September 28, 2015, through October 2, 2015, covering the review period of September 1, 2014, through August 31, 2015. HSAG provided a summary of the survey results and status in Kaiser NorCal’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, Kaiser NorCal’s CAP was in process and under review by DHCS. A letter from DHCS dated January 12, 2017, stated that Kaiser NorCal provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Utilization Management category during the September 26, 2016, through October 7, 2016, Medical Audit of Kaiser NorCal. Additionally, Kaiser NorCal fully resolved all outstanding deficiencies from the September 28, 2015, through October 2, 2015, DMHC SPD Medical Survey.

Opportunities for Improvement—Compliance Reviews

Kaiser NorCal has the opportunity to work with DHCS to ensure that the MCP resolves all deficiencies from the September 26, 2016, through October 7, 2016, A&I Medical and State Supported Services Audits. The deficiencies cut across the areas of quality and timeliness of, and access to health care.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS*^{®2} 2017 Compliance Audit Final Report of Findings for Kaiser NorCal contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance AuditTM.³ HSAG auditors determined that Kaiser NorCal followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for Kaiser NorCal's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	82.96% ⁺	76.85%	79.35%	2.50
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	98.81% ⁺	98.66% ⁺	98.49% ⁺	-0.17
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	89.84%	90.60%	90.00%	-0.60
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	89.49%	91.71%	90.75%	-0.96^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	90.81%	93.15%	92.99%	-0.16
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	33.90%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	93.57% ⁺	91.64% ⁺	92.52% ⁺	0.88 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	93.52% ⁺	91.54% ⁺	92.63% ⁺	1.09 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	81.15%	81.02%	81.65%	0.63
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	80.13% ⁺	Not Comparable
<i>Cervical Cancer Screening</i>	--	79.66% ⁺	84.93% ⁺	86.30% ⁺	1.37 [^]
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	73.95%	75.67% ⁺	73.28%	-2.39
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	93.28% ⁺	93.10% ⁺	92.89% ⁺	-0.21
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	95.38% ⁺	92.74% ⁺	92.73% ⁺	-0.01
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	93.78% ⁺	90.98%	91.40%	0.42
<i>Asthma Medication Ratio—Total</i>	--	--	--	84.84% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	83.19% ⁺	79.14% ⁺	77.64% ⁺	-1.50

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	64.13%	68.11% ⁺	73.08% ⁺	4.97 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	57.87%	61.39% ⁺	62.98% ⁺	1.59
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	27.96% ⁺	27.15% ⁺	24.54% ⁺	-2.61 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	94.97% ⁺	93.18% ⁺	94.71% ⁺	1.53 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	92.96% ⁺	89.85% ⁺	88.84%	-1.01
<i>Controlling High Blood Pressure</i>	--	84.00% ⁺	83.75% ⁺	84.17% ⁺	0.42
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	14.84%	14.08%	14.82%	0.74
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	49.65	47.19	44.67	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	447.02	426.09	434.33	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	42.86% ⁺	37.81%	33.33%	-4.48
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	55.81%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	100.00%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	88.07% ⁺	85.82% ⁺	82.35% ⁺	-3.47 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Kaiser NorCal’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures improved significantly from RY 2016 to RY 2017 and remained above the HPLs for the third consecutive year. These measures report documentation of counseling for nutrition and counseling for physical activity during outpatient visits with beneficiaries ages 3 to 17. Kaiser NorCal had no measures within the Preventive Screening and Children’s Health domain with rates below the MPLs in RY 2017.

Preventive Screening and Women’s Health

The rate for the *Cervical Cancer Screening* measure improved significantly and remained above the HPL for the third consecutive year. Additionally, the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure remained above the HPL for the third consecutive year. The MCP had no measures within the Preventive Screening and Women’s Health domain with rates below the MPLs in RY 2017.

Performance measure results show that Kaiser NorCal continues to exceed DHCS’s HPLs for ensuring that female beneficiaries:

- ◆ Ages 21 to 64 are screened for cervical cancer within the appropriate time frames.

- ◆ Who deliver a live birth received a prenatal care visit in the first trimester or within 42 days of enrollment in Kaiser NorCal.

Care for Chronic Conditions

In RY 2017, Kaiser NorCal performed above the HPLs for seven of nine measures (78 percent) within the Care for Chronic Conditions domain and had no rates within this domain below the MPLs. The MCP performed above the HPLs for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for the third consecutive year
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for the third consecutive year
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal Performed)* (Note that the rate for this measure improved significantly from RY 2016 to RY 2017.)
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* for the third consecutive year (Note that the MCP's performance improved significantly for this measure from RY 2016 to RY 2017.)
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* for the third consecutive year (Note that the rate for this measure improved significantly from RY 2016 to RY 2017.)
- ◆ *Controlling High Blood Pressure* for the third consecutive year

Appropriate Treatment and Utilization

In RY 2017, the MCP had no rates within the Appropriate Treatment and Utilization domain below the MPLs. The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017; however, the rate remained above the HPL for the third consecutive year.

Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to Kaiser NorCal's performance.

Assessment of Improvement Plans

Kaiser NorCal was not required to submit any improvement plans in RY 2016. Based on RY 2017 results, the MCP is not required to submit any improvement plans for RY 2017.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	19.27%	10.28%	8.99^^	14.82%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.15	41.20	Not Tested	44.67
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	885.37	381.15	Not Tested	434.33
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	95.41%	90.46%	4.95^	92.73%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	94.79%	88.80%	5.99^	91.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	98.48%	Not Comparable	98.49%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	100.00%	89.73%	10.27^	90.00%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	100.00%	90.37%	9.63^	90.75%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	100.00%	92.68%	7.32^	92.99%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	15.01%	16.18%	19.27%	3.09
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	87.64	78.94	74.15	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	899.26	848.88	885.37	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	96.81%	95.70%	95.41%	-0.29
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	95.86%	94.12%	94.79%	0.67
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	94.78%	100.00%	100.00%	0.00
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	96.67%	100.00%	100.00%	0.00
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	94.39%	100.00%	100.00%	0.00

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	14.47%	11.45%	10.28%	-1.17
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	44.28	43.34	41.20	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	383.06	374.84	381.15	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	93.34%	90.21%	90.46%	0.25
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	91.06%	88.44%	88.80%	0.36
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	98.80%	98.65%	98.48%	-0.17
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	89.69%	90.36%	89.73%	-0.63
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	89.15%	91.40%	90.37%	-1.03^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	90.57%	92.83%	92.68%	-0.15

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in RY 2017 for measures that Kaiser NorCal stratified by the SPD and non-SPD populations:

- ◆ For SPD rates for which a comparison could be made between RY 2016 and RY 2017, no statistically significant changes occurred for any SPD rates between RY 2016 and RY 2017.
- ◆ For non-SPD rates for which a comparison could be made between RY 2016 and RY 2017, only one measure showed statistically significant variation—The RY 2017 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* measure was significantly worse than the RY 2016 non-SPD rate.
- ◆ For measures for which a comparison could be made between the RY 2017 SPD rates and RY 2017 non-SPD rates, the RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years*
- ◆ The RY 2017 SPD rate was significantly worse than the RY 2017 non-SPD rate for the *All-Cause Readmissions* measure; however, a higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

HSAG auditors determined that Kaiser NorCal followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all measure domains, Kaiser NorCal performed above the HPLs for 12 of 18 measures (67 percent) and the MCP had no measures with rates below the MPLs.

Opportunities for Improvement—Performance Measures

Based on RY 2017 performance measure results, HSAG has no recommendations for Kaiser NorCal in the area of performance measures.

4. Performance Improvement Projects

Kaiser NorCal had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

Kaiser NorCal selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to Kaiser NorCal and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

Kaiser NorCal set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, increase the rate from 79.2 percent to 84.2 percent for postpartum visits among Medi-Cal beneficiaries who have delivered a baby at Kaiser Permanente Center A.⁶

Failure Modes

The following, listed in priority order, are the failure modes Kaiser NorCal identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not attend the postpartum visit appointment because she does not see value in the appointment.
- ◆ Obstetrician fails to inform the beneficiary of the value of the postpartum visit prior to discharge.
- ◆ No reminder sent to the beneficiary regarding the postpartum visit.
- ◆ Beneficiary delivers early or late, and postpartum visit appointment falls outside of the 21 to 56 days' post-delivery time period.

⁶ Center name removed for confidentiality.

- ◆ Beneficiary does not show for the 36th through 38th week prenatal visit.
- ◆ Administrator forgets to book the postpartum appointment during 36th through 38th week prenatal visit.
- ◆ Administrator books the appointment with the wrong provider or the wrong location, leading to beneficiary no-shows.
- ◆ Postpartum visit appointment made but not communicated to the beneficiary.

Intervention Testing

During the reporting period, Kaiser NorCal selected to test the following:

- ◆ Enrolling beneficiaries in the California Black Infant Health Program, which addresses the key driver of beneficiary engagement through community programs.
- ◆ Texting beneficiaries to improve the postpartum visit show rate, which addresses the key driver of beneficiary engagement.
- ◆ Providing free transportation to beneficiaries who indicate needing rides to their postpartum visits. This intervention addresses beneficiary engagement and utilization of the multidisciplinary case management team to address non-medical needs.

Although Kaiser NorCal completed intervention testing through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Kaiser NorCal's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

Kaiser NorCal selected initial health assessment completion for adults as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for Kaiser NorCal's MCP-specific PIP.

Upon initial review of the module, HSAG determined that Kaiser NorCal met some required validation criteria; however, HSAG identified opportunities for improvement related to describing the priority-ranking process to determine potential interventions.

After receiving technical assistance from HSAG, Kaiser NorCal incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to Kaiser NorCal on the Plan portion of the PDSA cycle for the interventions that the MCP selected to test. HSAG sent periodic check-in email communications to Kaiser NorCal to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Kaiser NorCal set the SMART Aim for the *Initial Health Assessment Completion for Adults* PIP as follows:

By June 30, 2017, increase the initial health assessment completion rate (physical exam and health questionnaire) from 19.30 percent to 24.30 percent for new adult beneficiaries with Kaiser Permanente Center B.⁷

Failure Modes

The following, listed in priority order, are the failure modes that Kaiser NorCal identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not show up for the initial health assessment physical exam.
- ◆ Beneficiary refuses to complete the health questionnaire and attend the scheduled appointment.
- ◆ Provider does not code the clinic visit booked by a beneficiary outreach specialist as a routine physical exam.
- ◆ Provider cannot easily locate the health questionnaire in the electronic health record system.
- ◆ Provider is not familiar with Medi-Cal initial health assessment requirements.
- ◆ Provider does not answer and/or return beneficiary outreach specialist's outreach phone call.

Intervention Testing

During the reporting period, Kaiser NorCal selected to test the following:

- ◆ Conducting for customer service staff telephone skills training, which addresses the key driver of beneficiary engagement.
- ◆ Developing and disseminating initial health assessment job aid for adult and family medicine providers, which addresses the key driver of provider education awareness and the failure mode of using correct coding for initial health assessments.
- ◆ Making appointment reminder calls to beneficiaries at high risk for missing their initial health assessment physical exams, which addresses the key driver of beneficiary engagement.

Although Kaiser NorCal completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Kaiser NorCal's 2017–18 MCP-specific evaluation report.

⁷ Center name removed for confidentiality.

Strengths

Through HSAG's PIP validation and technical assistance, Kaiser NorCal improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Kaiser NorCal’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Kaiser NorCal’s self-reported actions.

Table 5.1—Kaiser NorCal’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure resolution of all deficiencies from the September 28, 2015, through October 2, 2015, DMHC SPD Medical Survey.	Kaiser NorCal provided DHCS with a final response on all open DMHC SPD CAPs on December 19, 2016. All CAP responses were reviewed by DHCS and found Kaiser NorCal in compliance. DHCS closed Kaiser NorCal’s DMHC SPD CAPs on January 12, 2017.
2. To prevent further decline in performance, identify the causes for the rate declining significantly from RY 2015 to RY 2016 for the <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> measure.	HSAG originally recommended that Kaiser NorCal had an opportunity to determine the cause for the rate decrease in the <i>Annual Monitoring for Patients on Persistent Medications — Diuretics</i> measure to avoid further decline. The rate dropped from 93.78 percent in RY 2015 to 90.98 percent in RY 2016. The rate was still above the MPL so no PDSA was required. The RY 2016 rate was between the 75th percentile and the 90th percentile (very close to the 90th). For RY 2017, rates for this measure went up to 91.4 percent, demonstrating an improvement.
3. To prevent further decline in the rate for the <i>Childhood Immunization Status—Combination 3</i> measure, assess if changes are needed in the MCP’s improvement efforts for childhood immunizations.	For RY 2017, the <i>Childhood Immunization Status—Combination 3</i> measure rate rose to 79.4 percent, demonstrating an improvement over the RY 2016 rate of 76.9 percent. Technological and workflow improvements were put in place that contributed to the improvement in this measure. Those included but were not limited to: <ul style="list-style-type: none"> ◆ Black Box—a web-based program that helps with outreach and inreach for each patient on every primary care provider panel (the program uses real-time data that can be acted upon when the patient is in the office or for follow-up phone calls).

2015–16 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<ul style="list-style-type: none"> ◆ Physician immunization champions took on larger roles to ensure that real-time data and lists were addressed by colleagues. Additionally, patient care teams (where there is a consistent pairing of medical assistants and medical doctors) also took accountability for working lists and physician patient panels to address patient needs.
<p>4. Incorporate HSAG’s initial feedback on Plan portion of Module 4s prior to testing interventions for the <i>Postpartum Care</i> PIP.</p>	<p>Kaiser NorCal staff have met with HSAG technical assistance advisors and have incorporated HSAG feedback into Module 4s. The final PIP modules on postpartum care was submitted to DHCS and HSAG on August 15, 2017.</p>

2016–17 Recommendations

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

- ◆ Ensure resolution of all deficiencies from the September 26, 2016, through October 7, 2016, A&I Medical and State Supported Services Audits.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix T:
Performance Evaluation Report
Kaiser SoCal
(KP Cal, LLC, in San Diego County)
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), KP Cal, LLC, in San Diego County (commonly known as “Kaiser Permanente South” and referred to in this report as “Kaiser SoCal” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Kaiser SoCal’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Kaiser SoCal is a full-scope MCP delivering services to beneficiaries 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 Kaiser SoCal, San Diego County’s beneficiaries may select from the following MCPs:

- ◆ Care1st Partner Plan
- ◆ Community Health Group Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Molina Healthcare of California Partner Plan, Inc.

Kaiser SoCal became operational in San Diego County to provide MCMC services effective January 1998. As of June 30, 2017, Kaiser SoCal had 52,333 beneficiaries.¹ This represents 7 percent of the beneficiaries enrolled in San Diego County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Aug 25, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Kaiser SoCal. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Kaiser SoCal. A&I conducted the on-site audits from September 26, 2016, through October 7, 2016.

**Table 2.1—DHCS A&I Medical and State Supported Services Audits of Kaiser SoCal
 Audit Review Period: September 1, 2015, through August 31, 2016**

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

Follow-Up on 2015 Seniors and Persons with Disabilities Medical Survey

The Department of Managed Health Care (DMHC) conducted a Seniors and Persons with Disabilities (SPD) Medical Survey of Kaiser SoCal from September 28, 2015, through October 2, 2015, covering the review period of September 1, 2014, through August 31, 2015. HSAG provided a summary of the survey results and status in Kaiser SoCal’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, Kaiser SoCal’s CAP was in process and under review by DHCS. A letter from DHCS dated January 12, 2017, stated that Kaiser SoCal provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

Kaiser SoCal fully resolved all outstanding deficiencies from the September 28, 2015, through October 2, 2015, DMHC SPD Medical Survey.

Opportunities for Improvement—Compliance Reviews

Kaiser SoCal has the opportunity to work with DHCS to ensure that the MCP resolves all deficiencies from the September 26, 2016, through October 7, 2016, A&I Medical and State Supported Services Audits. The deficiencies cut across the areas of quality and timeliness of, and access to health care.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Kaiser SoCal* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that Kaiser SoCal followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for Kaiser SoCal's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Kaiser SoCal—San Diego County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	88.11% ⁺	86.75% ⁺	81.58% ⁺	81.57% ⁺	-0.01
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	99.51% ⁺	97.84%	98.25% ⁺	98.29% ⁺	0.04
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	93.60% ⁺	95.61% ⁺	93.77% ⁺	91.55%	-2.22 ^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	89.97%	93.09%	94.28%	93.77%	-0.51
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	88.17%	93.00%	94.44%	94.33%	-0.11
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	34.06%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	87.79% ⁺	96.16% ⁺	95.71% ⁺	94.73% ⁺	-0.98 ^{^^}
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	91.18% ⁺	97.51% ⁺	97.16% ⁺	96.11% ⁺	-1.05 ^{^^}
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	73.70%	83.94% ⁺	78.87%	71.68%	-7.19 ^{^^}
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	84.58% ⁺	Not Comparable
<i>Cervical Cancer Screening</i>	87.21% ⁺	85.86% ⁺	83.78% ⁺	83.35% ⁺	-0.43
<i>Prenatal and Postpartum Care—Postpartum Care</i>	69.86%	79.31% ⁺	77.42% ⁺	79.74% ⁺	2.32
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	91.39%	93.10% ⁺	91.94% ⁺	93.10% ⁺	1.16
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	93.76% ⁺	93.73% ⁺	91.49%	94.06% ⁺	2.57 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	93.57% ⁺	93.62% ⁺	90.73%	93.65% ⁺	2.92 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	87.76% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	88.86% ⁺	86.34% ⁺	84.49% ⁺	82.82% ⁺	-1.67

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	81.71% ⁺	85.70% ⁺	84.56% ⁺	85.69% ⁺	1.13
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	69.19% ⁺	65.85% ⁺	67.21% ⁺	65.54% ⁺	-1.67
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	17.88% ⁺	21.04% ⁺	19.85% ⁺	20.49% ⁺	0.64
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	96.56% ⁺	95.72% ⁺	95.55% ⁺	95.36% ⁺	-0.19
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	94.91% ⁺	92.71% ⁺	95.33% ⁺	94.91% ⁺	-0.42
<i>Controlling High Blood Pressure</i>	86.37% ⁺	87.59% ⁺	86.62% ⁺	88.56% ⁺	1.94
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	11.42%	16.14%	15.03%	15.52%	0.49
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	30.39	33.00	32.50	28.81	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	406.16	469.28	490.40	489.16	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	NA	NA	51.67% ⁺	65.15% ⁺	13.48
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	3.25%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	100.00%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	88.00% ⁺	89.89% ⁺	84.88% ⁺	82.38% ⁺	-2.50

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Kaiser SoCal’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

In RY 2017, Kaiser SoCal performed above the HPLs for three of four measures (75 percent) within the Preventive Screening and Children’s Health domain for all RYs displayed in Table 3.1 The MCP had no measures within this domain with rates below the MPLs in RY 2017. The rates for the following measure were above the HPLs:

- ◆ *Childhood Immunization Status—Combination 3*, which reports the percentage of beneficiaries who receive their specified immunization dosages by age 2.
- ◆ Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, which report on the documentation by providers of counseling for nutrition and counseling for physical activity during outpatient visits with beneficiaries 3 to 17 years of age.
 - Note that while the rates for both of these measures were above the HPLs in RY 2017, the rates declined significantly from RY 2016 to RY 2017.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure declined significantly from RY 2016 to RY 2017. Kaiser SoCal indicated that during the review period for this report the Kaiser SoCal physician offices conducted monthly outreach to address the rate for this measure declining significantly from RY 2015 to RY 2016. (See Table 5.1.) Kaiser SoCal also noted in

Table 5.1 that the MCP is planning to conduct focused outreach to beneficiaries ages 3 to 6 in September, October, and November 2017 to address the MCP's continued declining performance on this measure.

Preventive Screening and Women's Health

In RY 2017, Kaiser SoCal performed above the HPLs for all three measures within the Preventive Screening and Women's Health domain, with the rates for all three measures being above the HPLs for at least three consecutive years. Performance measure results show that the MCP consistently exceeded DHCS' HPLs for ensuring that female beneficiaries:

- ◆ Ages 21 to 64 are screened for cervical cancer within the appropriate time frames.
- ◆ Who deliver a live birth receive a prenatal care visit in the first trimester or within 42 days of enrollment in Kaiser SoCal.
- ◆ Who deliver a live birth complete a postpartum visit on or between 21 and 56 days after delivery.

Care for Chronic Conditions

In RY 2017, Kaiser SoCal performed above the HPLs for all nine measures within the Care for Chronic Conditions domain, with the rates for seven of nine measures (78 percent) being above the HPLs for all RYs in Table 3.1. The rates for both *Annual Monitoring for Patients on Persistent Medications* measures improved significantly from RY 2016 to RY 2017, resulting in the rates for both measures moving to above the HPLs in RY 2017. Performance measure results show that Kaiser SoCal consistently exceeded DHCS' HPLs for measures within the Care for Chronic Conditions domain.

Appropriate Treatment and Utilization

Kaiser SoCal performed above the HPLs for both measures within the Appropriate Treatment and Utilization domain, with the rate for the *Use of Imaging Studies for Low Back Pain* measure being above the HPL for all RYs in Table 3.1. Performance measure results show that Kaiser SoCal consistently exceeded DHCS' HPLs for ensuring:

- ◆ The appropriate use of antibiotics for beneficiaries ages 18 to 64 with a primary diagnosis of acute bronchitis.
- ◆ That only beneficiaries with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Improvement Plans

Kaiser SoCal was not required to submit any improvement plans in RY 2016. Based on RY 2017 results, the MCP is not required to submit any improvement plans for RY 2017.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Kaiser SoCal—San Diego County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.76%	13.64%	3.12	15.52%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	51.57	25.02	Not Tested	28.81
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	951.91	412.14	Not Tested	489.16
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	94.42%	94.04%	0.38	94.06%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	97.01%	93.39%	3.62	93.65%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	98.28%	Not Comparable	98.29%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	100.00%	91.40%	8.60 [^]	91.55%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	100.00%	93.59%	6.41 [^]	93.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	100.00%	94.18%	5.82 [^]	94.33%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
Kaiser SoCal—San Diego County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	11.41%	19.04%	15.93%	16.76%	0.83
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	59.41	61.23	59.03	51.57	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	890.21	972.64	1,010.07	951.91	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	96.68%	95.32%	93.45%	94.42%	0.97
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	96.13%	95.71%	94.77%	97.01%	2.24
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	98.80%	98.89%	100.00%	100.00%	0.00
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	99.08%	95.28%	100.00%	100.00%	0.00
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	96.32%	96.34%	100.00%	100.00%	0.00

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
Kaiser SoCal—San Diego County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	11.46%	9.91%	13.16%	13.64%	0.48
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	26.61	29.60	27.81	25.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	343.04	408.75	398.43	412.14	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.99%	91.89%	91.14%	94.04%	2.90 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.03%	91.36%	89.98%	93.39%	3.41 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	99.50%	97.83%	98.24%	98.28%	0.04
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	93.49%	95.54%	93.66%	91.40%	-2.26 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.42%	93.01%	94.11%	93.59%	-0.52
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.65%	92.89%	94.29%	94.18%	-0.11

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in RY 2017 for measures that Kaiser SoCal stratified by the SPD and non-SPD populations:

- ◆ For the three *Children and Adolescents' Access to Primary Care Practitioners* measures for which comparisons could be made between the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the *25 Months–6 Years*, *7–11 Years*, and *12–19 Years* measures.

- ◆ For SPD rates for which a comparison could be made between RY 2016 and RY 2017, no statistically significant changes occurred for any SPD rates between RY 2016 and RY 2017.
- ◆ The RY 2017 non-SPD rate was significantly better than the RY 2016 non-SPD rate for both *Annual Monitoring for Patients on Persistent Medications* measures.
- ◆ The RY 2017 non-SPD rate was significantly worse than the RY 2016 non-SPD rate for the *Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years* measure.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to Kaiser SoCal’s participation in California’s Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Kaiser SoCal report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.5 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.5—Multi-Year MLTSSP Performance Measure Results
Kaiser SoCal—San Diego County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	50.03	42.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	731.40	699.80	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	89.58%	93.71%	4.13

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member’s “contribution” to the total yearly membership.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from RY 2016 to RY 2017.

Strengths—Performance Measures

HSAG auditors determined that Kaiser SoCal followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all measure domains, Kaiser SoCal performed above the HPLs for 17 of 18 measures (94 percent) and the MCP had no measures with rates below the MPLs.

Opportunities for Improvement—Performance Measures

Kaiser SoCal has the opportunity to assess whether or not the MCP's outreach efforts are resulting in an increased percentage of beneficiaries ages 3 to 6 being seen for one or more well-child visit(s) with a primary care provider (PCP). If the outreach efforts do not result in improvement, Kaiser SoCal has the opportunity to identify the causes and develop new strategies to ensure that beneficiaries ages 3 to 6 are seen for well-child visits.

