

# SCHA – Quality Improvement/Quality Assurance (QIQA) Committee

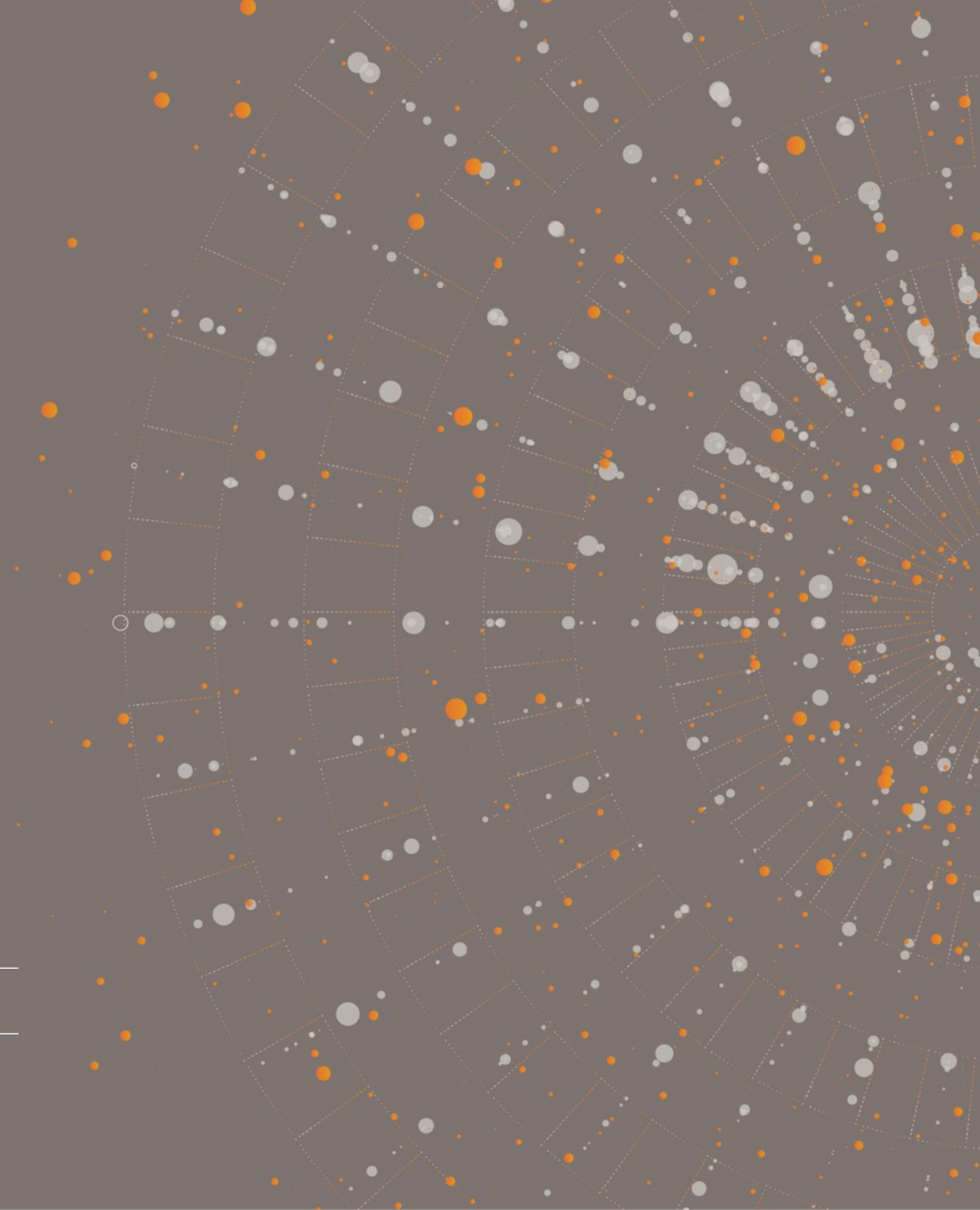
NORC Quantitative Data Planning

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# Overview

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# Background

NORC is contracted to assist Sacramento County and the SCHA in evaluating Medi-Cal managed care performance in the county

NORC will support the QIQA subcommittee and the SCHA as a whole in identifying, collecting, and analyzing quantitative data from both publicly available data sources and data shared with the SCHA by Medi-Cal managed care plans (MCP)



NORC is conducting an environmental scan to support SCHA oversight and coordination to improve managed care plan performance

Produce a data inventory that contains key data sources and metrics evaluating Medi-Cal Managed Care performance in Sacramento

Informed by the Community Health Assessment (CHA) and other data sources/published reports

NORC identified potential measures to monitor over time

The goal for health plan engagement will be to request and receive data on a select set of measures that reflect SCHA priorities with sufficient detail to study variation in performance by select characteristics of the enrolled populations and their geographic location.

