Population Needs Assessment Report

UnitedHealthcare Community Plan of California

Report Year 2022

Responsible Health Education and/or Cultural and Linguistics Staff

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I. Population Needs Assessment Overview

The Population Needs Assessment (PNA) Report assesses UnitedHealthcare Community Plan of California's (UnitedHealthcare) strategic efforts to develop health education, culturally competent and linguistically appropriate services, as well as continuous quality improvement programs while reducing health disparities among the diverse populations we service in San Diego County among our Medi-Cal beneficiaries.

The Plan is committed to address any health disparities associated with UnitedHealthcare's members' age, gender, geographic distribution, race and ethnicity, language, and disability; and overall, social determinants of health to reduce health disparities and improve our member's quality of health and the community they live in.

UnitedHealthcare will utilize this report as a means of incorporating findings from various health plan data evaluations, identifying disparate populations to impact healthcare in 2022. The PNA is the responsibility of the Clinical Quality Manager who oversees member engagement, health education, and cultural and linguistic programs. The Plan Chief Medical Officer and Director of Clinical Quality and Health Equity maintain oversight of the Population Health programs including member engagement, health education, and cultural and linguistics. The Clinical Quality Manager attends the quarterly California Department of Health Care Services (DHCS), Health Education and Cultural and Linguistics Workgroup.

The Population Needs Assessment Report will address the Plan's initial Action Plan Goals and Objectives including:

1. Recognition of diversity among health plan members.
2. Knowledge of disease prevalence in specific diverse populations.
3. Continuous development of programs and policies that address the needs of diverse and disparate populations.
4. Ongoing program evaluation to improve and meet changing needs while monitoring the effectiveness of current programs.
5. Data analysis to identify gaps in health and establishing dashboards capable of identifying disparity in diverse populations.
6. Provider and staff training to create awareness of cultural diversity.
7. Encouraging Community Advisory Committee (CAC), Provider Advisory Committee (PAC), and Public Policy Committee (PPC) input on relevant issues.

UnitedHealthcare will use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA. These will include, but not limited to, the data set and surveys below:

<u>Data Sets</u>

1. Beneficiary demographics
2. Claims and encounter data
3. Health Disparities Report (Individual MCP level disparity data)
4. Member Level Data (MLD) Report
5. Member Grievance and Appeals
6. County data

7. Member Health Status Indicators

Surveys and Studies

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data
2. Provider Satisfaction Survey
3. Member Satisfaction Survey or Net Promoter Score (NPS)
4. Quality studies
5. Community Advisory Committee (CAC) Member feedback
6. Provider Advisory Committee (PAC) Provider feedback
7. Public Policy Committee (PPC) Member and Provider feedback

II. Data Sources

As aforementioned, UnitedHealthcare will use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA. These will include, but not limited to, the data set and surveys defined below:

Data Sources/Sets

1. Beneficiary demographics: California State 834 enrollment files as of December 31, 2021.
2. Claims and encounter data: ICD-10 codes received via member claims. Includes all claims within the split data year. Top diagnoses reflect the unique number of members who had the given diagnoses as a primary, secondary, or tertiary diagnosis as of June 30, 2021.
3. Health Disparities Report: Measurement Year (MY) 2020/Report Year (RY) 2021, individual MCP level disparity data detailed care gap report by race/ethnicity, gender, language, age.
4. HEDIS® report as submitted to NCQA for Reporting Year 2021.
5. Member Level Data (MLD) Report: validated individual member data as of year-end 2021.
6. Member Grievance and Appeals: Cultural, linguistics, or discrimination related grievance and appeals suggestive of disparity from January 1, 2021, to December 31, 2021.
7. County data: most recent published health statistics that describe health behaviors, diseases, and injuries for specific populations, in addition to health trends and comparisons to national target.
8. Member Health Status Indicators: health plan measures of illnesses and diseases from claims and encounter data for the measurement year.

Surveys and Studies

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data: CAHPS® 5.0H survey conducted from February 9, 2021, through May 26, 2021.
2. Provider Satisfaction Survey (PSS): a provider satisfaction survey assesses provider satisfaction and access. The PSS is conducted to meet the Department of Managed Health Care (DMHC)'s Timely Access and the California Department of Insurance (CDI's) Network Adequacy requirement.
3. Member Satisfaction Survey or Net Promotor Score (NPS): a member satisfaction survey that is completed over the telephone by a contracted vendor. The NPS survey helps UnitedHealthcare improve the overall member experience based on member responses and qualitative feedback.
4. Quality studies: 2021 HEDIS® Annual Report; 2021 Annual Assessment of Network Adequacy Report; 2021 CAHPS® Report; 2021 Health Education Class Evaluation Report; and 2021 Population Health Management Evaluation Report, among others.
5. CAC Member feedback held throughout 2021

6. PAC Provider feedback held throughout 2021
7. PPC Member and Provider feedback held throughout 2021

III. Key Data Assessment Findings

1. Membership/Group Profile

The PNA includes stratification of members based upon age, gender, race/ethnicity, geographic distribution, language, and Medi-Cal eligibility categories.

Membership is further broken down to include physical and behavioral health diagnoses, as well as an assessment of the needs of children and adolescents, disabled members, and members with serious and persistent mental illness (SPMI) [see Section 2. Health Status and Disease Prevalence].

The demographic data (age, gender, language, and ethnicity) is member self-reported data and is received monthly via State 834 enrollment files. Children and adolescents are defined by the state as individuals under the age of 21. Eligibility and disability categories are designated by the State Medicaid (Medi-Cal) agency and are also provided to the plan via the monthly State 834 files. Demographic, eligibility, and disability categories are current as of December 31, 2021.

Table 1. 2021 Number of Members by Age and Gender

2021 Number of Members by Age and Gender				
Age	**Male**	**Female**	**Total**	**Percent**
0 - 20	4,061	3,733	7,794	29.53%
21 - 40	5,222	6,037	11,259	42.65%
41 - 60	2,655	2,519	5,174	19.60%
61+	978	1192	2,170	8.22%
Total	**12,916**	**13,481**	**26,397**	**100.00%**

Data Source: California State 834 Files. Current as of 12/31/2021.

Data Analysis

The predominant age group is members aged 21-40 at over 42.65% of the membership. The predominant age/agender groups is male ages 21-40 (19.78%) and female ages 21-40 (22.87%). The predominant gender group overall is female, accounting for 51.07%, just over half of the overall membership. UnitedHealthcare's membership grew by 6,501 members between year-end 2020 to year-end 2021; however, the age and gender distribution between the years remained the same.

Geographic Distribution

UnitedHealthcare serves San Diego County, which is divided into four geographic regions, including: Central Region, East Region, North Region, and South Region. To further define the four major geographic regions some of the major cities for each region include but are not limited to the following: Central Region (San Diego, Del Mar, Poway, La Jolla); East Region (El Cajon, Santee, La Mesa, Lemon Grove); North

Region (Escondido, Oceanside, San Mateo, Vista); and South Region (San Ysidro, National City, Chula Vista, Imperial Beach).

Figure 1. Regional Map of San Diego County

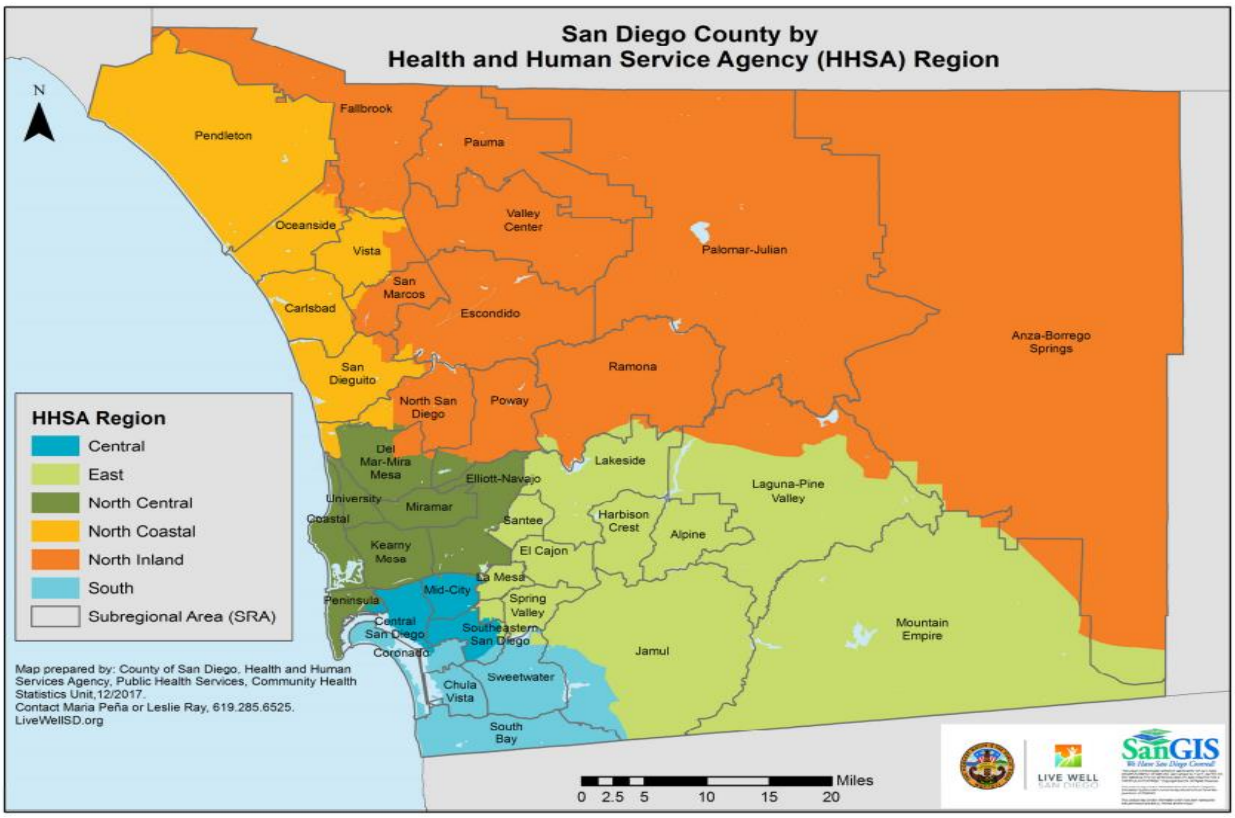


Table 2. 2021 Number and Percent of Members by San Diego County Region

2021 Number and Percent of Members by San Diego County Region		
Region	**Number**	**Percent**
Central	10688	40.49%
East	4653	17.63%
South	4452	16.87%
North (Central, Coastal, Inland)	6529	0.25%
Other	75	0.00%
Total	**26,397**	**100.00%**

Data Source: California State 834 Files. Current as of 12/31/2021.

Data Analysis

The geographic distribution by region in 2021 is consistent with 2020. Data analysis indicates that the predominant San Diego County Region with highest membership is within the Central County region which accounts for 40.49% of the overall membership when compared to the other San Diego County regions. Of

note, the category “Other” indicates membership that do not live in San Diego County and are outliers to the current data, comprising of 0.00% of the overall membership.

The top 5 zip codes include 91911, 92105, 91910, 92115, and 92154 located in San Diego County Central Region and South Region.

Table 3. 2021 Top 5 Zip Codes

2021 Top 5 Zip Codes		
Zip Code	**Member Count**	**Percent**
91911 (Chula Vista, South Region)	827	22.01%
92105 (City Heights, Central Region)	803	21.37%
91910 (Chula Vista, South Region)	720	19.16%
92115 (College Grove, Central Region)	709	18.87%
92154 (Otay Mesa, South Region)	699	18.60%
Total	**3,758**	**100.00%**

Data Source: California State 834 Files. Current as of 12/31/2021.

The most populated zip code among our membership is 91911, Chula Vista. Chula Vista is the second largest city in San Diego County and has the highest proportion of Hispanic residents compared to other San Diego County South Region cities. Chula Vista’s racial and ethnic makeup is as follows: 64.8% White Only, 59.8% Hispanic or Latino, 16.8% White Not Hispanic or Latino, 16.4% Asian, 5.4% two more races, 4.7% Black or African American, 0.4% American Indian and Alaska Native, and 0.5% Native Hawaiian (U.S. Census Bureau, 2022).

According to local data collection, the main health concerns in the City of Chula Vista are obesity and overweight among youth and adults, diabetes, low rate of physical activity, inadequate consumption of fruits and vegetables, asthma, and mental health issues. The western part of the city faces inequities such as lower incomes, lower quantity, and quality of public resources such as parks and sidewalks, higher concentration of fast-food restaurants, and fewer healthy food option (Human Impact Partners, 2022). The local data aligns nearly identically with the health issues and social factors our membership is challenged with.

Medi-Cal Eligibility Categories

UnitedHealthcare analyzed Medi-Cal eligibility categories to further identify our membership population and determine any potential social determinants of health that should be considered as part of our program planning and development. Table 4 below indicates 2021 Number and Percent of Members by Eligibility Categories.

Table 4. 2021 Number and Percent of Members by Eligibility Categories

2021 Number and Percent of Members by Eligibility Categories		
Eligibility Categories	**Total Number**	**% of Total Membership**
CA TANF	22842	86.53%
CA TANF RADY	1564	5.92%
CA Seniors and Persons with Disabilities	892	3.38%
CA Duals	662	2.51%
CA California Children Services	208	0.79%
CA California Children Services RADY	105	0.40%
CA In Home Supportive Services Program	82	0.31%
CA Seniors and Persons with Disabilities RADY	30	0.11%
CA Long Term Care Program	8	0.03%
CA Optional Targeted Low-Income Children	2	0.01%
CA Genetically Handicapped Persons Program	1	0.00%
CA CCS/GHPP	1	0.00%
Grand Total	**26,397**	**100.00%**

Data Source: California State 834 Files. Current as of 12/31/2021.

Data Analysis

Data observed indicates that a large part of our membership is primarily enrolled through the Temporary Assistance for Needy Families (TANF) program. Members who are eligible for TANF/TANF RADY in and of itself indicate a member is at or near the poverty level. Overall, 92.45% of plan members are TANF eligible. These members have unique socioeconomic stressors related to issues with housing, food, transportation, employment, and health literacy. UnitedHealthcare also observed low-income members enrolled through the Medi-Cal Expansion program, disabled individuals, and individuals with functional disabilities who remain in the community through Long Term Care programs. These results are consistent with reporting year 2020 and 2021.

Race/Ethnicity

Table 5. 2021 Number and Percent of Members by Race/Ethnicity

2021 Number and Percent of Members by Race/Ethnicity		
Race/Ethnicity	**Number**	**Percent**
Other	8613	32.63%
Hispanic	7163	27.14%
Caucasian	6000	22.73%
Asian	2103	7.97%
Black	1486	5.63%
Unknown	822	3.11%

Native Hawaiian	23	2.80%
Native American	100	0.38%
Pacific Islander	87	0.33%
Total	**26,397**	**100.00%**

Data Source: California State 834 Files. Current as of 12/31/2021.

Data Analysis

The predominant racial group among the membership is “Other” at 32.63% of the total membership, followed by the second largest predominant racial group, Hispanic at 27.14%. A diverse racial/ethnic membership was identified at the plan, remaining consistent over reporting years 2020 and 2021.

Language

Table 6. 2021 Number and Percent of Members by Language

2021 Number and Percent of Members by Language		
Language	**Number**	**Percent**
English	23635	89.54%
Spanish	1648	6.24%
Mandarin	274	1.04%
Miscellaneous	271	1.03%
Cantonese	160	0.61%
Arabic	111	0.42%
Farsi	83	0.31%
Tagalog	79	0.30%
Vietnamese	44	0.17%
Russian	33	0.13%
Cambodian	15	0.06%
Korean	15	0.06%
Sign Language	9	0.03%
Chinese	6	0.02%
Portuguese	5	0.02%
Laotian	4	0.02%
French	3	0.01%
Japanese	1	0.00%
Thai	1	0.00%
Grand Total	**26,397**	**100.00%**

Data Source: California State 834 Files. Current as of 12/31/2021.