4. Performance Improvement Projects

Kaiser SoCal had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

Kaiser SoCal selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to Kaiser SoCal to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

Kaiser SoCal set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, increase the Kaiser Permanente Center A⁶ beneficiaries' disease management control rate (for all ages), evidenced by hemoglobin A1c (HbA1c) less than 8.0 percent from 70.6 percent (January–December 2015) to 72.8 percent.

Failure Modes

The following, listed in priority order, are the failure modes Kaiser SoCal identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not want to follow the plan of care.
- ◆ Varied results and outcomes by diabetes care managers.
- ◆ Beneficiary does not accept the diabetes diagnosis or medication.
- ◆ MCP is unable to contact the beneficiary.
- ◆ Beneficiary is out of the service area.

⁶ Center name removed for confidentiality.

Intervention Testing

During the reporting period, Kaiser SoCal selected to test the standardization of diabetes care managers' work flows to address the varied results and outcomes of diabetes care managers.

Although Kaiser SoCal completed intervention testing through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Kaiser SoCal's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

Kaiser SoCal selected initial health assessment within 120-days of enrollment as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for Kaiser SoCal's MCP-specific PIP.

Upon initial review of the module, HSAG determined that Kaiser SoCal met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map
- ◆ Including team members responsible for completing the process mapping and the failure modes and effects analysis (FMEA)
- ◆ Including a narrative description of the method used to select the sub-processes
- ◆ Supporting the sub-processes selection with the MCP's data and/or experiences
- ◆ Including all required components of the FMEA
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim

After receiving technical assistance from HSAG, Kaiser SoCal incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to Kaiser SoCal on the Plan portion of the PDSA cycle for the interventions that the MCP selected to test. HSAG sent periodic check-in email communications to Kaiser SoCal to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Kaiser SoCal set the SMART Aim for the *Initial Health Assessment Within 120-days of Enrollment* PIP as follows:

By June 30, 2017, increase the completion rate of initial health assessments within 120-days of enrollment among all Kaiser SoCal beneficiaries, from 23 percent to 53 percent.

Failure Modes

The following, listed in priority order, are the failure modes that Kaiser SoCal identified during the Intervention Determination phase of the PIP process:

- ◆ Outreach efforts are not captured in electronic medical record system.
- ◆ Children ages 0 to 18 months are not identified for priority outreach.
- ◆ Beneficiary is not contacted timely to complete the initial health assessment.
- ◆ MCP does not have standardized adult visit codes.
- ◆ MCP is unable to contact the beneficiary.
- ◆ Beneficiary refuses to complete the initial health assessment.
- ◆ Beneficiary does not show up to complete the initial health assessment.

Intervention Testing

During the reporting period, Kaiser SoCal selected to test the following to address call center staff workflows:

- ◆ Documenting telephonic outreach efforts in electronic medical record system
- ◆ Assigning a staff member to conduct outreach specifically to children ages 0 to 2 years
- ◆ Making a first call attempt for the initial health assessment at the same time as assigning the beneficiary's primary care provider

Although Kaiser SoCal completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Kaiser SoCal's 2017–18 MCP-specific evaluation report.

Strengths

Through HSAG's PIP validation and technical assistance, Kaiser SoCal improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Kaiser SoCal’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Kaiser SoCal’s self-reported actions.

Table 5.1—Kaiser SoCal’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure resolution of all deficiencies from the September 28, 2015, through October 2, 2015, DMHC SPD Medical Survey.	On January 12, 2017, Kaiser SoCal received a letter from DHCS that stated: <ul style="list-style-type: none"> ◆ DMHC conducted an on-site SPD Medical Survey of the MCP from September 28, 2015, through October 2, 2015. The survey covered the period of September 1, 2014, through August 31, 2015. ◆ On December 19, 2016, the MCP provided DHCS with additional information regarding its CAP in response to the report originally issued on July 20, 2016. ◆ All items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS’ final response to the MCP’s CAP.
2. To prevent further decline in performance, identify the causes for the rates declining significantly from RY 2015 to RY 2016 for the following measures: <ol style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors and ARBs</i> b. <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> c. <i>Immunizations for Adolescents—Combination 1</i> 	<ol style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors and ARBs</i> b. <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> <ul style="list-style-type: none"> ◆ Kaiser SoCal physician offices conduct outreach to patients when refilling medications. ◆ In Quarter 4 2017 a new centralized process will be implemented to initiate text message/phone call outreach. c. <i>Immunizations for Adolescents—Combination 1</i> <ul style="list-style-type: none"> ◆ In May 2015, Kaiser SoCal established a new Ambulatory Pediatric Quality Committee that focuses on efforts related to improving performance on clinical measures. The

2015–16 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>multidisciplinary committee includes pediatric and primary care physician leadership, executive and medical office administrative leadership, and dedicated project management support.</p> <ul style="list-style-type: none"> ◆ The Committee sponsored the following performance improvement elements during 2016–17: <ul style="list-style-type: none"> ■ PIP: Interventions included increased adolescent immunization administration by partnering human papillomavirus (HPV) with TDAP (tetanus, diphtheria, pertussis) as young as age 10; utilizing effective communication without confrontation; and care actors. Participating physicians were granted continuing medical education (CME) credits and Level 4 maintenance of certification (MOC) units (2016). ■ Analysis of physician-level data: Identified high performers and high opportunities, with focus on addressing missed opportunities (starting May 2016). ■ Incomplete immunizations: Conducted a monthly data pull to evaluate for proper documentation of immunization, with focus on immunizations that were ordered but not administered (starting 2017). ■ Outreach calls: Expanded outreach calls for immunizations to include adolescents in primary care and pediatrics (starting October 2015).
<p>3. To prevent further decline in the rate for the <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> measure, assess if changes are needed in the MCP’s ongoing improvement efforts for well-child visits.</p>	<ul style="list-style-type: none"> ◆ Kaiser SoCal physician offices conduct monthly outreach. ◆ A focused outreach to 3-to-6-year-olds is planned for September, October, and November 2017.

2015–16 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
4. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Diabetes</i> PIP.	<ul style="list-style-type: none"> ◆ Kaiser SoCal incorporated HSAG pre-validation review recommendations received on June 24, 2016, prior to testing the intervention for the <i>Diabetes</i> PIP: <ul style="list-style-type: none"> ■ Confirmed that intervention testing included both standardized workflows for diabetes care managers and use of a standardized treatment algorithm. ■ Provided the standardized workflow and treatment algorithm. ◆ On November 11, 2016, Kaiser SoCal received written confirmation that HSAG reviewed Kaiser SoCal’s Module 4 progress report update for the <i>Diabetes</i> PIP. HSAG advised that it appeared that the MCP has made appropriate progress with intervention testing. HSAG did not have any additional questions or further interventions.

2016–17 Recommendations

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

- ◆ Ensure resolution of all deficiencies from the September 26, 2016, through October 7, 2016, A&I Medical and State Supported Services Audits.
- ◆ Assess whether or not the MCP’s outreach efforts are resulting in an increased percentage of beneficiaries ages 3 to 6 being seen for one or more well-child visit(s) with a PCP. If the outreach efforts do not result in improvement, identify the causes and develop new strategies to ensure that beneficiaries ages 3 to 6 are seen for well-child visits.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix U:
Performance Evaluation Report
L.A. Care Health Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), L.A. Care Health Plan (“L.A. Care” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in L.A. Care’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

L.A. Care is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in L.A. Care, the LI MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan (CP).

L.A. Care became operational in Los Angeles County to provide MCMC services effective March 1997. As of June 30, 2017, L.A. Care had 2,037,337 beneficiaries in Los Angeles County.¹ This represents 67 percent of the beneficiaries enrolled in Los Angeles County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 04, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for L.A. Care. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of L.A. Care. A&I conducted the on-site audits from July 25, 2016, through August 5, 2016.

**Table 2.1—DHCS A&I Medical and State Supported Services Audits of L.A. Care
 Audit Review Period: July 1, 2015, through June 30, 2016**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	Yes	Closed.
Administrative and Organizational Capacity	Yes	Closed.
State Supported Services	No	Not applicable.

Follow-Up on Previous Reviews

Audits & Investigations Division Medical Audit

DHCS conducted a Medical Audit of L.A. Care from July 20, 2015, through July 31, 2015, covering the review period of July 1, 2014, through June 30, 2015. HSAG provided a summary of the audit results and status in L.A. Care’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, L.A. Care’s CAP was in process and under review by DHCS. A letter from DHCS dated December 16, 2016, stated that L.A. Care provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Department of Managed Health Care Seniors and Persons with Disabilities Medical Survey

The Department of Managed Health Care (DMHC) conducted a Seniors and Persons with Disabilities (SPD) Medical Survey of L.A. Care from July 20, 2015, through July 24, 2015, covering the review period of July 1, 2014, through June 30, 2015. HSAG provided a summary of the survey results and status in L.A. Care's 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, L.A. Care's CAP was in process and under review by DHCS. A letter from DHCS dated December 16, 2016, stated that L.A. Care provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Case Management and Coordination of Care and State Supported Services categories during the July 25, 2016, through August 5, 2016, Medical and State Supported Services Audits of L.A. Care. Additionally, the MCP fully resolved the deficiencies that A&I identified during the Medical Audit. Finally, L.A. Care fully resolved all outstanding deficiencies from the July 2015 A&I Medical Audit and the July 2015 DMHC SPD Medical Survey.

Opportunities for Improvement—Compliance Reviews

L.A. Care has no outstanding deficiencies from the July 25, 2016, through August 5, 2016, and July 2015 A&I Medical and State Supported Services Audits or the July 2015 DMHC SPD Medical Survey; therefore, HSAG has no recommendations for the MCP in the area of compliance review.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for L.A. Care Health Plan* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance AuditTM.³ HSAG auditors determined that L.A. Care followed the appropriate specifications to produce valid rates; however, the auditors noted during the audit that a small percentage of beneficiaries had retroactive eligibility. The auditors recommended that L.A. Care determine the percentage of retroactive enrollment that occurs; determine the impact on the rates; and consider removing these beneficiaries for future HEDIS reporting, as allowed by NCQA.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. See Table 3.1 for L.A. Care’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’ *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- *Asthma Medication Ratio*
- *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
L.A. Care—Los Angeles County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	77.78%	77.65%	73.61%	71.50%	-2.11
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	91.83%	92.26%	90.11%	93.04%	2.93 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	82.82%	84.21%	83.75%	83.69%	-0.06
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	83.89%	86.49%	88.59%	87.35%	-1.24^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	79.45%	82.39%	85.04%	83.80%	-1.24^{^^}
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	28.26%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	73.06%	80.15% ⁺	76.76%	77.69%	0.93
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	62.62%	69.35%	68.52%	68.04%	-0.48
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	69.49%	69.52%	71.43%	78.49%	7.06 [^]
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	59.31%	Not Comparable
<i>Cervical Cancer Screening</i>	64.25%	61.79%	57.63%	59.31%	1.68
<i>Prenatal and Postpartum Care—Postpartum Care</i>	54.24%	57.04%	55.23%	56.17%	0.94
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	79.90%	82.16%	74.21%	75.06%	0.85
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.93%	86.55%	87.12%	88.17%	1.05 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.17%	85.67%	86.40%	87.67%	1.27 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	57.58%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.05%	65.13%	58.55%	60.04%	1.49

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	46.25%	49.65%	58.00%	54.74%	-3.26
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	41.65%	45.96%	47.09%	48.72%	1.63
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	47.46%	41.80%	41.64%	39.96%	-1.68
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	83.54%	83.14%	86.00%	87.77%	1.77
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.99%	86.61%	94.36% ⁺	92.15%	-2.21
<i>Controlling High Blood Pressure</i>	57.14%	66.83%	68.28%	67.78%	-0.50
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	15.50%	20.83%	20.96%	18.61%	-2.35 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	35.61	33.99	40.61	39.71	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	310.27	301.62	345.93	295.32	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.88%	29.73%	29.66%	31.51%	1.85 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	99.87%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	1.37%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	80.40%	79.73%	78.01%	74.61%	-3.40 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (⁺), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of L.A. Care’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

L.A. Care performed between the HPLs and MPLs for all measures within the Preventive Screening and Children’s Health domain in RY 2017; and the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure improved significantly from RY 2016 to RY 2017.

Preventive Screening and Women’s Health

L.A. Care performed between the HPLs and MPLs for all measures within the Preventive Screening and Women’s Health domain in RY 2017. The rates for both *Prenatal and Postpartum Care* measures improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in both rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017. L.A. Care provided information on actions that the MCP took during the review period to address the rates for the *Prenatal and Postpartum Care* measures being below the MPLs in RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the activities that L.A. Care conducted through PDSA cycles to improve the MCP’s rates for these measures. L.A. Care’s efforts may have contributed to the rates for the *Prenatal and Postpartum Care* measures improving to above the MPLs in RY 2017.

Care for Chronic Conditions

L.A. Care performed between the HPLs and MPLs for all measures within the Care for Chronic Conditions domain in RY 2017. The rates for both *Annual Monitoring for Patients on Persistent Medications* measures improved significantly from RY 2016 to RY 2017.

Appropriate Treatment and Utilization

L.A. Care performed between the HPLs and MPLs for all measures within the Appropriate Treatment and Utilization domain in RY 2017. The rates for the following measures improved significantly from RY 2016 to RY 2017:

- ◆ *All-Cause Readmissions*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. L.A. Care provided information on actions that the MCP took during the review period to address the rate for this measure declining significantly from RY 2015 to RY 2016. (See Table 5.1.) The significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to L.A. Care's performance. The MCP has the opportunity to determine the cause for this measure's rate continuing to decline significantly, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, L.A. Care was required to submit IP/PDSA cycles for both *Prenatal and Postpartum Care* measures. The rates for both measures moved from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Prenatal and Postpartum Care—Postpartum Care

L.A. Care conducted two PDSA cycles to help improve the MCP's performance for the *Prenatal and Postpartum Care—Postpartum Care* measure. The MCP set the same SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective for both PDSA cycles:

By January 31, 2017, establish a baseline rate of women who recently gave birth and received postpartum care in one high-volume/low-performing provider group in Los Angeles County.

The planned intervention for both PDSA cycles consisted of an independent physician association (IPA) using utilization management data to create a list of L.A. Care beneficiaries who were discharged from obstetric services. L.A. Care health educators then used the list, along with MCP data, to conduct beneficiary outreach to schedule timely postpartum care appointments. Additionally, L.A. Care provided monetary incentives to beneficiaries who completed timely postpartum care appointments.

After the first PDSA cycle was completed, L.A. Care reported that it met the SMART objective and that the MCP decided to adopt the intervention. L.A. Care noted that the MCP was unable to contact 44 of 66 beneficiaries (67 percent) and that the IPA experienced challenges delivering the eligibility report to the MCP due to competing priorities.

After the second PDSA cycle was completed, L.A. Care reported that, because the MCP had staff attrition in the quality improvement lead roles and because the IPA was also the partner for the *Timeliness of Prenatal Care* PDSA cycles and therefore had competing priorities, the intervention was not implemented as planned. L.A. Care did not indicate whether or not the MCP would adopt, adapt, or abandon the intervention moving forward.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

L.A. Care conducted two PDSA cycles to help improve the MCP's performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure. The MCP set the same SMART objective for both PDSA cycles:

By January 31, 2017, establish a baseline rate of pregnant women with a first prenatal visit, or a prenatal visit after enrolling with L.A. Care, in one high-volume/low-performing provider group in Los Angeles County.

The planned intervention for the first PDSA cycle consisted of L.A. Care identifying eligible beneficiaries through the Estimated Date of Delivery (EDD) field in the MCP's monthly enrollment file and the IPA conducting beneficiary outreach using the list of eligible beneficiaries from L.A. Care. After the first PDSA cycle was completed, L.A. Care reported that it met the SMART objective and that the MCP decided to adapt the intervention. L.A. Care noted that the IPA, due to competing priorities, only conducted outreach to eligible beneficiaries for one month.

For the second PDSA cycle, rather than the IPA contacting eligible beneficiaries, L.A. Care health education staff members contacted the eligible beneficiaries to schedule their prenatal visits. After the second PDSA cycle, L.A. Care reported that it met the SMART objective but did not indicate whether or not the MCP would adopt, adapt, or abandon the intervention moving forward. The MCP indicated that lag time related to processing EDD data, poor beneficiary contact information, and coordination issues between the IPA and MCP regarding appointment scheduling contributed to weak results.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, L.A. Care will not be required to submit any IP/PDSA cycles for RY 2017.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for L.A. Care—Los Angeles County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	24.68%	13.58%	11.10^^	18.61%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	68.17	37.14	Not Tested	39.71
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	557.34	271.67	Not Tested	295.32
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.83%	87.21%	2.62^	88.17%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.16%	86.13%	4.03^	87.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	93.85%	93.04%	0.81	93.04%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.06%	83.62%	2.44^	83.69%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.49%	87.29%	1.20^	87.35%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.44%	83.82%	-0.38	83.80%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

Table 3.3—Multi-Year SPD Performance Measure Trend Table
L.A. Care—Los Angeles County

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	18.44%	25.53%	26.90%	24.68%	-2.22 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	57.87	58.66	70.03	68.17	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	421.46	450.94	621.22	557.34	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.22%	87.63%	88.33%	89.83%	1.50 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.52%	87.55%	88.32%	90.16%	1.84 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	79.34%	83.56%	92.16%	93.85%	1.69
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	81.02%	84.22%	84.06%	86.06%	2.00 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.01%	86.87%	88.15%	88.49%	0.34
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	77.77%	81.92%	83.04%	83.44%	0.40

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
L.A. Care—Los Angeles County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	9.19%	13.55%	14.98%	13.58%	-1.40 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	32.50	31.16	37.56	37.14	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	294.71	284.50	317.46	271.67	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.24%	85.50%	86.35%	87.21%	0.86 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	77.33%	83.81%	85.13%	86.13%	1.00 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	91.98%	92.33%	90.09%	93.04%	2.95 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	82.88%	84.21%	83.74%	83.62%	-0.12
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.93%	86.47%	88.61%	87.29%	-1.32 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	79.56%	82.42%	85.17%	83.82%	-1.35 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that L.A. Care stratified by the SPD and non-SPD populations:

- ◆ The RY 2017 SPD rates were significantly better than the RY 2016 SPD rates for the following measures:
 - *All-Cause Readmissions*
 - Both *Annual Monitoring for Patients on Persistent Medications* measures

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- ◆ The RY 2017 non-SPD rates were significantly better than the RY 2016 non-SPD rates for the following measures:
 - *All-Cause Readmissions*
 - *Both Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- ◆ The RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - *Both Annual Monitoring for Patients on Persistent Medications* measures
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- ◆ The RY 2017 SPD rate was significantly worse than the RY 2017 non-SPD rate for the *All-Cause Readmissions* measure. 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 beneficiaries.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to L.A. Care's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that L.A. Care report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.5 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.5—Multi-Year MLTSSP Performance Measure Results
L.A. Care—Los Angeles County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	59.09	60.61	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	538.37	495.85	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	11.68%	20.92%	9.24 [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure improved significantly from RY 2016 to RY 2017.

Strengths—Performance Measures

HSAG auditors determined that L.A. Care followed the appropriate specifications to produce valid rates.

The rates for the two *Prenatal and Postpartum Care* measures moved from below the MPLs in RY 2016 to above the MPLs in RY 2017. In Table 3.1, across all domains, the rates for five of 19 measures for which comparisons were made from RY 2016 to RY 2017 (26 percent) improved significantly from RY 2016 to RY 2017.

Opportunities for Improvement—Performance Measures

L.A. Care has the opportunity to determine the percentage of retroactive enrollment that occurs for the MCP; determine the impact on the rates; and consider removing these beneficiaries for future HEDIS reporting, as allowed by NCQA. L.A. Care also has the opportunity to determine the causes for the MCP's continued declining performance for the *Use of Imaging for Low Back Pain* measure, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

L.A. Care had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

L.A. Care selected immunizations of two-year-olds as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to L.A. Care and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

L.A. Care set the SMART Aim for the *Immunizations of Two-Year-Olds* PIP as follows:

By June 30, 2017, the percentage of beneficiaries who receive three diphtheria, tetanus, and acellular pertussis (DTaP) and three pneumococcal conjugate vaccine (PCV) doses by 12 months of age at Provider A⁶ will increase by 7 percentage points, from 59.5 percent to 66.5 percent.

Failure Modes

The following, listed in priority order, are the failure modes that L.A. Care identified during the Intervention Determination phase of the PIP process:

- ◆ Parent/guardian unable to schedule an appointment date beyond one month, when six to eight weeks are required between immunizations.
- ◆ Appointment scheduling process is too difficult for the parent/guardian.
- ◆ Parent/guardian does not have information on the importance of following the Advisory Committee on Immunization Practices (ACIP) immunization schedule.
- ◆ Parent/guardian does not know to schedule an appointment when the beneficiary is two-months old.

⁶ Provider name removed for confidentiality.

- ◆ Parent/guardian does not understand the risk of diseases and disabilities associated with not being vaccinated according to ACIP immunization schedule.
- ◆ Parent/guardian does not reschedule missed appointment.
- ◆ Parent/guardian and beneficiary do not show up for the appointment.
- ◆ Parent/guardian does not have time to take the beneficiary to the scheduled immunization appointment.

Intervention Testing

During the reporting period, L.A. Care selected to test an intervention that ensures that beneficiaries have scheduled appointments for their next immunizations. This intervention addresses:

- ◆ Falling behind on the ACIP recommended immunization schedule.
- ◆ Scheduling difficulties resulting in missed immunizations.
- ◆ Using more appropriate time-sensitive reports to help identify beneficiaries missing immunizations and needing appointments.

Although L.A. Care completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in L.A. Care's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

L.A. Care selected medication management for people with asthma as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated modules 1 and 2 for L.A. Care's MCP-specific PIP, revised due to changes to the SMART Aim measure's baseline, goal, and measurement period. Upon review, HSAG determined that L.A. Care had met all validation criteria for modules 1 and 2.

Additionally, HSAG validated Module 3 for L.A. Care's MCP-specific 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 the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Including all required components of the failure modes and effects analysis (FMEA).
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, L.A. Care incorporated HSAG's feedback into the PIP modules. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to L.A. Care on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to L.A. Care and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

L.A. Care set the SMART Aim for the *Medication Management for People With Asthma* PIP as follows:

By June 30, 2017, at Provider B,⁷ increase from 17.24 percent to 32.18 percent the percentage of Hispanic beneficiaries ages 5 to 18 years who remained on an asthma controller medication for at least 75 percent of their treatment period.

Failure Modes

The following, listed in priority order, are the failure modes that L.A. Care identified during the Intervention Determination phase of the PIP process:

- ◆ Physician prescribes a 30-day supply rather than a 90-day supply of asthma controller medication.
- ◆ Pharmacist converts a prescription with a 90-day supply into three 30-day supplies, requiring the beneficiary to visit the pharmacy more frequently.
- ◆ Beneficiary does not collect the medication.
- ◆ Physician prescribes a 90-day supply of asthma controller medication with no refills.
- ◆ Beneficiary does not choose Provider B's in-office pharmacy to fill the prescription.
- ◆ The Asthma Action Plan does not help the beneficiary with medication adherence.
- ◆ Beneficiary uses quick-relief medication instead of asthma controller medication (wrong medication used).

Intervention Testing

During the reporting period, L.A. Care selected to test an automatic-refill program to reduce barriers that prevent a beneficiary from filling a prescription for asthma controller medication.

Although L.A. Care completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the

⁷ Provider name removed for confidentiality.

reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in L.A. Care's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, L.A. Care improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

Based on L.A. Care's PIP progression, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from L.A. Care’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of L.A. Care’s self-reported actions.