The intention would be to use this information to assess disparities in care delivery and identify areas for targeted improvement for plan/county collaboration.

**Today's meeting objectives:**

- To walk the QIQA Committee through the comprehensive data workbook
- To review NORC's recommended measures.

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# Data Collection Methodology

## Data Collection Process

- **The NORC team leveraged previous work conducted by the county to identify publicly available data sources and included other data sources identified by the team.**
  - NORC reviewed the Sellers Dorsey data inventory in addition to conducting an independent environmental scan to identify publicly available data related to Medi-Cal Managed Care Plan performance.
  - NORC compiled the data into a comprehensive data spreadsheet down to the measure level.
  - Data sources include EQRO Technical Reports, DHCS Preventive Services Reports, various DHCS dashboards, CAHPS reports, and data received from DMHC upon special request.



## Data Workbook Layout

- **The data workbook NORC created provides a visual representation of the publicly-available data that can be used to monitor MCP performance**
  - For most measures, the most recent publicly available data is from Calendar Year 2023.
  - Data presented in the data workbook reflect performance under the prior MCP contract period (\*start of current contract period is January 1, 2024”).
  - Considerations for your review of the data workbook:
    - This is a "living" document and will continue to evolve as more current data come online and new data sources are available (e.g., CalAIM measures)
    - We report out data at the plan/county level where feasible. The publicly available data for Kaiser is regional and not county-specific (KP North includes Sacramento, Amador, El Dorado, and Placer counties)
    - County comparators (where feasible to compare data) are:
      - San Diego – the only other GMC county in California
      - San Joaquin – shares many of the same demographic characteristics and health system composition
      - Alameda – shares a similar population to Sacramento and has a Local Initiative model
      - Orange – provides a comparison to a County Organized Healthy System (COHS) model



## Two-Pronged Approach to Data Analysis

**The NORC work includes a two-pronged approach to analysis of the data:**

- 1. Comprehensive Data Spreadsheet Maintenance:** As new publicly available data becomes available, NORC will update the data workbook.
  - This document will be shared, and commissioners can review and provide input and feedback at the next QIQA meeting.
- 2. Analysis of Select Measures:** After the SCHA selects a subset of measures to request from the MCPs and data is received, NORC will conduct a series of analyses on the data to display performance at various levels of disaggregation.

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# Initial Measure Selection Recommendations

## Criteria Used for Measure Selection

### **The criteria NORC used for selection of these subsets of measures included:**

- Measures with financial incentives
- Measures that can be disaggregated (race/ethnicity, sex)
- Comparative measure performance
  - Plans in Sacramento not meeting the MPL or exceeding the HPL
  - Plans in Sacramento compared to county comparators
- Measures aligned with county population health concerns: diabetes, obesity, mental health
- Measures aligned with DHCS Bold Goals, QIQA Committee priorities: children's health, behavioral health, maternity care
- Minimize level of effort to produce data files: selecting measures relying on administrative data
- Measures that will be included in MCAS for future years

# List of Select Measures for QIQA Committee Consideration

**Childhood Immunization  
Status (CIS-10)**

**Child and Adolescent  
Well-Care Visits – Total  
(WCV)**

**Lead Screening in  
Children (LSC)**

**Prenatal and  
Postpartum Care –  
Postpartum Care (PPC-  
Post)**

**Breast Cancer  
Screening – Total (BCS)**

**Cervical Cancer  
Screening (CCS)**

**Asthma Medication  
Ratio – Total (AMR)**

**Controlling High Blood  
Pressure – Total (CBP)**

**Hemoglobin A1c  
(HbA1c) Control for  
Patients with Diabetes  
(HbA1c Poor Control  
(>9.0%) (HBD-H9)**

**Follow-Up After  
Emergency Department  
Visit for Mental Illness –  
30-Day Follow-up –  
Total (FUM-30)**

**Follow-Up After  
Emergency Department  
Visit for Substance  
Abuse-30-Day Follow-  
up – Total (FUA-30)**

**Plan All-Cause  
Readmissions Observed  
Readmissions – Total  
(PCR)**

Domain	Color
Children's Health	Blue
Reproductive Health	Orange
Cancer Prevention	Red
Chronic Disease Management	Yellow
Behavioral Health	Purple
Report Only	Green