Data Analysis

The predominant preferred languages identified other than English (89.54%), included Spanish at 6.24% among the membership. Also observed, was that the additional non-English languages meet the California

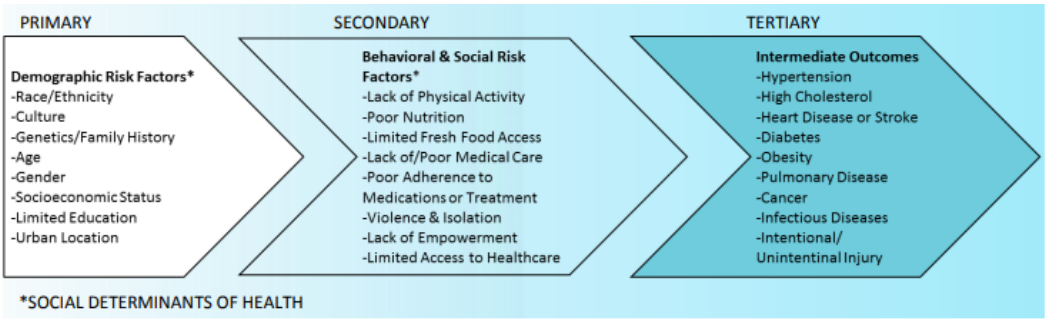
Department of Health Care Services (DHCS) identified San Diego County threshold languages including Arabic (0.42%), Cantonese (0.61%), Farsi (0.31%), Mandarin (1.04%), Tagalog (0.30%), and Vietnamese (0.17%) are among the top ten languages identified in 2021. Other languages identified among the top ten are Miscellaneous (1.03%) and Russian (0.13%). The reported languages remain consistent compared to reporting year 2021.

Membership Summary

Overall, the key findings the PNA identified include the most populated zip code among our membership is in Chula Vista, or in San Diego County's South Region, accounting for 40.49% of the overall membership when compared to other San Diego County regions. Our members mirror the demographic makeup of San Diego County, predominantly reported as Other (32.63%) followed by the second largest racial group, Hispanic (27.14%), who speak predominantly English and are 21 to 40 years old, or an average age of 30.5 years old. Possibly defining first- , second- , third- , or higher- generation Hispanic born in the United States to U.S. born parents. This aligns to the cultural detailing of San Diego County, where San Diego, California is heavily influenced by American and Mexican cultures due to its position as a border town, large Hispanic population, and its unique history as part of Spanish America and Mexico. San Diego's long-time association with the U.S. military also contributes to its culture, with a 9.1% veteran population (U.S. Census Bureau, 2022). These cultural details are important as cultural views are considered for program planning and outreach strategies preferred by our membership. Furthermore, 92.45% plan members are TANF eligible, this rate is consistent with reporting years 2020 and 2021. That is nearly the entire membership population who are at or near the poverty level. These members have unique socioeconomic stressors related to issues with housing, food, transportation, employment, and education, health literacy that impede them from going to a regular doctor visit or take care of their health.

According to Live Well San Diego South Region Community Health Assessment, the South Region experiences the highest percentage of chronic disease related deaths. Four specific chronic conditions account for most of these high death percentages; cancer, vascular disease, such as heart disease and stroke, type 2 diabetes, and pulmonary diseases, such as asthma. In 2009, cancer deaths were higher among White South Region residents compared to any other racial or ethnic group in any other region. The rates of diabetes death, hospitalization, and emergency department discharge in South Region residents were disproportionately higher among Latinos and older adults than their counterparts in other regions. In 2007, heart disease and stroke ranked first and third as the leading causes of death in South Region. South Region has one of the highest rates of coronary heart disease deaths in the County. South Region's communities of color are disproportionately affected by heart disease and stroke. South Region's Latinos also had a higher rate of heart disease death, compared to the same ethnic group in other parts of the County (Live Well San Diego, 2014). The San Diego County has also identified these issues as of paramount concern to the population including obesity and overweight among youth and adults, lack of physical activity, inadequate consumption of fruits and vegetables, limited access to fresh food, poor nutrition, lack of/poor medical care, poor adherence to medications or treatment, limited access to healthcare, asthma, and mental health issues (Human Impact Partners, 2022). The Critical Pathway (Figure 2) is an illustrative representation of how demographic and social/behavioral risk factors contribute to the development of chronic disease as seen in San Diego County's South Region.

Figure 2. Critical Pathway for South Region (Lack of Physical Activity, Poor Diet, Lack of Safety, Lack of Access to Health Care)



Note: This figure conveys the aspects of primary secondary, and tertiary prevention for chronic diseases in each Region. The tertiary prevention factors are specific for each given Region, resulting in identification of primary and secondary prevention factors.

Due to the detailed investigation of our membership, we agree these are the most priority needs of our population as well. Additionally, UnitedHealthcare based our assessment of our membership needs on the disease prevalence in our members, the most frequent visit types, the results of Healthcare Effectiveness Data and Information Set (HEDIS®) Medi-Cal Managed Care Accountability Set, or MCAS for our members, and the self-identified concerns as expressed in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Member Satisfaction Survey, or Net Promoter Score (NPS). Based on this, our population is assessed to have the following needs requiring attention from the Plan and from the healthcare community: access to preventive care, understanding of the importance of preventive health care, efforts to reduce the impact of the COVID-19 pandemic on limiting utilization of healthcare services, diabetes care, and hypertension care.

2. Health Status and Disease Prevalence

A. Population Health Management Evaluation

In 2021, UnitedHealthcare conducted a Population Health Management Evaluation study to assess top in-patient and out-patient diagnoses by age, disability, and Severe or Persistent Mental Illness (SPMI). Clinical data is reported based upon ICD-10 codes received via member claims and includes all claims within the split data year. Top diagnoses reflect the unique number of members who had the given diagnoses as a primary, secondary, or tertiary diagnosis during July 1, 2020, and June 30, 2021. The tables below demonstrate data yielded from that study.

Table 7. Top Diagnoses Child/Adolescent (2-19)

Top Diagnoses Child/Adolescent (2-19)		
Top Five Outpatient Diagnoses- Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
Routine Child Exam	Routine Child Exam	Routine Child Exam
Acute Upper Respiratory Infection	Immunization	Immunization
Acute Pharyngitis	Acute Upper Respiratory Infection	Contact with Exposure Other Virus
Screening for Disease of the Blood	Child Health Exam w/Abnormal Finding	Contact with & Exposure to Covid Virus
Screening Disorders	Cough	Encounter for Screening-Other Disorder
Top Five Inpatient Diagnoses – Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
Acute Respiratory Failure	Acute Appendicitis	Acute Appendicitis
Mild Persistent Asthma	Lobar Pneumonia	Covid-Acute Respiratory Distress
Acute Bronchiolitis	Perforation Tympanic Membrane	Fever Unspecified
Failure to Thrive (Child)	Dehydration	Major Depressive Disorder

**Data based on split year July 1 – June 30 of the measurement period.* *Data Source: SMART Data Warehouse/Claims*

The most common diagnoses seen among adolescents and children were for routine health exams, immunizations and in 2021 diagnoses related to Covid-19. Prenatal and Newborn needs are addressed through the Healthy First Steps program, which aims to identify pregnant women as early as possible with a goal of achieving the best health outcomes for pregnant women and newborns through the first year of life. Relevant needs of healthy adolescents and children are inherently linked to overall social determinants of health including but not limited to securing safe housing, adequate access to food, education, and health care. These needs are then impacted by socioeconomic status, social & family support systems, language, and health literacy.

Table 8. Top Diagnoses Ages 20 and Over

Top Diagnoses Ages 20 and Over		
Top Five Outpatient Diagnoses- Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
General Adult Medical Exam	General Adult Medical Exam	Contact with Exposure Other Virus
Primary Hypertension	Primary Hypertension	General Adult Medical Exam
Chest Pain	Chest Pain	Encounter for B/P w/o Abnormal Finding
Routine GYN Exam	Hyperlipidemia	Primary Hypertension
Abdominal Pain	Encounter in Specified Consultation	Health Services Encounter-Other Circumstances
Top Five Inpatient Diagnoses – Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
Sepsis Unspecified Organism	Single Live Infant Delivery	Sepsis Unspecified Organism
Alcohol Dependence w/Withdrawal	Sepsis Unspecified Organism	Covid-Acute Respiratory Distress
Acute Kidney Failure	Primary Hypertension	Acute Respiratory Failure w/Hypoxia
Hypertensive heart Disease	Acute Kidney Failure	Acute Kidney Failure
	Acute Respiratory Failure	Unspecified Abdominal Pain

**Data based on split year July 1-June 30 of the measurement period.* *Data Source: SMART Data Warehouse/Claims*

The most common diagnoses for adults include hypertension and respiratory failure. Overall, the membership remains healthy as outpatient services for routine medical exams continue to be in the top five. However, in 2021 exposure to as well as treatment for Covid-19 was found in both the inpatient and outpatient groups. Health status, health care utilization, and health-promoting behaviors among adults vary considerably by age and other sociodemographic characteristics. Needs for this group include a healthy diet, regular physical exercise, preventive health care and resources to facilitate maintaining life work balance, as well as mental health services.

Table 9. Top Diagnoses Members with Severe and Persistent Mental Illness (SPMI)

Top Diagnoses Members with Severe and Persistent Mental Illness (SPMI)		
Top Five Outpatient Diagnoses- Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
Major Depressive Disorder	Major Depressive Disorder Single	Major Depressive Disorder Single
Anxiety Disorder	Major Depressive Disorder Recurrent	Encounter for B/P w/o Abnormal Finding
Major Depressive Disorder Recurrent	Anxiety Disorder	Anxiety Disorder
General Adult Medical Exam	Encounter for Immunizations	Contact with Exposure Other Virus
Primary Hypertension	Primary Hypertension	Health Services Encounter-Other Circumstances
Top Five Inpatient Diagnoses – Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
Unspecified Psychosis	Unspecified Psychosis	Unspecified Psychosis
Chest Pain	Major Depressive Disorder Recurrent	Preprocedural Lab Exam
Other Nonspecific Abnormal Finding	Bipolar Disorder	Major Depressive Disorder-Single
Major Depressive Disorder	Chest Pain	Altered Mental Status
Encounter Adjustment Management	Schizophrenia	Major Depressive Disorder Recurrent

**Data based on split year July 1-June 30 of the measurement period* *Data Source: SMART Data Warehouse/Claims*

Members with Serious and Persistent Mental Illness (SPMI) are also a particularly vulnerable population with unique issues. The biggest and most frequently overlooked obstacle being the social stigma associated with mental illness. The stigma around mental health and illness continues to be a factor for those affected, to not to seek or to discontinue treatment. An analysis of this membership showed prevalent diagnoses that include both medical and behavioral conditions of major depressive disorder, anxiety disorder, and psychosis. Although each specific disorder has unique challenges, they share a common thread of causing impairment to function, along with emotional and/or physical pain, which may result in increased utilization of emergency services. This common thread disrupts life, interferes with healthy function in family, work and community and creates an increased risk in mortality. UHCCP CA connects case management resources with the appropriate behavioral health services, to reduce delays or gaps in care as well as to prevent duplication of services.

Table 10. Top Diagnoses Members with Disabilities

Top Diagnoses Members with Disabilities		
Top Five Outpatient Diagnoses- Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
Primary Hypertension	Primary Hypertension	Primary Hypertension
Illness Unspecified	Encounter for Immunizations	Encounter for Immunizations
General Adult Medical Exam	Illness Unspecified	General Adult Medical Exam
Type 2 Diabetes Mellitus	Type 2 Diabetes Mellitus	Health Services Encounter-Other Circumstances
Immunizations	General Adult Medical Exam	Contact with Exposure Other Virus
Top Five Inpatient Diagnoses – Based on unique count of members with the diagnosis		
2019	**2020**	**2021**
Nonspecific Abnormal Finding	Chest Pain Unspecified	Non-specified Abnormal Findings
Pleural Effusion	Nonspecific Abnormal Finding	Chest Pain Unspecified
Acute Kidney Failure	Pleural Effusion	Sepsis
Sepsis	Sepsis	Unspecified Abdominal Pain
Chest Pain Unspecified	Shortness of Breath	Altered Mental Status

**Data based on split year July 1-June 30 of the measurement period* *Data Source: SMART Data Warehouse/Claims*

Members with an array of disabilities make up approximately 4% of the population. Subpopulations of members with disabilities include Seniors and Persons with Disabilities (SPD), Developmental Disabilities Children (DD/DV), and Age Blind Disabled (ABD). There are two types of disabilities; cognitive and medical/physical and it is not uncommon for people to have both types. The disabled face unique challenges inside their homes as well as out in the community. Many require assistance with personal as well as social activities of daily living, safe housing, transportation, home modifications and assistive devices for communication. Members with disabilities and/or chronic illnesses require additional community support such as identifying federal or state program eligibility and getting enrolled, assistance managing their conditions along with navigating the health care system and transportation to appointments. People with multiple chronic illnesses may experience suboptimal health outcomes which result in increased health care expenses and often cause increased social isolation, anxiety, and depression. Together these factors negatively impact both the length and quality of life for people living with chronic illness. Prevalent diagnoses among these members include hypertension, chest pain, and sepsis.

B. COVID-19 Membership Data Analysis

UnitedHealthcare conducted an analysis after the conclusion of 2021. The data showed during calendar year 2021, there were a total of 1,033 members identified who were diagnosed as positive with COVID-19.

As one of the known risk factors is ethnicity, an analysis was conducted focusing on these demographic elements.

Table 11. Members with a Positive COVID-19 Diagnosis by Ethnicity

Members with a Positive COVID-19 Diagnosis by Ethnicity		
Ethnicity	**Positive Cases**	**%**
Unknown	401	38.82%
Hispanic	321	31.07%
Caucasian/White	183	17.72%
Asian	91	8.81%
African American	31	3.00%
Native American	4	0.39%
Pacific Islander	2	0.19%
Total	**1,033**	**100.00%**

Data Source: Facets/Claims January 1, 2021 to December 31, 2021

Data Analysis

The data identified the most prevalent ethnicities with positive COVID-19 diagnoses were among Unknown (38.82%), Hispanic (31.07%), Caucasian/White (17.72%), followed by Asian (8.81%) and African American (3.00%). There is no clear outlying ethnicity with more cases identified compared to overall UnitedHealthcare membership or San Diego County data. These ethnicity rankings mirror the ethnicity rankings of our overall membership. These rankings are also like those of COVID-19 cases in San Diego County (San Diego County “Summary of Cases by Race and Ethnicity”, 2022), except for Unknown ethnicity. However, the accuracy of health plan data for Unknown/Other ethnicity is a known barrier.

When compared to a CDC analysis of Race/Ethnicity COVID-19 case prevalence, there is some alignment as their rankings also demonstrate prevalence as Hispanic/Latino, although when compared to 2020, prevalence among American Indian or Alaskan Native is slightly higher. UnitedHealthcare membership data does not align with the CDC’s next most prevalent ethnicities which are Black or African American, Caucasian/White, followed by Asian (National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, 2022), which may reflect the low percentage of Black and African American members enrolled with our Plan.

Table 12. Members with a Positive COVID-19 Diagnosis by Age

Members with a Positive COVID-19 Diagnosis by Age		
Age	**Positive Cases**	**%**
0-3	44	4.26%
4-10	41	3.97%
11-18	43	4.16%

19-30	250	24.20%
31-45	266	25.75%
46-65	345	33.40%
66-80	42	4.07%
80+	2	0.19%
Total	**1,033**	**100.00%**

Data Source: Facets/Claims January 1, 2021 to December 31, 2021

Data Analysis

The data for UnitedHealthcare members with COVID-19 cases illustrates it is more common among those between ages 19 to 65, which was also observed during the prior year 2020. This aligns with the CDC data which shows that COVID-19 is most prevalent among individuals between aged 18-29 in terms of cumulative total number of cases. When comparing positive cases across age bands there is no difference noted by the CDC, indicating the age disparity has leveled off compared to the 2020, when the CDC noted that individuals between 18-65 were twice as likely to contract the virus than those in other age groups (National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, 2022). This age range also represents the majority of health plan membership.

Additionally, UnitedHealthcare tracked hospital, outpatient, and telemedicine visits among the 1,033 members with a positive COVID-19 diagnoses. As a result, UnitedHealthcare identified 1 Emergency Room (ER) Hospital Admission, 169 ER Visits, 89 Hospital Admissions, 642 Outpatient Visits, and 132 Telemedicine Visits. No member mortality was identified during the claims period dated January 1, 2021, to December 31, 2021.

3. Access to Care

A. Provider Satisfaction Survey (PSS)

To comply with the DMHC's Timely Access to Non-Emergency Health Care Services Regulations, NCQA, and DHCS provider satisfaction requirements, the Center for the Study of Services (CSS), an independent survey research organization, completed the 2021 Provider Satisfaction Survey (PSS) and collected survey results on behalf of UnitedHealthcare Community Plan of California (UHCCP CA).

1) Your patient's access to the Language Assistance Program for:
    a. Interpreter services
    b. Translation services

2) UHC's Language Assistance Program and the:
    a. Coordination of appointments with an interpreter?
    b. Availability of the appropriate range of interpreters?
    c. Training and competency of the available interpreters?