Table 5.1—L.A. Care’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure resolution of all deficiencies from the July 2015 A&I medical audit.	The 2015 A&I Medical Audit was closed out by DHCS on December 16, 2016. L.A. Care conducts ongoing CAP monitoring of the 2015 deficiencies that repeated in 2016 to oversee implementation and effectiveness of CAPs.
2. Ensure resolution of all deficiencies from the July 2015 DMHC SPD Medical Survey.	The 2015 SPD Medical Survey was closed out by DHCS on December 16, 2016. L.A. Care conducts ongoing CAP monitoring of the 2015 deficiencies that repeated in 2016 to oversee implementation and effectiveness of CAPs.
3. Ensure that year-end encounter data are received, loaded, and processed within the MCP’s system prior to sampling the hybrid populations.	<p>The Encounters team monitors the inbound files received from trading partners daily to ensure the following steps are in place:</p> <ul style="list-style-type: none"> a. All received files must be processed and translated by electronic data interchange (EDI). b. Translated files must be loaded into ENCPR (encounter system) by PL/SQL team. c. Each file must be processed completely in the ENCPR—including validation edits, potential duplicate check, and void/replacement process. d. Error reports are generated and distributed to the trading partners once the submitted file is processed. <p>The Health Outcomes and Analysis team processed all encounters data loaded into L.A. Care’s systems prior to the sampling run for hybrid measures at the time that samples were required by the auditors.</p>

2015–16 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>4. Explore the causes for the MCP’s declining performance or performance below the MPLs for the following measures</p> <ul style="list-style-type: none"> a. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> b. <i>Prenatal and Postpartum Care—Postpartum Care</i> c. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> d. <i>Use of Imaging Studies for Low Back Pain</i> 	<p>For the <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> measure, L.A. Care had a rate of 58.55 percent in RY 2016, which improved to 60.04 percent in RY 2017 and met the NCQA Quality Compass Medicaid HMO 50th percentile. In 2016, L.A. Care implemented interventions that included providing physicians and provider groups listings of members who had diabetes and needed to be evaluated. L.A. Care also provided physicians incentives for improvement in rates. Going forward, L.A. Care has now added a provider group incentive program to track and improve rates. In addition, we plan to work with provider groups to integrate from electronic medical record (EMR) reporting of blood pressure readings and to be able to identify those who have high blood pressure readings and need follow-up care.</p> <p>For the <i>Prenatal and Postpartum Care—Postpartum Care</i> measure, L.A. Care had a rate of 55.23 percent in RY 2016, which was below the MPL, and has improved the rate for RY 2017 to 56.17 percent, which met the NCQA Quality Compass Medicaid HMO 25th percentile. During 2016, the availability of a list of members who had a live delivery was limited. This resulted in a reduction in L.A. Care’s ability to conduct member outreach calls. A health education staff member assists with scheduling timely postpartum visits, offering transportation, if needed, and coordinating for an interpreter for the visit. In May 2017, L.A. Care connected with a hospital discharge data system, which enables the Health Education Department to receive about 75 percent of MCP’s discharge information. The volume of identified members has increased by 750 percent. L.A. Care will continue to conduct member outreach to ensure that they are scheduled for timely postpartum visits.</p> <p>For the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> measure, L.A. Care had a rate of 74.21 percent in RY 2016, which was below the MPL, and has improved the rate for RY 2017 to 75.06 percent, which met the NCQA Quality Compass Medicaid HMO 25th percentile. In September 2016, L.A. Care began to conduct live agent outreach calls to newly pregnant members in order to assist with the scheduling of timely prenatal care within 42 days of enrollment.</p> <p>For the <i>Use of Imaging Studies for Low Back Pain</i> measure, L.A. Care had a rate of 78.01 percent in RY 2016, which declined to 74.61 percent in RY 2017 (the rate continued to meet the NCQA Quality Compass Medicaid HMO 25th percentile in RY 2017). L.A. Care has plans to initiate a strong provider and member</p>

2015–16 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	education effort to address this measure. The clinical indication is that imaging studies are not necessary for most initial acute back pain, so education to providers on clinical practice guidelines is critical. The education for members is focused on conservative treatment and activity. There is a secondary quality focus on limiting the use of opioid medication and dependence.
5. For the <i>Immunizations of Two-Year-Olds</i> PIP, incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention.	<p>For the <i>Childhood Immunization Status—Combination 3</i> measure, L.A. Care had a rate of 73.61 percent in RY 2016; the rate declined to 71.50 percent in RY 2017, but still met the NCQA Quality Compass Medicaid HMO 50th percentile. L.A. Care has an active PIP for childhood immunizations that includes member outreach to schedule immunization appointments. HSAG did respond to our PIP Module 4 submission and asked us to be more specific to the outreach intervention to detail who is responsible and the process. L.A. Care has completed a detailed accounting of this process. The intervention will be measured and findings shared within the next six months.</p> <p>L.A. Care has also conducted significant outreach to incentivize providers to use the immunization registry, but the California Immunization Registry (CAIR) had a change in software during 2016 and 2017 that caused limited access for providers. Now that CAIR2 has been fully implemented, we will start a new outreach program to get providers enrolled. L.A. Care also re-vamped our provider opportunity reports and will be increasing the frequency of these reports. Incentives for physicians were already implemented, and new group-level incentives were added.</p>

2016–17 Recommendations

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

- ◆ Determine the percentage of retroactive enrollment that occurs for the MCP; determine the impact on the rates; and consider removing these beneficiaries for future HEDIS reporting, as allowed by NCQA.
- ◆ Determine the causes for the MCP’s continued declining performance for the *Use of Imaging for Low Back Pain* measure. Identifying the causes will help the MCP to determine whether current improvement strategies need to be modified or expanded to address the MCP’s continued declining performance on this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix V:
Performance Evaluation Report
Molina Healthcare of California
Partner Plan, Inc.
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Molina Healthcare of California Partner Plan, Inc. (“Molina” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Molina’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

In Riverside and San Bernardino counties, Molina is a full-scope MCP delivering services to beneficiaries as a commercial plan (CP) under the Two-Plan Model (TPM). Beneficiaries may enroll in Molina, the CP; or in Inland Empire Health Plan, the alternative “local initiative.”

In Sacramento and San Diego counties, Molina delivers services to beneficiaries under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of Sacramento and San Diego. 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:

- ◆ 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:

- ◆ Care1st Partner Plan
- ◆ Community Health Group Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser SoCal

In Imperial County, Molina delivers services to beneficiaries under the Imperial model. Beneficiaries may enroll in Molina or California Health & Wellness Plan, the other CP.

Molina became operational in Riverside and San Bernardino counties to provide MCMC services in December 1997. 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.

The MCP expanded to Sacramento County in 2000 and San Diego County in 2005. Molina began providing services in Imperial County effective November 1, 2013.

Table 1.1 shows the number of beneficiaries for Molina for each county, the percentage of beneficiaries enrolled in the county, and the MCP’s total number of beneficiaries as of June 30, 2017.¹

Table 1.1—Molina Enrollment as of June 30, 2017

County	Enrollment as of June 30, 2017	Percentage of Beneficiaries Enrolled in the County
Imperial	60,691	79%
Riverside*	89,748	13%
Sacramento	60,071	14%
San Bernardino*	77,664	11%
San Diego	228,470	32%
Total	516,644	

* Note that DHCS allows Molina to report Riverside and San Bernardino counties as a combined (i.e., single reporting unit) rate.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Aug 25, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Molina. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Molina. A&I conducted the on-site audits from August 1, 2016, through August 12, 2016.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Molina
Audit Review Period: August 1, 2015, through July 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	No	Not applicable.
Member’s Rights	Yes	Closed.
Quality Management	Yes	Closed.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

DHCS identified no deficiencies in the Case Management and Coordination of Care, Access and Availability of Care, Administrative and Organizational Capacity, and State Supported Services categories during the August 2016 A&I Medical and State Supported Services Audits. Additionally, Molina’s responses to the MCP’s CAP for the deficiencies that A&I identified during the Medical Audit resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

Molina has no outstanding deficiencies from the August 2016 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Molina Healthcare of California Partner Plan, Inc.* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that Molina followed the appropriate specifications to produce valid rates; however, the auditors identified that the MCP’s use of the “order date” and “collection date” fields for lab data were inconsistent in the MCP’s two non-standard supplemental databases. Although both databases successfully passed primary source validation and proof-of-service documentation review, the auditors recommended that Molina apply standardized abstraction methodologies and guidelines and implement an interrater reliability monitoring process.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for Molina’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.4:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’ *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ Although HSAG includes information on the MCP’s performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*
- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Molina—Imperial County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	34.04%	56.96%	64.35%	7.39
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	85.65%	83.56%	93.16%	9.60^
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	77.44%	76.48%	76.50%	0.02
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	NA	81.59%	76.30%	-5.29^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	NA	79.95%	73.34%	-6.61^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	19.61%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	56.51%	75.72%	75.06%	-0.66
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	44.37%	71.96% ⁺	67.99%	-3.97
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	58.94%	61.81%	71.52%	9.71^
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	56.05%	Not Comparable
<i>Cervical Cancer Screening</i>	--	40.22%	41.00%	49.55%	8.55^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	51.89%	54.18%	52.54%	-1.64
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	76.22%	73.58%	76.27%	2.69
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	90.05%	89.47%	91.45%	1.98
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	91.03%	95.00% ⁺	90.98%	-4.02
<i>Asthma Medication Ratio—Total</i>	--	--	--	76.24% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	46.93%	60.49%	65.27%	4.78

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	54.51%	55.19%	57.52%	2.33
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	25.27%	38.19%	46.46%	8.27 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	67.15%	53.20%	45.35%	-7.85 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	86.64%	82.12%	88.50%	6.38 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	81.59%	91.17% ⁺	91.15%	-0.02
<i>Controlling High Blood Pressure</i>	--	40.00%	65.03%	65.53%	0.50
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	S	13.70%	11.85%	-1.85
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	56.81	54.35	52.35	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	446.79	238.30	221.57	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	NA	34.04%	35.62%	1.58
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	100.00%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.54%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	59.18%	54.62%	62.13%	7.51

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
Molina—Riverside/San Bernardino Counties

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	69.57%	68.21%	51.43%	64.90%	13.47 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	92.67%	90.64%	90.28%	91.83%	1.55
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	85.02%	81.86%	83.68%	81.40%	-2.28^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	85.15%	84.29%	84.53%	84.56%	0.03
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	83.63%	83.18%	83.42%	82.64%	-0.78^{^^}
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	22.08%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	66.00%	69.35%	67.11%	73.95%	6.84 [^]
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	57.40%	52.13%	49.89%	62.25%	12.36 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	72.73%	66.67%	65.78%	69.09%	3.31
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	59.22%	Not Comparable
<i>Cervical Cancer Screening</i>	60.81%	58.53%	50.00%	50.11%	0.11
<i>Prenatal and Postpartum Care—Postpartum Care</i>	47.46%	43.68%	46.89%	52.67%	5.78
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	71.52%	68.96%	73.33%	77.78%	4.45
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.83%	85.10%	85.20%	87.58%	2.38 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.60%	84.02%	82.89%	86.99%	4.10 [^]
<i>Asthma Medication Ratio—Total</i>	--	--	--	63.36%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	59.60%	54.75%	51.21%	59.51%	8.30 [^]

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.99%	43.93%	48.79%	56.86%	8.07 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	38.19%	37.75%	41.94%	52.21%	10.27 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	48.79%	51.43%	47.46%	37.17%	-10.29 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	82.56%	81.68%	83.22%	89.82%	6.60 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.90%	86.31%	88.52% ⁺	92.48%	3.96 [^]
<i>Controlling High Blood Pressure</i>	47.22%	39.82%	49.47%	50.64%	1.17
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	14.03%	15.59%	17.67%	14.89%	-2.78 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	39.94	39.85	39.30	37.65	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	206.96	354.46	198.33	197.38	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	27.64%	31.68%	34.32%	32.89%	-1.43
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.02%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	77.08%	74.85%	73.57%	70.35%	-3.22

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.3—Multi-Year Performance Measure Results*
Molina—Sacramento County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	59.42%	59.29%	41.06%	58.94%	17.88 [^]
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	94.51%	89.13%	89.09%	88.98%	-0.11
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	83.89%	80.42%	80.68%	76.64%	-4.04 ^{^^}
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	82.85%	80.44%	81.84%	82.53%	0.69
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	80.58%	79.99%	79.68%	78.83%	-0.85
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	18.98%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	56.51%	79.33% ⁺	70.64%	74.83%	4.19
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	49.89%	55.11%	53.42%	59.60%	6.18
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	67.31%	70.97%	68.87%	61.59%	-7.28 ^{^^}
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	60.24%	Not Comparable
<i>Cervical Cancer Screening</i>	60.63%	57.27%	55.11%	50.77%	-4.34
<i>Prenatal and Postpartum Care—Postpartum Care</i>	43.93%	39.96%	53.44%	50.68%	-2.76
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	74.39%	69.54%	76.05%	75.34%	-0.71
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.52%	83.95%	87.38%	86.33%	-1.05
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.48%	82.45%	87.37%	85.58%	-1.79
<i>Asthma Medication Ratio—Total</i>	--	--	--	68.58%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	52.76%	53.64%	57.17%	55.43%	-1.74

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	48.79%	48.79%	48.34%	54.77%	6.43
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.25%	44.81%	46.58%	54.99%	8.41 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	46.36%	43.93%	42.38%	31.93%	-10.45 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	79.25%	77.04%	81.24%	86.92%	5.68 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.47%	80.57%	89.85% ⁺	91.35%	1.50
<i>Controlling High Blood Pressure</i>	47.23%	50.99%	54.39%	58.05%	3.66
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.71%	15.15%	14.80%	16.40%	1.60
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	50.20	58.83	60.04	56.32	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	257.68	454.21	277.80	220.47	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	32.39%	27.23%	22.32%	35.20%	12.88 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	81.50%	80.60%	78.59%	76.04%	-2.55

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Performance Measure Results*
Molina—San Diego County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	76.89%	74.61%	65.12%	65.56%	0.44
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	95.73%	93.95%	90.89%	92.95%	2.06^
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	88.81%	86.38%	85.76%	84.93%	-0.83^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	89.06%	89.81%	89.38%	88.60%	-0.78^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	86.20%	87.03%	87.44%	85.93%	-1.51^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	22.74%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	62.28%	72.41%	72.41%	76.82%	4.41
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	53.57%	56.51%	59.16%	64.90%	5.74
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	74.29%	70.06%	74.39%	69.32%	-5.07
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	63.55%	Not Comparable
<i>Cervical Cancer Screening</i>	68.11%	51.02%	50.89%	59.51%	8.62^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	64.68%	54.20%	56.44%	69.11%	12.67^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	83.00%	83.21%	83.78%	83.33%	-0.45
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.03%	84.41%	89.39%	91.61%	2.22^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.07%	84.90%	89.67%	91.59%	1.92^
<i>Asthma Medication Ratio—Total</i>	--	--	--	69.03%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.71%	58.72%	55.85%	59.91%	4.06

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	55.63%	60.93%	55.19%	59.02%	3.83
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	49.45%	55.19%	48.57%	56.79%	8.22 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	41.50%	34.44%	40.62%	35.63%	-4.99
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	87.64%	89.85%	87.86%	87.97%	0.11
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.99%	87.42% ⁺	91.83% ⁺	91.76%	-0.07
<i>Controlling High Blood Pressure</i>	53.88%	46.44%	53.60%	56.90%	3.30
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	14.93%	16.01%	16.41%	13.82%	-2.59 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	40.54	41.47	41.62	40.57	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	228.23	443.05	265.05	266.96	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	28.29%	28.90%	30.20%	33.18%	2.98
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	99.73%	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.45%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	68.64%	68.42%	70.74%	69.79%	-0.95

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Molina’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Notable results in RY 2017 within the Preventive Screening and Children’s Health domain included:

- ◆ The rates for the *Childhood Immunization Status—Combination 3* measure in Imperial, Riverside/San Bernardino, and San Diego counties moved from below the MPL in RY 2016 to above the MPL in RY 2017, with the rate in Riverside/San Bernardino counties improving significantly from RY 2016 to RY 2017.
- ◆ The rate for the *Childhood Immunization Status—Combination 3* measure in Sacramento County improved significantly from RY 2016 to RY 2017; however, the rate was below the MPL for all RYs displayed in Table 3.3.
- ◆ The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in Riverside/San Bernardino counties improved significantly from RY 2016 to RY 2017.
- ◆ The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Imperial County improved significantly from RY 2016 to RY 2017, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Sacramento County declined significantly from RY 2016 to RY 2017, resulting in the rate for this measure moving from above the MPL in RY 2016 to below the MPL in RY 2017.

Performance measure results show that Sacramento County has the most opportunity for improvement in this domain based on this reporting unit having two of four measures (50 percent) with rates below the MPLs in RY 2017 and the other reporting units having no measures with rates below the MPLs in RY 2017.

Molina should continue to implement the strategies in Sacramento County that contributed to the significant improvement in the rate for the *Childhood Immunization Status—Combination 3* measure from RY 2016 to RY 2017, to ensure that beneficiaries in this reporting unit receive appropriate immunizations by age 2. Additionally, Molina should assess the causes for the MCP's performance moving to below the MPL in RY 2017 for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Sacramento County and, as applicable, duplicate strategies that have been successful in other reporting units for ensuring that beneficiaries 3 to 6 years of age are seen for one or more well-child visit(s) with a primary care provider (PCP) during the MY.

Preventive Screening and Women's Health

Notable results in RY 2017 within the Preventive Screening and Women's Health domain included:

- ◆ The rates for the *Cervical Cancer Screening* measure in Imperial and San Diego counties improved significantly from RY 2016 to RY 2017, resulting in the rates in both reporting units moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ The rate for the *Cervical Cancer Screening* measure in Riverside/San Bernardino counties improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ The rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Imperial, Riverside/San Bernardino, and Sacramento improved from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure in San Diego County improved significantly from RY 2016 to RY 2017.
- ◆ The rates for the *Prenatal and Postpartum Care—Postpartum Care* measure in Imperial, Riverside/San Bernardino, and Sacramento counties were below the MPL for all RYs with rates displayed for this measure in Table 3.1, Table 3.2, and Table 3.3.

Performance measure results show that, across all reporting units, the MCP performed best in San Diego County within the Preventive Screening and Women's Health domain, based on this reporting unit having no rates below the MPLs in RY 2017 within this domain. Performance measure results also show that Molina has the opportunity to assess the causes for the MCP's performance being below the MPL for the *Prenatal and Postpartum Care—Postpartum Care* measure in Imperial, Riverside/San Bernardino, and Sacramento counties and, as applicable, duplicate strategies that have been successful in San Diego County for ensuring that each female beneficiary who delivers a live birth completes a postpartum visit on or between 21 and 56 days after delivery.

Care for Chronic Conditions

Notable results in RY 2017 within the Care for Chronic Conditions domain included:

- ◆ Across all reporting units, Molina had no rates below the MPLs within the Care for Chronic Conditions domain.
- ◆ Across all reporting units for rates for which a comparison was made between RY 2016 and RY 2017, 17 of 36 rates (47 percent) reflected statistically significant improvement from RY 2016 to RY 2017. The MCP's performance on the following measures improved significantly from RY 2016 to RY 2017:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in Riverside/San Bernardino and San Diego counties. The improvement in Riverside/San Bernardino counties for the *Diuretics* measure resulted in the rate in this reporting unit moving from below the MPL in RY 2016 to above the MPL in RY 2017.
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Riverside/San Bernardino counties, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Riverside/San Bernardino counties.
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in all four reporting units. The improvement in Imperial County resulted in the rate in this county moving from below the MPL in RY 2016 to above the MPL in RY 2017.
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Imperial, Riverside/San Bernardino, and Sacramento counties. The improvement in Imperial County resulted in the rate in that county moving from below the MPL in RY 2016 to above the MPL in RY 2017.
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Imperial, Riverside/San Bernardino, and Sacramento counties. The improvement in Imperial and Sacramento counties resulted in the rates in these counties moving from below the MPL in RY 2016 to above the MPL in RY 2017.
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Riverside/San Bernardino counties.
- ◆ The rate for the *Controlling High Blood Pressure* measure in Riverside/San Bernardino counties improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.

Appropriate Treatment and Utilization

Notable results in RY 2017 within the Appropriate Treatment and Utilization domain included:

- ◆ The rates for the *All-Cause Readmissions* measure in Riverside/San Bernardino and San Diego counties improved significantly from RY 2016 to RY 2017, reflecting a reduction in unplanned acute readmissions within 30 days of discharge for beneficiaries 21 years of age and older in these reporting units.

- ◆ The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Sacramento County improved significantly from RY 2016 to RY 2017. Note that the significant improvement in this rate may be due to NCQA’s RY 2017 specification changes for this measure and therefore may not be related to Molina’s performance in this reporting unit.
- ◆ The rates for the *Use of Imaging Studies for Low Back Pain* measure in Imperial and San Diego counties were below the MPL for all RYs with rates displayed for this measure in Table 3.1 and Table 3.4. HSAG is unable to determine whether the MCP’s performance below the MPL in these two reporting units in RY 2017 is as a result of NCQA’s RY 2017 specification changes; however, given the consecutive years of performance below the MPL, the MCP should assess the improvement efforts referenced in Table 5.1 to determine if changes need to be made and apply lessons learned across Imperial and San Diego counties to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Corrective Action Plan and Improvement Plans

Corrective Action Plan

Molina’s Quality of Care CAP was initiated in December 2015 for a period of four years or until Molina achieves the CAP goals. The CAP outlines the overall goals that Molina must achieve, along with yearly CAP milestones. Molina’s CAP covers five measures across two reporting units. In Sacramento County, Molina is required to address performance related to the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics* measures
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ Both *Prenatal and Postpartum Care* measures

In Riverside/San Bernardino counties, the MCP is required to address performance related to both *Prenatal and Postpartum Care* measures.

DHCS expanded the CAP in September 2016 to include the *Controlling High Blood Pressure* measure in Riverside/San Bernardino counties.

To address performance related to the *Prenatal and Postpartum Care—Postpartum Care* and *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics* measures, DHCS required Molina to conduct two CAP performance improvement projects (PIPs). Information regarding Molina’s progress on its *Postpartum Care* and *Annual Monitoring of Patients on Persistent Medications* PIPs is included in Section 4 of this report (“Performance Improvement Projects”).

To address performance related to the *Childhood Immunization Status—Combination 3*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, and *Controlling High Blood Pressure* measures, DHCS required Molina to conduct PDSA cycles. Molina submitted quarterly reports to DHCS on the PDSA cycles that the MCP conducted to improve performance on these measures, and DHCS provided feedback to the MCP following each quarterly submission.

Improvement Plan/Plan-Do-Study-Act Cycles

In addition to the measures covered under the CAP, DHCS required Molina to conduct IP/PDSA cycles for the following measures with rates below the MPLs in RY 2016:

- ◆ *Cervical Cancer Screening* in Imperial, Riverside/San Bernardino, and San Diego counties
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Riverside/San Bernardino and San Diego counties
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in Imperial County
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Imperial County
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Imperial and Sacramento counties
- ◆ *Use of Imaging for Low Back Pain* in Imperial and San Diego counties
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Imperial County

DHCS required Molina to submit quarterly reports to DHCS on the PDSA cycles that the MCP conducted to improve performance on these measures, and DHCS provided feedback to the MCP following each quarterly submission.

Progress on Corrective Action Plan and Improvement Plans

Molina's CAP and IP/PDSA cycles focused on activities at the MCP-, provider-, and beneficiary-levels to improve the MCP's performance. Molina implemented gap-in-care reports and provider and beneficiary incentives. Additionally, Molina conducted in-home visits as part of the beneficiary outreach efforts and worked with providers within their offices to help the providers develop more efficient workflows. Finally, under the leadership of the MCP's Associate Vice President of Quality, Molina reorganized the MCP's quality improvement program, including restructuring the provider incentive program to target low-performing measures, developing regional provider advisory committees to engage providers, and developing new, supplemental data collection tools.

HSAG observed the following notable results in RY 2017 for measures included in the MCP's CAP:

- ◆ Five of eight rates (63 percent) were above the MPLs in RY 2017:
 - The rates for both *Annual Monitoring for Patients on Persistent Medications* measures in Sacramento County, which moved from below the MPLs in RY 2015 to above the MPLs in RY 2016, remained above the MPLs in RY 2017.
 - The rate for the *Controlling High Blood Pressure* measure in Riverside/San Bernardino counties improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.
 - The rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Riverside/San Bernardino and Sacramento counties improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rates moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ The rate for the *Childhood Immunization Status—Combination 3* measure in Sacramento County improved significantly from RY 2016 to RY 2017; however, the rate remained below the MPL in

RY 2017. The rates for *Prenatal and Postpartum Care—Postpartum Care* measure in Riverside/San Bernardino and Sacramento counties were also below the MPLs in RY 2017.

HSAG observed the following notable results in RY 2017 for measures for which DHCS required Molina to conduct IP/PDSA cycles:

- ◆ Ten of 12 rates (83 percent) moved from below the MPLs in RY 2016 to above the MPLs in RY 2017. The rates for the following measures addressed by the IP/PDSA cycles were above the MPLs in RY 2017:
 - *Cervical Cancer Screening* in Imperial, Riverside/San Bernardino, and San Diego counties
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Riverside/San Bernardino and San Diego counties
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in Imperial County
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Imperial County
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in Imperial and Sacramento counties
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Imperial County
- ◆ The rates for the *Use of Imaging for Low Back Pain* measure in Imperial and San Diego counties remained below the MPL in RY 2017.

Corrective Action Plan Requirements for RY 2017

Based on RY 2017 performance measure results, DHCS will require Molina to do the following related to measures included in the CAP:

- ◆ Molina will conduct a PIP to address the MCP's performance below the MPL for the *Childhood Immunization Status—Combination 3* measure in Sacramento County.
- ◆ Molina will conduct a PIP to address the MCP's performance below the MPL for the *Prenatal and Postpartum Care—Postpartum Care* measure in Riverside/San Bernardino and Sacramento counties.
 - Note that the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was below the MPL in Imperial County in RY 2017; therefore, Molina may want to apply the lessons learned through the PIP to help improve the MCP's performance to above the MPL.
- ◆ To help sustain the improvement achieved from RY 2016 to RY 2017, DHCS is requiring Molina to continue conducting PDSA cycles and submitting quarterly progress reports to DHCS for the *Controlling High Blood Pressure* measure in Riverside/San Bernardino counties and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Riverside/San Bernardino and Sacramento counties.