## Enrollment in Sacramento County – by Plan

Year	Anthem	Health Net	Molina	Kaiser	Aetna	Total
July 2025	256,083	148,513	73,925	136,972	-	615,493
	41.6%	24.1%	12.0%	22.3%	N/A	
Dec 2023	233,752	142,386	59,935	127,952	25,031	589,056
	39.7%	24.2%	10.2%	21.7%	4.3%	

**Source:** Medi-Cal Managed Care Enrollment Report, July 2025

<https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report>

# Childhood Immunization Status – Combination 10

**Measure Name:** Childhood Immunization Status – Combination 10 (CIS-10)

**Domain:** Children’s Health

**Definition:** This measure assesses the percentage of children who received all 10 recommended vaccines by their second birthday, according to the CDC’s Advisory Committee on Immunization Practices (ACIP).

**Numerator:** Children in the denominator who received all 10-vaccine series in the measure on or before their second birthday.

**Denominator:** Children who turn two years old during the measurement year and were continuously enrolled in the health plan from birth through their second birthday (with allowable gaps).

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
18.6%	23.1%	29.2%	23.6%	48.9%	30.9%	45.3%

Data Point Color Coding Key
Green indicates the measure is above the HPL
Red indicates the measure is below the MPL
Black indicates the measure is in between the MPL and HPL

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Child and Adolescent Well-Care Visits - Total

**Measure Name:** Child and Adolescent Well-Care Visits – Total (WCV)

**Domain:** Children’s Health

**Definition:** The percentage of children and adolescents who had one or more comprehensive well-care visits during the measurement year.

**Numerator:** At least one well-care visit with a primary care practitioner, OB/GYN, pediatrician, physician assistant, or nurse practitioner during the measurement year.

**Denominator:** Patients 3-21 years of age as of December 31<sup>st</sup> of the measurement year.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
31.8%	43.9%	50.8%	42.3%	53.7%	48.1%	61.2%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)



# Lead Screening in Children

**Measure Name:** Lead Screening in Children (LSC)

**Domain:** Children’s Health

**Definition:** Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

**Numerator:** At least one lead capillary or venous blood test on or before the child’s second birthday.

**Denominator:** Children 2 years of age during the measurement year (with allowable gaps).

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
45.9%	47.3%	48.2%	51.8%	43.8%	62.8%	79.3%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Prenatal and Postpartum Care – Postpartum Care

**Measure Name:** Prenatal and Postpartum Care – Postpartum Care (PPC-Post)

**Domain:** Reproductive Health

**Definition:** Percentage of deliveries that had a postpartum visit on or between 21 and 84 days after delivery.

**Numerator:** Percentage of live birth deliveries with a

**Denominator:** Live births within the measurement year (with allowable gaps).

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
69.0%	74.3%	72.5%	69.7%	81.3%	78.1%	84.6%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Breast Cancer Screening--Total

**Measure Name:** Breast Cancer Screening--Total (BCS)

**Domain:** Cancer Prevention

**Definition:** The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

**Numerator:** One or more mammograms any time on or between the cutoff dates of the measurement year.

**Denominator:** Women 50-74 years of age who had a mammogram to screen for breast cancer.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
30.7%	48.8%	43.5%	37.5%	78.7%	52.6%	62.7%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Cervical Cancer Screening

**Measure Name:** Cervical Cancer Screening (CCS)

**Domain:** Cancer Prevention/ Women’s Health

**Definition:** The percentage of women 21–64 years of age who were screened for cervical cancer using any of the defining criteria.

**Numerator:** The number of women who were screened for cervical cancer and meet the defining criteria.

**Denominator:** Women 21-64 years of age who were screened for cervical cancer using the defining criteria.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
35.6%	50.7%	50.0%	43.6%	72.4%	57.1%	66.5%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Asthma Medication Ratio--Total

**Measure Name:** Asthma Medication Ratio--Total (AMR)

**Domain:** Chronic Disease Management

**Definition:** Patients 5-64 years of age having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

**Numerator:** Ratio of controller medications to total asthma medications of 0.50 or greater.

**Denominator:** Patients 5-64 with persistent asthma and claims for asthma medications.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
72.7%	62.1%	60.5%	60.8%	79.1%	65.6%	75.9%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Controlling High Blood Pressure--Total