On September 30, 2021, 2,188 UHCCP CA Medi-Cal contracted California Providers were sent the Measurement Year (MY) 2021 PSS. Of those 2,188 Providers, 156 (7%) (100 PCPs and 56 Specialists) completed the survey. An assessment of all results was completed by the Quality department. All analyses were separated into Primary Care Physicians and Specialists-level results.

In 2018, UnitedHealthcare established a goal of 80% satisfaction and continued that goal for subsequent surveys. To measure satisfaction, answers of Very Satisfied and Satisfied were included in the numerator. The Plan met or exceeded that goal, as outlined in the table below, for all Language Assistance Program related questions (3a. to 4c.) below.

Table 13. Provider Satisfaction Survey Results

Provider Satisfaction Survey				
	Primary Care Physicians (n=100)		Specialists (n=56)	
Questions: How satisfied are you with...	**2020 % Satisfied/ Very Satisfied (Goal: 80%)**	**2021 % Satisfied/ Very Satisfied (Goal: 80%)**	**2020 % Satisfied/ Very Satisfied (Goal: 80%)**	**2021 % Satisfied/ Very Satisfied (Goal: 80%)**
3a. Your patient's access to the Language Assistance Program for interpreter services?	**90%**	**98%**	**100%**	**94%**
3b. Your patient's access to the Language Assistance Program for translation services?	**90%**	**98%**	**100%**	**100%**
4a. UHC's Language Assistance Program and the coordination of appointments with an interpreter?	**90%**	**98%**	**100%**	**100%**
4b. UHC's Language Assistance Program and the availability of the appropriate range of interpreters?	**94%**	**98%**	**100%**	**94%**
4c. UHC's Language Assistance Program and the training and competency of the available interpreters?	**92%**	**98%**	**100%**	**92%**

Data Source: Provider Satisfaction Survey 2020

Data Analysis

The 2021 PSS results indicated the following:

a. ***Primary Care Physicians*** indicated increases in satisfaction for all questions.

b. ***Specialists*** indicated decreases for "Your patient's access to the Language Assistance Program for Interpreter Services", "UHC's Language Assistance Program and the availability of the appropriate range of interpreters", and "UHC's Language Assistance Program and the training and competency of the available interpreters", however, all measures met goal.

The most significant barrier with the MY2021 PSS was receiving a completed survey back from the Plan's contracted PCPs and Specialists. As noted in the Analysis section above, only 7% of the eligible population returned the completed survey to UHCCP CA's contracted survey vendor. This is a decrease in participation from MY 2020 that had 10% of eligible providers complete the survey. It is unclear how the providers who responded might differ from the providers who did not respond. The low participation rate presents several missed opportunities for Providers to submit feedback to the Plan and advocate for their patients' unmet needs in areas including the referral/authorization.

Another consideration for the lack of participation could be the lasting impact of the COVID-19 pandemic. In 2021, providers were still transitioning from providing most services through telehealth to in-person care. This transition could have caused providers to miss the survey, or it could have been lost between the back and forth of working virtually and in-person. Additionally, utilization of healthcare services decreased in 2020 but was ramping back up in 2021. It could be inferred that the utilization changes could have led to providers not utilizing certain services within UHCCP CA and not being able to provide an answer for satisfaction and responding with a "N/A or Unknown" response.

Results of this analysis were reviewed at the Provider Advisory Committee on May 18, 2022 and will be reviewed at the Quality Management Committee (QMC) on June 23, 2022.

B. Annual Assessment of Network Adequacy

Assessment of Network Responsiveness is built on a foundation of data. One source of data is self-reported member language from the Benefit Enrollment and Maintenance Information provided, monthly, to UnitedHealthcare. This information is stored in and extracted from the Operational Reporting Business Intelligence Tool (ORBIT). Since population changes may be more apparent at the state level, than within a health plan's membership; each UHCCP health plan incorporates state census information from the Modern Language Association (MLA) Language Map Data Center - https://apps.mla.org/map_data.

To determine the current linguistic needs as well as to plan for future changes in the demographics of the membership, each UHCCP health plan seeks to identify and assess predominant languages other than English. To assess the effects of changing demographics at the plan level, each UHCCP health plan also compares state enrollment data (member self-reported languages, extracted from ORBIT) against the State Census results MLA Language Map – https://apps.mla.org/map_data to determine language preferences.

Membership census and language data are analyzed to determine threshold and uncommon language using the process defined in the job aid - *Identifying Threshold and Uncommon Languages*. The Threshold and Uncommon Language results generate the language profile, which is compared with available credentialing information from practitioners and practitioner staff, to determine how well the network capacity meets member needs for language services. The practitioner and practitioner office staff language(s) are taken from the UnitedHealthcare Network (UHN) database and reported out from Network Data Analytics Reporting (NDAR).

The reported language preferences are assessed and defined as either a Threshold Language or an Uncommon Language. The definitions of these are:

- *Threshold Languages* are defined as all languages other than English spoken by five percent of the population or by 1,000 eligible members, whichever is less.
- *Uncommon Languages* are defined as languages spoken by more than one percent, but less than five percent, of the population or by at least 200, but fewer than 1,000 eligible members, up to a maximum of 15 languages.

The Threshold and Uncommon Language results are also compared with available credentialing information from practitioners and practitioner staff, to determine how well the network capacity meets member needs for language services. The practitioner and practitioner office staff language(s) are taken from the UnitedHealthcare Network (UHN) database and reported out from Network Data Analytics Reporting (NDAR).

Cultural assessment includes a review of member and practitioner data. The culture question included in the CAHPS®[1] 5.0H survey is analyzed along with member complaints, to determine member satisfaction with culture. To assess the cultural aspects of the practitioner, network an analysis of physician race, ethnicity, and language data along with member satisfaction with access to practitioners who understand their culture is performed. A second source of data is self-reported practitioner cultural competency training.

In addition, the following data sources are used to evaluate network responsiveness:

- Supplemental questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey evaluate members' level of difficulty in finding a practitioner that understands their language and culture.
- Member complaint data reflects the entire universe of members' requests for and dissatisfaction with practitioner type by race, ethnicity, cultural sensitivity, and language received by member services.
- Practitioner attestation to completion of cultural training (data is pulled from NDAR).
- Onsite interpreter data is reported quarterly to UnitedHealthcare by individual language line vendors. These results are reviewed to evaluate network responsiveness and define UHCCP's ability to deliver culturally competent care.

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

- Race and Ethnicity of Direct Care Physicians by State - Data derived from Associate of American Medical Colleges (AAMC) 2013 Minority Physician Database, 2013 AMA Physician Masterfile, US Census Bureau and extrapolated by the Association of American Medical Colleges.

The data and qualitative analysis are provided in the *2021 National Combined Lang. Profile Net. Response. Cultural Needs Data Report*.

C. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

California Department of Health Care Services CAHPS® Survey

In partnership with the California Department of Health Care Services (DHCS), the Health Services Advisory Group, Inc. (HSAG) administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey every two years for UnitedHealthcare's adult and child Medi-Cal population. An adult and child version of the surveys were distributed and collected via mail. The survey was offered in English and Spanish. The final survey results report was completed on May 25, 2021, for Measurement Year (MY) 2020. The report findings are broken down by adult and child member survey results. Examples of the survey questions for both adult and child members include the member's overall experience with accessing care, ease of scheduling medical appointments, interaction and communication with their medical provider, understandability of health plan forms, and overall experience with the health plan. The adult survey included additional questions to assess completion of a flu vaccine and support for smoking or tobacco use cessation.

Additionally, in the previous CAHPS® year study (MY2018) RY2019, UnitedHealthcare and other Medi-Cal managed health care plans identified a need to incorporate supplemental questions to better understand and identify language or cultural barriers in our member's access to care. In 2020, the DHCS Health Education and Cultural and Linguistics Workgroup (HECLW) meeting held in February 2020, worked together to identify CAHPS® questions that may better identify the health promotion, education, language, and cultural barriers among Medi-Cal beneficiaries. As a result, this CAHPS® year study (MY2020) RY2021 included a total of 48 questions, with 8 added supplemental questions at the end of the adult survey and a total of 51 questions with 10 added supplemental questions at the end of the child survey. These questions were selected specific to what may be helpful for purposes of the PNA RY 2022.

Adult Survey

The sample size for the adult population consisted of 2,984 UnitedHealthcare members. Two hundred seventy-one (n=271) members were eligible and completed the survey (9.20%). The rate of completed surveys was much lower this CAHPS® year study compared to the completion rate of 13.60% (n=290) in the previous CAHPS® Survey (MY2018) RY2019. The remaining 2,713 members were ineligible or did not complete the survey. The number of incomplete and ineligible surveys was much higher compared to the previous CAHPS® study, 1,843 members who did not complete the survey.

Table 14. CAHPS® Adult Survey Year-Over-Year

Adult Survey	CAHPS® Survey (MY2018) RY2019	CAHPS® Survey (MY2020) RY2021	Year-Over-Year (YOY) Point Difference %
Final Sample Size: Includes Oversampling	2,133	2,984	+16.63%
Number Complete and Eligible	290 (13.6%)	271 (9.2%)	-4.40%
Number Incomplete or Ineligible	1,843	2,713	+19.10%

Data Source: DHCS CAHPS® Survey RY2019 and RY2021

UnitedHealthcare adult members were asked about the following:

1. Rating of All Health Care
2. Rating of Health Plan
3. Rating of Personal Doctor
4. Rating of Specialist Seen Most Often
5. Getting Care Quickly
6. Getting Needed Care
7. How Well Doctors Communicate
8. Coordination of Care
9. Customer Service
10. Forms Were Easy to Fill Out
11. Experience of Care
12. Receiving a flu vaccination (ages 18-64)
13. Reporting Medical Assistance with Smoking and Tobacco Use Cessation
14. Supplemental Questions:

    Q41. How would you like to get health information from your health plan about how to stay healthy?
    Q42. An interpreter is someone who helps you talk with others who do not speak your language. In the last 6 months, did you need an interpreter at your personal doctor's office?
    Q43. In the last 6 months, during visits to your personal doctor's office, how often did you get an interpreter when you needed one? Do not include times when you used a family member or friend to be an interpreter for you.
    Q44. Some health plans help with nonmedical concerns, like housing, food, financial, and social isolation issues. In the last 6 months, did you talk with your personal doctor or someone from your health plan about getting help for any of these issues?
    Q45. Your health plan can help you with transportation to doctors' offices or clinics. This help can be an arranged ride, a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, how often did the help with transportation meet your needs?
    Q46. In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service?
    Q47. In the last 6 months, did you need help from anyone in your health plan to manage your care among these different providers and services?

Q48. In the last 6 months, did you get the help you needed from your health plan to manage your care among these different providers and services?

This year's CAHPS® study did not include a previous question 8 in the Adult survey that was specific to gaining member feedback regarding discussing ways to prevent illness with their doctor. This question was relevant to measure health promotion and education. UnitedHealthcare would analyze current data and compare the data for similar questions from this year's CAHPS® (MY2020) RY2021 study compared to the previous CAHPS® (MY2018) RY2019 study where appropriate.

Adult participants were asked to share their perspectives for the following questions that were selected to capture member satisfaction as it identifies a health education, cultural and/or linguistics barrier(s) to our members:

a. Q.12. Personal doctor explained things
b. Q13. Personal doctor listened carefully
c. Q.14. Personal doctor showed respect
d. Q.25. Customer service treated member with courtesy and respect
e. Q.27. Health plan forms were easy to fill
f. Q.31. Flu Vaccinations for Adults Ages 18-64
g. Medical Assistance With Smoking and Tobacco Use Cessation
    a. Q.32. Percent Current Smokers
    b. Q.33. Advising Smokers and Tobacco Users to Quit
    c. Q.34. Discussing Cessation Medications
    d. Q.35. Discussing Cessation Strategies

Results were provided by the DHCS to all Medi-Cal Managed Health Plans statewide. Results for question 12, *Personal doctor explained things*, indicated that 76.27% of the respondents agreed that their personal doctor *Always* explains things to them, compared to a combined 94.07% of respondents who stated their personal doctor *Always and/or Usually* explains things to them.

Results for question 13, *Personal doctor listened carefully*, indicated that 79.49% of respondents agreed that their personal doctor *Always* listens to them carefully, compared to a combined 96.58% of respondents who stated their personal doctor *Always and/or Usually* explains things to them.

Results for question 14, *Personal doctor showed respect*, indicated that 81.20% (+4.65%) of the respondents agreed that their personal doctor *Always* showed respect, compared to a combined 97.44% (+7.78%) of respondents who stated their personal doctor *Always and/or Usually* showed respect. These results were overall much higher compared to the previous CAHPS® study results indicating 76.55% of respondents *Always* find that their personal doctor showed respect, and a combined 89.66% of respondents find that they *Always and/or Usually* find that their personal doctor showed respect.

Results for question 25, *Customer service treated member with courtesy and respect*, indicated that 78.1% (+10.81%)of the respondents agreed that customer service *Always* treated the member with courtesy and respect, compared to a combined 97.14% (+1.62%) of respondents who indicated they *Always and/or Usually* get treated with courtesy and respect from our customer service team. These

results were overall much higher compared to the previous CAHPS® study results indicating that 67.29% of respondents indicated they *Always* get treated with courtesy and respect from our customer service team, and 95.52% of respondents stated that they *Always and/or Usually* get treated with courtesy and respect from our customer service team.

Results for question 27, *Health plan forms were easy to fill*, indicated that 97.57% (+12.73%) of respondents indicated our health plan forms are *Always* easy to fill, compared to 98.08% (2.77%) of respondents who indicated our health plan forms are *Always and/or Usually* easy to fill. These results were overall much higher compared to the previous CAHPS® study, where 84.84% of respondents indicated our health plan forms are *Always* easy to fill, compared to 95.31% of respondents who stated they *Always and/or Usually* agree that health plan forms are easy to fill. Results demonstrate an improvement over time from one survey study to the next.

Results for question 31, *Flu Vaccinations for Adults Ages 18-64* indicated that 41.13% (-4.70%) of our members surveyed reported they had a flu vaccination. This response rate was lower compared to a 45.83% response rate in the previous CAHPS® study. Finally, results for *Medical Assistance with Smoking and Tobacco Use Cessation* questions, indicated that 17.04% (-0.98%) of our members surveyed reported they are current smokers, this rate was lower compared to 18.02% of members surveyed who indicated they are current smokers in the previous CAHPS® study.

Furthermore, Adult survey respondents' average health plan rating was 2.07 (-0.19%), compared to 2.26 from the previous CAHPS® study, which indicates opportunities for improvement. Additionally, there were no results provided for the supplemental questions to infer analysis, and there was no data reported for the questions pertaining to the Medical Assistance With Smoking and Tobacco Use Cessation to better understand the needs for our membership. Furthermore, there were no results provided for the supplemental questions to infer analysis of the needs of our members.

Child Survey

The sample size for the child population consisted of 2,162, compared to a sample size of 512 members in the previous CAHPS® study. One hundred sixty-four (164) members were eligible and completed the survey (7.64%), this was significantly lower than the 12.01% response rate from the previous CAHPS® survey. However, the sample size was much smaller then. The remaining 1,998 did not complete the survey. This number was significantly higher than the remaining 451 members who did not complete the survey.

Table 15. CAHPS® Child Survey Year-Over-Year

Child Survey	CAHPS® Survey (MY2018) RY2019	CAHPS® Survey (MY2020) RY2021	Year-Over-Year (YOY) Point Difference %
Final Sample Size: Includes Oversampling	512	2,162	+61.71%
Number Complete and Eligible	61 (12.01%)	164 (7.64%)	-4.37%
Number Incomplete or Ineligible	451	1,998	+63.17%

Data Source: DHCS CAHPS® Survey RY2019 and RY2021

UnitedHealthcare parent/guardian of child members were asked about the following:

1. Rating of All Health Care
2. Rating of Health Plan
3. Rating of Personal Doctor
4. Rating of Specialist Seen Most Often
5. Getting Care Quickly
6. Getting Needed Care
7. How Well Doctors Communicate
8. Coordination of Care
9. Customer Service
10. Forms Were Easy to Fill Out
11. Experience of Care
12. Supplemental Questions:
    - Q42. In the last 6 months, did your child's personal doctor or anyone from that office ask you about your child's mental or emotional health?
    - Q43. In the last 6 months, did your child get all the mental health care or counseling that he or she needed?
    - Q44. An interpreter is someone who helps you talk with others who do not speak your language. In the last 6 months, did you need an interpreter at your child's personal doctor's office?
    - Q45. In the last 6 months, during visits to your child's personal doctor's office, how often did you get an interpreter when you needed one? Do not include times when you used a family member or friend to be an interpreter for you.
    - Q46. Some health plans help with nonmedical concerns like housing, food, clothing, and childcare issues. In the last 6 months, did you talk with your child's personal doctor or health plan about getting help for any of these issues?
    - Q47. In the last 6 months, how often did you get help from your child's personal doctor or health plan for non-medical concerns when you needed it?
    - Q48. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?
    - Q49. In the last 6 months, did you need help from anyone in your child's personal doctor's office or health plan to manage your child's care among these different providers and services?
    - Q50. In the last 6 months, did you get the help you needed from your child's personal doctor's office or health plan to manage your child's care among these different providers and services?
    - Q51. Your child's health plan can help with transportation to doctors' offices or clinics. This help can be an arranged ride, a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, how often did the help with transportation meet you and your child's needs?