Improvement Plan Requirements for RY 2017

Based on RY 2017 performance measure results, Molina will be required to submit IP/PDSA cycles and quarterly progress reports for the following measures:

- ◆ *Use of Imaging Studies for Low Back Pain* in Imperial and San Diego counties
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County

Seniors and Persons with Disabilities Performance Measure Results

Table 3.5 through Table 3.8 present the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.5—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Imperial County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	17.83%	9.06%	8.77^^	11.85%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	96.92	49.49	Not Tested	52.35
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	506.57	203.30	Not Tested	221.57
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	97.10%	89.66%	7.44^	91.45%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	97.78%	87.50%	10.28^	90.98%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	93.16%	Not Comparable	93.16%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	NA	76.39%	Not Comparable	76.50%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	76.67%	76.29%	0.38	76.30%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	78.18%	73.12%	5.06	73.34%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.5 through Table 3.8.

Table 3.6—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Riverside/San Bernardino Counties

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	21.70%	11.31%	10.39^^	14.89%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.01	35.49	Not Tested	37.65
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	352.50	188.15	Not Tested	197.38
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.17%	86.45%	4.72^	87.58%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.47%	85.48%	5.99^	86.99%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.86%	Not Comparable	91.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.33%	81.37%	1.96	81.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.75%	84.53%	1.22	84.56%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.33%	82.62%	0.71	82.64%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.7—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Sacramento County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	21.92%	11.37%	10.55^^	16.40%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	92.84	51.16	Not Tested	56.32
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	420.83	192.13	Not Tested	220.47
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.38%	86.29%	0.09	86.33%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.07%	84.49%	2.58	85.58%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	89.40%	Not Comparable	88.98%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	78.85%	76.59%	2.26	76.64%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.00%	82.44%	2.56	82.53%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	71.27%	79.29%	-8.02^^	78.83%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.8—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—San Diego County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	17.63%	12.09%	5.54 ^{^^}	13.82%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	74.15	38.43	Not Tested	40.57
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	591.50	246.33	Not Tested	266.96
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	94.56%	90.33%	4.23 [^]	91.61%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	95.42%	89.76%	5.66 [^]	91.59%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	92.97%	Not Comparable	92.95%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.50%	84.83%	5.67 [^]	84.93%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.78%	88.54%	2.24	88.60%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.67%	85.87%	1.80	85.93%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^{^^} Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.9 through Table 3.12 present the four-year trending information for the SPD population, and Table 3.13 through Table 3.16 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.9—Multi-Year SPD Performance Measure Trend Table
Molina—Imperial County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	NA	18.97%	17.83%	-1.14
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	132.65	114.05	96.92	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	899.94	567.98	506.57	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	NA	96.21%	97.10%	0.89
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	NA	100.00%	97.78%	-2.22
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	NA	76.67%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	NA	78.18%	Not Comparable

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.10—Multi-Year SPD Performance Measure Trend Table
Molina—Riverside/San Bernardino Counties**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.27%	19.55%	26.38%	21.70%	-4.68 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	72.83	71.10	74.73	74.01	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	312.01	571.37	341.18	352.50	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.83%	85.53%	88.40%	91.17%	2.77 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.26%	84.93%	87.26%	91.47%	4.21 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	78.45%	80.74%	81.29%	83.33%	2.04
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.40%	83.99%	84.29%	85.75%	1.46
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	76.02%	75.52%	78.99%	83.33%	4.34 [^]

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.11—Multi-Year SPD Performance Measure Trend Table
Molina—Sacramento County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	15.39%	16.14%	17.87%	21.92%	4.05^^
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	68.46	80.14	86.33	92.84	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	423.73	799.21	509.35	420.83	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.05%	84.69%	87.30%	86.38%	-0.92
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.25%	85.01%	88.41%	87.07%	-1.34
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	80.95%	75.00%	86.59%	78.85%	-7.74
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	79.07%	77.42%	83.54%	85.00%	1.46
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	74.85%	70.32%	70.97%	71.27%	0.30

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.12—Multi-Year SPD Performance Measure Trend Table
Molina—San Diego County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	17.07%	18.01%	20.98%	17.63%	-3.35 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	71.93	75.48	76.51	74.15	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	434.68	913.25	571.94	591.50	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.49%	85.90%	91.66%	94.56%	2.90 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.57%	88.06%	92.84%	95.42%	2.58 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	86.83%	85.64%	89.50%	90.50%	1.00
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.92%	88.47%	88.25%	90.78%	2.53
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.87%	83.53%	86.17%	87.67%	1.50

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.13—Multi-Year Non-SPD Performance Measure Trend Table
Molina—Imperial County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	S	11.24%	9.06%	-2.18
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	55.82	50.01	49.49	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	440.92	214.32	203.30	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	90.37%	87.02%	89.66%	2.64
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	90.07%	92.68%	87.50%	-5.18
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	85.65%	83.56%	93.16%	9.60 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	77.36%	76.10%	76.39%	0.29
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	81.56%	76.29%	-5.27 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	79.87%	73.12%	-6.75 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 non-SPD rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.14—Multi-Year Non-SPD Performance Measure Trend Table
Molina—Riverside/San Bernardino Counties**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.46%	10.87%	11.52%	11.31%	-0.21
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	35.41	37.13	36.92	35.49	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	192.15	335.56	188.78	188.15	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.84%	84.73%	83.91%	86.45%	2.54 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.00%	83.25%	81.11%	85.48%	4.37 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	92.80%	90.92%	90.23%	91.86%	1.63
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.22%	81.89%	83.72%	81.37%	-2.35 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.22%	84.31%	84.54%	84.53%	-0.01
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.03%	83.65%	83.62%	82.62%	-1.00 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.15—Multi-Year Non-SPD Performance Measure Trend Table
Molina—Sacramento County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	7.34%	10.98%	11.63%	11.37%	-0.26
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	44.36	54.54	55.21	51.16	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	204.58	384.77	235.22	192.13	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.06%	83.15%	87.47%	86.29%	-1.18
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	75.81%	80.02%	86.28%	84.49%	-1.79
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	94.72%	89.21%	89.41%	89.40%	-0.01
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.98%	80.54%	80.57%	76.59%	-3.98^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	83.01%	80.57%	81.76%	82.44%	0.68
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.09%	80.93%	80.32%	79.29%	-1.03

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.16—Multi-Year Non-SPD Performance Measure Trend Table
Molina—San Diego County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.52%	14.02%	13.65%	12.09%	-1.56 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	35.84	38.26	39.08	38.43	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	197.22	398.66	242.72	246.33	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.81%	83.18%	88.13%	90.33%	2.20 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.50%	82.50%	87.78%	89.76%	1.98 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	95.85%	93.94%	90.87%	92.97%	2.10 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.86%	86.40%	85.68%	84.83%	-0.85 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.22%	89.86%	89.42%	88.54%	-0.88 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.40%	87.20%	87.49%	85.87%	-1.62 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

SPD and Non-SPD Rate Changes from RY 2016 to RY 2017

For measures for which HSAG could make a comparison between RY 2016 and RY 2017, HSAG observed the following notable results for measures that Molina stratified by the SPD and non-SPD populations:

- ◆ The SPD rate improved significantly from RY 2016 to RY 2017 for the following measures:
 - *All-Cause Readmissions* in Riverside/San Bernardino and San Diego counties
 - Both *Annual Monitoring for Patients on Persistent Medication* measures in Riverside/San Bernardino and San Diego counties
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Riverside/San Bernardino counties
- ◆ The non-SPD rate improved significantly from RY 2016 to RY 2017 for the following measures:
 - *All-Cause Readmissions* in San Diego County
 - Both *Annual Monitoring for Patients on Persistent Medication* measures in Riverside/San Bernardino and San Diego counties
 - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* in Imperial and San Diego counties
- ◆ The RY 2017 SPD rate was significantly worse than the RY 2016 SPD rate for the *All-Cause Readmissions* measure in Sacramento County.
- ◆ The RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* Riverside/San Bernardino, Sacramento, and San Diego counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Imperial and San Diego counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Imperial, Riverside/San Bernardino, and San Diego counties.

RY 2017 SPD and RY 2017 Non-SPD Rate Comparisons

For measures for which HSAG could compare the RY 2017 SPD rates to the RY 2017 non-SPD rates, HSAG observed the following notable results for measures that Molina stratified by the SPD and non-SPD populations:

- ◆ The SPD rates were significantly better than the non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medication* measures in Imperial, Riverside/San Bernardino, and San Diego counties.
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* measure in San Diego County.

- ◆ The SPD rate was significantly worse than the non-SPD rate for the following measures:
 - *All-Cause Readmissions* in all four 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 beneficiaries.
 - *Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years* measure in Sacramento County. This significant difference may be attributed to children and adolescents in the SPD population in this age group, based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from PCPs.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to Molina’s participation in California’s Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP) in two reporting units—Riverside/San Bernardino and San Diego counties—DHCS required that Molina report rates for three HEDIS measures for those two MLTSS reporting units for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.17 and Table 3.18 present the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.17—Multi-Year MLTSSP Performance Measure Results
Molina—Riverside/San Bernardino Counties**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	91.97	94.18	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	536.26	565.48	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	3.39%	27.54%	24.15 [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member’s “contribution” to the total yearly membership.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.18—Multi-Year MLTSSP Performance Measure Results
Molina—San Diego County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	84.73	79.48	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	826.99	866.54	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	3.58%	27.79%	24.21 [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member’s “contribution” to the total yearly membership.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rates for the *Medication Reconciliation Post-Discharge* measure improved significantly from RY 2016 to RY 2017 in Riverside/San Bernardino and San Diego counties.

Strengths—Performance Measures

HSAG auditors determined that Molina followed the appropriate specifications to produce valid rates.

In Table 3.1 through Table 3.4 across all reporting units and domains, 28 of 76 rates (37 percent) improved significantly from RY 2016 to RY 2017, with the Care for Chronic Conditions domain having the highest percentage of rates improving from RY 2016 to RY 2017 (47 percent) and being the only domain with no rates below the MPLs in RY 2017. Riverside/San Bernardino counties had the highest percentage of measures with rates that improved significantly from RY 2016 to RY 2017, with 12 of 19 rates (63 percent) improving significantly. Riverside/San Bernardino counties showed the most improvement within the Care for Chronic Conditions domain, with eight of nine rates (89 percent) within this domain improving significantly from RY 2016 to RY 2017. Across all reporting units and domains, 18 of the 24 rates that were below the MPLs in RY 2016 (75 percent) moved to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

To ensure consistent lab data capture, the MCP has the opportunity to apply standardized abstraction methodologies and guidelines and implement an interrater reliability monitoring process for the MCP's two non-standard supplemental databases.

Based on performance measure results across all reporting units and domains, seven of 72 rates for which the MCP was held accountable to meet the MPLs (10 percent) were below the MPLs in RY 2017. Molina has the opportunity to assess whether current improvement strategies need to be modified, expanded, or duplicated to ensure that:

- ◆ Beneficiaries in Sacramento County receive their specified immunization dosages by age 2.
- ◆ Beneficiaries ages 3 to 6 in Sacramento County are seen for one or more well-child visit(s) with a PCP during the MY.
- ◆ Female beneficiaries in Imperial, Riverside/San Bernardino, and Sacramento counties who deliver a live birth complete a postpartum visit on or between 21 and 56 days after delivery.
- ◆ In Imperial and San Diego counties, only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

Molina had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

Molina selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to Molina to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

Molina set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, increase from 39.1 percent to 44.1 percent the rate of postpartum visits among eligible beneficiaries in a high-volume, low-performing provider office in Sacramento County.

Failure Modes

The following, listed in priority order, are the failure modes Molina identified during the Intervention Determination phase of the PIP process:

- ◆ Postpartum visit occurs out of the required time frame.
- ◆ Beneficiary thinks she had a postpartum checkup prior to discharge from the hospital.
- ◆ Molina quality improvement (QI) team members are not notified of the delivery in a timely manner.
- ◆ Molina QI team members are not notified of the delivery.
- ◆ Molina QI team members are unable to establish contact with the beneficiary.
- ◆ Beneficiary does not understand the postpartum visit.
- ◆ Beneficiary who had a Caesarean section has the first postpartum visit 7 to 10 days after delivery, which is outside of the required time frame, and therefore does not qualify as a postpartum visit within 21 to 56 days' post delivery.

- ◆ Beneficiary refuses to attend her postpartum visit.
- ◆ Postpartum-visit data are not documented correctly.
- ◆ Postpartum data are not received by Molina to verify compliance.

Intervention Testing

During the reporting period, Molina selected to test the effectiveness of performing in-home postpartum assessments within 21 to 56 days' post delivery. This intervention addresses beneficiaries' lack of motivation for seeking timely postpartum care.

Although Molina completed intervention testing through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Molina's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

Molina selected annual monitoring of patients on persistent medications as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated modules 1 and 2 for Molina's MCP-specific PIP, which was revised due to changes to the narrowed focus. Upon review, HSAG determined that Molina met all validation criteria for modules 1 and 2.

Additionally, HSAG validated Module 3 for Molina's MCP-specific PIP. Upon initial review of the module, HSAG determined that Molina met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.

After receiving technical assistance from HSAG, Molina incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to Molina on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to Molina to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Molina set the SMART Aim for the *Annual Monitoring of Patients on Persistent Medications* PIP as follows:

By June 30, 2017, increase the rates of annual monitoring for beneficiaries on persistent medications, from 84.92 percent to 89.92 percent for beneficiaries on angiotensin-converting enzyme inhibitors/angiotensin receptor blockers (ACE/ARBs) and from 83.95 percent to 88.95 percent for beneficiaries on diuretics, among beneficiaries receiving services from a high-volume, low-performing clinic in Sacramento County.

Failure Modes

The following, listed in priority order, are the failure modes that Molina identified during the Intervention Determination phase of the PIP process:

- ◆ Provider is not aware that the beneficiary needs a lab test.
- ◆ Beneficiary is not aware or does not understand the purpose of the lab test.
- ◆ Beneficiary is given the lab order but does not complete the lab test.
- ◆ Provider does not receive lab data.
- ◆ Beneficiary's medication list is not updated appropriately in the medical record.
- ◆ Provider receives lab data but does not submit an encounter to the MCP.
- ◆ Provider neglects to order the lab test that the beneficiary needs.
- ◆ Beneficiary does not have transportation to the provider office.

Intervention Testing

During the reporting period, Molina selected to test the effectiveness of sending, to a selected high-volume, low-performing clinic via secure email, a monthly list of members on persistent medications and who need a monitoring lab test. The clinic will use the list to identify beneficiaries with whom to target outreach efforts and with whom to schedule appointments. This intervention addresses the failure mode that providers are not aware of which beneficiaries need services.

Although Molina completed intervention testing through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Molina's 2017–18 MCP-specific evaluation report.

Strengths

Through HSAG's PIP validation and technical assistance, Molina improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the MCP completed during the reporting period.

Opportunities for Improvement

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Molina’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Molina’s self-reported actions.

Table 5.1—Molina’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. Assess whether or not current improvement strategies need to be modified or expanded for performance measures for which the MCP performed below the MPLs in RY 2016.</p>	<p>Throughout the period of June 2016 through July 2017, Molina continually reassessed ongoing improvement strategies for performance measures that fell below the MPLs in RY 2016.</p> <p>Improvement interventions and results were discussed during monthly calls with the DHCS nurse consultant and DHCS medical director. Molina submitted PDSA cycle reports to DHCS and participated in quarterly PDSA cycle review calls. These 2016–17 PDSA cycles included:</p> <ul style="list-style-type: none"> ◆ <i>Cervical Cancer Screening</i>—Imperial County ◆ <i>Childhood Immunization Status (CIS)—Combination 3</i>—Sacramento County (SAC) ◆ <i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing and HbA1c Control (<8.0 Percent)</i>—Imperial County ◆ <i>Controlling High Blood Pressure (CBP)</i>—Riverside/San Bernardino Counties (R/SB) ◆ <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>—R/SB <p>Also, intervention summaries were submitted for two at-risk measures:</p> <ul style="list-style-type: none"> ◆ <i>Use of Imaging Studies for Low Back Pain</i>—San Diego County ◆ <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>—R/SB <p>Quarterly executive summaries of ongoing improvement strategies were submitted to DHCS and discussed during in-person meetings with DHCS.</p> <p>Periodic updates on PIPs’ intervention progress were submitted to HSAG. Final PIP modules 4 and 5 for <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics</i> and <i>Prenatal and</i></p>

2015–16 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations		
	<p><i>Postpartum Care—Postpartum Care</i> PIPs were submitted to HSAG for review and validation in August 2017.</p> <p>RY 2017 results for measures falling below the MPLs in RY 2016 demonstrated that interventions were effective in improving the following HEDIS rates:</p>		
	PDSA Cycles—Goal: Exceed MPLs		
<i>Cervical Cancer Screening</i>	Exceeded 25th percentile in all regions, including Imperial.	Goal met.	
<i>CIS—Childhood Immunization Status</i>	Rebounded rates from significant decrease in RY 2016 in SAC.	Goal not fully met—continue interventions.	
<i>Comprehensive Diabetes Care—Eye Exam (Retinal)</i>	RY 2016—Exceeded the 25th percentile in R/SB.	Goal met. No PDSA was required in 2016–17.	
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing and HbA1c Control (<8.0 Percent)</i>	Exceeded 25th percentile in all regions, including Imperial.	Goal met.	
<i>CBP—Controlling Blood Pressure</i>	Exceeded the 25th percentile in R/SB.	Goal met. After a review of improved performance and discussion with DHCS leadership and our DHCS nurse consultant, it was determined that reporting for 2017–18 will continue as a quarterly summary report of interventions for 2017–18. No PDSA will be required.	

2015–16 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations		
	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	Exceeded 25th percentile in all regions, including R/SB and SAC.	Goal met. After a review of improved performance and discussion with DHCS leadership and our DHCS nurse consultant, it was determined that reporting for 2017–18 will continue as a quarterly summary report of interventions for 2017–18. No PDSA will be required.
Intervention Summaries—Goal: Exceed MPLs			
	<i>Use of Imaging Studies for Low Back Pain—San Diego County</i>	Failed to exceed the 25th percentile in San Diego.	Goal not met—interventions will be expanded. After a review of current performance and discussion with DHCS leadership and our DHCS nurse consultant, it was determined that reporting for 2017–18 will continue as a quarterly summary report of interventions for 2017–18. No PDSA will be required.
	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Exceeded the 25th percentile in R/SB.	Goal met. After a review of improved performance and discussion with DHCS leadership and our DHCS nurse consultant, it was determined that reporting for 2017–18 will continue as a quarterly summary report of interventions for 2017–18. No PDSA will be required.

2015–16 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations		
	PIPs—Goal: Exceed MPLs		
	<i>MPM (ACE/ARBs, Diuretics)</i>	Exceeded 25th percentile two years in a row for SAC.	Goal met.
	<i>PPC—Postpartum</i>	A consistent improvement year over year in R/SB.	Goal not fully met—continue interventions.
	Imperial County Performance—Goal: Exceed MPLs		
	All measures	Due to the successful improvement strategies being implemented in Imperial County, total measures above the MPL increased from 11 of 22 (50 percent) in RY 2016 to 16 of 18 (89 percent) in RY 2017. This is a 78 percent improvement.	Goal not fully met—continue interventions.
<p>2. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Postpartum Care</i> PIP.</p>	<p>Based on the Module 4 pre-validation review feedback that HSAG provided on June 29, 2016, Molina indicated that intervention testing for the <i>Postpartum Care</i> PIP will:</p> <ul style="list-style-type: none"> ◆ Include that the intervention will be tested with the narrowed focus of the PIP at one specified clinic. ◆ Extend testing of the intervention to allow for the full 56 days after birth for all members. ◆ Follow HSAG’s recommendation that, after the test cycle is complete, if the intervention is successful Molina will continue testing it through the SMART Aim end date and track the rates for sustained improvement. ◆ When submitting Module 4 for validation, a succinct data tracking tool that is specifically used to evaluate the intervention will be included. In addition, the survey questions will be included with the submission. <p>HSAG reviewed Molina’s Module 4 progress update for the <i>Postpartum Care</i> PIP in October 2016 and confirmed that Molina had made appropriate progress with intervention testing. Molina provided clarification in its update to address HSAG’s feedback and recommendations from the Module 4 Plan pre-validation review. HSAG did not have any questions or further recommendations.</p>		

2016–17 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 consistent lab data capture, apply standardized abstraction methodologies and guidelines and implement an interrater reliability monitoring process for the MCP’s two non-standard supplemental databases.
- ◆ Assess whether current improvement strategies need to be modified, expanded, or duplicated to address the MCP’s performance below the MPL in RY 2017 for the following measures:
 - *Childhood Immunization Status—Combination 3* measure in Sacramento County.
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County.
 - *Prenatal and Postpartum Care—Postpartum Care* measure in Imperial, Riverside/San Bernardino, and Sacramento counties.
 - *Use of Imaging Studies for Low Back Pain* in Imperial and San Diego counties.
- ◆ To help sustain the improvement achieved from RY 2016 to RY 2017 for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Riverside/San Bernardino and Sacramento counties, identify which strategies were successful and expand them, as applicable, to other partner providers.

In the next annual review, HSAG will evaluate continued successes of Molina as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix W:
Performance Evaluation Report
Partnership HealthPlan of California
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Partnership HealthPlan of California (“Partnership” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in Partnership’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Partnership is a full-scope MCP delivering services to beneficiaries in the County Organized Health System (COHS) model.

Partnership became operational to provide MCMC services in Solano County effective May 1994, in 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 the number of beneficiaries for Partnership for each county and the MCP's total number of beneficiaries as of June 30, 2017.¹

Table 1.1—Partnership Enrollment as of June 30, 2017

County	Enrollment as of June 30, 2017
Del Norte	11,378
Humboldt	52,277
Lake	30,506
Lassen	7,375
Marin	39,622
Mendocino	37,801
Modoc	3,031
Napa	28,604
Shasta	59,418
Siskiyou	17,719
Solano	110,832
Sonoma	112,664
Trinity	4,343
Yolo	53,380
Total	568,950

DHCS allows Partnership to combine data into four regions for reporting purposes. 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

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Sep 18, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Partnership. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the most recent Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Partnership. A&I conducted the on-site audits from January 30, 2017, through February 3, 2017. Note that while DHCS issued the final closeout letter to Partnership on August 17, 2017, which is outside the review period for this MCP-specific evaluation report, HSAG includes the audit results and status because A&I conducted the on-site audits during the review period.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Partnership
Audit Review Period: January 1, 2016, through December 31, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Case Management and Coordination of Care	Yes	Closed.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	No	Not applicable.
State Supported Services	No	Not applicable.

Table 2.2 summarizes the results and status of the 2016 A&I Medical and State Supported Services Audits of Partnership. A&I conducted the on-site audits from January 25, 2016, through February 5, 2016. Note that while A&I conducted the audits outside of the review period for this MCP-specific evaluation report, HSAG includes the audit results and status because DHCS issued the final audit reports on October 25, 2016, and the closeout letter on January 20, 2017, which were during the review period for this MCP-specific evaluation report.

**Table 2.2—DHCS A&I Medical and State Supported Services Audits of Partnership
Audit Review Period: January 1, 2015, through December 31, 2015**

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Case Management and Coordination of Care	No	Not applicable.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	Yes	Closed.
Administrative and Organizational Capacity	Yes	Closed.
State Supported Services	No	Not applicable.

Follow-Up on 2015 Seniors and Persons with Disabilities Medical and Rural Expansion Survey

The Department of Managed Health Care (DMHC) conducted an on-site 1115 Waiver Seniors and Persons with Disabilities (SPD) Medical and Rural Expansion Survey of Partnership from February 23, 2015, through February 27, 2015, covering the review period of December 1, 2013, through November 30, 2014. HSAG provided a summary of the survey results and status in Partnership’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, in a letter dated February 1, 2016, DHCS had provisionally closed one deficiency in the Availability and Accessibility category and had closed all other deficiencies identified during the survey.

A letter dated December 8, 2016, stated that Partnership provided DHCS with additional information regarding the provisionally-closed deficiency and that DHCS had therefore closed the CAP.

Strengths—Compliance Reviews

Partnership has fully resolved all deficiencies from the 2016 and 2017 A&I Medical Audits and 2015 DMHC SPD Medical and Rural Expansion Survey.