**Measure Name:** Controlling High Blood Pressure--Total (CBP)

**Domain:** Chronic Disease Management

**Definition:** The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.

**Numerator:** Members with a diagnosis of hypertension whose blood pressure is adequately controlled (<140/90 mmHg).

**Denominator:** Members aged 18-85 with a diagnosis of hypertension.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
48.2%	54.3%	57.0%	58.9%	77.0%	61.3%	72.2%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Hemoglobin A1c (HbA1c) Control for Patients With Diabetes--HbA1c Poor Control (>9.0%)

**Measure Name:** Hemoglobin A1c (HbA1c) Control for Patients With Diabetes--HbA1c Poor Control (>9.0%) (HBD-H9)

**Domain:** Chronic Disease Management

**Definition:** The percentage of members 18-75 years of age with diabetes who had HbA1c poor control.

**Numerator:** Patients whose most recent HbA1c level is >9.0%.

**Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
47.5%	38.0%	37.5%	43.6%	25.7%	38.0%	29.4%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)



# Follow-Up After Emergency Department Visit for Mental Illness--30-Day Follow-up--Total

**Measure Name:** Follow-Up After Emergency Department Visit for Mental Illness--30-Day Follow-up--Total (FUM-30)

**Domain:** Behavioral Health

**Definition:** Percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service.

**Numerator:** A follow-up service for mental health within 30 days after the ED visit.

**Denominator:** Members 6 years of age or older as of the ED Visit.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
28.1%	40.9%	35.4%	26.7%	80.0%	54.9%	73.3%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Follow-Up After Emergency Department Visit for Substance Abuse--30-Day Follow-up--Total

**Measure Name:** Follow-Up After Emergency Department Visit for Substance Abuse--30-Day Follow-up--Total (FUA-30)

**Domain:** Behavioral Health

**Definition:** The percentage of ED visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a follow-up visit within 30 days of the ED visit.

**Numerator:** A follow-up visit or a pharmacology dispensing event within 30 days after the ED visit.

**Denominator:** Members 13 years of age or older as of the ED visit.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser	MPL	HPL
24.9%	31.7%	28.6%	32.2%	39.1%	36.3%	53.4%

Note: MPL stands for Minimum Performance Level. HPL stands for High Performance Level. Both metrics are benchmarks established by DHCS.  
Source: Data in the table above is sourced from Medi-Cal Managed Care Physical Health External Quality Review Technical Report (23-24)

# Plan All-Cause Readmissions Observed Readmissions—Total

**Measure Name:** Plan All-Cause Readmissions Observed Readmissions—Total (PCR)

**Domain:** Report Only

**Definition:** The number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

**Numerator:** Count of 30-Day Readmissions.

**Denominator:** Count of Index Hospital Stays.

**Data Source:** Managed Care Accountability Sets (MCAS)

**Measurement Year:** 2023

Aetna	Anthem	Health Net	Molina	Kaiser
6.8%	8.7%	8.7%	10.0%	8.9%

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# Discussion

Items to consider in our discussion today

- Are these the right measures to study longitudinally?
- Are there measures that should be removed from consideration?
- Are there different measures the committee would like to consider instead?
- Which measures do you recommend for Commission consideration (up to five)?

Principles established in May 2024 for health plan monitoring include:

- **Align** with goal areas of focus for SCHA
- **Leverage** existing state Medi-Cal Monitoring activities, including measurement, analysis, related MCP reporting and published reports
- **Be feasible** including considerations for accessibility and timeliness as data as well as limiting administrative burden for MCPs
- **Be meaningful** with respect to equitable and quality care
- **Target** opportunities for improvement

## List of Select Measures for QIQA Committee Consideration

Childhood Immunization Status (CIS-10)	Child and Adolescent Well-Care Visits – Total (WCV)	Lead Screening in Children (LSC)
Prenatal and Postpartum Care – Postpartum Care (PPC-Post)	Breast Cancer Screening – Total (BCS)	Cervical Cancer Screening (CCS)
Asthma Medication Ratio – Total (AMR)	Controlling High Blood Pressure – Total (CBP)	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HbA1c Poor Control (>9.0%) (HBD-H9)
Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-up – Total (FUM-30)	Follow-Up After Emergency Department Visit for Substance Abuse-30-Day Follow-up – Total (FUA-30)	Plan All-Cause Readmissions Observed Readmissions – Total (PCR)

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# Next Steps

## Committee Member “Homework”

- Review the slide deck and data spreadsheet with recommended measures
- Provide feedback to NORC on measure priorities
- Send recommendations for up to 5 measures to Gina Patterson by September 11, 2025