Participants were asked to share their perspectives in the following questions that were selected to capture member satisfaction as it identifies a health education, cultural and/or linguistics barrier(s) to our members.

a. Q12. Personal doctor explained things
b. Q13. Personal doctor listened carefully
c. Q14. Personal doctor showed respect
d. Q28. Customer service treated member with courtesy and respect
e. Q30. Health plan forms were easy to fill

However, like the last CAHPS® study child survey, there was limited, or no data reported to UnitedHealthcare on most categories and questions, where results were reported as *NA*. For example, *NA* was reported for Q12, Q13, Q14 and Q28.

Results for question 28, *Health plan forms were easy to fill*, indicated that 90.51% of respondents indicated our health plan forms are *Always* easy to fill, compared to 96.84% of respondents who indicated our health plan forms are *Always and/or Usually* easy to fill. These results cannot be compared to the previous CAHPS® study, as these categories were reported as *NA* for MY2018, RY2019.

Other results reported included results for Q21. Rating of Personal Doctor, where 86.96% of respondents indicated they would rate their Personal Doctor with an 8+9+10 rating, compared to 79.13% of respondents who indicated they would rate their Personal Doctor with an 9+10 rating. Additionally, 81.13% of child survey respondents for Q31. Rating of Health Plan, indicated they would rate their health plan with an 8+9+10 rating, compared to 64.15% of respondents who indicated they would rate their Health Plan with a 9+10 rating. Furthermore, there were no results provided for the supplemental questions to infer analysis of the needs of our members.

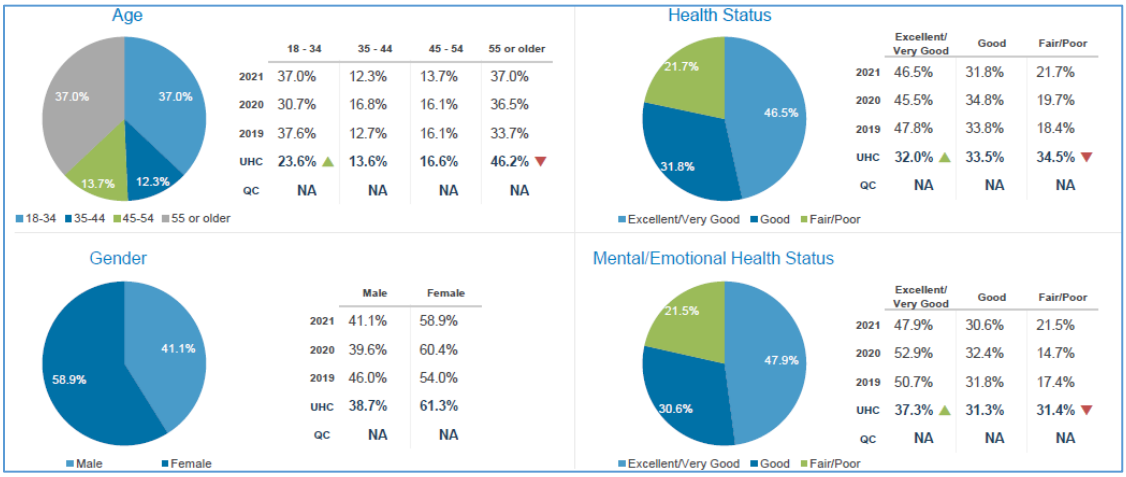
Overall, UnitedHealthcare identified limitations to the data findings for both the adult and child surveys as it relates to an in-depth analysis of the need of our members for health education and cultural and linguistics programs. In the previous CAHPS® study, the health plan identified a need to incorporate supplemental questions to understand and identify language and/or cultural barriers in our member's access to care. As a result, the DHCS gathered all Medi-Cal Managed Health Plan feedback and included these questions into the adult and child survey. However, the results were not provided, resulting in a data gap, limiting the Plan's ability to address any issues identified by our surveyed members. Having the availability of all results for each question will help UnitedHealthcare better understand the needs of our surveyed members and enhance and/or create programs that will improve our members' overall health.

UnitedHealthcare Community Plan of California CAHPS® Survey

UnitedHealthcare participated in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H survey from February 9, 2021, through May 26, 2021, for the 2020 measurement year (MY). The Survey was used to accurately capture customer feedback and expand on the scope of information gathered relative to quality of care issues. UnitedHealthcare surveys member satisfaction with access to practitioners who speak their language and understand their culture via CAHPS®. NCQA used the Agency for Healthcare Research and Quality (AHRQ) new 5.1 version of the CAHPS survey for 2021. The modified

HEDIS® CAHPS surveys include minor changes to some of the instructions and survey items to indicate the different ways in which patients may be receiving care: in person or via telehealth. There are no new questions on the 5.1 version, but existing questions have been modified so that respondents know they should include telehealth visits as an appointment type as they respond to the survey. The new wording about care "in person, by phone or by video" has been added to appropriate questions and introductions throughout the survey. The CAHPS® vendor followed NCQA protocol to achieve survey responses from the demographic characteristics of the Plans member population. NCQA did not provide Quality Compass demographic benchmarks in 2020. The demographic makeup of UnitedHealthcare's member base may not mirror the "average" plan; therefore, caution is recommended when making comparisons to benchmark data. The survey demographics of respondents for this survey are detailed in the tables below.

Table 16. UnitedHealthcare CAHPS® Survey Demographics (Age, Gender, Health Status, Mental/Emotional Health Status)



Age	18 - 34	35 - 44	45 - 54	55 or older
2021	37.0%	12.3%	13.7%	37.0%
2020	30.7%	16.8%	16.1%	36.5%
2019	37.6%	12.7%	16.1%	33.7%
UHC	23.6% ▲	13.6%	16.6%	46.2% ▼
QC	NA	NA	NA	NA

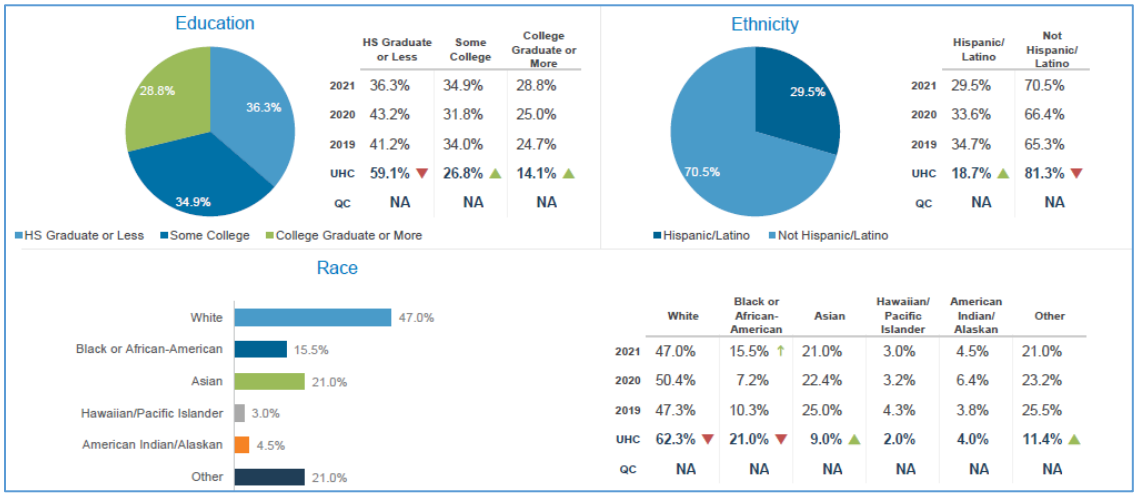
Health Status	Excellent/ Very Good	Good	Fair/Poor
2021	46.5%	31.8%	21.7%
2020	45.5%	34.8%	19.7%
2019	47.8%	33.8%	18.4%
UHC	32.0% ▲	33.5%	34.5% ▼
QC	NA	NA	NA

Gender	Male	Female
2021	41.1%	58.9%
2020	39.6%	60.4%
2019	46.0%	54.0%
UHC	38.7%	61.3%
QC	NA	NA

Mental/Emotional Health Status	Excellent/ Very Good	Good	Fair/Poor
2021	47.9%	30.6%	21.5%
2020	52.9%	32.4%	14.7%
2019	50.7%	31.8%	17.4%
UHC	37.3% ▲	31.3%	31.4% ▼
QC	NA	NA	NA

Data Source: UnitedHealthcare CAHPS® Survey RY2021

Table 17. UnitedHealthcare CAHPS® Survey Demographics (Education, Race, and Ethnicity)



Education	HS Graduate or Less	Some College	College Graduate or More
2021	36.3%	34.9%	28.8%
2020	43.2%	31.8%	25.0%
2019	41.2%	34.0%	24.7%
UHC	59.1% ▼	26.8% ▲	14.1% ▲
QC	NA	NA	NA

Ethnicity	Hispanic/ Latino	Not Hispanic/ Latino
2021	29.5%	70.5%
2020	33.6%	66.4%
2019	34.7%	65.3%
UHC	18.7% ▲	81.3% ▼
QC	NA	NA

Race	White	Black or African-American	Asian	Hawaiian/ Pacific Islander	American Indian/ Alaskan	Other
2021	47.0%	15.5% ↑	21.0%	3.0%	4.5%	21.0%
2020	50.4%	7.2%	22.4%	3.2%	6.4%	23.2%
2019	47.3%	10.3%	25.0%	4.3%	3.8%	25.5%
UHC	62.3% ▼	21.0% ▼	9.0% ▲	2.0%	4.0%	11.4% ▲
QC	NA	NA	NA	NA	NA	NA

Data Source: UnitedHealthcare CAHPS® Survey RY2021

Surveys were collected via a mail, phone, and internet methodology. Members eligible for the survey were those 18 years and older (as of December 31 of the measurement year) who had been continuously enrolled in the plan for at least five of the last six months of the measurement year. There were 1,853 eligible members and 221 (101 mail, 31 internet and 89 phone) members completed the survey.

Additionally, respondents were given the option of completing the survey in Spanish. Two telephone surveys were completed in Spanish, none were completed by mail or internet. UnitedHealthcare partnered with the National Population Health, UnitedHealthcare Clinical Services team to identify the survey questions and targeted population, and plan operations for survey delivery and analysis of the results.

Participants were asked to share their perspectives in the following areas:

1) Health Plan Overall
2) Health Care Overall
3) Personal Doctor Overall
4) Specialist Overall
5) Customer Service*
6) Getting Needed Care
7) Getting Care Quickly
8) How Well Doctors Communicate*
9) Coordination of Care

The following supplemental questions were selected to identify language or cultural barrier(s):

1) Happy with the language help you got in the doctor's office
2) Got an interpreter when needed
3) Easy to find a doctor that respects your beliefs and cultural traditions

Table 18. UnitedHealthcare CAHPS® Survey Summary Rate Score

Survey Item	Category Responses (Based on Valid Responses Per Question)				Plan Summary Rate Score			2021 UHC Summary Rate Score
					2019	2020	2021	
Q43. In the last 6 months, how often were you happy with the language help you got in the doctor's office?	Never	Sometimes	Usually	Always	—	—	(n = 192)	(n = 4041)
	5.7%	5.7%	18.2%	70.3%	---	---	**88.5%**	**87.7%** p
Q44. In the last 6 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?	Never	Sometimes	Usually	Always	(n = 94)	(n = 54)	(n = 74)	(n = 1425)
	50.0%	20.3%	6.8%	23.0%	**39.4%**	**38.9%**	**29.7%**	**36.6%** q
Q45. In the last 6 months, how often was it easy to find a doctor that respects your beliefs and cultural traditions?	Never	Sometimes	Usually	Always	—	—	(n = 172)	(n = 4321)
	11.0%	7.6%	19.2%	62.2%	**—**	**—**	**81.4%**	**83.5%**

Data Source: UnitedHealthcare CAHPS® Survey RY2021

UnitedHealthcare developed improvement actions and was able to assess important aspects of members' healthcare needs based on comments from adult consumers across the country with health insurance coverage. Comments that were reflective of health education and promotion, language, or cultural needs included:

I. *"They provide an annual goal sheet for me to fill out, which holds me accountable for my health. It helps me regulate my daily actions, which helps me meet my desired goals."*
II. *"Because they are proactive. They tend to make sure that I am making my appointments, and from time to time they will send me information on how to improve my health with diet and exercise."*
III. *"My doctor actually steps up to tell me about my weight and how I should watch it. Even though I am pretty much healthy, I like that she talks to me as we can work on a plan to lose it. But I have had doctors who just see me for who I am and don't really pay attention to me or my concerns."*
IV. *"Overall, the doctors knew what they were doing. However, I would have given them a higher rating if my doctor truly cared about me as a person. My example for this was when I asked her questions, she made it out like I didn't know what I was talking about."*
V. *"He listens, takes as much time as you need and makes sure he answers all your questions. I always have a say in my care. If he doesn't know something, he tells you and will find out for you. He also advocates on my behalf with other doctors."*
VI. *Some are good, some are not so good. My cancer specialists also takes the time and listens, so I'm satisfied."*
VII. *"No matter how trivial or how serious I thought something was, he wanted to hear about anything I perceived to be a health issue or emerging problem. It was a very refreshing approach."*
VIII. *"If they branch off from what you say, it means that they are actually listening to you. This is good, as they are trying to process what you are saying and build off of it."*
IX. *"For me, doctors show respect when they acknowledge me by giving me eye contact and waiting for an answer when they ask a question. They also show respect when they engage me in a dialogue to help resolve an issue or concern."*
X. *"I didn't have any difficulties filling out forms. My local family services office handled most of the paperwork. I just provided basic information."*

Additionally, it is worth noting that the Medical Assistance with Smoking and Tobacco Use Cessation was the only section in which all questions in relation to health education were rated below the 8th percentile.

i. Q: Advising smokers and tobacco users to quit
ii. Q: Discussing cessation medications
iii. Q: Discussing cessation strategies

During the 2021 survey UnitedHealthcare increased oversampling from the previous year by 20% which increased the response rate however it is important to note response rates remain lower than those prior to the pandemic. Out of 1,853 eligible members, 221 (11.9%) completed the CAHPS Survey. This was a decrease from 2019, which had a 13% response rate. Response rate is an important indicator of quality and this low level of participation suggests considerable challenges for UnitedHealthcare due to lack of member engagement. It is important to note that sampling bias may result which can lead to questionable reliability and validity of survey results.

The COVID-19 pandemic caused significant disruption throughout 2020 and continuing into 2021; determining next steps while also considering these survey results, provides UnitedHealthcare with

thoughtful opportunities for improvement. Additionally, only English surveys were mailed to members to complete. Members were given the option of completing the survey in Spanish. A telephone number was provided on the survey cover letter for members to call if they would like to complete the survey in Spanish. UnitedHealthcare believes that the low Spanish survey completion rate (1%) demonstrates inadequate representation of the membership. UnitedHealthcare also has members who speak other primary non-English languages such as Arabic, Tagalog, Vietnamese, Farsi, and Chinese. Since surveys were not available in those languages, those member perspectives were not included. This missed opportunity may have an impact on overall cultural and/or linguistic experiences from our members who are more representative of San Diego county's primary non-English languages, which in turn have an overall impact on our health plan ratings.

UnitedHealthcare remains deeply committed to providing coordinated and collaborative activities and initiatives that promote services for members that are accessible, of high quality, and contribute to positive health outcomes in a cost efficient and effective manner. Based upon the 2021 CAHPS® 5.1H Medicaid Adult Survey for MY 2020, UnitedHealthcare took steps towards improvement. These include:

- Reorganized the CAHPS program with the Member Experience team to align the member Net Promoter Score (NPS) Survey initiatives
- Established a Member Experience workgroup that includes evaluation of both NPS and CAHPS survey results for overall greater improvement opportunities
- Explore including a CAHPS section in the Network News e-newsletter Rating of Personal Doctor, Coordination of Care & Tips to increase patient satisfaction
- Presenting findings at Q3 Quality Management Committee meeting

Planned long-term strategies include:

1. Place outbound practice-level phone calls to assess appointment availability among high-impact and high-volume specialty providers.
2. Create member-centric materials encouraging healthier living and strong patient-provider relationships for distribution to UnitedHealthcare membership.
3. Develop resources containing broad-based improvement strategies and enhancement recommendations for contracted providers and provider office staff.