Opportunities for Improvement—Compliance Reviews

Partnership has no outstanding deficiencies from the 2016 and 2017 A&I Medical Audits and 2015 DMHC SPD Medical and Rural Expansion Survey; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Partnership HealthPlan of California* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that Partnership followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for Partnership's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.4:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	58.64%	56.61%	56.54%	-0.07
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	94.08%	91.69%	91.93%	0.24
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	80.79%	81.83%	80.44%	-1.39^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	NA	80.72%	80.69%	-0.03
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	NA	83.31%	81.74%	-1.57^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	11.19%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	55.96%	58.64%	58.88%	0.24
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	40.39%	51.58%	51.82%	0.24
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	62.04%	63.66%	65.10%	1.44
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	50.67%	Not Comparable
<i>Cervical Cancer Screening</i>	--	45.99%	42.09%	52.07%	9.98^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	52.80%	49.27%	61.56%	12.29^
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	78.83%	72.44%	81.27%	8.83^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	82.11%	81.68%	82.40%	0.72
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	83.23%	83.40%	84.77%	1.37
<i>Asthma Medication Ratio—Total</i>	--	--	--	50.89%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	56.69%	64.23%	70.32%	6.09

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	34.79%	43.07%	49.64%	6.57
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	48.91%	44.04%	52.07%	8.03 [^]
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	42.58%	46.96%	38.69%	-8.27 [^]
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	87.35%	86.86%	85.89%	-0.97
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	76.16%	87.35%	89.78%	2.43
<i>Controlling High Blood Pressure</i>	--	48.42%	54.74%	64.30%	9.56 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	14.55%	15.25%	12.47%	-2.78 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	68.85	73.36	58.66	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	248.98	239.00	227.19	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	22.31%	27.22%	36.13%	8.91 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	0.04%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	80.46%	81.63%	76.30%	-5.33^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
Partnership—Northwest (Del Norte and Humboldt Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYS 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	56.13%	56.54%	60.00%	3.46
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	96.54%	95.06%	95.33%	0.27
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	87.40%	85.80%	86.14%	0.34
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	NA	86.57%	84.48%	-2.09^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	NA	87.00%	85.83%	-1.17
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	17.52%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	46.47%	57.18%	63.41%	6.23
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	36.25%	56.20%	59.51%	3.31
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	62.53%	60.05%	71.65%	11.60^
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	46.04%	Not Comparable
<i>Cervical Cancer Screening</i>	--	49.64%	44.04%	49.15%	5.11
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	50.36%	59.37%	65.08%	5.71
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	82.97%	80.54%	84.42%	3.88
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	80.41%	78.82%	85.55%	6.73^
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	83.65%	80.46%	86.06%	5.60^
<i>Asthma Medication Ratio—Total</i>	--	--	--	50.39%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	58.39%	60.58%	63.26%	2.68

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	39.17%	42.82%	47.93%	5.11
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	56.20%	48.42%	51.09%	2.67
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	31.14%	39.66%	40.15%	0.49
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	92.21% ⁺	83.70%	91.24%	7.54 [^]
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	85.89%	85.16%	87.83%	2.67
<i>Controlling High Blood Pressure</i>	--	47.45%	60.34%	48.10%	-12.24^{^^}
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	13.22%	11.45%	10.91%	-0.54
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	55.74	57.05	46.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	251.63	228.31	214.55	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	29.35%	34.43%	32.51%	-1.92
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	84.26% ⁺	85.71% ⁺	81.16%	-4.55^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.3—Multi-Year Performance Measure Results*
Partnership—Southeast (Napa, Solano, and Yolo Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	Ry 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	72.32%	68.66%	71.67%	74.56%	2.89
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	96.81%	94.46%	94.07%	94.32%	0.25
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	87.79%	86.65%	85.06%	85.05%	-0.01
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	85.84%	85.98%	86.22%	86.83%	0.61
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	83.80%	84.19%	84.94%	85.31%	0.37
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	30.17%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	65.12%	73.11%	81.40% ⁺	80.18% ⁺	-1.22
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	54.15%	67.97%	76.28% ⁺	75.30% ⁺	-0.98
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	73.83%	75.30%	77.64%	78.04%	0.40
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	57.20%	Not Comparable
<i>Cervical Cancer Screening</i>	69.59%	58.19%	60.10%	67.09%	6.99 [^]
<i>Prenatal and Postpartum Care—Postpartum Care</i>	68.85%	69.17%	66.38%	72.51%	6.13
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	80.00%	87.50%	84.46%	85.44%	0.98
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.71%	88.26%	86.39%	87.11%	0.72
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.42%	88.88%	85.33%	86.20%	0.87
<i>Asthma Medication Ratio—Total</i>	--	--	--	66.67%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.21%	61.95%	63.66%	63.81%	0.15

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	60.34%	54.15%	60.98%	59.41%	-1.57
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	52.31%	53.66%	54.15%	54.03%	-0.12
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	37.47%	35.37%	35.61%	34.72%	-0.89
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	82.48%	88.05%	85.12%	84.35%	-0.77
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.86% ⁺	84.88%	87.56%	90.46%	2.90
<i>Controlling High Blood Pressure</i>	56.72%	58.52%	65.59%	61.70%	-3.89
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	15.60%	15.07%	14.81%	13.83%	-0.98
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	53.57	58.01	59.17	50.03	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	311.38	331.00	281.18	235.96	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	34.31%	34.83%	34.81%	42.55% ⁺	7.74 [^]
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	89.17% ⁺	87.12% ⁺	86.27% ⁺	83.03% ⁺	-3.24 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Performance Measure Results*
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	Ry 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	--	73.72%	66.77%	66.85%	0.08
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	--	95.78%	95.62%	95.15%	-0.47
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	--	88.92%	87.55%	87.74%	0.19
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	--	89.77%	89.30%	88.34%	-0.96^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	--	87.86%	88.67%	87.92%	-0.75^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	28.22%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	--	62.77%	72.99%	76.56%	3.57
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	--	53.77%	63.75%	72.07% ⁺	8.32 [^]
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	--	72.02%	73.13%	75.61%	2.48
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	52.06%	Not Comparable
<i>Cervical Cancer Screening</i>	--	56.20%	57.78%	59.06%	1.28
<i>Prenatal and Postpartum Care—Postpartum Care</i>	--	68.37%	68.33%	69.17%	0.84
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	--	86.13%	91.94% ⁺	89.44%	-2.50
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	83.20%	83.40%	84.92%	1.52 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	83.30%	85.03%	84.85%	-0.18
<i>Asthma Medication Ratio—Total</i>	--	--	--	59.74%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	64.48%	71.29%	68.61%	-2.68

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	--	49.15%	54.01%	57.42%	3.41
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	--	46.72%	48.91%	51.34%	2.43
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	--	43.31%	40.15%	37.71%	-2.44
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	--	87.10%	87.10%	89.29%	2.19
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	--	76.64%	86.62%	84.67%	-1.95
<i>Controlling High Blood Pressure</i>	--	54.01%	65.53%	64.89%	-0.64
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	--	14.24%	12.44%	11.40%	-1.04
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	--	50.01	52.36	45.42	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	--	333.19	302.06	253.48	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	--	40.97% ⁺	41.15% ⁺	44.06% ⁺	2.91
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	S	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	--	88.00% ⁺	87.86% ⁺	83.84% ⁺	-4.02^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

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 an RY 2016 or RY 2017 rate is suppressed, HSAG also suppresses the RY 2016–17 rate difference.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of Partnership’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ All four *Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

Across all regions within the Preventive Screening and Children’s Health domain, three of 16 rates (19 percent) were above the HPLs in RY 2017, and two rates (13 percent) improved significantly from RY 2016 to RY 2017. Two of the four rates that were below the MPLs in RY 2016 (50 percent) improved to above the MPLs in RY 2017, and two rates were below the MPLs within this domain in RY 2017. The Southeast and Southwest regions had no rates below the MPLs in the Preventive Screening and Children’s Health domain in RY 2017.

The rates for the following measures were above the HPLs in RY 2017:

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* in the Southeast Region
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total* in the Southeast and Southwest regions

The rates for the following measures improved significantly from RY 2016 to RY 2017:

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total* in the Southwest Region.

- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northwest Region, resulting in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in the Northeast Region improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.

The rates for the *Childhood Immunization Status—Combination 3* measure in the Northeast and Northwest regions were below the MPLs in RY 2017.

Performance measure results within the Preventive Screening and Children’s Health domain show that Partnership has the opportunity for improvement related to ensuring that beneficiaries in the Northeast and Northwest regions receive their specified immunization dosages by age 2.

Preventive Screening and Women’s Health

Across all regions within the Preventive Screening and Women’s Health domain, all rates for which MCPs were held accountable to meet the MPLs were between the HPLs and MPLs in RY 2017, and four of 12 rates (33 percent) improved significantly from RY 2016 to RY 2017. Additionally, all four rates that were below the MPLs in RY 2016 improved to above the MPLs in RY 2017.

The rates for the following measures improved significantly from RY 2016 to RY 2017:

- ◆ *Cervical Cancer Screening* in the Northeast and Southeast regions.
 - The significant improvement in the Northeast Region resulted in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ Both *Prenatal and Postpartum Care* measures in the Northeast Region, resulting in the rates for both measures moving from below the MPLs in RY 2016 to above the MPLs in RY 2017.

The rate for the *Cervical Cancer Screening* measure in the Northwest Region improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.

Care for Chronic Conditions

Across all regions within the Care for Chronic Conditions domain, seven of 36 rates (19 percent) improved significantly from RY 2016 to RY 2017. Three of the seven rates that were below the MPLs in RY 2016 (43 percent) moved from below the MPLs in RY 2016 to above the MPLs in RY 2017. Seven of 36 rates for which MCPs were held accountable to meet the MPLs (19 percent) were below the MPLs within the Care for Chronic Conditions domain in RY 2017, and one rate within this domain declined significantly from RY 2016 to RY 2017. The Southeast Region was the only region with no rates below the MPLs within the Care for Chronic Conditions domain in RY 2017.

The rates for the following measures improved significantly from RY 2016 to RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northwest and Southwest regions; however, despite the significant improvement, the rates in both regions remained below the MPL in RY 2017.
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northwest Region, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in the Northeast Region.
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in the Northeast Region.
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* in the Northwest Region.
- ◆ *Controlling High Blood Pressure* in the Northeast Region.

The rates for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure in the Northeast and Northwest regions improved from RY 2016 to RY 2017. Although the improvement was not statistically significant, the change resulted in the rates moving from below the MPL in RY 2016 to above the MPL in RY 2017.

The rates for the following measures were below the MPLs in RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northeast, Northwest, and Southwest regions
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northeast and Southwest regions
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in the Northwest and Southwest regions

The rate for the *Controlling High Blood Pressure* measure in the Northwest Region declined significantly from RY 2016 to RY 2017.

Performance measure results within the Care for Chronic Conditions domain show that Partnership has the opportunity for improvement related to ensuring that:

- ◆ Beneficiaries in the Northeast, Northwest, and Southwest regions ages 18 and older on angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) receive annual monitoring.
- ◆ Beneficiaries in the Northeast and Southwest regions ages 18 and older on diuretics receive annual monitoring.
- ◆ Beneficiaries in the Northwest and Southwest regions ages 18 to 75 with diabetes (type 1 and type 2) receive a nephropathy screening or monitoring test.
- ◆ Beneficiaries in the Northwest Region ages 18 to 85 with a diagnosis of hypertension have their blood pressure adequately controlled during the MY based on specified criteria for their ages.

Appropriate Treatment and Utilization

Across all regions within the Appropriate Treatment and Utilization domain, four of eight rates (50 percent) were above the HPLs in RY 2017 and no rates were below the MPLs. For measures for which a comparison was made between RY 2016 and RY 2017, three of 12 rates (25 percent) improved significantly from RY 2016 to RY 2017 and four of the 12 rates (33 percent) declined significantly from RY 2016 to RY 2017.

The rates for the following measures were above the HPLs in RY 2017:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in the Southeast and Southwest regions.
 - The rate for this measure in the Southeast region improved significantly from RY 2016 to RY 2017.
 - Partnership performed above the HPL for this measure for the third consecutive year in the Southwest Region.
- ◆ *Use of Imaging Studies for Low Back Pain* in the Southeast and Southwest regions. Note that despite the rates for this measure in both regions declining significantly from RY 2016 to RY 2017, the rates remained above the HPL for at least the third consecutive year in both regions.

In addition to the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in the Southeast region improving significantly from RY 2016 to RY 2017, the rates for the following measures improved significantly from RY 2016 to RY 2017:

- ◆ *All-Cause Readmissions* in the Northeast Region
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in the Northeast Region

In addition to the rates for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017 in the Southeast and Southwest regions, the rates for this measure in the Northeast and Northwest regions also declined significantly from RY 2016 to RY 2017. Note that the significant decline in the rates for the *Use of Imaging Studies for Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to Partnership's performance.

Performance measure results show that Partnership has the opportunity to explore the causes for the rates for the *Use of Imaging Studies for Low Back Pain* measure declining significantly from RY 2016 to RY 2017 in all four regions, to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Strategies to Improve Performance

Partnership provided information on actions that it took during the review period to improve the MCP's performance on measures with rates that were below the MPLs in RY 2016. (See Table 5.1.) Additionally, under the "Assessment of Improvement Plans" heading in this section of the report, HSAG

provides a summary of the PDSA cycles that Partnership conducted during the review period to improve the MCP's performance. Partnership's efforts may have contributed to the improvement that HSAG noted under the "Performance Measure Findings" heading.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, DHCS required Partnership to submit IP/PDSA cycles for the following measures:

- ◆ Both *Annual Monitoring for Patients on Persistent Medications* measures in the Northeast, Northwest, and Southwest regions
- ◆ *Cervical Cancer Screening* in the Northeast and Northwest regions
- ◆ *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions
- ◆ *Immunizations for Adolescents—Combination 1* in the Northeast Region (Note that in RY 2017 DHCS replaced this measure with the *Immunizations for Adolescents—Combination 2* measure; therefore, HSAG provides no information on Partnership's PDSA cycles for this measure.)
- ◆ Both *Prenatal and Postpartum Care* measures in the Northeast Region

In lieu of PDSA cycles for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for the Northeast and Northwest regions, DHCS required Partnership to submit triannual quality improvement summaries on the MCP's efforts to improve its performance for this measure.

The rates for the following measures for which Partnership conducted IP/PDSA cycles or submitted triannual quality improvement summaries improved from below the MPLs in RY 2016 to above the MPLs in RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northwest Region
- ◆ *Cervical Cancer Screening* in the Northeast and Northwest regions
- ◆ Both *Prenatal and Postpartum Care* measures in the Northeast Region
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in the Northeast and Northwest regions

The rates for the following measures for which Partnership conducted IP/PDSA cycles or submitted triannual quality improvement summaries remained below the MPLs in RY 2017:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northeast, Northwest, and Southwest regions
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northeast and Southwest regions
- ◆ *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions

Annual Monitoring for Patients on Persistent Medications

Partnership conducted two PDSA cycles to address the MCP's performance below the MPLs in RY 2016 for the *ACE Inhibitors or ARBs* measure in the Northeast, Northwest, and Southwest regions and the *Diuretics* measure in the Northeast and Northwest regions. For both PDSA cycles, the MCP partnered with a low-performing provider group to test whether or not using the flag alert feature in the provider's electronic health record (EHR) system to identify beneficiaries who are in need of their annual lab tests, having the medical assistant create lab orders for those beneficiaries in need of lab tests, and having the medical assistant communicate with the provider about the lab order would improve the lab testing rate for beneficiaries who are taking ACE inhibitors, ARBs, and diuretics. For both PDSA cycles, the SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective was to increase, from a baseline of 0 percent to 90 percent, the rate of completed lab testing occurring on the same date as the scheduled appointment with the provider.

After completing the first PDSA cycle, Partnership reported that it did not meet the SMART objective and that the MCP decided to adapt the intervention to include the MCP conducting outreach to beneficiaries who did not complete their lab tests on the day of their appointments to learn what led to these beneficiaries not completing the lab tests.

Following the second PDSA cycle, Partnership reported that it did not meet the SMART objective and that the MCP decided to adapt the intervention to include the provider conducting the beneficiary outreach using a gap list.

Partnership indicated that using the flag alert feature in the EHR system to identify non-compliant beneficiaries and having the medical assistants initiate lab orders were successful strategies for ensuring that the provider approved the lab orders and initiated communication with the beneficiaries to complete the labs on the same day of the provider appointment.

Cervical Cancer Screening

Partnership conducted two PDSA cycles to address the MCP's performance below the MPL in RY 2016 for the *Cervical Cancer Screening* measure in the Northeast and Northwest regions. For both PDSA cycles, the MCP partnered with the same medical center to test whether or not targeted beneficiary outreach combined with timely appointment availability would improve cervical cancer screening rates. The SMART objective for both PDSA cycles was to increase by 10 percentage points the rate of cervical cancer screening at the partnered medical center.

For the first PDSA cycle, both the MCP and provider conducted the beneficiary outreach. After the first cycle was completed, Partnership reported that it did not meet the SMART objective. Based on beneficiaries' negative responses to the MCP conducting the outreach calls, the MCP decided to adapt the intervention to have only the provider conduct the outreach.

After completing the second PDSA cycle, Partnership reported that while it did not meet the SMART objective the MCP decided to adopt the intervention. The MCP also reported that it was valuable to combine robust beneficiary contact practices with next-day follow-up after no-shows.

Childhood Immunization Status—Combination 3

To improve the rates for the *Childhood Immunization Status—Combination 3* measure in the Northeast and Northwest regions, Partnership conducted two PDSA cycles. For both PDSA cycles, the MCP partnered with the same clinic to test whether or not developing and implementing a modified workflow process to improve the efficiency of the provider's time during well-child visits would result in an increase in the percentage of beneficiaries receiving their specified immunizations by age 2.

For the first PDSA cycle, the SMART objective was to increase by 30 percentage points the rate of well-child visits that resulted in beneficiaries receiving their specified immunization dosages. Partnership reported that it did not meet the SMART objective and that the MCP decided to adapt the intervention for the second PDSA cycle. The adaptation included providing trainings to medical assistant and nursing staff and modifying the workflow process to further optimize the provider's time during well-child visits.

For the second PDSA cycle, the SMART objective was to increase by 10 percentage points the rate of well-child visits that resulted in beneficiaries receiving their specified immunization dosages. Partnership reported that it met the SMART objective and that the MCP decided to adopt the intervention.

Partnership reported on lessons learned through the PDSA cycle process, including:

- ◆ No comprehensive, age-appropriate education exists specific to the importance of receiving timely immunizations.
- ◆ The structure of the well-child visit appointment did not offer much opportunity for educating the parent/guardian or answering previously-reviewed questions.
- ◆ Individual and team efforts to ensure efficient and effective use of clinical and staff members' time were crucial to improvement.

Prenatal and Postpartum Care—Postpartum Care

Partnership conducted two PDSA cycles to address the MCP's performance below the MPL in RY 2016 for the *Prenatal and Postpartum Care—Postpartum Care* measure in the Northeast Region. For both PDSA cycles, the MCP partnered with the same medical clinic to test whether or not conducting beneficiary outreach phone calls coupled with mailing appointment reminder cards promoting timely postpartum appointment attendance would improve the postpartum care rate. The SMART objective for the first PDSA cycle was to improve the postpartum care appointment completion rate by 5 percentage points for beneficiaries seen by the clinic partner for prenatal services and who had a live birth. The SMART objective for the second PDSA cycle was to maintain the improved rate achieved from the first PDSA cycle.

Partnership reported that it met the SMART objective for the first PDSA cycle and that the MCP decided to adapt the intervention. For the second PDSA cycle, instead of Partnership conducting telephonic surveys with beneficiaries to collect qualitative data, the clinic staff members administered

the qualitative survey on-site at the clinic. This modification was based on the MCP having difficulty reaching the beneficiaries for the qualitative survey.

Partnership reported that while it did not meet the SMART objective for the second PDSA cycle, the MCP decided to adopt the intervention. Partnership also indicated that the MCP considers the combined approach of the clinic conducting outreach phone calls, sending appointment reminder cards, and reinforcing the importance of postpartum visits to be the clinic's outreach best practice.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Partnership conducted two PDSA cycles to address the MCP's performance below the MPL in RY 2016 for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in the Northeast Region. For both PDSA cycles, the MCP partnered with the same health center to test whether or not modifying EHR workflows and templates to ensure that the providers capture all documentation needed for the *Timeliness of Prenatal Care* measure would improve the health center partner's prenatal appointment completion rate. The SMART objective for the first PDSA cycle was to improve by 5 percentage points the health center partner's prenatal appointments completion rate. The SMART objective for the second PDSA cycle was to maintain the improved rate achieved from the first PDSA cycle.

Partnership reported that it met the SMART objective for the first PDSA cycle and that the MCP decided to adapt the intervention. For the second PDSA cycle, the MCP and health center partner modified the prenatal reminder in the EHR to present within the pop-up interface. Partnership reported that it met the SMART objective for the second PDSA cycle and that the MCP had decided to adopt the intervention.

The MCP reported on lessons learned through the PDSA cycle process, including:

- ◆ It is valuable to communicate the *Timeliness of Prenatal Care* measure requirements to primary care providers (PCPs) to ensure that those providers offer and document early prenatal care.
- ◆ Providers are willing to embrace a workflow that is simple to follow and that includes appropriate guidance and prompts.
- ◆ Effective streamlining of the EHR workflow helps to ensure that providers are prompted and guided to capture all necessary documentation to fully meet the *Timeliness of Prenatal Care* measure requirements.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

In the MCP's triannual quality improvement summaries submitted to DHCS, Partnership identified the following barriers to the MCP performing above the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in the Northeast and Northwest regions:

- ◆ Limited health care services, including primary care, are available in these rural regions.
- ◆ Providers lack knowledge about the HEDIS measures.
- ◆ Rural communities have challenges that may impact health equity.

The MCP implemented the following interventions to address the barriers:

- ◆ Conducted provider education on the efficient and complete utilization of the *Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM-160)*.
- ◆ Conducted provider training on the clinical guidelines, HEDIS measure specifications, and HEDIS rates.
- ◆ Added the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure to the MCP's provider incentive program.
- ◆ Increased provider capacity to improve primary care access.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, Partnership will be required to submit IP/PDSA cycles for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for the Northeast, Northwest, and Southwest regions
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* for the Northeast and Southwest regions

Based on RY 2017 performance measure results, Partnership will be required to submit a PIP in lieu of IP/PDSA cycles for the following measures:

- ◆ *Childhood Immunization Status—Combination 3* for the Northeast and Northwest regions
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* for the Northwest and Southwest regions

Seniors and Persons with Disabilities Performance Measure Results

Table 3.5 through Table 3.8 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.5—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.15%	9.61%	6.54^^	12.47%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	97.28	54.02	Not Tested	58.66
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	413.11	204.85	Not Tested	227.19
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.04%	79.41%	7.63^	82.40%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.89%	81.31%	8.58^	84.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.84%	Not Comparable	91.93%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	87.05%	80.27%	6.78^	80.44%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	87.50%	80.43%	7.07^	80.69%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.76%	81.61%	2.15	81.74%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.5 through Table 3.8.