UnitedHealthcare will conduct ongoing analysis and evaluation of services and interventions provided to members. Persistent, close, and thoughtful examination of qualitative and quantitative feedback will occur to better understand how it can better meet the needs of the UnitedHealthcare membership.

D. Member Satisfaction Survey, or Net Promoter Score (NPS)

UnitedHealthcare conducted a member satisfaction survey via the Net Promotor Score (NPS) during 2021. The objectives of the NPS member satisfaction survey are as follows:

- To expand the UHC focus on member perceptions and experiences;
- To support the growth of member intimacy through easy access to member perception insights; and
- To establish metrics that show UnitedHealthcare's true performance change at the macro level, with the ability to also cut data by micro views

The NPS member satisfaction surveys are completed over the telephone by a contracted vendor, Burke, Inc., an independent market research. The telephone surveys are conducted monthly, and results are published quarterly. The telephone surveys are available in English and Spanish. Members were called by an interviewer on behalf of UnitedHealthcare over the telephone to ask the member about their overall satisfaction with the Plan and services. Members had the opportunity to respond to two specific questions regarding UnitedHealthcare's cultural and linguistic services. Below is the question asked by the interviewer for response:

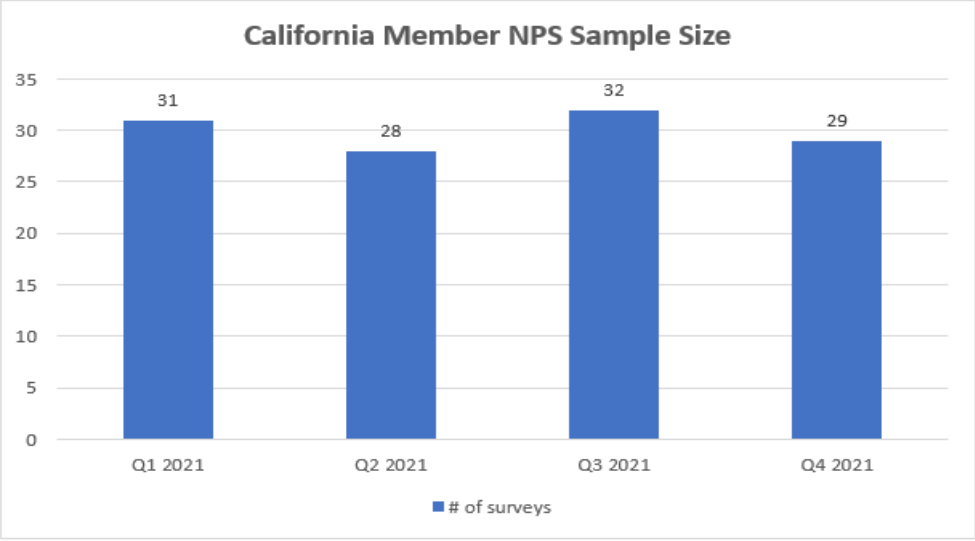
Please tell me how you would rate your health plan on each of the following statements. For each statement, please use a scale from 0 to 10, where 0 means poor and 10 means excellent.

a. *"Gives you materials that are easy to understand"*
b. *"Helps you clearly understand your plan"*

UnitedHealthcare received 120 responses from the member satisfaction survey conducted throughout 2021. Due to a small sample size results are likely to be more volatile from reporting period to reporting period. A single member moving from promoter to detractor on the "likelihood to recommend" question can swing the NPS score by 10 points. Although we have low survey responses, we use the scores and member verbatims as guidance of how members feel about us to try to understand the full picture of their ratings.

Below are the NPS Scores per quarter for calendar year 2021, and January 2022. Of note, the tables provided below depict comparative data to other UHC Medicaid markets.

Table 19. California Member NPS Sample Size



Data Source: California Member NPS Sample Size

2021 Medicaid State NPS

ST	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	Goal
AZ	73	78	63	47	76	59	59	68	57	73	71	72	71	60	61	72	66	70
	1	1	1	1	1	1	1	1	1	1	1	1	3	3	3	3	12	
CA	-	25	60	10	89	44	40	60	50	10	30	0	43	47	50	14	39	17
	1	10	15	10	9	9	10	10	12	10	10	9	31	28	34	23	126	
CO	53	73	37	47	80	78	83	63	31	75	80	62	54	68	59	72	63	57
	30	30	27	30	30	27	30	30	26	32	30	26	87	87	86	88	348	
FL	59	60	56	59	58	59	59	63	54	55	60	64	58	59	59	60	59	62
	75	58	66	70	60	64	58	68	68	67	67	67	199	194	204	201	798	
HI	-	100	67	100	56	80	33	100	100	67	0	67	83	79	78	44	71	58
	-	3	3	4	9	5	3	2	2	3	3	3	6	18	7	9	40	
KS	73	66	61	54	73	68	66	59	53	63	56	59	67	65	59	59	63	69
	59	59	57	59	60	57	58	59	57	59	61	56	175	176	174	176	701	
KY	-	-	-	-	55	66	65	61	61	42	69	62	-	60	62	58	60	50
	-	-	-	-	56	58	66	66	66	19	35	37	-	114	198	91	403	
LA	82	71	73	76	69	70	67	69	83	70	62	64	76	72	73	65	72	78
	100	94	74	135	100	99	99	100	96	84	84	72	268	340	295	240	1143	
MD	63	53	70	61	49	48	65	50	50	60	69	67	62	53	55	65	59	64
	64	53	57	59	53	58	60	58	60	50	48	46	174	170	178	144	666	
MI	61	53	42	59	66	53	62	69	48	62	64	69	52	60	60	65	59	64
	76	60	66	69	62	66	69	68	66	58	53	39	201	197	203	150	751	
MO	76	65	58	80	52	58	77	56	48	43	61	58	67	64	60	54	61	68
	70	46	57	59	44	57	61	61	60	60	59	60	175	160	182	179	696	
MS	79	68	77	72	48	75	76	70	73	80	85	73	75	66	73	80	73	74
	84	34	60	58	31	57	67	64	64	60	60	60	178	146	196	180	699	
NC	-	-	-	-	-	-	-	-	-	44	63	64	-	-	-	57	57	50
	-	-	-	-	-	-	-	-	-	27	8	14	-	-	-	49	49	
NE	91	53	37	75	62	68	65	68	73	67	100	100	61	68	69	89	71	63
	22	38	27	28	37	34	26	25	26	30	2	4	87	99	77	36	299	
NJ	52	70	61	53	55	72	55	56	63	52	47	64	61	60	58	54	58	59
	100	60	77	79	60	66	66	64	62	75	76	58	237	204	251	209	901	
NV	52	31	63	61	47	77	71	63	63	68	72	61	49	61	64	67	60	63
	50	51	40	61	58	39	31	64	64	37	78	66	141	158	159	181	639	
NY	58	71	41	48	59	61	42	53	44	53	54	54	56	56	47	53	53	55
	99	99	101	101	101	100	99	101	98	99	99	97	299	302	298	295	1194	
OH	62	56	63	63	61	58	57	53	47	62	59	51	60	61	52	58	58	62
	79	80	70	80	68	63	77	78	73	69	64	51	229	251	228	194	892	
PA	55	61	71	51	52	53	48	62	52	60	50	58	62	52	54	56	56	59
	85	77	77	79	62	78	61	76	79	78	78	78	239	230	236	234	948	
RI	63	60	30	56	36	56	67	33	79	58	50	70	52	49	59	59	55	61
	30	30	27	25	28	16	30	12	14	12	20	33	87	69	56	65	277	
TN	69	63	74	77	76	61	72	67	72	62	78	73	69	72	70	71	70	75
	100	99	101	101	100	101	99	96	95	91	90	77	300	302	290	258	1150	
TX	77	63	61	88	75	71	77	74	71	64	75	83	68	78	74	74	73	81
	75	43	49	67	59	58	62	58	58	58	59	54	167	184	178	171	700	
VA	57	47	48	60	67	39	66	44	47	48	30	57	51	55	52	45	51	58
	30	30	27	30	30	18	32	32	30	31	30	30	87	78	94	91	350	
WA	68	54	49	48	49	43	40	43	47	50	51	46	57	47	43	49	49	52
	71	55	56	60	58	69	63	70	68	66	67	67	191	217	201	200	809	
WI	60	73	57	73	57	61	72	54	50	64	52	56	63	64	59	58	61	62
	60	60	60	59	60	57	58	63	60	59	61	59	180	176	181	179	716	

2022 Medicaid State NPS

ST	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	Goal
AZ	69	-	-	-	-	-	-	-	-	-	-	-	69	-	-	-	69	67
	1												1				1	
CA	100	-	-	-	-	-	-	-	-	-	-	-	100	-	-	-	100	42
	1												1				1	
CO	69	-	-	-	-	-	-	-	-	-	-	-	69	-	-	-	69	64
	29												29				29	
FL	64	-	-	-	-	-	-	-	-	-	-	-	64	-	-	-	64	61
	67												67				67	
KS	77	-	-	-	-	-	-	-	-	-	-	-	77	-	-	-	77	64
	36												36				36	
KY	100	-	-	-	-	-	-	-	-	-	-	-	100	-	-	-	100	61
	9												9				9	
LA	76	-	-	-	-	-	-	-	-	-	-	-	76	-	-	-	76	73
	100												100				100	
MD	74	-	-	-	-	-	-	-	-	-	-	-	74	-	-	-	74	61
	65												65				65	
MI	59	-	-	-	-	-	-	-	-	-	-	-	59	-	-	-	59	61
	65												65				65	
MO	66	-	-	-	-	-	-	-	-	-	-	-	66	-	-	-	66	62
	65												65				65	
MS	78	-	-	-	-	-	-	-	-	-	-	-	78	-	-	-	78	74
	65												65				65	
NC	68	-	-	-	-	-	-	-	-	-	-	-	68	-	-	-	68	59
	19												19				19	
NE	33	-	-	-	-	-	-	-	-	-	-	-	33	-	-	-	33	72
	3												3				3	
NJ	48	-	-	-	-	-	-	-	-	-	-	-	48	-	-	-	48	60
	79												79				79	
NV	56	-	-	-	-	-	-	-	-	-	-	-	56	-	-	-	56	61
	16												16				16	
NY	46	-	-	-	-	-	-	-	-	-	-	-	46	-	-	-	46	55
	60												60				60	
OH	65	-	-	-	-	-	-	-	-	-	-	-	65	-	-	-	65	60
	79												79				79	
PA	54	-	-	-	-	-	-	-	-	-	-	-	54	-	-	-	54	58
	62												62				62	
RI	18	-	-	-	-	-	-	-	-	-	-	-	18	-	-	-	18	57
	17												17				17	
TN	66	-	-	-	-	-	-	-	-	-	-	-	66	-	-	-	66	71
	101												101				101	
TX	67	-	-	-	-	-	-	-	-	-	-	-	67	-	-	-	67	74
	67												67				67	
VA	65	-	-	-	-	-	-	-	-	-	-	-	65	-	-	-	65	53
	23												23				23	
WA	38	-	-	-	-	-	-	-	-	-	-	-	38	-	-	-	38	51
	66												66				66	
WI	74	-	-	-	-	-	-	-	-	-	-	-	74	-	-	-	74	62
	61												61				61	

Data Source: State Level NPS – Medicaid. Scores listed in orange have a sample size of less than 30 and, as a result, are likely to be more volatile from reporting period to reporting period (even at a sample size of 20, one member moving from a 9 (promoter) to a 6 (detractor) on the "likelihood to recommend" question can swing the NPS score by 10 points). Scores are only listed to give directional reference and should not be used as official scores.

2021 Summary

UnitedHealthcare conducted an analysis in 2021 for an average NPS score. Overall, results indicate that the total NPS member sample size of 120 resulted in an NPS of 39 which demonstrated to fall significantly below the enterprise Medicaid goal, NPS 64.

Per the NPS Comparative Results 2018-2021 in the table below, when members were asked to rate whether the Plan "Has written materials that are easy to understand," the score was 67%, a 1% decrease rate compared to the year prior; and when asked to rate the Plan on "Helps me clearly understand my plan," the score was 62%, a 6% increase rate compared to the year prior. The table below highlights the percent of scores ranked from 9 or 10 on a 10-point Likert scale. There were no pertinent issues identified to health education, cultural and linguistics, or language assistance based on member responses. Historically, UnitedHealthcare has identified limitations to the Member Satisfaction Survey conducted due to low member responses, and the data and trending is limited to test for statistically significant results.

Table 20. NPS Member Attribute Summary

	Member Attribute Summary	2018	2019	2020	2021
Loyalty	Overall satisfaction	49%	55%	43%	56%
	Likelihood to continue coverage	64%			
	Is the health insurance compay of choice	65%	51%	49%	58%
	Has earned my trust	56%	57%	55%	61%
Coverage	Gives me the ability to get the prescriptions I need	61%	59%	51%	62%
	Gives me the ability to see the doctor I prefer	58%	51%	59%	63%
	Makes me feel healthcare needs will be covered	58%	58%	59%	59%
	Offers plan features not availabile from other insurers	39%	44%	31%	42%
	Meets expectations on out-of-pocket costs	72%	56%	69%	66%
	Offers the best plan for my needs	57%	53%	46%	61%
Interactions	Makes interactions easy	60%	57%	46%	57%
	Cares for me as a member	66%	56%	57%	66%
	Helps me live a healthier life	70%	60%	57%	65%
	Makes all interactions with me personally relevant	57%	59%	46%	54%
Simplicity	Provides me peace of mind	60%	59%	65%	66%
	Offers simplicity so I can focus on what matters	57%	63%	53%	60%
	Makes it easy to use my plan	56%	62%	49%	64%
	Helps me clearly understand my plan	56%	46%	57%	62%
	Written materials are easy to understand	57%	54%	68%	67%

Data Source: NPS Comparative Results 2019 - 2021

In addition to the scores on these questions, UnitedHealthcare gives members the opportunity to provide any qualitative feedback that can help us better serve our members. This feedback was reviewed, and no issues were identified pertinent to our health education, cultural and linguistics, and language assistance programs from all related questions asked on the telephone survey.

4. Health Disparities

A. Analysis of DHCS Health Disparities Rate Sheets

The Health Services Advisory Group (HSAG) created a health disparities data file for all Managed Care Plans (MCP) on behalf of the CA DHCS. The CA DHCS provided all health plans with their specific health disparities data for reporting year (RY) 2021 reflecting measurement year (MY) 2020 and member-level DHCS demographic information with stratified rates. The data file included a compilation of aggregated and county specific Medi-Cal Managed Care Accountability Set, or MCAS, a set of performance measures that the CA DHCS selects for annual reporting by Medi-Cal MCPs indicator data collected for a reporting year.

In reporting year 2021, all Medi-Cal MCPs were held accountable to 19 measures listed below (also refer to attachment). UnitedHealthcare met 9 measures for which the Plan was held accountable to the MPL including the following: AMM-Acute, AMM-Cont, CDC-H9, CHL, CIS-10, PPC-Pre, PPC-Pst, SSD, and WCC. The MPL was based on the CA DHCS MCAS for MCPs RY 2021 (MY 2020).

Table 21. Medi-Cal Managed Care Accountability Set (MCAS) Indicator Abbreviations

	Indicator Abbreviations	
No.	**Indicator Abbreviation**	**Indicator Name**
1.	**AMM–Acute**	**Antidepressant Medication Management—Effective Acute Phase Treatment**
2.	**AMM–Cont**	**Antidepressant Medication Management—Effective Continuation Phase Treatment**
3.	**AMR**	**Asthma Medication Ratio**
4.	**APM**	**Metabolic Monitoring for Children and Adolescents on Antipsychotics**
5.	**BCS**	**Breast Cancer Screening**
6.	**CBP**	**Controlling High Blood Pressure**
7.	**CCS**	**Cervical Cancer Screening**
8.	**CDC–H9**	**Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**
9.	**CHL**	**Chlamydia Screening in Women—Total**
10.	**CIS–10**	**Childhood Immunization Status—Combination 10**
11.	**IMA–2**	**Immunizations for Adolescents—Combination 2**
12.	**PPC–Pre**	**Prenatal and Postpartum Care—Timeliness of Prenatal Care**
13.	**PPC–Pst**	**Prenatal and Postpartum Care—Postpartum Care**
14.	**SSD**	**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**
15.	**W30**	**Well-Child Visits in the First 30 Months of Life**
16.	**WCC–BMI**	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total**
17.	**WCC–N**	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total**

18.	**WCC–PA**	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total**
19.	**WCV**	**Child and Adolescent Well-Care Visits—Total**

Furthermore, UnitedHealthcare focused on analyzing health disparate populations among the following HEDIS® priority measures that each MCP is held accountable for to the MPL, including: AMM-Acute, AMM-Cont, AMR, APM, BCS, CBP, CCS, CDC-H9, CHL, CIS-10, IMA-2, PPC-Pre, PPC-Pst, SSD, W30, WCC, and WCV. The MPL was based on the CA DHCS MCAS for MCPs RY 2021 (MY 2020).