Table 3.6—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Northwest (Del Norte and Humboldt Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	15.09%	8.12%	6.97^^	10.91%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	86.42	42.89	Not Tested	46.87
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	383.59	197.53	Not Tested	214.55
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.38%	83.02%	7.36^	85.55%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.19%	83.10%	8.09^	86.06%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	95.30%	Not Comparable	95.33%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	92.25%	85.99%	6.26^	86.14%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	91.52%	84.23%	7.29^	84.48%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.93%	85.67%	3.26	85.83%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.7—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Southeast (Napa, Solano, and Yolo Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.92%	11.78%	5.14^^	13.83%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	88.36	46.75	Not Tested	50.03
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	425.85	219.72	Not Tested	235.96
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.21%	85.68%	4.53^	87.11%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.69%	83.96%	6.73^	86.20%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	94.34%	Not Comparable	94.32%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	84.52%	85.06%	-0.54	85.05%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.80%	86.70%	3.10^	86.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	83.48%	85.41%	-1.93	85.31%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.8—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	16.13%	9.07%	7.06^^	11.40%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	90.11	42.23	Not Tested	45.42
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	484.79	237.01	Not Tested	253.48
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.40%	83.58%	4.82^	84.92%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.62%	83.60%	4.02^	84.85%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	95.12%	Not Comparable	95.15%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	90.45%	87.69%	2.76	87.74%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.74%	88.30%	1.44	88.34%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	88.30%	87.91%	0.39	87.92%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

** Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

Table 3.9 through Table 3.12 present the four-year trending information for the SPD population, and Table 3.13 through Table 3.16 present the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.9—Multi-Year SPD Performance Measure Trend Table
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	16.60%	17.81%	16.15%	-1.66
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	109.59	127.31	97.28	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	413.55	431.95	413.11	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	85.14%	86.51%	87.04%	0.53
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	85.41%	87.57%	89.89%	2.32
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	88.41%	87.20%	87.05%	-0.15
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	87.50%	87.50%	0.00
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	84.84%	83.76%	-1.08

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.10—Multi-Year SPD Performance Measure Trend Table
Partnership—Northwest (Del Norte and Humboldt Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	14.92%	14.76%	15.09%	0.33
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	98.00	106.26	86.42	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	420.22	405.91	383.59	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	83.83%	83.62%	90.38%	6.76 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	87.36%	85.64%	91.19%	5.55 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	90.63%	97.25%	92.25%	-5.00
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	93.02%	91.52%	-1.50
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	89.67%	88.93%	-0.74

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.11—Multi-Year SPD Performance Measure Trend Table
Partnership—Southeast (Napa, Solano, and Yolo Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	16.98%	16.32%	19.17%	16.92%	-2.25
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	81.68	89.77	104.12	88.36	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	565.93	602.57	488.22	425.85	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.49%	89.41%	88.74%	90.21%	1.47
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.39%	90.76%	89.42%	90.69%	1.27
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	92.31%	95.35%	93.55%	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	85.68%	84.08%	86.02%	84.52%	-1.50
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.27%	85.40%	86.19%	89.80%	3.61 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.25%	81.39%	81.49%	83.48%	1.99

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.12—Multi-Year SPD Performance Measure Trend Table
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	16.07%	15.53%	16.13%	0.60
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	91.33	98.56	90.11	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	590.09	553.37	484.79	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	84.83%	87.28%	88.40%	1.12
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	86.29%	89.81%	87.62%	-2.19
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	91.02%	88.15%	90.45%	2.30
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	87.14%	91.49%	89.74%	-1.75
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	84.88%	87.67%	88.30%	0.63

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.13—Multi-Year Non-SPD Performance Measure Trend Table
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	11.25%	13.05%	9.61%	-3.44 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	62.01	66.30	54.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	221.32	213.75	204.85	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	78.60%	78.33%	79.41%	1.08
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	80.40%	80.00%	81.31%	1.31
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	94.10%	91.63%	91.84%	0.21
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	80.61%	81.68%	80.27%	-1.41 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	80.43%	80.43%	0.00
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	83.21%	81.61%	-1.60 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.14—Multi-Year Non-SPD Performance Measure Trend Table
Partnership—Northwest (Del Norte and Humboldt Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	10.44%	8.95%	8.12%	-0.83
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	49.00	51.30	42.89	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	225.00	207.55	197.53	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	76.35%	75.62%	83.02%	7.40 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	78.86%	77.21%	83.10%	5.89 [^]
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	96.54%	95.04%	95.30%	0.26
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	87.34%	85.56%	85.99%	0.43
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	NA	86.27%	84.23%	-2.04 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	NA	86.82%	85.67%	-1.15

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.15—Multi-Year Non-SPD Performance Measure Trend Table
Partnership—Southeast (Napa, Solano, and Yolo Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	7.48%	10.71%	11.49%	11.78%	0.29
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	45.79	51.68	54.90	46.75	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	240.94	276.89	261.52	219.72	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.91%	85.52%	85.13%	85.68%	0.55
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.24%	84.59%	82.98%	83.96%	0.98
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	96.88%	94.45%	94.08%	94.34%	0.26
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	87.88%	86.73%	85.03%	85.06%	0.03
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	85.88%	86.02%	86.22%	86.70%	0.48
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	84.15%	84.52%	85.18%	85.41%	0.23

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.16—Multi-Year Non-SPD Performance Measure Trend Table
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	--	11.99%	10.64%	9.07%	-1.57 [^]
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	--	45.75	48.71	42.23	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	--	306.70	282.20	237.01	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	--	81.82%	81.65%	83.58%	1.93 [^]
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	--	80.31%	82.60%	83.60%	1.00
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	--	95.76%	95.67%	95.12%	-0.55
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	--	88.89%	87.54%	87.69%	0.15
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	--	89.87%	89.24%	88.30%	-0.94 ^{^^}
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	--	88.03%	88.71%	87.91%	-0.80 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

-- Indicates that the rate is not available.

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

For rates for which comparisons could be made, HSAG observed the following notable results for measures that Partnership stratified by the SPD and non-SPD populations:

SPD Rate Changes from RY 2016 to RY 2017

- ◆ No statistically significant changes occurred for any SPD rates between RY 2016 and RY 2017 in the Northeast and Southwest regions.
- ◆ The RY 2017 SPD rate was significantly better than the RY 2016 SPD rate for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in the Northwest Region
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in the Southeast Region

Non-SPD Rate Changes from RY 2016 to RY 2017

- ◆ No statistically significant changes occurred for any non-SPD rates between RY 2016 and RY 2017 in the Southeast Region.
- ◆ The RY 2017 non-SPD rate was significantly better than the RY 2016 non-SPD rate for the following measures:
 - *All-Cause Readmissions* in the Northeast and Southwest regions
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northwest and Southwest regions
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northwest Region
- ◆ The RY 2017 non-SPD rate was significantly worse than the RY 2016 non-SPD rate for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in the Northeast Region
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in the Northwest and Southwest regions
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in the Northeast and Southwest regions

Differences between RY 2017 SPD and RY 2017 Non-SPD Rates

- ◆ The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for the following measures:
 - Both *Annual Monitoring for Patients on Persistent Medications* measures in all four regions
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in the Northeast and Northwest regions
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in the Northeast, Northwest, and Southeast regions
- ◆ The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the *All-Cause Readmissions* measure in all four 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 beneficiaries.

Strengths—Performance Measures

HSAG auditors determined that Partnership followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all domains and regions, seven of 72 rates (10 percent) were above the HPLs in RY 2017. Additionally, nine of the 15 rates that were below the MPLs in RY 2016 (60 percent) moved to above the MPLs in RY 2017. Finally, 16 of the 76 rates for which comparisons were made between RY 2016 and RY 2017 (21 percent) improved significantly from RY 2016 to RY 2017.

Opportunities for Improvement—Performance Measures

To ensure that the MCP is performing above the MPLs for all required measures, Partnership has the opportunity to:

- ◆ Assess whether current strategies need to be modified or expanded to improve the MCP's performance to above the MPLs for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northeast, Northwest, and Southwest regions
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northeast and Southwest regions
 - *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions
- ◆ Identify the causes for the rates for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure being below the MPL in RY 2017 in the Northwest and Southwest regions, to assist the MCP with developing strategies to improve its performance to above the MPL in these regions.

- ◆ Identify the causes for the rate for the *Controlling High Blood Pressure* measure declining significantly from RY 2016 to RY 2017 in the Northwest Region, and assess whether the interventions tested as part of the MCP's *Hypertension* performance improvement project (PIP) could be adapted or adopted to help prevent the rate for the *Controlling High Blood Pressure* measure from continuing to decline in the Northwest Region.
- ◆ Identify the causes for the rates in all four regions declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain*, and determine whether or not the MCP needs to develop strategies to prevent the rates from continuing to decline.

4. Performance Improvement Projects

Partnership had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

Partnership selected hypertension as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for Partnership’s DHCS-priority PIP, which the MCP had revised due to identifying additional information prior to intervention testing. Upon review, HSAG determined that the MCP met all validation criteria for Module 3.

HSAG also reviewed and provided feedback to Partnership on the Plan portion of the PDSA cycle for the interventions the MCP selected to test. HSAG sent periodic check-in email communications to Partnership and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

Partnership set the SMART Aim for the *Hypertension* PIP as follows:

By June 30, 2017, Partnership will partner with Provider A⁶ in Humboldt County to improve blood pressure control rates from 41.95 percent (below the 25th percentile) to 56.20 percent (at or above the 50th percentile) among beneficiaries with hypertension.

Failure Modes

The following, listed in priority order, are the failure modes that Partnership identified during the Intervention Determination phase of the PIP process:

- ◆ Medical assistant may take an inaccurate blood pressure measurement due to using an improper technique.

⁶ Provider name removed for confidentiality.

- ◆ Medical assistant's update to the provider involves a discussion on whether the blood pressure measurement is too high/low for that specific beneficiary based on age and co-morbidities; however, no pre-defined thresholds have been set.
- ◆ Care team does not consistently schedule appointments for beneficiaries to follow up with the nurse.
- ◆ No home blood pressure monitoring kits are available in the care team's treatment/workspace areas.
- ◆ Beneficiaries struggle with how to accurately apply the cuff as well as initiate, read, and record home blood pressure measurements.
- ◆ Beneficiaries miss or cancel the next follow-up visit, and more than six months pass from the last visit.
- ◆ Electronic health records are not set up to automatically prompt the provider through a Best Practice Alert for beneficiaries presenting with uncontrolled blood pressure.
- ◆ Beneficiaries do not bring in their current medications or medication lists. Beneficiaries also do not bring in their home blood pressure logs.
- ◆ Medical assistant intake space is in a hallway nook on the way to exam room, so the environment is not conducive to making the beneficiaries feel at ease before blood pressure measurements are taken.
- ◆ Care team staff calling beneficiaries to confirm their appointments do not stress the importance of bringing the beneficiaries' home blood pressure logs and a list of current medications to the appointments.
- ◆ Medical assistant's intake space is not designed to accommodate a chair for proper arm positioning to ensure consistent/accurate blood pressure measurements.

Intervention Testing

During the reporting period, Partnership selected to test the following interventions:

- ◆ Setting blood pressure targets for beneficiaries on the EPIC EHR system to address the lack of pre-defined blood pressure thresholds when the medical assistant discusses beneficiaries' blood pressure measurements with the provider.
- ◆ Providing medical assistants with training on hypertension best practices and blood pressure monitoring protocols to address improper technique for taking blood pressure measurements.
- ◆ Standardizing nurse visit processes for interacting with beneficiaries who are newly diagnosed with hypertension, have medication changes, or have controlled hypertension to address beneficiary engagement and health education for hypertension management.

Although Partnership completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Partnership's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

Partnership selected diabetes as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for Partnership's MCP-specific PIP.

Upon initial review of the module, HSAG determined that Partnership met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including all required components of the failure modes and effects analysis.
- ◆ Describing the priority-ranking process to determine potential interventions.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, Partnership incorporated HSAG's feedback into the PIP modules. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for all submitted modules.

During the reporting period, HSAG also reviewed and provided feedback to Partnership on the Plan portion of the PDSA cycle for the interventions the MCP selected to test. HSAG sent periodic check-in email communications to Partnership and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

During intervention testing, Partnership learned that its provider partner was not following the established data collection methodology. HSAG conducted technical assistance calls with the MCP to determine the best approach for revising the data collection methodology in a way that could be followed by the provider partner.

SMART Aim

Partnership set the SMART Aim for the *Reducing Diabetes-Associated Vision Loss through Expanded Primary Care Retinopathy Screening* PIP as follows:

By June 30, 2017, increase from 25 percent to 68 percent the rate of *Comprehensive Diabetes Care—Eye Exam (Retinopathy) Performed* measure among Provider B⁷ beneficiaries living with diabetes.

⁷ Provider name removed for confidentiality.

Failure Modes

The following, listed in priority order, are the failure modes that Partnership identified during the Intervention Determination phase of the PIP process:

- ◆ Registry is not updated with beneficiaries who are newly diagnosed with diabetes.
- ◆ Registry is not updated with beneficiaries with diabetes who are new to the clinic.
- ◆ Poor retinopathy image quality due to beneficiaries not being a good candidate for retinal imaging without pupils dilated.
- ◆ Beneficiaries do not see an eye specialist for retinal exam.
- ◆ Registry does not have current information for beneficiaries with up-to-date retinal screening performed by an eye specialist.
- ◆ Beneficiaries do not show up for retinal exam appointment due to access barriers.
- ◆ Beneficiaries do not show up for retinal exam appointment because they are not engaged in their health care.
- ◆ Registry does not have current information for beneficiaries with up-to-date retinal exam performed in the clinic.
- ◆ Poor retinopathy image quality due to light in the exam room.
- ◆ Poor retinopathy image quality due to beneficiary movement.

Intervention Testing

During the reporting period, Partnership selected to test the following interventions:

- ◆ Having the biller include a note when a beneficiary has been newly diagnosed to address the registry not being updated with information on beneficiaries who are newly diagnosed with diabetes.
- ◆ Having intake staff notify the lead retinal camera photographer when new beneficiaries with diabetes join the clinic to address the registry not being updated with information on beneficiaries with diabetes who are new to the clinic.
- ◆ Developing a process for beneficiaries with unreadable retinopathy images to return for a second retinal exam that includes pupil dilation.

Although Partnership completed testing the interventions through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in Partnership's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG’s PIP validation and technical assistance, Partnership improved its proficiency in conducting the rapid-cycle PIP process.

Opportunities for Improvement—Performance Improvement Projects

Based on Partnership’s PIP progression, HSAG identified no opportunities for improvement.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from Partnership’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of Partnership’s self-reported actions.

Table 5.1—Partnership’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. Work with DHCS to prioritize areas for improvement related to the performance measures showing declining performance or performance below the MPLs in RY 2016.</p>	<p>Southern Region: There was one measure—<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>—below the MPL for the Southwest Region during RY 2016. Partnership responded by conducting three PDSA cycles for this measure by partnering with St. Helena Family Health Center. Key lessons learned were the effectiveness of using EHR alerts to remind the care team about the overdue lab tests and the need to increase outreach to patients who are overdue.</p> <p>Northern Region (NR) Improvement Projects: As a result of RY 2016, there were nine HEDIS indicators with demonstrated performance below the MPLs in Partnership’s NR service area. The following measures had rates below MPLs in both the Northeast and Northwest regions: <i>Cervical Cancer Screening; Comprehensive Diabetes Care—Eye Exam (Retinal) Performed; Childhood Immunization Status—Combination 3; Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs; Annual Monitoring for Patients on Persistent Medications—Diuretics; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. Immunizations for Adolescents—Combination 1</i> and both <i>Prenatal and Postpartum Care</i> measures were reported as measures with below MPL performance in only the Northeast Region. While all measure indicators below the MPLs were addressed through a variety of improvement activities, specific mandated PDSAs, under the Model for Improvement framework, were requested by DHCS for <i>Immunizations for Adolescents</i>—</p>

2015–16 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p><i>Combination 1, Childhood Immunization Status—Combination 3, Cervical Cancer Screening, and both Prenatal and Postpartum Care</i> measures. In August 2016, DHCS communicated that a mandated PDSA would not be required for <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>. Instead, DHCS requested a quarterly summary report of improvement activities specific to this measure. DHCS also directed Partnership NR staff members to track the progress of improvement work being led in the Southern Region under the continuing <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs PDSA</i> and the <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i> PIP. DHCS explained its expectation that best practices and learnings identified through these projects are spread MCP-wide.</p> <p>A summary of NR improvement work per measure:</p> <p><i>Immunizations for Adolescents—Combination 1:</i> PDSA-driven activities to further improvement in immunizations recommended for adolescents was focused on a collaborative partnership with Shasta County Public Health. With the clinical support of public health, arrangements were made to offer and promote a convenient, well-timed immunization clinic. Internal Partnership resources were utilized to encourage attendance at the event through targeted member outreach, and representative clinics were held in August 2016, February 2017, and May 2017. Learnings gleaned from two PDSA cycles included a better understanding of the influence of varying modes of member outreach and the value of in-person dialogue with parents/guardians on the importance of these immunizations.</p> <p><i>Childhood Immunizations—Combination 3:</i> In an attempt to influence receipt of childhood immunizations, Partnership teamed up with a Shasta County provider, Hill Country Health and Wellness Center, to influence member behaviors in an area where anti-vaccination beliefs are commonplace. In a PDSA format, improvement activities included the refinement of outreach protocols and an adaptation of a workflow that limited well-child visit capacity. Utilizing the well-child visit, assessment and education were optimized to encourage the receipt of recommended vaccinations and resulted in significant improvement in both the volume of completed well-child visits and full, periodicity compliance with vaccination recommendations for this age group.</p> <p><i>Cervical Cancer Screening:</i> Often providers share pervasive member resistance to complying with this measure. Partnership successfully partnered with Shingletown Medical Center by</p>

<p>2015–16 External Quality Review Recommendations Directed to Partnership</p>	<p>Self-Reported Actions Taken by Partnership during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations</p>
	<p>leveraging the clinic’s chief medical officer’s passion for engaging patients on the importance of cervical cancer screening. The PDSA cycles targeted member outreach combined with timely appointment availability. Initial results were disappointing; but early learnings led to several adaptations, from which improvement was finally realized at the conclusion of this project. A notable lesson learned was that repeated outreach efforts by the clinical staff members of the member’s provider were effective in encouraging, educating, and completing screenings. Members responded more favorably to clinic staff who they knew were representing their provider. Additionally, the clinic found success by utilizing unrelated appointments to deliver this screening, often referred to in national change packages as the sneak-a-PAP approach.</p> <p><i>Prenatal and Postpartum Care—Postpartum Care:</i> Partnership partnered with Fairchild Medical Clinics in testing new methods to improve member engagement and timely postpartum appointment care. A PDSA was developed and implemented to test the influence of appointment reminder cards promoting a Partnership perinatal program in addition to the clinic’s usual workflow. While quantitative improvement was appreciated against the baseline, it was the qualitative data that provided supportive evidence on best practices that influence timely appointment attendance.</p> <p><i>Prenatal and Postpartum Care—Timeliness of Prenatal Care:</i> Shasta Community Health Center agreed to partner in a PDSA to positively influence timely receipt of prenatal care when pregnant members presented in the primary care setting. The team tested the effects of enhanced provider education on the measure combined with EHR workflow modifications to improve capture of last menstrual period dates and expected delivery dates, and to obtain a complete obstetric history. Significant improvement was observed in the quality and detail of medical documentation whenever a pregnant member presented.</p> <p><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life:</i> Improvement activities that were focused on this measure included the support of numerous Partnership- contracted PCP hosted events delivering well-child visits with targeted member outreach. Partnership also partnered with Churn Creek Healthcare in Shasta County to conduct the Birthday Club PDSA. In this PDSA, Partnership and the provider targeted member outreach promoting the completion of a well-child visit in the member’s birthday month. If a member successfully completed the well-child visit in response to the promotion, the provider directly awarded the</p>

<p>2015–16 External Quality Review Recommendations Directed to Partnership</p>	<p>Self-Reported Actions Taken by Partnership during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations</p>
	<p>member with a gift card at the conclusion of the visit. (This member incentive was proposed by Partnership and approved by DHCS in advance.) A key lesson learned was the importance of having current member contact information, especially for members unestablished with the provider. Of members successfully reached, a positive response and improvement gains were realized within 60 days of targeted members’ birthdays. Additionally, our improvement summaries highlighted a series of lunch n’ learn-style on-site trainings afforded to interested PCP sites. These focused trainings on HEDIS measures included education specific to PM-160 form completion and best practices in documenting the elements necessary to meet the <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> measure.</p>
<p>2. As applicable, test successful interventions from the MCP’s <i>Reducing Diabetes-Associated Vision Loss through Expanded Primary Care Retinopathy Screening</i> PIP in the Northeast and Northwest regions to address the MCP performing below the MPLs for the <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i> measure in these two regions.</p>	<p>RY 2017 indicates performance above the MPL in all regions for <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>. Notable improvement occurred in the Northwest and Northeast regions to achieve this.</p> <p>Partnership is in the process of completing modules 4 and 5 of the PIP, in which it has partnered with Baechtel Creek Medical Clinic to test refinements of offering diabetic retinopathy screening on-site. Partnership does not attribute the improvement in the performance on the <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i> measure to what the MCP learned from the PIP.</p> <p>Partnership believes the improvement between RY 2016 and RY 2017 was largely due to an MCP-wide effort to improve diabetic retinopathy screening via the provision of a digital camera, the use of telemedicine, and training and technical assistance for participating PCP organizations. Through this effort, these PCP organizations could offer eye screenings on-site, making the screenings more accessible to Partnership’s members. Six clinics were granted cameras to test this model of retinopathy screening. Their locations were the following:</p> <p>Northwest—one clinic Northeast—two clinics Southwest—one clinic Southeast—two clinics</p> <p>Following the first year of the program, four of the six clinics remain in the program, which helped both Partnership and the practices to better understand the value and limitations of using this model of retinopathy screening. These four clinics will continue to offer retinopathy screening, and two new clinics (both located in the</p>

2015–16 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
	<p>Northeast Region) have begun using the digital cameras to offer retinopathy screening on-site.</p> <p>Lessons learned at both the MCP and practice levels included: (1) better understanding of the coding and complexity relative to the business case for offering retinopathy screening at a PCP site, (2) needed resources (staff, physical plant, time) to offer retinopathy screening, and (3) different practice models (e.g., use of a scheduled eye clinic versus drop-in retinopathy screening). Further, the effort underscored the value of improving communication and documentation with eye specialists that perform the diabetic retinopathy screening as another means to raise performance on this measure.</p>
<p>3. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Hypertension</i> PIP.</p>	<p>Partnership is in the process of completing modules 4 and 5 of the <i>Hypertension</i> PIP, in which it has partnered with Open Door Community Health Clinics in Eureka. All PDSA testing concluded for this PIP as of June 30, 2017.</p> <p>Over the course of the prior year, three Module 4 PDSA plans were submitted for HSAG review and feedback. The initial feedback referenced in this recommendation is specific to the initial Module 4 PDSA plan submitted in June 2016. This Module 4 PDSA plan’s objective was to achieve a documented blood pressure target within a standard location in EPIC for all hypertensive patients aged 18 or older assigned to specific pod teams at Eureka Community Health Center. In feedback provided by HSAG on June 27, 2016, clarifications were requested on the description of the intervention, linkage to key drivers, and predicted results. Partnership requested a technical assistance call with HSAG to review this feedback, which was completed in early July 2016. Then, a revised plan for this Module 4 PDSA was submitted by Partnership on August 1, 2016. HSAG responded later that month, requesting detailed clarifications on specific aspects of the intervention methodology and data collection plan. Partnership addressed the questions posed by HSAG through subsequent revisions to the module document. Per HSAG’s request, Partnership provided an updated Module 4 PDSA submission in November 2016 that included all requested revisions and the status of intervention testing through November 21, 2016. No additional HSAG feedback specific to this PDSA has been received, and iterative testing continued through the spring of 2017.</p>

2016–17 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 the following to the MCP:

- ◆ Assess whether or not current strategies need to be modified or expanded to improve the MCP’s performance to above the MPLs for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northeast, Northwest, and Southwest regions
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northeast and Southwest regions
 - *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions
- ◆ To assist the MCP with developing strategies to improve its performance to above the MPL for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure in the Northwest and Southwest regions, identify the causes for the rates for this measure being below the MPL in RY 2017 in these regions.
- ◆ Identify the causes for the rate for the *Controlling High Blood Pressure* measure declining significantly from RY 2016 to RY 2017 in the Northwest Region, and assess whether or not the interventions tested as part of the MCP’s *Hypertension* PIP could be adapted or adopted to help prevent the rate for the *Controlling High Blood Pressure* measure from continuing to decline in the Northwest Region.
- ◆ Identify the causes for the rates in all four regions declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain*, and determine whether or not the MCP needs to develop strategies to prevent the rates from continuing to decline.

In the next annual review, HSAG will evaluate continued successes of Partnership as well as the MCP’s progress with these recommendations.

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix X:
Performance Evaluation Report
San Francisco Health Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), San Francisco Health Plan (“SFHP” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in SFHP’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

SFHP is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in SFHP, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan (CP).

SFHP became operational in San Francisco County to provide MCMC services effective January 1997. As of June 30, 2017, SFHP had 136,427 beneficiaries in San Francisco County.¹ This represents 87 percent of the beneficiaries enrolled in San Francisco County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Jul 10, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SFHP. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical and State Supported Services Audits of SFHP. A&I conducted the on-site audits from March 21, 2016, through April 1, 2016. While A&I conducted the audits outside the review period for this report, HSAG includes the results because DHCS issued the final report and closeout letter during the review period.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SFHP
Audit Review Period: March 1, 2015, through February 29, 2016

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	Closed.
Case Management and Coordination of Care	Yes	Closed.
Access and Availability of Care	Yes	Closed.
Member’s Rights	Yes	Closed.
Quality Management	No	Not applicable.
Administrative and Organizational Capacity	Yes	Closed.
State Supported Services	No	Not applicable.

Strengths—Compliance Reviews

During the March 21, 2016, through April 1, 2016, A&I Medical and State Supported Services Audits, DHCS identified no deficiencies in the Quality Management and State Supported Services categories. Additionally, SFHP’s responses to the MCP’s CAP for the deficiencies that A&I identified during the Medical Audit resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

SFHP has no outstanding deficiencies from the March 21, 2016, through April 1, 2016, A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for San Francisco Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that SFHP followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for SFHP's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
SFHP—San Francisco County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	85.42% ⁺	82.87% ⁺	81.48% ⁺	83.18% ⁺	1.70
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.01%	93.66%	93.39%	91.96%	-1.43
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	92.55%	90.01%	90.23%	85.47%	-4.76^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	94.70%	94.11%	93.01%	90.01%	-3.00^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	91.04%	91.05%	89.97%	87.51%	-2.46^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	39.25%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	82.41% ⁺	81.48% ⁺	85.42% ⁺	87.59% ⁺	2.17
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	79.17% ⁺	77.78% ⁺	84.26% ⁺	84.07% ⁺	-0.19
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	86.81% ⁺	85.42% ⁺	82.18%	82.18%	0.00
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	62.66%	Not Comparable
<i>Cervical Cancer Screening</i>	74.47%	74.00%	61.56%	68.72%	7.16^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	70.40%	70.59%	74.23% ⁺	70.83%	-3.40
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	93.24% ⁺	90.12%	90.07%	85.19%	-4.88^^
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.32%	86.47%	87.75%	87.85%	0.10
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.31%	86.94%	87.00%	86.85%	-0.15
<i>Asthma Medication Ratio—Total</i>	--	--	--	80.02% ⁺	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	76.57% ⁺	75.41% ⁺	71.30%	74.71%	3.41

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	62.41%	68.91% ⁺	74.07% ⁺	70.53% ⁺	-3.54
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	63.57% ⁺	62.41% ⁺	68.29% ⁺	63.11% ⁺	-5.18
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	24.36% ⁺	25.06% ⁺	18.98% ⁺	26.68% ⁺	7.70^^
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	89.33%	91.42%	94.44% ⁺	90.72%	-3.72^^
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.77% ⁺	87.94% ⁺	89.58% ⁺	88.40%	-1.18
<i>Controlling High Blood Pressure</i>	63.42%	72.19% ⁺	75.06% ⁺	71.02% ⁺	-4.04
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	13.86%	19.71%	18.54%	17.65%	-0.89
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	33.03	34.32	34.77	37.28	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	383.10	369.40	356.17	338.64	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	44.01% ⁺	45.34% ⁺	43.14% ⁺	48.43% ⁺	5.29
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	11.21%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	84.86% ⁺	86.16% ⁺	81.58%	76.64%	-4.94^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading⁺ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of SFHP's performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP's performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ *All four Children and Adolescents' Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children's Health

SFHP performed above the HPLs for three of four measures (75 percent) within the Preventive Screening and Children's Health domain for all RYs displayed in Table 3.1 and had no measures within the domain with rates below the MPLs. The rates for the following measures were above the HPLs:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Both Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

Performance measure results show that SFHP consistently exceeded DHCS' HPLs for ensuring that beneficiaries are receiving their appropriate immunization dosages by age 2 and for documenting counseling for nutrition and physical activity during outpatient visits with beneficiaries ages 3 to 17.

Preventive Screening and Women's Health

SFHP provided information on actions that the MCP took during the reporting period to address the rate for the *Cervical Cancer Screening* measure declining significantly from RY 2015 to RY 2016. (See Table 5.1.) SFHP's efforts may have contributed to the rate for this measure improving significantly from RY 2016 to RY 2017.

The MCP had no rates below the MPLs within the Preventive Screening and Women’s Health domain; however, the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure declined significantly from RY 2016 to RY 2017. SFHP has the opportunity to explore the causes for the MCP’s decline in performance for this measure, to ensure that pregnant female beneficiaries receive a prenatal care visit in the first trimester or within 42 days of enrollment in SFHP.

Care for Chronic Conditions

SFHP performed above the HPLs for the following four of nine measures (44 percent) within the Care for Chronic Conditions domain in RY 2017:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- ◆ *Controlling High Blood Pressure*

Note that the MCP has performed above the HPLs for at least three consecutive years for all four measures.

SFHP had no rates below the MPLs within the Care for Chronic Conditions domain; however, the MCP’s performance declined significantly from RY 2016 to RY 2017 for the following measures:

- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*—Note that, despite the significant decline from RY 2016, the MCP continued to perform above the HPL for this measure in RY 2017.
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing.*

Appropriate Treatment and Utilization

Within the Appropriate Treatment and Utilization domain, SFHP performed above the HPLs for all RYs displayed in Table 3.1 for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, which assesses appropriate use of antibiotics for beneficiaries ages 18 to 64 with a primary diagnosis of acute bronchitis.

The MCP had no measures with rates below the MPLs within this domain for RY 2017; however, the rate declined significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure. SFHP provided information on actions that the MCP took to address the rate for this measure declining significantly from RY 2015 to RY 2016. (See Table 5.1.) Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA’s RY 2017 specification changes for this measure and therefore may not be related to SFHP’s performance.

Assessment of Improvement Plans

SFHP was not required to submit any improvement plans in RY 2016. Based on RY 2017 performance measure results, the MCP is not required to submit any improvement plans for RY 2017.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for SFHP—San Francisco County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	23.34%	13.47%	9.87^^	17.65%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	94.53	31.46	Not Tested	37.28
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	568.12	315.31	Not Tested	338.64
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.34%	88.09%	-0.75	87.85%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.70%	86.41%	1.29	86.85%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	91.99%	Not Comparable	91.96%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	80.70%	85.53%	-4.83	85.47%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	84.57%	90.14%	-5.57^^	90.01%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	81.19%	87.70%	-6.51^^	87.51%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
SFHP—San Francisco County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	17.88%	25.15%	24.74%	23.34%	-1.40
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	75.73	78.27	87.38	94.53	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	615.01	621.71	592.07	568.12	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.62%	87.32%	87.23%	87.34%	0.11
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.98%	88.21%	86.43%	87.70%	1.27
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	83.33%	84.00%	84.80%	80.70%	-4.10
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	89.41%	88.38%	88.52%	84.57%	-3.95
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.96%	82.37%	84.69%	81.19%	-3.50

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
SFHP—San Francisco County

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	5.69%	9.81%	12.47%	13.47%	1.00
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	23.26	27.68	28.69	31.46	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	330.07	331.26	328.91	315.31	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.25%	85.37%	88.03%	88.09%	0.06
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.72%	85.24%	87.35%	86.41%	-0.94
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.04%	93.78%	93.41%	91.99%	-1.42
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	92.69%	90.09%	90.30%	85.53%	-4.77^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	94.85%	94.27%	93.11%	90.14%	-2.97^^
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	91.16%	91.33%	90.14%	87.70%	-2.44^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that SFHP stratified by the SPD and non-SPD populations:

- ◆ For SPD rates for which a comparison could be made between RY 2016 and RY 2017, no statistically significant changes occurred between RY 2016 and RY 2017.

- ◆ For non-SPD rates for which a comparison could be made between RY 2016 and RY 2017, the RY 2017 non-SPD rate was significantly lower than the RY 2016 non-SPD rate for the following measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- ◆ For measures for which a comparison could be made between the RY 2017 SPD rate and RY 2017 non-SPD rate, the SPD rates were significantly worse than the non-SPD rates for the following measures:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*

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 beneficiaries. Additionally, the significantly lower SPD rate for two of the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age groups (i.e., *7–11 Years* and *12–19 Years*), based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Strengths—Performance Measures

HSAG auditors determined that SFHP followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Across all domains, SFHP performed above the HPLs for eight of 18 measures (44 percent) in RY 2017 and had no rates below the MPLs. The rates for all eight measures were above the HPLs for at least three consecutive years. The Preventive Screening and Children's Health domain had the highest percentage of measures above the HPLs (75 percent).

The rate for the *Cervical Cancer Screening* measure, which had declined significantly from RY 2015 to RY 2016, improved significantly from RY 2016 to RY 2017.

Opportunities for Improvement—Performance Measures

SFHP has the opportunity to identify the causes for the rates declining significantly from RY 2016 to RY 2017 for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measures. Identifying the causes for the declining rates for these measures will help the MCP to develop strategies to ensure that pregnant female beneficiaries receive a prenatal care visit in the first trimester or within 42 days of enrollment in SFHP and that beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) receive an HbA1c test during the MY. Additionally, SFHP has the opportunity to identify the causes for the continued decline in

performance for the *Use of Imaging Studies for Low Back Pain* measure. Identifying the causes will help the MCP to determine whether or not current improvement strategies related to this measure need to be modified to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

SFHP had one DHCS-priority performance improvement project (PIP) and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

SFHP selected postpartum care as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG reviewed and provided feedback to SFHP on the updated Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG also sent periodic check-in email communications to SFHP and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

SFHP set the SMART Aim for the *Postpartum Care* PIP as follows:

By June 30, 2017, increase the rate of SFHP beneficiaries who deliver at Hospital A⁶ who receive a postpartum visit with an obstetrician/gynecologist (OB/GYN) or primary care provider (PCP) within three to eight weeks of delivery from 57 percent to 70 percent.

Failure Modes

The following, listed in priority order, are the failure modes SFHP identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary not engaged to receive postpartum care.
- ◆ Referral process is confusing/does not exist.
- ◆ Lack of care coordination with postpartum women.
- ◆ Beneficiary not provided with information about postpartum visits.

⁶ Hospital name removed for confidentiality.

- ◆ Beneficiary does not have transportation to keep the postpartum visit appointment.
- ◆ Beneficiary forgets about the postpartum visit appointment.
- ◆ Outreach materials have poor messaging or are not targeted towards beneficiary.
- ◆ Beneficiary does not have viable childcare option during postpartum visit appointment time.
- ◆ The PCP phone system is difficult to navigate.
- ◆ Beneficiary cannot afford the cost/time to attend postpartum visit appointment.

Intervention Testing

During the reporting period, SFHP selected to test provider training to OB/GYN clinical staff on the importance of postpartum care, disparities in care, and motivational interviewing. This intervention addresses:

- ◆ Quality of care concerns, including beneficiary satisfaction, experience of care, and customer service.
- ◆ Beneficiary education.
- ◆ Appropriate beneficiary care following delivery.
- ◆ Continuity of care among the hospital, PCP, and OB/GYN.
- ◆ Concerns with discharge planning.
- ◆ Poor provider communication.

Although SFHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in SFHP's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

SFHP selected patient experience as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for SFHP's MCP-specific PIP and determined that SFHP had met all validation criteria for Module 3 in its initial submission.

HSAG also reviewed and provided feedback to SFHP on the Plan portion of the PDSA cycle for the two interventions that the MCP selected to test. HSAG sent periodic check-in email communications to SFHP and conducted technical assistance calls with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

SFHP set the SMART Aim for the *Patient Experience* PIP as follows:

By June 30, 2017, increase performance in the San Francisco Health Plan Customer Service Survey in beneficiaries responding “always” in getting the information they need from Customer Service from 76 percent to 81 percent.

Failure Modes

The following, listed in priority order, are the failure modes that SFHP identified during the Intervention Determination phase of the PIP process:

- ◆ The MCP’s customer service representatives (CSRs) are not using evidence-based practices in reaching mutual understanding with beneficiaries.
- ◆ Beneficiaries’ issues can only be resolved by an external health care entity.
- ◆ The MCP’s internal departments do not notify CSRs of their new processes; internal departments are not available to consult with CSRs; and no internal liaison exists for each internal department.
- ◆ Beneficiaries do not understand the difference between MCMC and the MCP.
- ◆ Beneficiaries are not interested in understanding the information provided by the MCP.
- ◆ CSRs are unable to determine if transferring the calls or referring the beneficiaries to an external entity resolves the beneficiaries’ health concerns.
- ◆ CSRs do not have information they need to answer beneficiaries’ questions in one phone call.
- ◆ Beneficiaries are unaware of how to navigate various health care systems.

Intervention Testing

During the reporting period, to address beneficiary inquiries, SFHP selected to test three-way phone calls occurring among the beneficiary, the MCP, and the MCMC representative. However, the MCP abandoned the intervention testing due to being understaffed and the time-intensive nature of the intervention.

Instead, SFHP selected to test using key words at key times to increase beneficiary satisfaction. Although SFHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in SFHP’s 2017–18 MCP-specific evaluation report.

Strengths

Through HSAG's PIP validation and technical assistance, SFHP improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from SFHP’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of SFHP’s self-reported actions.

Table 5.1—SFHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
<p>1. To prevent further decline in performance, identify the causes for the rates declining significantly from RY 2015 to RY 2016 for the following measures:</p> <ul style="list-style-type: none"> a. <i>Cervical Cancer Screening</i> b. <i>Use of Imaging Studies for Low Back Pain</i> 	<p>A. <i>Cervical Cancer Screening (CCS):</i></p> <ul style="list-style-type: none"> • CCS was a priority clinical measure for 16 participants of SFHP’s P4P Practice Improvement Program in 2016, which increased provider incentive funding. • SFHP introduced additional provider incentives for CCS improvement. • In 2016, SFHP launched a provider outreach program that included sending lists of non-compliant members to six provider groups, clinic staff incentives with a staff lunch for doing panel management, and a gift card raffle for members. • SFHP provided a disparities analysis of data to encourage a disparities focus in CCS outreach. • CCS was a focus for every HEDIS results dissemination meeting with medical groups. • The MCP included an article on CCS in <i>Your Health Matters</i>, SFHP’s member newsletter. • MY 2016 demonstrated a 7 percent improvement, just below the national Medicaid 90th percentile. <p>B. <i>Use of Imaging Studies for Low Back Pain (LBP)</i></p> <ul style="list-style-type: none"> • LBP was a focus in HEDIS results dissemination meetings with provider groups that had declining performance. • SFHP introduced a series in the MCP’s provider newsletter that highlighted recommendations that affect LBP from the Choosing Wisely initiative.

2015–16 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
2. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Postpartum Care</i> PIP.	SFHP integrated HSAG’s feedback on both Module 4 documents submitted in 2016. SFHP incorporated the feedback into its planning process prior to testing its postpartum care interventions.

2016–17 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:

- ◆ To prevent further decline in performance:
 - Identify the causes for the rates declining significantly from RY 2016 to RY 2017 for the following measures:
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*
 Identifying the causes will help SFHP to develop strategies, as applicable, to address the MCP’s performance being below the MPL for these measures.
 - Identify the causes for the continued decline in performance for the *Use of Imaging Studies for Low Back Pain* measure. Identifying the causes will help the MCP to determine whether or not current improvement strategies related to this measure need to be modified.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix Y:
Performance Evaluation Report
Santa Clara Family Health Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care health plan (MCP), Santa Clara Family Health Plan (“SCFHP” or “the MCP”). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this MCP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in SCFHP’s 2017–18 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all MCP- and specialty health plan (SHP)-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

SCFHP is a full-scope MCP delivering services to beneficiaries as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in SCFHP, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan (CP).

SCFHP became operational in Santa Clara County to provide MCMC services effective February 1997. As of June 30, 2017, SCFHP had 266,775 beneficiaries in Santa Clara County.¹ This represents 78 percent of the beneficiaries enrolled in Santa Clara County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2017*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: Oct 02, 2017.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SCFHP. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Follow-Up on 2016 Audits & Investigations Division Medical Audit

DHCS’ Audits & Investigations Division (A&I) conducted Medical and State Supported Services Audits of SCFHP from April 18, 2016, through April 29, 2016, covering the review period of April 1, 2015, through March 31, 2016. HSAG provided a summary of the results and status of the audits in SCFHP’s 2015–16 MCP-specific evaluation report. At the time of the 2015–16 MCP-specific report publication, SCFHP’s CAP was in process and under review by DHCS.

A letter from DHCS dated March 29, 2017, stated that SCFHP had provided DHCS with additional information regarding the CAP and that DHCS had either closed or provisionally closed all deficiencies, resulting in DHCS closing the CAP. A letter from DHCS dated August 29, 2017, stated that SCFHP had submitted additional information and that DHCS determined that the provisionally closed deficiencies were in full compliance. While the August 29, 2017, letter was sent outside the review period for this report, HSAG includes the information because it reflects full resolution of all deficiencies from the April 2016 Medical and State Supported Services Audits.

Strengths—Compliance Reviews

SCFHP fully resolved all deficiencies from the April 2016 A&I Medical and State Supported Services Audits.

Opportunities for Improvement—Compliance Reviews

SCFHP has no outstanding deficiencies from the April 2016 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®2} 2017 Compliance Audit Final Report of Findings for Santa Clara Family Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit^{TM,3}. HSAG auditors determined that SCFHP followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 for SCFHP's performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS' *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, DHCS does not establish a high performance level (HPL) or minimum performance level (MPL) for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ DHCS established no HPLs or MPLs for the following measures for RY 2017 because no comparable benchmarks exist:
 - *Immunizations for Adolescents—Combination 2*
 - *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
 - *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*
- ◆ Although HSAG includes information on the MCP's performance related to the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2017 because RY 2017 was the first year that MCPs reported rates for these measures:
 - *Asthma Medication Ratio*
 - *Breast Cancer Screening*

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet MPLs for utilization measures; and HSAG does not compare performance for these measures against HPLs and MPLs. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
- ◆ In order to assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are bolded.
- ◆ For RYs 2016 and 2017, the HPLs and MPLs represent the NCQA Quality Compass[®],⁴ Medicaid HMO 90th and 25th percentiles, respectively.
- ◆ For RYs 2014 and 2015, the HPLs and MPLs represent the NCQA HEDIS Audit Means, Percentiles, and Ratios 90th and 25th percentiles, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, where a lower rate indicates more favorable performance, the HPL and MPL are based on the 10th and 75th percentiles, respectively.
- ◆ HSAG includes the specific HPL and MPL values for RY 2017 in Section 5 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017* (“Performance Measures”).
- ◆ Although HSAG includes information on the MCP’s performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RYs 2015 through 2017 (i.e., DHCS did not require MCPs to submit improvement plans [IPs]/Plan-Do-Study-Act [PDSA] cycles if rates for the measures were below the MPLs). DHCS made this decision due to the small range of variation between the HPL and MPL thresholds for each measure.
- ◆ Due to changes NCQA made to the specifications for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in RY 2017, NCQA released guidance to exercise caution when trending the results for the two measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these two measures, as differences in rates may be a result of the specification changes rather than a reflection of performance.

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

Table 3.1—Multi-Year Performance Measure Results*
SCFHP—Santa Clara County

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
Preventive Screening and Children’s Health					
<i>Childhood Immunization Status—Combination 3</i>	75.43%	71.53%	72.02%	77.37%	5.35
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.15%	94.65%	92.58%	92.60%	0.02
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	88.94%	87.69%	85.58%	84.66%	-0.92^^
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	90.46%	90.15%	89.47%	88.98%	-0.49
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	87.46%	86.77%	86.09%	85.25%	-0.84^^
<i>Immunizations for Adolescents—Combination 2</i>	--	--	--	36.50%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	67.40%	74.94%	63.50%	68.13%	4.63
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	49.15%	61.80%	53.04%	65.45%	12.41^
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	69.59%	78.35%	74.45%	73.97%	-0.48
Preventive Screening and Women’s Health					
<i>Breast Cancer Screening</i>	--	--	--	60.25%	Not Comparable
<i>Cervical Cancer Screening</i>	67.40%	57.18%	50.36%	57.42%	7.06^
<i>Prenatal and Postpartum Care—Postpartum Care</i>	59.61%	61.07%	64.23%	68.61%	4.38
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	86.13%	82.24%	79.56%	82.48%	2.92
Care for Chronic Conditions					
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.39%	87.74%	87.01%	86.42%	-0.59
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.91%	86.65%	86.39%	86.00%	-0.39
<i>Asthma Medication Ratio—Total</i>	--	--	--	44.94%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	56.69%	60.58%	37.96%	59.37%	21.41^

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	46.72%	48.66%	51.09%	62.29%	11.20 [^]
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	54.01%	58.15%	60.10% ⁺	53.77%	-6.33
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**</i>	33.82%	29.68% ⁺	32.36%	37.23%	4.87
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	86.86%	91.48%	86.37%	88.32%	1.95
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	83.45%	90.51% ⁺	85.64%	88.81%	3.17
<i>Controlling High Blood Pressure</i>	52.55%	54.99%	36.01%	66.91%	30.90 [^]
Appropriate Treatment and Utilization					
<i>All-Cause Readmissions**</i>	15.20%	16.92%	18.60%	18.95%	0.35
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months***</i>	32.64	34.98	35.65	34.12	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months***</i>	260.02	233.52	262.31	240.19	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	29.40%	30.94%	30.99%	31.93%	0.94
<i>Screening for Clinical Depression and Follow-Up Plan—Performance Rate</i>	--	--	--	NA	Not Comparable
<i>Screening for Clinical Depression and Follow-Up Plan—Reporting Rate</i>	--	--	--	10.21%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	86.37% ⁺	85.52% ⁺	78.86%	74.40%	-4.46 ^{^^}

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

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

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

-- Indicates that the rate is not available.

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The following is a summary of SCFHP’s performance on the External Accountability Set (EAS) measures. DHCS did not hold MCPs accountable to meet MPLs for the following measures; therefore, HSAG did not include these measures in its assessment of the MCP’s performance related to MPLs and HPLs:

- ◆ *All-Cause Readmissions*
- ◆ *Both Ambulatory Care* measures
- ◆ *Asthma Medication Ratio*
- ◆ *Breast Cancer Screening*
- ◆ *All four Children and Adolescents’ Access to Primary Care* measures
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Performance Rate*
- ◆ *Screening for Clinical Depression and Follow-Up Plan—Reporting Rate*

HSAG includes analyses related to the following measures; however, caution should be used when interpreting the analyses related to these two measures as changes in rates may be a result of NCQA specification changes rather than a reflection of performance:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*

Preventive Screening and Children’s Health

SCFHP performed between the HPLs and MPLs for all measures within the Preventive Screening and Children’s Health domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017. The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total* measure improved significantly from RY 2016 to RY 2017.

Preventive Screening and Women’s Health

SCFHP performed between the HPLs and MPLs for all measures within the Preventive Screening and Women’s Health domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017.

The rate for the *Cervical Cancer Screening* measure improved significantly from RY 2016 to RY 2017, resulting in the rate for this measure moving from below the MPL in RY 2016 to above the MPL in RY 2017. SCFHP provided information on actions that the MCP took during the review period to improve its performance on measures with rates below the MPLs in RY 2016 and on measures with rates that significantly declined from RY 2015 to RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the PDSA cycles that SCFHP conducted during the review period to improve the MCP’s performance on the

Cervical Cancer Screening measure. SCFHP's efforts may have contributed to the rate for the *Cervical Cancer Screening* measure improving significantly from RY 2016 to RY 2017.

Care for Chronic Conditions

Within the Care for Chronic Conditions domain, SCFHP performed between the HPLs and MPLs for all measures for which DHCS held MCPs accountable to meet the MPLs in RY 2017. The rates improved significantly from RY 2016 to RY 2017 for the following measures:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*.
- ◆ *Controlling High Blood Pressure*, resulting in the rate moving from below the MPL in RY 2016 to above the MPL in RY 2017.

SCFHP provided information on actions that the MCP took during the review period to improve its performance on measures with rates below the MPLs in RY 2016 and on measures with rates that significantly declined from RY 2015 to RY 2016. (See Table 5.1.) Additionally, under the “Assessment of Improvement Plans” heading in this section of the report, HSAG provides a summary of the MCP's efforts to improve performance on the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure. Finally, information on SCFHP's *Controlling High Blood Pressure* performance improvement project (PIP) is included in Section 4 of this report (“Performance Improvement Projects”). SCFHP's efforts may have contributed to the rates improving significantly from RY 2016 to RY 2017 for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Controlling High Blood Pressure* measures.

Appropriate Treatment and Utilization

SCFHP performed between the HPLs and MPLs for all measures within the Appropriate Treatment and Utilization domain for which DHCS held MCPs accountable to meet the MPLs in RY 2017. The rate for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from RY 2016 to RY 2017. Note that the significant decline in the rate for the *Use of Imaging Studies for Low Back Pain* measure from RY 2016 to RY 2017 may be due to NCQA's RY 2017 specification changes for this measure and therefore may not be related to SCFHP's performance.

Based on performance measure results within the Appropriate Treatment and Utilization domain, SCFHP has the opportunity to identify the causes for the rate declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, DHCS required SCFHP to submit IP/PDSA cycles for the *Cervical Cancer Screening* measure and triannual quality improvement summaries for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure. The rates for both measures improved significantly from RY 2016 to RY 2017, resulting in the rates moving from below the MPLs in RY 2016 to above the MPLs in RY 2017.

Cervical Cancer Screening

SCFHP 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, SCFHP set the following SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objective:

Increase by 50 beneficiaries (from 338 to 388) the number of women ages 21 to 64 receiving a Pap smear test who are assigned to the clinic partner and who have not had a Pap smear test within the past three years.

SCFHP tested whether conducting educational beneficiary outreach calls using a gap in care report at the clinic provider would increase the number of beneficiaries completing their Pap smear tests. The intervention targeted beneficiaries who had not received their Pap smear tests within the past three years.

SCFHP indicated that it did not meet the SMART objective and that the MCP decided to adapt the intervention.

Plan-Do-Study-Act Cycle 2

For the second PDSA cycle, SCFHP set the following SMART objective:

Increase by 60 beneficiaries (from 343 to 403) the number of women ages 21 to 64 receiving a Pap smear test who are assigned to the clinic partner and who have not had a Pap smear test within the past three years.

SCFHP tested the same intervention as in the first PDSA cycle; however, the MCP redesigned the incentive forms to make the incentive process easier for the clinic partner and beneficiaries to complete and to make it easier for beneficiaries to obtain the \$15 gift card incentives following completion of their cervical cancer screenings. SCFHP indicated that it did not meet the SMART objective and decided to adapt the intervention. Additionally, SCFHP reported on lessons learned through the PDSA cycle process, including:

- ◆ Beneficiaries do not attend screening appointments if they do not understand the relevance and value of routine screening; therefore, educational strategies need to account for specific subpopulation characteristics.