The Plan categorized the HEDIS® priority measures under the following chronic disease illness and preventive care measures including asthma, behavioral health, chronic disease illness, women's health, prenatal and postpartum care, and children's health measures. The Plan also completed a data analysis of additional measures that may contribute to the identification and findings of health disparities population(s).

a. Asthma HEDIS® Measures

1. **Asthma Medication Ratio (AMR)**

UnitedHealthcare did not meet the MPL for the measure AMR with an overall care gap closure of 57.58%. Among the 33 members that had a HEDIS® care gap for this measure, members were predominantly 19-50 years of age. UnitedHealthcare observed a higher denominator of males (n=19; 57.58%) compared to their counterpart, females (n=14; 42.42%). There was a higher HEDIS® care gap closure rate of 63.16% among males compared to females, 50.00%. The population for this measure comprised of predominantly English-speaking members (n=31; 93.94%) whose race and/or ethnicity was predominantly White (n=13; 39.39%).

Table 22. Asthma Medication Ratio (AMR) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
5–11 Years	4	4	100.00%
12–18 Years	3	4	75.00%
19–50 Years	7	18	38.89%
51–64 Years	5	7	71.43%
Gender			
F	7	14	50.00%
M	12	19	63.16%
Language			
English	18	31	58.06%
Spanish	0	1	0.00%
Other	1	1	100.00%
Race/Ethnicity			
White	9	13	69.23%
Black or African American	1	4	25.00%

Hispanic or Latino	4	6	66.67%
Other	5	10	50.00%
Total			
All	19	33	57.58%

Data Source: DHCS Health Disparities Rate Sheet

b. Behavioral Health HEDIS® Measures

1. Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–Acute)

UnitedHealthcare met the MPL for the measure AMM-Acute with an overall care gap closure of 54.91%. Among the 173 members that had a HEDIS® care gap for this measure, members were predominantly 18 and older. UnitedHealthcare observed a higher denominator of females (n=106; 61.27%) compared to their counterpart, males (n=67; 38.73%). However, there was a higher HEDIS® care gap closure rate of 61.19% among males compared to females, 50.94%. The population for this measure comprised of predominantly English-speaking members (n=159; 91.91%) whose race and/or ethnicity was predominantly reported as Other (n=61; 35.26%).

Table 23. Antidepressant Medication Management - Effective Acute Phase Treatment (AMM-Acute) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
18+ Years	95	173	54.91%
Gender			
F	54	106	50.94%
M	41	67	61.19%
Language			
English	89	159	55.97%
Russian	1	1	100.00%
Spanish	4	12	33.33%
Other	1	1	100.00%
Race/Ethnicity			
White	36	60	60.00%
American Indian or Alaska Native	1	1	100.00%
Asian	2	3	66.67%
Black or African American	10	16	62.50%
Hispanic or Latino	11	29	37.93%
Other	33	61	54.10%
Unknown/Missing	2	3	66.67%
Total			
All	95	173	54.91%

Data Source: DHCS Health Disparities Rate Sheet

2. Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont)

UnitedHealthcare met the MPL for the measure AMM-Cont with an overall care gap closure of 36.99%. Among the 173 members that had a HEDIS® care gap for this measure, members were predominantly 18 and older. UnitedHealthcare observed a higher denominator of females (n=106; 61.27%) compared to their counterpart, males (n=67; 38.73%). However, there was a higher HEDIS® care gap closure rate of 41.79% among males compared to females, 33.96%. The population for this measure comprised of predominantly English-speaking members (n=159; 91.91%) whose race and/or ethnicity was predominantly reported as Other (n=61; 35.26%).

Table 24. Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
18+ Years	64	173	36.99%
Gender			
F	36	106	33.96%
M	28	67	41.79%
Language			
English	61	159	38.36%
Russian	0	1	0.00%
Spanish	2	12	16.67%
Other	1	1	100.00%
Race/Ethnicity			
White	23	60	38.33%
American Indian or Alaska Native	0	1	0.00%
Asian	1	3	33.33%
Black or African American	7	16	43.75%
Hispanic or Latino	9	29	31.03%
Other	22	61	36.07%
Unknown/Missing	2	3	66.67%
Total			
All	64	173	36.99%

Data Source: DHCS Health Disparities Rate Sheet

3. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

UnitedHealthcare met the MPL for the measure SSD with an overall care gap closure of 85.57%. Among the 97 18–64-year-old members who had a HEDIS® care gap for this measure were predominantly English-speaking (n=94; 96.91%) White (n=45; 46.39%) males (n=54;55.67%).

UnitedHealthcare observed a slightly higher care gap closure rate among females, 86.05%, compared to males, 85.19%.

Table 25. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
18–64 Years	83	97	85.57%
Gender			
F	37	43	86.05%
M	46	54	85.19%
Language			
English	80	94	85.11%
Cambodian	1	1	100.00%
Spanish	2	2	100.00%
Race/Ethnicity			
White	41	45	91.11%
Asian	2	2	100.00%
Black or African American	9	9	100.00%
Hispanic or Latino	8	10	80.00%
Other	20	27	74.07%
Unknown/Missing	3	4	75.00%
Total			
All	83	97	85.57%

Data Source: DHCS Health Disparities Rate Sheet

b. **Chronic Disease Illness HEDIS® Measures**

1. **Controlling Blood Pressure (CBP)**

UnitedHealthcare did not meet the MPL for the measure CBP with an overall care gap closure of 55.96%. Among the 411 members that had a HEDIS® care gap for this measure, members were predominantly 45-64 years of age. UnitedHealthcare observed a slightly higher denominator of females (n=208, 50.61%) compared to their counterpart, males (n=203; 49.39%). There was a higher HEDIS® care gap closure rate of 56.73% among females compared to males, 55.17%. The population for this measure comprised of predominantly English-speaking members (n=282; 68.61%) whose race and/or ethnicity was predominantly reported as Other (n=132; 32.12%).

Table 26. Controlling Blood Pressure (CBP) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
18–20 Years	0	1	0.00%
21–44 Years	38	66	57.58%
45–64 Years	141	252	55.95%
65+ Years	51	92	55.43%
Gender			
F	118	208	56.73%
M	112	203	55.17%
Language			
English	159	282	56.38%
Arabic	1	1	100.00%
Cambodian	0	1	0.00%
Chinese	13	28	46.43%
Farsi	1	3	33.33%
Korean	1	3	33.33%
Russian	2	5	40.00%
Spanish	40	63	63.49%
Tagalog	6	10	60.00%
Vietnamese	1	1	100.00%
Other	5	12	41.67%
Unknown/Missing	1	2	50.00%
Race/Ethnicity			
White	57	88	64.77%
American Indian or Alaska Native	0	2	0.00%
Asian	35	76	46.05%
Black or African American	22	37	59.46%
Hispanic or Latino	45	66	68.18%
Native Hawaiian or Other Pacific Islander	0	1	0.00%
Other	67	132	50.76%
Unknown/Missing	4	9	44.44%
Total			
All	230	411	55.96%

Data Source: DHCS Health Disparities Rate Sheet

2. **Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDC–H9)**
UnitedHealthcare met the MPL for the measure CDC-H9 with an overall care gap closure of 43.09%. Among the 376 members that had a HEDIS® care gap for this measure, members were predominantly 45-64 years of age. UnitedHealthcare observed a higher denominator of males (n=193; 51.33%) compared to their counterpart, females (n=183; 48.67%). There was a higher

HEDIS® care gap closure rate of 50.78% among males compared to females, 34.97%. The population for this measure comprised of predominantly English-speaking members (n=271;72.07%) whose race and/or ethnicity was predominantly reported as Other (n=129; 34.31%).

Table 27. Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDC–H9) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
18-20 Years	2	2	100.00%
21-44 Years	55	100	55.00%
45-64 Years	85	216	39.35%
65+ Years	20	58	34.48%
Gender			
F	64	183	34.97%
M	98	193	50.78%
Language			
English	124	271	45.76%
Chinese	4	12	33.33%
Farsi	1	3	33.33%
Korean	1	1	100.00%
Russian	0	1	0.00%
Spanish	26	68	38.24%
Tagalog	3	11	27.27%
Vietnamese	0	2	0.00%
Other	3	6	50.00%
Unknown/Missing	0	1	0.00%
Race/Ethnicity			
White	23	59	38.98%
Asian	24	63	38.10%
Black or African American	13	29	44.83%
Hispanic or Latino	38	84	45.24%
Native Hawaiian or Other Pacific Islander	5	5	100.00%
Other	55	129	42.64%
Unknown/Missing	4	7	57.14%
Total			
All	162	376	43.09%

Data Source: DHCS Health Disparities Rate Sheet

c. Women's Health HEDIS® Measures

1. Breast Cancer Screening (BCS)

UnitedHealthcare did not meet the MPL for the measure BCS with an overall care gap closure of 53.57%. Among the 308 members that had a HEDIS® care gap for this measure, members were predominantly English speaking (n=210; 68.18%) White (n=69; 22.40%) or Asian (n=69; 22.40%) females ages 50-64 years old with an overall HEDIS® care gap closure rate of 55.46 %. UnitedHealthcare noted that there was a higher HEDIS® care gap closure rate among females ages 50-64 years old, 55.46% compared to females ages 65-74 years old, 47.14%. Additionally, the data indicates that there was a higher HEDIS® care gap closure rate among White females (56.52%) compared to Asian females (52.17%).

Table 28. Breast Cancer Screening (BCS) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
50–64 Years	132	238	55.46%
65–74 Years	33	70	47.14%
Gender			
F	165	308	53.57%
Language			
English	109	210	51.90%
Chinese	22	33	66.67%
Farsi	2	3	66.67%
Korean	3	3	100.00%
Russian	1	1	100.00%
Spanish	24	44	54.55%
Tagalog	2	5	40.00%
Vietnamese	0	1	0.00%
Other	2	7	28.57%
Unknown/Missing	0	1	0.00%
Race/Ethnicity			
White	39	69	56.52%
Asian	36	69	52.17%
Black or African American	11	20	55.00%
Hispanic or Latino	34	64	53.13%
Other	43	80	53.75%
Unknown/Missing	2	6	33.33%
Total			
All	165	308	53.57%

Data Source: DHCS Health Disparities Rate Sheet

2. **Chlamydia Screening in Women—Total (CHL)**

   UnitedHealthcare met the MPL for the measure CHL with an overall care gap closure of 62.05%. Among the 361 members that had a HEDIS® care gap for this measure, members

were predominantly ages 21-24 years old (n=237;65.65%), English-speaking females (n=307; 85.04%) who reported their race/ethnicity as Other (n=124; 34.35%). UnitedHealthcare observed a HEDIS® care gap closure rate of 63.29% among females ages 21-24 years old compared to females ages 16-20 years old, 59.68%. Additionally, UnitedHealthcare observed an overall higher HEDIS® care gap closure rate among Black or African American females, 71.43% compared to other race/ethnicity categories.

Table 29. Chlamydia Screening in Women—Total (CHL) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
16–20 Years	74	124	59.68%
21–24 Years	150	237	63.29%
Gender			
F	224	361	62.05%
Language			
English	191	307	62.21%
Arabic	1	1	100.00%
Chinese	1	2	50.00%
Farsi	1	2	50.00%
Russian	1	1	100.00%
Spanish	27	43	62.79%
Tagalog	0	2	0.00%
Other	2	2	100.00%
Unknown/Missing	0	1	0.00%
Race/Ethnicity			
White	36	75	48.00%
American Indian or Alaska Native	0	1	0.00%
Asian	9	21	42.86%
Black or African American	15	21	71.43%
Hispanic or Latino	74	113	65.49%
Native Hawaiian or Other Pacific Islander	1	2	50.00%
Other	86	124	69.35%
Unknown/Missing	3	4	75.00%
Total			
All	224	361	62.05%

Data Source: DHCS Health Disparities Rate Sheet

3. **Cervical Cancer Screening (CCS)**

UnitedHealthcare did not meet the MPL for the measure CCS with an overall care gap closure of 52.55%. Among the 411 members that had a HEDIS® care gap for this measure, members were

predominantly English-speaking females (n=345; 83.94%) who reported their race/ethnicity as Other (n=151; 36.74%), ages 21-64 years old with an overall HEDIS® care gap closure rate of 52.55%. UnitedHealthcare observed there was a higher HEDIS® care gap closure rate among females who were reported as Other (58.28%) compared to other race/ethnicity reported.

Table 30. Cervical Cancer Screening (CCS) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
21-64 Years	216	411	52.55%
Gender			
F	216	411	52.55%
Language			
English	183	345	53.04%
Cambodian	0	1	0.00%
Chinese	5	5	100.00%
Farsi	1	2	50.00%
Russian	0	1	0.00%
Spanish	23	48	47.92%
Tagalog	1	4	25.00%
Vietnamese	1	1	100.00%
Other	2	3	66.67%
Unknown/Missing	0	1	0.00%
Race/Ethnicity			
White	53	94	56.38%
American Indian or Alaska Native	1	2	50.00%
Asian	11	38	28.95%
Black or African American	13	17	76.47%
Hispanic or Latino	48	102	47.06%
Native Hawaiian or Other Pacific Islander	0	2	0.00%
Other	88	151	58.28%
Unknown/Missing	2	5	40.00%
Total			
All	216	411	52.55%

Data Source: DHCS Health Disparities Rate Sheet

d. Prenatal and Postpartum Care

1. Prenatal and Postpartum Care—Timeliness of Prenatal Care

UnitedHealthcare met the MPL for the measure PPC-Pre with an overall care gap closure of 87.85%. UnitedHealthcare observed that the 247 members that had a HEDIS® care gap for this measure were predominantly English-speaking (n=200; 80.97%), women who reported their race/ethnicity as Other (n=91; 87.50%) ages 21 to 34 years of age (n=189; 76.52%).

Table 31. Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
18-20 Years	9	12	75.00%
21-34 Years	168	189	88.89%
35-44 Years	39	45	86.67%
45+ Years	1	1	100.00%
Gender			
F	217	247	87.85%
Language			
English	179	200	89.50%
Chinese	1	1	100.00%
Farsi	1	1	100.00%
Korean	1	1	100.00%
Spanish	32	41	78.05%
Other	3	3	100.00%
Race/Ethnicity			
White	36	43	83.72%
American Indian or Alaska Native	1	1	100.00%
Asian	12	12	100.00%
Black or African American	11	13	84.62%
Hispanic or Latino	74	84	88.10%
Native Hawaiian or Other Pacific Islander	1	1	100.00%
Other	81	91	89.01%
Unknown/Missing	1	2	50.00%
Total			
All	217	247	87.85%

Data Source: DHCS Health Disparities Rate Sheet

2. Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)

UnitedHealthcare met the MPL for the measure PPC-Pst with an overall care gap closure of 79.76%. Similarly, to the PPC-Pre HEDIS® measure, UnitedHealthcare observed that the 247 members that had a HEDIS® care gap for this measure were predominantly English-speaking (n=200; 80.97%), women who reported their race/ethnicity as Other (n=91; 87.50%) ages 21 to 34 years of age (n=189; 76.52%).

Table 32. Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
18-20 Years	9	12	75.00%
21-34 Years	150	189	79.37%

35-44 Years	37	45	82.22%
45+ Years	1	1	100.00%
Gender			
F	197	247	79.76%
Language			
English	160	200	80.00%
Chinese	1	1	100.00%
Farsi	1	1	100.00%
Korean	1	1	100.00%
Spanish	31	41	75.61%
Other	3	3	100.00%
Race/Ethnicity			
White	31	43	72.09%
American Indian or Alaska Native	0	1	0.00%
Asian	11	12	91.67%
Black or African American	12	13	92.31%
Hispanic or Latino	65	84	77.38%
Native Hawaiian or Other Pacific Islander	1	1	100.00%
Other	76	91	83.52%
Unknown/Missing	1	2	50.00%
Total			
All	197	247	79.76%

Data Source: DHCS Health Disparities Rate Sheet

e. Children's Health HEDIS® Measures

1. Metabolic Monitoring for Children and Adolescents on Antipsychotics (MPM)

Based on the CA DHCS Disparities UnitedHealthcare Rate Sheet, there was nothing reported for the APM measure. Thus, UnitedHealthcare was not able to infer any observations as there was no data available for analysis.

2. Childhood Immunization Status—Combination 10 (CIS–10)

UnitedHealthcare met the MPL for the measure CIS-10 with an overall care gap closure of 40.27%. Among the 298 2-year-old members who had a HEDIS® care gap for this measure, members were predominantly English-speaking (n=218; 73.15%) Hispanic or Latino (n=132; 44.30%) males (n=157;52.68%). UnitedHealthcare observed a higher care gap closure rate among males, 43.31%, compared to females 36.88%.

Table 33. Childhood Immunization Status—Combination 10 (CIS–10) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
2 Years	120	298	40.27%

Gender			
F	52	141	36.88%
M	68	157	43.31%
Language			
English	87	218	39.91%
Arabic	1	2	50.00%
Farsi	0	1	0.00%
Russian	0	2	0.00%
Spanish	27	65	41.54%
Tagalog	1	1	100.00%
Other	3	8	37.50%
Unknown/Missing	1	1	100.00%
Race/Ethnicity			
White	12	46	26.09%
American Indian or Alaska Native	1	1	100.00%
Asian	8	13	61.54%
Black or African American	4	15	26.67%
Hispanic or Latino	57	132	43.18%
Native Hawaiian or Other Pacific Islander	1	2	50.00%
Other	31	80	38.75%
Unknown/Missing	6	9	66.67%
Total			
All	120	298	40.27%

Data Source: DHCS Health Disparities Rate Sheet

3. Immunizations for Adolescents—Combination 2 (IMA–2)

UnitedHealthcare did not meet the MPL for the measure IMA-2 with an overall care gap closure of 28.85%. Among the 104 13-year-old members who had a HEDIS® care gap for this measure, members were predominantly English-speaking (n=74; 71.15%) Hispanic or Latino (n=50; 48.08%) females (n=54; 51.92%). UnitedHealthcare observed a higher care gap closure rate among females, 35.19%, compared to males 22.00%.

Table 34. Immunizations for Adolescents—Combination 2 (IMA–2) Heatlh Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
13 Years	30	104	28.85%
Gender			
F	19	54	35.19%
M	11	50	22.00%
Language			
English	18	74	24.32%

Chinese	0	2	0.00%
Spanish	11	25	44.00%
Vietnamese	0	2	0.00%
Other	1	1	100.00%
Race/Ethnicity			
White	4	18	22.22%
American Indian or Alaska Native	0	2	0.00%
Asian	2	10	20.00%
Black or African American	1	9	11.11%
Hispanic or Latino	18	50	36.00%
Other	4	14	28.57%
Unknown/Missing	1	1	100.00%
Total			
All	30	104	28.85%

Data Source: DHCS Health Disparities Rate Sheet

4. Well-Child Visits in the First 30 Months of Life (W30)- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

UnitedHealthcare did not meet the MPL for the measure W30 (15 months) with an overall care gap closure of 17.39%. Among the 138 15-month-old members who had a HEDIS® care gap for this measure were predominantly English-speaking (n=112; 81.16%) females (n=75; 54.35%) whose race/ethnicity is reported as Other (n=47; 34.06%) UnitedHealthcare observed a higher care gap closure rate among males, 20.63%, compared to females, 14.67%.

Table 35. Well-Child Visits in the First 30 Months of Life (W30) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
15 Months	24	138	17.39%
Gender			
F	11	75	14.67%
M	13	63	20.63%
Language			
English	18	112	16.07%
Cambodian	1	1	100.00%
Chinese	0	1	0.00%
Farsi	0	1	0.00%
Spanish	5	21	23.81%
Tagalog	0	1	0.00%
Other	0	1	0.00%
Race/Ethnicity			

White	2	24	8.33%
Asian	1	4	25.00%
Black or African American	0	9	0.00%
Hispanic or Latino	10	44	22.73%
Other	10	47	21.28%
Unknown/Missing	1	10	10.00%
Total			
All	24	138	17.39%

Data Source: DHCS Health Disparities Rate Sheet

5. Well-Child Visits in the First 30 Months of Life—Well Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits

UnitedHealthcare did not meet the MPL for the measure W30 (15-30 months) with an overall care gap closure of 36.98%. Among the 192 30-month-old members who had a HEDIS® care gap for this measure were predominantly English-speaking (n=149; 77.60%) Hispanic or Latino (n=80; 41.67%) males (n=100; 52.08%). UnitedHealthcare observed a slightly higher care gap closure rate among males, 39.00% compared to females (34.78%).

Table 36. Well-Child Visits in the First 30 Months of Life—Well Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
30 Months	71	192	36.98%
Gender			
F	32	92	34.78%
M	39	100	39.00%
Language			
English	56	149	37.58%
Arabic	1	2	50.00%
Spanish	13	35	37.14%
Tagalog	0	1	0.00%
Other	1	4	25.00%
Unknown/Missing	0	1	0.00%
Race/Ethnicity			
White	10	29	34.48%
Asian	1	8	12.50%
Black or African American	4	14	28.57%
Hispanic or Latino	33	80	41.25%
Native Hawaiian or Other Pacific Islander	2	2	100.00%
Other	20	51	39.22%

Unknown/Missing	1	8	12.50%
Total			
All	71	192	36.98%

Data Source: DHCS Health Disparities Rate Sheet

6. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total (WCC–BMI)

UnitedHealthcare met the MPL for the measure WCC-BMI with an overall care gap closure rate of 83.21%. Among the 411 members that had a HEDIS® care gap for this measure, members were predominantly 3-11 years old. UnitedHealthcare observed a higher denominator of males (n=213; 51.82%) compared to their counterpart, females (n=198; 48.18%). UnitedHealthcare observed a slightly higher HEDIS® care gap closure rate of 84.04% among males compared to females, 82.32%. The population for this measure comprised of predominantly English-speaking members (n=288; 70.07%) whose race and/or ethnicity was predominantly reported as Hispanic or Latino (n=191; 46.47%).

Table 37. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total (WCC–BMI) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
3–11 Years	235	282	83.33%
12–17 Years	107	129	82.95%
Gender			
F	163	198	82.32%
M	179	213	84.04%
Language			
English	230	288	79.86%
Arabic	1	1	100.00%
Cambodian	1	1	100.00%
Chinese	7	8	87.50%
Farsi	1	2	50.00%
Korean	1	1	100.00%
Spanish	85	93	91.40%
Tagalog	2	2	100.00%
Vietnamese	1	1	100.00%
Other	13	14	92.86%
Race/Ethnicity			
White	54	74	72.97%
American Indian or Alaska Native	3	5	60.00%
Asian	21	27	77.78%
Black or African American	28	31	90.32%
Hispanic or Latino	163	191	85.34%

Other	70	80	87.50%
Unknown/Missing	3	3	100.00%
Total			
All	342	411	83.21%

Data Source: DHCS Health Disparities Rate Sheet

7. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total (WCC–N)

UnitedHealthcare met the MPL for the measure WCC-N with an overall care gap closure rate of 72.51%. Among the 411 members that had a HEDIS® care gap for this measure, members were predominantly 3-11 years old. UnitedHealthcare observed a higher denominator of males (n=213; 51.82%) compared to their counterpart, females (n=198; 48.18%). UnitedHealthcare observed a slightly higher HEDIS® care gap closure rate of 73.24% among males compared to females, 71.72%. The population for this measure comprised of predominantly English-speaking members (n=288; 70.07%) whose race and/or ethnicity was predominantly reported as Hispanic or Latino (n=191; 46.47%).

Table 38. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total (WCC–N) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
3–11 Years	204	282	72.34%
12–17 Years	94	129	72.87%
Gender			
F	142	198	71.72%
M	156	213	73.24%
Language			
English	200	288	69.44%
Arabic	1	1	100.00%
Cambodian	1	1	100.00%
Chinese	7	8	87.50%
Farsi	1	2	50.00%
Korean	1	1	100.00%
Spanish	74	93	79.57%
Tagalog	2	2	100.00%
Vietnamese	1	1	100.00%
Other	10	14	71.43%
Race/Ethnicity			
White	49	74	66.22%
American Indian or Alaska Native	1	5	20.00%
Asian	19	27	70.37%

Black or African American	21	31	67.74%
Hispanic or Latino	144	191	75.39%
Other	62	80	77.50%
Unknown/Missing	2	3	66.67%
Total			
All	298	411	72.51%

Data Source: DHCS Health Disparities Rate Sheet

8. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total (WCC–PA)

UnitedHealthcare met the MPL for the measure WCC-PA with an overall care gap closure rate of 71.78%. Among the 411 members that had a HEDIS® care gap for this measure, members were predominantly 3-11 years old. UnitedHealthcare observed a higher denominator of males (n=213; 51.82%) compared to their counterpart, females (n=198; 48.18%). UnitedHealthcare observed a slightly higher HEDIS® care gap closure rate of 72.30% among males compared to females, 71.21%. The population for this measure comprised of predominantly English-speaking members (n=288; 70.07%) whose race and/or ethnicity was predominantly reported as Hispanic or Latino (n=191; 46.47%).

Table 39. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total (WCC–PA) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
3–11 Years	201	282	71.28%
12–17 Years	94	129	72.87%
Gender			
F	141	198	71.21%
M	154	213	72.30%
Language			
English	197	288	68.40%
Arabic	1	1	100.00%
Cambodian	1	1	100.00%
Chinese	7	8	87.50%
Farsi	1	2	50.00%
Korean	1	1	100.00%
Spanish	74	93	79.57%
Tagalog	2	2	100.00%
Vietnamese	1	1	100.00%
Other	10	14	71.43%
Race/Ethnicity			
White	46	74	62.16%

American Indian or Alaska Native	1	5	20.00%
Asian	18	27	66.67%
Black or African American	21	31	67.74%
Hispanic or Latino	143	191	74.87%
Other	64	80	80.00%
Unknown/Missing	2	3	66.67%
Total			
All	295	411	71.78%

Data Source: DHCS Health Disparities Rate Sheet

9. Child and Adolescent Well-Care Visits—Total (WCV)

UnitedHealthcare did not meet the MPL for the measure WCV with an overall care gap closure rate of 22.94%. Among the 2,995 members that had a HEDIS® care gap for this measure, members were predominantly 3-11 years old. UnitedHealthcare observed a higher denominator of males (n=1,579; 52.72%) compared to their counterpart, females (n=1,416; 47.28%). UnitedHealthcare observed a slightly higher HEDIS® care gap closure rate of 23.38% among females compared to males, 22.55%. The population for this measure comprised of predominantly English-speaking members (n=2,211; 73.82%) whose race and/or ethnicity was predominantly reported as Hispanic or Latino (n=1,239; 41.37%)

Table 40. Child and Adolescent Well-Care Visits—Total (WCV) Health Disparities Analysis

Demographic variable	Numerator	Denominator	Rate
Age			
3–11 Years	391	1,539	25.41%
12–17 Years	201	809	24.85%
18–21 Years	95	647	14.68%
Gender			
F	331	1,416	23.38%
M	356	1,579	22.55%
Language			
English	477	2,211	21.57%
Arabic	2	10	20.00%
Cambodian	1	3	33.33%
Chinese	20	51	39.22%
Farsi	4	11	36.36%
Korean	1	2	50.00%
Russian	1	8	12.50%
Spanish	157	590	26.61%
Tagalog	2	26	7.69%
Vietnamese	5	15	33.33%
Other	17	64	26.56%
Unknown/Missing	0	4	0.00%

Race/Ethnicity			
White	115	567	20.28%
American Indian or Alaska Native	3	20	15.00%
Asian	61	237	25.74%
Black or African American	55	253	21.74%
Hispanic or Latino	308	1,239	24.86%
Native Hawaiian or Other Pacific Islander	1	8	12.50%
Other	138	622	22.19%
Unknown/Missing	6	49	12.24%
Total			
All	687	2,995	22.94%

Data Source: DHCS Health Disparities Rate Sheet

B. Additional HEDIS® Measures Considered to Identify Health Disparate Populations

UnitedHealthcare reviewed and analyzed the remaining CA DHCS HEDIS® priority measures MCPs are ***not*** held accountable to the MPL as listed below:

f. Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase (ADD-C&M)
g. Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Init)
h. Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total (AMB-ED)
i. Contraceptive Care—Postpartum Women—Long-Acting Reversible Contraception (LARC)—3 Days—Ages 15–20 Years CCP-(LARC3-1520)
j. Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years CCP-(LARC3-2144)
k. Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years CCP-(LARC60-1520)
l. Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years CCP-(LARC60-2144)
m. Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception (MMEC)—3 Days—Ages 15–20 Years (CCP-MMEC3-1520)
n. Contraceptive Care—Postpartum Women—MMEC—3 Days—Ages 21–44 Years (CCP-MMEC3-2144)
o. Contraceptive Care—Postpartum Women—MMEC—60 Days—Ages 15–20 Years (CCP-MMEC60-1520)
p. Contraceptive Care—Postpartum Women—MMEC—60 Days—Ages 21–44 Years (CCP-MMEC60-2144)
q. Contraceptive Care—All Women—LARC—Ages 15–20 Years (CCW-LARC-1520)
r. Contraceptive Care—All Women—LARC—Ages 21–44 Years (CCW-LARC-2144)
s. Contraceptive Care—All Women—MMEC—Ages 15–20 Years (CCW-MMEC-1520)
t. Contraceptive Care—All Women—MMEC—Ages 21–44 Years (CCW-MMEC-2144)
u. Screening for Depression and Follow-Up Plan—Ages 12–17 Years (CDF-1217)
v. Screening for Depression and Follow-Up Plan—Ages 18+ Years (CDF-18+)
w. Concurrent Use of Opioids and Benzodiazepines (COB)

x. Developmental Screening in the First Three Years of Life—Total (DEV)
y. Use of Opioids at High Dosage in Persons Without Cancer (OHD)
z. Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR-OR)

After an in-depth analysis of each measure, UnitedHealthcare observed a larger number of English-speaking Hispanic or Latino members with an open care gap for specific Children's Health HEDIS® measures including CIS-10, IMA-2, W30 (Well Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits), WCC, and WCV measures. UnitedHealthcare will take this into consideration when building quality initiatives targeting these populations. Ensuring appropriate health literacy, illustrations and images are culturally representative of the membership we target. Additionally, UnitedHealthcare did not observe any other specific health disparate populations that were statistically significant to singularly address and create a targeted quality initiative that would prove to be cost efficient and impactful at a larger scale. This could have been due to our larger membership reporting to be predominantly under the category of "Other." This category does not identify a specific race or ethnic group, making it challenging for UnitedHealthcare to detect a health disparate need and design programs to enhance the participation of members who have been determined to be underrepresented. Therefore, in 2022, UnitedHealthcare will continue to offer a broad repertoire of member engagement programs targeting the state priority measures and design appropriate quality initiatives as needed while ensuring our programs are culturally and linguistically appropriate to our membership needs.

5. Health Education, C&L, and/or Quality Improvement Program Gap Analysis

The following sections contain summaries of Health Education, Cultural and Linguistic, and Quality Improvement programs and interventions that were implemented during the measurement period.

A. Access to Care

The quantitative and qualitative data UnitedHealthcare analyzed was derived from various access to care surveys, such as the member and provider satisfaction surveys. Data analysis demonstrated that there are gaps in our services, including the way we conduct our surveys to our members. It was an identified gap in service to only have our NPS surveys conducted by representatives that do not speak their language nor understand their culture; members are not satisfied with taking a survey over the phone in a different language that is not their preferred language.

Currently, our NPS surveys and CAHPS® surveys are only available in English and Spanish. The Plan will continue to explore solutions to increase NPS and CAHPS® surveys, including providing an opportunity to complete the survey in the member's preferred language. Last year, members expressed an interest to have more simplified versions of member informing materials. UnitedHealthcare focused efforts into simplifying materials and making them easier to fill out. Members stated this year that they do not have difficulties in filling out the forms. This upcoming year, UnitedHealthcare will focus on creating more member-centric material encouraging healthier living and strong patient-provider relationships. UnitedHealthcare will continue to work to ensure compliance with the newly revised California Department of HealthCare Services All Plan Letter APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services released on April 8, 2021. The APL provided Medi-Cal managed care health plans with clarification and guidance regarding the provision of member informing

materials in the members preferred language and/or alternative format. Going forward having these available in the member's preferred language and/or format may improve satisfaction and effectiveness to meet the member's needs.