- ◆ It is important to explore beneficiary barriers and to use the identified barriers to inform future improvement strategies.
- ◆ It is important to develop provider partnerships and to be open to exploring cross-agency collaborations.

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

SCFHP reported that the MCP implemented an incentive program in which beneficiaries who completed their comprehensive diabetes care blood pressure screenings each received a \$15 gift card. SCFHP informed beneficiaries of the incentive program through mailings. Additionally, the MCP sent health message letters to beneficiaries that described the importance of blood pressure monitoring and provider screening visits.

SCFHP indicated that the incentive program promoted the opportunity for beneficiaries to engage with their primary care providers about health-related issues associated with hypertension. SCFHP indicated that the MCP continues to send gap in care reports to providers to alert the providers of beneficiaries in need of blood pressure screening in addition to other targeted interventions.

Required Improvement Plans for RY 2017

Based on RY 2017 performance measure results, SCFHP will not be required to submit any IP/PDSA cycles.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 presents the Seniors and Persons with Disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates,⁵ and the total combined rate for each measure.

Table 3.2—RY 2017 (MY 2016) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for SCFHP—Santa Clara County

Measure	RY 2017 SPD Rate ¹	RY 2017 Non-SPD Rate ¹	SPD/ Non-SPD Rate Difference ²	RY 2017 Total Rate ³
<i>All-Cause Readmissions*</i>	24.31%	16.28%	8.03^^	18.95%
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	46.23	33.06	Not Tested	34.12
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	436.74	223.06	Not Tested	240.17
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.66%	85.19%	3.47^	86.43%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.05%	83.69%	6.36^	86.00%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	NA	92.63%	Not Comparable	92.60%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	80.54%	84.73%	-4.19^^	84.66%
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.26%	89.00%	-0.74	88.98%
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	78.80%	85.48%	-6.68^^	85.25%

¹ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

² Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

³ 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 SPD or non-SPD, the total rate is based on results reported for the available population.

* A lower rate indicates better performance for this measure.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading^ Indicates that the RY 2017 SPD rate is statistically significantly better than the RY 2017 non-SPD rate.

Red Shading^^ Indicates that the RY 2017 SPD rate is statistically significantly worse than the RY 2017 non-SPD rate.

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

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

⁵ HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.2.

Table 3.3 presents the four-year trending information for the SPD population, and Table 3.4 presents the four-year trending information for the non-SPD population across the measures that DHCS required MCPs stratify for the SPD and non-SPD populations for all four years. The tables also show the difference in rates between RY 2016 and RY 2017.

**Table 3.3—Multi-Year SPD Performance Measure Trend Table
SCFHP—Santa Clara County**

Measure	RY 2014 SPD Rate ¹	RY 2015 SPD Rate ²	RY 2016 SPD Rate ³	RY 2017 SPD Rate ⁴	RYS 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	18.25%	21.25%	23.40%	24.31%	0.91
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	45.66	44.71	45.34	46.23	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	411.17	399.37	446.55	436.74	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.10%	88.66%	88.83%	88.66%	-0.17
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.26%	88.35%	89.19%	90.05%	0.86
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	80.95%	67.31%	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.93%	84.40%	80.76%	80.54%	-0.22
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	88.55%	86.37%	86.10%	88.26%	2.16
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	86.53%	81.33%	78.28%	78.80%	0.52

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

NA = A *Not Applicable* audit finding because the denominator for the measure is too small to report (less than 30).

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Non-SPD Performance Measure Trend Table
SCFHP—Santa Clara County**

Measure	RY 2014 Non-SPD Rate ¹	RY 2015 Non-SPD Rate ²	RY 2016 Non-SPD Rate ³	RY 2017 Non-SPD Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>All-Cause Readmissions*</i>	8.29%	11.91%	15.91%	16.28%	0.37
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**</i>	30.95	33.98	34.88	33.06	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	240.37	216.50	247.61	223.06	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.83%	86.90%	86.13%	85.19%	-0.94
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.68%	85.22%	85.16%	83.69%	-1.47
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	97.31%	94.97%	92.60%	92.63%	0.03
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	88.94%	87.77%	85.64%	84.73%	-0.91^^
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	90.52%	90.30%	89.57%	89.00%	-0.57
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	87.49%	87.02%	86.40%	85.48%	-0.92^^

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ 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.

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

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results for measures that SCFHP stratified by the SPD and non-SPD populations:

- ◆ For SPD rates for which HSAG could make comparisons between RY 2016 and RY 2017, no statistically significant changes occurred for any SPD rates.
- ◆ For non-SPD rates for which HSAG made comparisons between RY 2016 and RY 2017, the RY 2017 non-SPD rates were significantly worse than the RY 2016 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *12–19 Years* measures.
- ◆ For measures for which HSAG could make comparisons between the RY 2017 SPD and RY 2017 non-SPD rates:
 - The RY 2017 SPD rates were significantly better than the RY 2017 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.
 - The RY 2017 SPD rates were significantly worse than the RY 2017 non-SPD rates for the following measures:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *12–19 Years* measures

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 beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age categories, based on complicated health care needs, relying on specialist providers as their care sources rather than accessing care from primary care practitioners.

Managed Long-Term Services and Supports Plan Performance Measure Results

Due to SCFHP's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that SCFHP report rates for three HEDIS measures for HSAG to validate as part of the NCQA HEDIS Compliance Audit.

Table 3.5 presents the rates for each required MLTSSP performance measure for RYs 2016 and 2017. The RY is the year in which the MLTSSP reported the rates. The RY rates reflect MY data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between RY 2016 and RY 2017.

**Table 3.5—Multi-Year MLTSSP Performance Measure Results
SCFHP—Santa Clara County**

Measure	RY 2016 Rate ¹	RY 2017 Rate ²	RYs 2016–17 Rate Difference ³
<i>Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*</i>	46.68	46.30	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	351.61	347.94	Not Tested
<i>Medication Reconciliation Post-Discharge</i>	20.44%	44.28%	23.84 [^]

¹ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

² RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

³ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

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

Green Shading[^] Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^{^^} Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Tested = An RY 2016–17 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure improved significantly from RY 2016 to RY 2017.

Strengths—Performance Measures

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

In Table 3.1 across all domains, SCFHP performed above the MPLs for all 18 measures for which DHCS held MCPs accountable to meet the MPLs in RY 2017. Across all domains, five of 19 measures for which comparisons can be made between RY 2016 and RY 2017 (26 percent) improved significantly from RY 2016 to RY 2017. Additionally, all three rates that were below the MPLs in RY 2016 improved to above the MPLs in RY 2017.

Opportunities for Improvement—Performance Measures

SCFHP has the opportunity to identify the causes for the rate declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.

4. Performance Improvement Projects

SCFHP had one DHCS-priority PIP and one MCP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

SCFHP selected diabetes as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG sent periodic check-in email communications to SCFHP and conducted a technical assistance call with the MCP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

SCFHP set the SMART Aim for the *Diabetes* PIP as follows:

By June 30, 2017, increase from 44.89 percent to 49.89 percent the rate of diabetic eye exams among beneficiaries living with diabetes ages 18 to 75 years, who reside in Santa Clara County, who have Provider Network A⁶, and who have had a diagnosis of retinopathy in the previous rolling 12-month period.

Failure Modes

The following, listed in priority order, are the failure modes that SCFHP identified during the Intervention Determination phase of the PIP process:

- ◆ Primary care provider does not offer scheduling assistance.
- ◆ Beneficiary is not educated about the importance of retinopathy eye exams.
- ◆ Beneficiary does not know how to select an eye exam provider.
- ◆ Beneficiary is not motivated to follow through with the scheduled eye exam appointment.
- ◆ Beneficiary does not have transportation to keep the eye exam appointment.

⁶ Provider network name removed for confidentiality.

- ◆ Beneficiary forgets about the eye exam appointment.
- ◆ No follow-up occurs to schedule a new appointment after a missed appointment.
- ◆ MCP does not provide scheduling assistance.
- ◆ Beneficiary is not educated about the benefits of the eye exam.
- ◆ Beneficiary does not believe it is important to get the eye exam.

Intervention Testing

During the reporting period, SCFHP selected to test promoting beneficiary incentives for completing eye exams, which addresses the key driver of beneficiary education.

Although SCFHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in SCFHP's 2017–18 MCP-specific evaluation report.

MCP-Specific Performance Improvement Project

SCFHP selected controlling high blood pressure as its MCP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated Module 3 for SCFHP's MCP-specific PIP. Upon initial review of the module, HSAG determined that SCFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to the following:

- ◆ Including a step-by-step flow of the overall process in the process map.
- ◆ Listing the appropriate potential interventions based on the ranked failure modes.
- ◆ Ensuring that the potential interventions have the opportunity to impact the SMART Aim.
- ◆ Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, SCFHP incorporated HSAG's feedback into the PIP module. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

During the reporting period, HSAG also reviewed and provided feedback to SCFHP on the Plan portion of the PDSA cycle for the intervention the MCP selected to test. HSAG sent periodic check-in email communications to SCFHP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

SCFHP set the SMART Aim for the *Controlling High Blood Pressure* PIP as follows:

By June 30, 2017, increase from 45.8 percent to 50.0 percent the percentage rate of Provider Network B⁷ beneficiaries ages 18 to 85 years, with a diagnosis of hypertension, whose blood pressure has been adequately controlled during the previous rolling 12 months.

Failure Modes

The following, listed in priority order, are the failure modes that SCFHP identified during the Intervention Determination phase of the PIP process:

- ◆ Beneficiary does not fill initial prescription.
- ◆ Beneficiary does not refill prescription.
- ◆ Beneficiary is not incentivized to follow through with the scheduled follow-up appointment.
- ◆ Beneficiary does not understand the importance of taking the hypertension medication.
- ◆ Beneficiary does not have transportation to keep the appointment.
- ◆ Beneficiary forgets to attend the appointment.

Intervention Testing

During the reporting period, SCFHP selected to test promoting beneficiary incentives for controlling blood pressure, which addresses the key driver of beneficiary education.

Although SCFHP completed testing the intervention through the SMART Aim end date of June 30, 2017, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in SCFHP's 2017–18 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, SCFHP improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for the PIP module that the MCP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

⁷ Provider network name removed for confidentiality.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 MCP-specific evaluation report. Table 5.1 provides EQR recommendations from SCFHP’s July 1, 2015, through June 30, 2016, MCP-specific evaluation report, along with the MCP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of SCFHP’s self-reported actions.

Table 5.1—SCFHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, MCP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Ensure resolution of all deficiencies from the April 2016 A&I Medical and State Supported Services audits.	DHCS accepted and closed SCFHP’s 2016 audit CAP with the intent to review the areas and progress during the April 2017 audit.
2. Identify the causes for measures with rates that declined significantly from RY 2015 to RY 2016 or with rates below the MPLs in RY 2016.	SCFHP had challenges with a late start to the medical record review for HEDIS 2016. As a result, measures that showed the largest declines were the measures impacted most by medical record data. The MCP did several interim builds during HEDIS off season to fix prior data problems and ensure timely production of HEDIS 2017 reporting. The testing and data fixes resulted in timely warehouse production and substantially better rates in HEDIS 2017, including no rates below the MPLs.
3. Continue to work with HSAG to ensure that the MCP’s <i>Controlling High Blood Pressure</i> PIP is methodologically sound to provide the best opportunity for the MCP to improve performance to above the MPL for this measure.	SCFHP struggled with the PIP selection. The MCP had to submit several proposals before finding a measure that aligned with the State’s quality strategy. During each module, the MCP took advantage of the technical assistance calls to work closely with the EQRO on refining the required components of the SMART Aim data methodology and included the required components of the SMART Aim measure. By the end of the measurement period, the MCP was proficient in the PIP process and was meeting all required criteria for PIP modules.
4. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Diabetes</i> PIP.	SCFHP has taken HSAG’s initial feedback on the member incentives used in the PIP and incorporated it into Module 4 for the final submission in August. The MCP anticipates a successful completion of the PIP using the feedback from HSAG.

2016–17 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:

- ◆ Identify the causes for the rate declining significantly from RY 2016 to RY 2017 for the *Use of Imaging Studies for Low Back Pain* measure. Identifying the causes will help SCFHP to develop strategies, as applicable, to address the MCP’s declining performance for this measure.

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

**Medi-Cal Managed Care
External Quality Review Technical Report**

**Appendix Z:
Performance Evaluation Report
SCAN Health Plan
July 1, 2016–June 30, 2017**

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS’ contracted Medi-Cal managed care specialty health plan (SHP), SCAN Health Plan (“SCAN” or “the SHP”). The purpose of this appendix is to provide SHP-specific results of each activity and an assessment of SCAN’s strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report). The review period for this SHP-specific evaluation report is July 1, 2016, through June 30, 2017. HSAG will report on activities that take place beyond the review period in SCAN’s 2017–18 SHP-specific evaluation report. This SHP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all Medi-Cal full-scope managed care health plan (MCP)- and SHP-specific performance evaluation reports reflect HSAG’s external, independent assessment of the quality and timeliness of, and access to, care that MCPs and SHPs are providing to beneficiaries.

Medi-Cal Managed Care Specialty Health Plan Overview

SCAN is a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) that contracts with DHCS as an SHP 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 beneficiaries assessed at the nursing facility-level of care and in nursing home custodial care. SCAN beneficiaries 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 SHP expanded into Riverside and San Bernardino counties in 1997. In 2006, DHCS, at the direction of the Centers for Medicare & Medicaid Services

(CMS), designated SCAN as an MCP. SCAN then functioned as a social health maintenance organization 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 as a full-risk, social SHP.

DHCS amended SCAN's contract in 2008 to include the same federal and State requirements as exist for MCPs. Among these requirements, DHCS specifies that SHPs participating in MCMC report on two performance measures annually and maintain two performance improvement projects (PIPs).

According to DHCS, as of June 30, 2017, SCAN had 8,775 beneficiaries in Los Angeles County, 2,484 beneficiaries in Riverside County, and 1,659 beneficiaries in San Bernardino County—for a total of 12,918 beneficiaries in the three counties combined.

2. Specialty Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SCAN. Unless noted, HSAG’s compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2017). The descriptions of the various types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the Audits & Investigations Division (A&I) Medical Audit of SCAN. A&I conducted the on-site audit from March 13, 2017, through March 24, 2017. Note that while DHCS issued the final audit report to SCAN on August 18, 2017, HSAG includes the audit results and status because A&I conducted the on-site audit during the review period for this SHP-specific evaluation report.

Table 2.1—DHCS A&I Medical Audit of SCAN
Audit Review Period: March 1, 2016, through February 28, 2017

Category Evaluated	Deficiencies (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review by DHCS.
Case Management and Coordination of Care	Yes	CAP in process and under review by DHCS.
Access and Availability of Care	Yes	CAP in process and under review by DHCS.
Member’s Rights	Yes	CAP in process and under review by DHCS.
Quality Management	Yes	CAP in process and under review by DHCS.
Administrative and Organizational Capacity	No	Not applicable.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Administrative and Organizational Capacity category during the March 2017 Medical Audit of SCAN.

Opportunities for Improvement—Compliance Reviews

SCAN has the opportunity to work with DHCS to ensure that the SHP resolves all deficiencies from the March 2017 A&I Medical Audit. The deficiencies cut across the areas of quality and timeliness of, and access to, health care.

3. Performance Measures

Performance Measure Validation Results

The *HEDIS^{®1} 2017 Compliance Audit Final Report of Findings for SCAN Health Plan* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance AuditTM.² HSAG auditors determined that SCAN followed the appropriate specifications to produce valid rates, and identified no issues of concern.

Performance Measure Results

After validating the SHP’s performance measure rates, HSAG assessed the results. See Table 3.1 for SCAN’s performance measure results for reporting years (RYs) 2014 through 2017. The RY is the year in which the SHP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

While DHCS established a RY 2017 high performance level (HPL) and minimum performance level (MPL) for the *Colorectal Cancer Screening* measure, DHCS did not hold SCAN accountable to meet the MPL for this measure in RY 2017 because RY 2017 was the first year that SCAN reported a rate for this measure.

¹ Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

² NCQA HEDIS Compliance AuditTM is a trademark of NCQA.

Table 3.1—Multi-Year Performance Measure Results*
SCAN— Los Angeles/Riverside/San Bernardino Counties

Measure	RY 2014 Rate ¹	RY 2015 Rate ²	RY 2016 Rate ³	RY 2017 Rate ⁴	RYs 2016–17 Rate Difference ⁵
<i>Colorectal Cancer Screening</i> **	--	--	--	73.24%	Not Comparable
<i>Osteoporosis Management in Women Who Had a Fracture</i> ***	41.14%	51.95%	50.72%	58.06%	7.34

¹ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

² RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ RY 2016 rates reflect MY data from January 1, 2015, through December 31, 2015.

⁴ RY 2017 rates reflect MY data from January 1, 2016, through December 31, 2016.

⁵ Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Rates indicating performance above the HPLs are shaded in gray and denoted with a cross (+), and rates indicating performance below the MPLs are **bolded**.

** The RY 2017 MPL and HPL for *Colorectal Cancer Screening* are based on the HEDIS 2016 national commercial HMO 25th and 90th percentiles, respectively, from NCQA’s Quality Compass®.

*** The RY 2016 and RY 2017 MPLs and HPLs for *Osteoporosis Management in Women Who Had a Fracture* are based on the HEDIS 2015 and HEDIS 2016 national Medicare HMO 25th and 90th percentiles, respectively, from NCQA’s Quality Compass. The MPL and HPL for previous RYs are based on the corresponding HEDIS years’ national Medicare HMO 25th and 90th percentiles, respectively, from NCQA’s HEDIS Audit Means, Percentiles, and Ratios.

-- Indicates that the rate is not available.

Green Shading^ Indicates that the rate for RY 2017 is statistically significantly better than the RY 2016 rate.

Red Shading^^ Indicates that the rate for RY 2017 is statistically significantly worse than the RY 2016 rate.

Not Comparable = An RY 2016–17 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Performance Measure Findings

RY 2017 was the first year that SCAN reported a rate for the *Colorectal Cancer Screening* measure; therefore, HSAG provides no assessment of SCAN’s performance related to this measure.

The rate for the *Osteoporosis Management in Women Who Had a Fracture* measure showed no statistically significant change from RY 2016 to RY 2017 and was between the HPL and the MPL in RY 2017.

Assessment of Improvement Plans

Based on RY 2016 performance measure results, SCAN was not required to submit any improvement plan (IP)/Plan-Do-Study-Act (PDSA) cycles in RY 2016. Based on RY 2017 performance measure results, the SHP is not required to submit any IP/PDSA cycles.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on SCAN's performance measure results, HSAG has no recommendations for the SHP in the area of performance measures.

4. Performance Improvement Projects

SCAN had one DHCS-priority PIP and one SHP-specific PIP in progress during the reporting period of July 1, 2016, through June 30, 2017.

DHCS-Priority Performance Improvement Project

SCAN selected diabetes medication adherence as its DHCS-priority PIP topic.

Validation Findings

During the reporting period, HSAG validated modules 1 and 2 for SCAN's DHCS-priority PIP, which the SHP had revised due to discovering errors with the numerator data in the original submission. Upon review, HSAG determined that SCAN met all validation criteria for modules 1 and 2.

Additionally, HSAG sent periodic check-in email communications to SCAN to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim measure.

SMART Aim

SCAN set the SMART Aim for the *Diabetes Medication Adherence* PIP as follows:

By June 30, 2017, increase from 67.21 percent to 82.21 percent the rate of diabetes medication adherence for oral anti-diabetic agent utilization among the dually-enrolled beneficiaries diagnosed with diabetes and assigned to Provider Group A.³

Failure Modes

The following, listed in priority order, are the failure modes that SCAN identified during the Intervention Determination phase of the PIP process:

- ◆ Physician does not have time to follow up by sending a fax to the pharmacy.
- ◆ Physician ignores the fax.
- ◆ Beneficiary is not interested in learning about the 90-day supply option.

³ Provider group name removed for confidentiality.

- ◆ Beneficiary still has medication left from the 30-day supply and does not need a refill when the 90-day supply is filled.
- ◆ Physician is not aware of the beneficiary's preferred pharmacy.
- ◆ Beneficiary does not want to commit to a 90-day supply.
- ◆ Physician is wary of authorizing the 90-day supply to the beneficiary.

Intervention Testing

During the reporting period, SCAN selected to test giving the partnered provider group a list of beneficiaries on 30-day supplies, but not 90-day supplies, of diabetic medications. The provider group will send 90-day supply prescriptions to physicians to authorize and then send the prescriptions to pharmacies on behalf of the physicians. This intervention addresses the key driver of beneficiary compliance with the treatment plan for medication management and adherence.

Although SCAN completed testing the intervention through the SMART Aim end date of June 30, 2017, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in SCAN's 2017–18 SHP-specific evaluation report.

SHP-Specific Performance Improvement Project

SCAN selected statin use in persons with diabetes as its SHP-specific PIP topic.

Validation Findings

During the reporting period, HSAG validated modules 1 and 2 for SCAN's SHP-specific PIP, which the SHP revised due to changes to the SMART Aim measurement methodology. Additionally, HSAG validated Module 3 that SCAN resubmitted after incorporating HSAG initial feedback. Upon HSAG's final review, HSAG determined that the SHP met all validation criteria for all submitted modules.

HSAG also reviewed and provided feedback to SCAN on the Plan portion of the PDSA cycle for the intervention the SHP selected to test. HSAG sent periodic check-in email communications to SCAN to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

SMART Aim

SCAN set the SMART Aim for the *Statin Use in Persons with Diabetes* PIP as follows:

By June 30, 2017, increase from 73.3 percent to 78.3 percent the rate of Provider Group B⁴ beneficiaries diagnosed with diabetes and with a dispensed statin.

Failure Modes

The following, listed in priority order, are the failure modes that SCAN identified during the Intervention Determination phase of the PIP process:

- ◆ Prescriber does not see the fax to prescribe statin.
- ◆ Prescriber ignores the fax to prescribe statin.
- ◆ Beneficiary is not aware of new prescription or does not want to fill it.
- ◆ Beneficiary does not understand the value and/or benefit of the new prescription.
- ◆ Prescriber does not agree to add statin therapy.
- ◆ Beneficiary cannot afford another prescription.

Intervention Testing

During the reporting period, SCAN selected to test supplying the provider group with monthly beneficiary data for those with gaps in statin therapy so that the provider group could conduct targeted outreach to physicians to ensure that prescriptions for statins are sent to the beneficiaries' pharmacies. This intervention addresses the key driver of beneficiary compliance with treatment plan for medication management and adherence.

Although SCAN completed testing the intervention through the SMART Aim end date of June 30, 2017, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the reporting period. Therefore, HSAG includes no outcomes information in this report. HSAG will report on the PIP outcomes in SCAN's 2017–18 SHP-specific evaluation report.

Strengths—Performance Improvement Projects

Through HSAG's PIP validation and technical assistance, SCAN improved its proficiency in conducting the rapid-cycle PIP process and met all required criteria for PIP modules that the SHP completed during the reporting period.

Opportunities for Improvement—Performance Improvement Projects

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

⁴ Provider group name removed for confidentiality.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2015–16 SHP-specific evaluation report. Table 5.1 provides EQR recommendations from SCAN’s July 1, 2015, through June 30, 2016, SHP-specific evaluation report, along with the SHP’s self-reported actions taken through June 30, 2017, that address the recommendations. Please note that HSAG made minimal edits to Table 5.1 to preserve the accuracy of SCAN’s self-reported actions.

Table 5.1—SCAN’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2015, through June 30, 2016, SHP-Specific Evaluation Report

2015–16 External Quality Review Recommendations Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period July 1, 2016–June 30, 2017, that Address the External Quality Review Recommendations
1. Incorporate HSAG’s initial feedback on the Plan portion of Module 4 prior to testing the intervention for the <i>Diabetes Medication Adherence</i> PIP.	<p>SCAN reviewed and integrated Module 4 initial feedback provided by HSAG in June 2016, revising the goal to increase the 90-day supply rate. Subsequently, modifications to Modules 1 and 2 were submitted in January 2017.</p> <p>Currently SCAN is reviewing all modules to ensure that appropriate updates are integrated in preparation for final submission on August 14, 2017.</p>
2. Incorporate HSAG’s feedback on Module 3 for the <i>Statin Use in Persons with Diabetes</i> PIP to ensure that all validation criteria are met for a methodologically sound PIP.	<p>SCAN reviewed and integrated Module 3 feedback provided by HSAG in June and July 2016, updating the:</p> <ul style="list-style-type: none"> ◆ Process map to include provider/member interaction. ◆ Method to select the sub-processes, using health plan and provider experience. ◆ Failure modes and effects analysis table to address the identified issues. ◆ Intervention table, adding member interventions that address the identified issues. <p>Currently SCAN is reviewing all modules to ensure that appropriate updates are integrated in preparation for final submission August 14, 2017.</p>

2016–17 Recommendations

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

- ◆ Work with DHCS to ensure that the SHP resolves all deficiencies from the March 2017 A&I Medical Audit.

In the next annual review, HSAG will evaluate continued successes of SCAN as well as the SHP’s progress with these recommendations.