As previously mentioned, UnitedHealthcare remains deeply committed to providing coordinated and collaborative activities and initiatives that promote services for members that are accessible, of high quality, and contribute to positive health outcomes in a cost efficient and effective manner. UnitedHealthcare will continue to take steps towards improving access to care and implement planned long-term strategies.

B. Language Needs

In comparison to previous PNA report years, UnitedHealthcare continues to enroll a diverse membership population, consistent with the cultural, ethnicity and language make-up of San Diego County. UnitedHealthcare continues to identify gaps in services beyond providing interpretation over the phone. Specifically, these areas were identified: ensuring prompt provision of interpreter services by maintaining a multi-cultural and multi-linguistic call center; including multiple languages as part of the workflow process for conducting surveys with third party vendors; offering surveys beyond only English and Spanish to at least meet at minimum San Diego County's now seven identified threshold languages: English, Spanish, Tagalog, Vietnamese, Arabic, Farsi and Chinese; and ensuring UnitedHealthcare contracts with diverse providers and specialists who represent cultures and languages representative of the Plan's Medi-Cal population. UnitedHealthcare has gradually seen resolutions to the identified gaps, partially meeting our goals of continuing to provide cultural and linguistic availability to our members by significantly expanding the provider network since the inception of the Plan in 2017; hiring more bilingual and/or multilingual staff to the member call center; and contracting with third party vendors that provide surveys and/or outreach campaigns beyond English and Spanish.

Additionally, UnitedHealthcare continues to make available interpreter services to members in need of a provider who meets their cultural and linguistic needs. Services include a telephone language line and in-person interpreters. UnitedHealthcare offers Relay services (TTY) to assist members who are deaf or hard-of-hearing, and with the recent COVID-19 public health emergency, has also offered on-demand video interpretation through LanguageLine Solutions for virtual appointments.

C. Cultural and Linguistic Competency

UnitedHealthcare identified many members who have reported their race and/or ethnicity as Other (32.63%), or Hispanic or Latino (27.14%), who speak predominantly English (89.54%) and/or Spanish (6.24%). It is important to note that this lack of specificity poses a barrier to identifying and implementing tailored programs for specific populations. As mentioned earlier, this analysis aligns to the cultural detailing of San Diego County, where San Diego, California is heavily influenced by American and Mexican cultures due to its position as a border city and county large Hispanic population, and its unique history as part of Spanish America and Mexico. Additionally, San Diego's long-time association with the U.S. military also contributes to its culture, with a 9.1% veteran population (U.S. Census Bureau, 2022). These cultural details are important as cultural views are considered for program planning, outreach strategies, and provider representation preferred by our membership. Further, cultural and linguistic competency training is important to the success of staff and Providers becoming more aware of who they serve while delivering the upmost respect in their care to our members. UnitedHealthcare offers tools to promote cultural awareness

and assist both UnitedHealthcare internal staff, providers, and provider office staff in recognizing and treating health disparities.

D. Health Education

Through the health disparities analysis, UnitedHealthcare identified the need to continue to educate our members in preventive care, illness and disease, and self-care management. More education, awareness and preventive practices need to be culturally and linguistically targeted to predominantly English and Spanish speaking members whose race/ethnicity is identified as Other and/or Hispanic or Latino populations to improve the current health status and participation in preventive care and self-management of chronic conditions. The plan also identified the continued need to develop health education materials that are more specific to address topics like complementary and alternative medicine such as stress management, yoga, meditation, and mindfulness to help relieve the stressors and mental/behavioral health impact of the COVID-19 pandemic as requested by our members. Based on this research and feedback obtained from members, the Plan developed a Health Education program including classes, programs, and member engagement.

a. Health Education Classes

UnitedHealthcare had the opportunity to continue partnership with Champions for Health (CFH) to deliver health education classes during the calendar year 2021. Like calendar year 2020, 2021 continued to present itself with its own unique set of circumstances for the Health Plan. We were unable to implement in-person health education classes due to the continued COVID-19 public health emergency. As a result, health education classes were offered via the virtual Zoom platform and relied on our CFH partners for their expertise delivery of virtual health education classes. The health education class topics included Chair Yoga, a Cooking Demonstration, Child Health, Women's Health, COVID-19 Update, and Diabetes, totaling a delivery of 12 health education classes. The health education class topic selections were based on member feedback to continue to offer interactive classes such as yoga and a cooking demonstration, as well as classes that targeted members with higher rates of open HEDIS® care gaps that would touch on well child visits, childhood and adolescent immunizations, women's health, and diabetes related measures and sub measures. Additionally, the health education classes were offered in both English and Spanish, and held on Thursday's late afternoons, on the 1st and the 2nd week of each month.

UnitedHealthcare tracked and trended class attendance. Overall, attendance was low, a total of 6 participants in attendance among all 12 classes offered throughout the year. Among the 6 participants, 2 participants were non-members and 4 were members. Results indicate that UnitedHealthcare's participation rate was, 40% compared to 60% among non-members. When compared to 2020, the total number of participants decreased from 23 to 6 participants, the Plan consequently also observed a decrease among member attendance from 4 members in attendance to 2.

Despite a low participation rate among our members compared to non-members, UnitedHealthcare made best efforts to provide member engagement solutions. The health education class flyer was promoted through various marketing communication channels including a member mailing, flyer distribution through our Marketing Department, UnitedHealthcare's public website, and via email to

our UnitedHealthcare provider network. As a result of UnitedHealthcare's promotional efforts, the Quality Department was able to track at minimum the health education class schedule mailing. For cost effectiveness, the Quality Department mailed a portion of the health education flyers within a concurring Quality HEDIS® project, a Preventive Letters project through the vendor ConsejoSano. The Preventive Letters project touched on any member with an open care gap. In 2021, the Quality Department observed more open care gaps than years before due to the COVID-19 pandemic and challenges with access to care due to the impact. To bring our members back to their doctor offices and promote the classes, the letter and flyer were mailed together. The health education class schedule was mailed along with the Preventive Letters in May 2021. A total of 5,804 mailings were sent. On May 26, 2021, a separate mailing of the health education class schedule was organized and executed for remaining 13,370 members who were not outreached through the ConsejoSano campaign.

UnitedHealthcare conducted a brief focus group during the Plan's stakeholder meetings, including the Community Advisory Committee (CAC) and Public Policy Committee (PPC) meetings. The health plan Health Educator asked attending committee members what topics they would be more inclined to attend. Members of the CAC expressed interest in topics such as an overview of Medi-Cal benefits and how to navigate their benefits preferably in-person and/or group sessions to encourage social interaction with other members. They also recommended more frequent mailings of the health education class flyers. Members of the PPC expressed interest in topics such as meditation and mindfulness to help alleviate some of the stressors brought on by the COVID-19 pandemic. They also recommended the distribution of emails within 1 to 2 days before each class to members, as well as reminder emails to registrants. The feedback provided by the committee membership was considered for planned health education class activities in calendar year 2022.

Furthermore, like previous years, UnitedHealthcare continued to ask participants the following series of questions during the class registration process:

- Q1: Contact Information – Name, Home Address, Email Address, and Phone Number
- Q2: Are you a member of UnitedHealthcare Community Plan of California? (You do not need to be a member to participate)
- Q3: Do you wish to be contacted by United Healthcare for future events?
- Q4: How did you hear about this event? (For example, a food drive, through work, etc.)

Overall results indicate that a total of 30 members and non-members registered for the health education classes. Among the 30 registrants, 30 (100%) registrants were predominantly English speaking compared to 0 (0%) Spanish speaking registrants. Additionally, below are the findings from Questions 2 and 3 of the survey. Results indicate that all 30 registrants responded to these questions. For Question 2, "Are you a member of UnitedHealthcare Community Plan of California?" A total of 17 registrants indicated they are a UnitedHealthcare member compared to 13 non-members. A total of 3 registrants indicated they do not know if they are a UnitedHealthcare member, and 1 registrant chose not to answer. For Question 3 "Do you wish to be contacted by UnitedHealthcare for future events?" a total of 13 registrants indicated they would like to be contacted by UnitedHealthcare; a total of 14 registrants indicated they do not want to be contacted by UnitedHealthcare for future events; 0 registrants responded they did not know; and 3 registrants chose not to answer. Furthermore, a total of 29 registrants responded to Question 4 "How did you

hear about this event? (For example, a food drive, through work, etc.)" Where a total of 20 registrants stated they received a letter from UnitedHealthcare; 5 registrants responded they saw an advertisement in a newspaper; and 4 registrants indicated they heard about the event through work, a friend or school.

Results indicate that the overall health education class attendance was low. This may have been due to the impact of COVID-19, such as internet or digital fatigue experienced by many during the pandemic; or, all other relevant stressors that has come with the pandemic, like the need for a job, food, money before registering and attending a health education class. UnitedHealthcare had originally planned to conduct in-person health education classes; however, due to the public health emergency, the Plan shifted implementation of in-person classes to a digital platform, Zoom. UnitedHealthcare will need to consider the digital divide and digital setting exhaustion during COVID-19 for calendar year 2022 while also keeping our members and community members safe.

Although participation rates may have been low, UnitedHealthcare observed greater interest in the Chair Yoga and Cooking Demonstration classes. These classes were the most popular topics among our members and non-members when compared to other topics offered. UnitedHealthcare will consider expansion of these and similar topics for calendar year 2022. When comparing participation rates in 2020 to 2021, there is a noticeable decrease in registration and class attendance due to bandwidth limitations in 2021, promotion was not possible via email. The UnitedHealthcare national marketing team has since developed a "self-service" tool for plans to create their own email content and distribute in mass in a convenient way. In 2022, this tool will be utilized to reach about 8,000 members with an email address on file. These members will likely be more digitally adept, and we expect to have more registrants through this communication channel.

Lastly, there is a need to provide non-monetary incentives to all attendees, such as UnitedHealthcare branded non-monetary incentives and coordination in a digital setting, like Zoom. This will allow both non-members and members to engage in the health education classes offered and sign up to other topics.

b. **Diabetes Prevention Program**

Since the release of the DHCS All Plan Letter 18-018 Diabetes Prevention Program, UnitedHealthcare continues to strive to remain compliant. UnitedHealthcare has continued our partnership with Solera Health, Inc., a third-party vendor, to deliver and facilitate the Diabetes Prevention Program for our Medi-Cal members on behalf of the Plan. Since the successful implementation of the DPP, the program has been offered in-person, online and/or digitally. The Plan continues to strive to offer the programs in English and Spanish. Due to the COVID-19 pandemic, Solera Health Inc. suspended their on-site class offerings in 2020 through the earlier 2021 calendar year in accordance with the Centers for Disease Control and Prevention (CDC) and San Diego County guidelines. However, the DPP program has continued to be conveniently available online and digitally. In 2022, Solera Health Inc. and UnitedHealthcare will continue to reassess the in-person class setting and offer the program where safely allowed.

Since the program launched through December 2021, UnitedHealthcare had a total of 311 members who have committed or have an interest in participating in the program. Overall, the demographic

enrollment has been consistently the similar over the past three years, demonstrating a larger participation rate among females (68%) compared to males (32%). The average age of participants is 45.5 years old with participants ranging from 18-44 years old (46.2%) compared to their counterparts 45-64 years old (48.1%), 65-74 years old (4.5%), and 75+ (1.3%). The data demonstrates that the average physical activity within weeks 1-9 is 184 minutes, a decrease from 196 minutes as of year-end 2020. The average weight loss at week 9 is 2.6%, a 0.9% increase from year-end 2020.

Data for year-end 2021 demonstrates that a majority of DPP participants selected to engage with an online DPP provider with 226 compared to 85 members who have committed to an on-site DPP Provider. Of those who committed to an online DPP provider, 147 have attended their first core session, 67 attended their first 4 core sessions and 27 attended 9 total core sessions. A total of 11 participants achieved their 5% weight loss goal, 1 achieved 9% weight loss goal, and 4 continued to complete 2 core maintenance sessions. Of those who committed to an on-site DPP provider 9 have attended their first core session, 5 attended their first 4 core sessions, and 1 attended 9 total core sessions. Furthermore, of the on-site participants 2 achieved their 5% weight loss goal, 1 achieved 9% weight loss and continued to complete 2 core maintenance sessions.

c. **Tobacco Cessation Program**

Since the inception of the plan in 2017, UnitedHealthcare has actively promoted the California Smokers' Helpline, or 1-800-NO-BUTTS, now known as Kick It California (KICA), for referral and support services to our entire membership and provider network. The health plan promotes the helpline through our member newsletters, health education materials, health plan website, provider newsletter, provider manual, stakeholder meetings (CAC, PAC, and PPC), as well as provided promotional campaigns to our provider network to ensure provider offices are aware of the Medi-Cal service available to our members at no cost.

In partnership with KICA, the organization has generated and provided reports since 2019 for our health plan for review and analysis. The report includes self-reported information provided by UnitedHealthcare Medi-Cal beneficiaries participating in the tobacco cessation program. Kick It California collects the data during their helpline intake process. Participants are asked about their gender, age, race, ethnicity, education level, behavioral and/or physical conditions, and their referral source into the program.

UnitedHealthcare conducted an analysis of the data report and identified a total of 203 members participated in the program during 2021, 66 more participants than 2020 (n=137). The demographic enrollment demonstrates a slightly higher participation rate among females (49.3%) compared to males (48.8%). The largest age group of participants is 65+ years old (42.4%), compared to their counterparts 45-64 years old (40.4%), 25-44 years old (14.3%), 18-24 years old (3.0%), and <18 (0%). Data also indicates that there is a larger participation rate among Caucasian/White members (49.8%), compared to their counterparts, Black/African American (17.7%); Hispanic/Latino (13.3%); Asian-American/Pacific Islander (5.4%); American Indian/Alaska Native (1.5%); Multi-racial (6.4%); and Other/blank/refused (5.9%). The predominant languages spoken among participating members are English (94.1%) and Spanish (3.4%), and there was a small percentage reported as Korean (0.5%) and Vietnamese (2.0%). Furthermore, the most reported educational level among participants

is Some college (28.6%), compared to their counterparts whose educational level are College degree or higher (27.1%); High school diploma (25.6%); 9th-12th grade, no diploma (14.3%); Blank/Refused to answer (2.5%); and less than 9th grade (2.0%). These findings demonstrate consistency with member demographic data between 2019, 2020 and 2021 with only slight differences in educational levels reported.

Participants are asked if they have any behavioral and/or physical conditions during the intake process. Findings indicate that program participants have a behavioral health condition including anxiety (41.9%); bipolar disorder (16.3%); depression (41.4%); Schizophrenia (9.4%); and/or Substance Use Disorder (12.8%). Participants have also indicated they have a physical condition such as High Blood Pressure (55.7%); Diabetes (18.7%); Heart Attack (9.9%); and/or Stroke (10.8%). UnitedHealthcare identified an increase in participants reporting anxiety (+3.9%), depression(+1.3%), substance use disorder (+1.1%), and stroke(+2.8%). However, UnitedHealthcare noted a decrease in participants reporting high blood pressure (-3.4%), diabetes (-1.0%), and heart attack (-4.0%). Although these findings are not statistically significant at $p<.05$ they are important to highlight.

Participants are also asked their referral source into the program, data demonstrated that most participants self-refer to the program due to mailings and television media. This data is consistent with 2020 data results. UnitedHealthcare analyzed the zip code data and continues to note some data limitations to self-reporting affecting the data results. For example, UnitedHealthcare only serves San Diego County; however, the zip code analysis indicates there were participants who reported they are UnitedHealthcare Medi-Cal beneficiaries and lived throughout California. Although San Diego is still the most reported individual county (n=53), the remaining 150 members reported living in another California county. This data limitation was also noted in 2019 and 2020 results.

As a result of the data limitations, KICA was invited to collaborate with UnitedHealthcare and explore other ways to data share and enhance current tobacco cessation program participation with active outreach to our members. In 2022, UnitedHealthcare will explore contracting with KICA to be able to share our data and implement live outbound calling activities to our members who have identified as tobacco and/or smoking users. Additionally, UnitedHealthcare will continue to attend the quarterly California Quits Managed Care Plan workgroup meetings to learn about statewide best practices.

E. Quality Improvement Efforts

UnitedHealthcare partnered with the enterprise National Quality team to implement a variety of member engagement programs. DHCS requires a program proposal be sent for review including a packet of member materials and program operations. Any program containing a member incentive requires a formal proposal and evaluation plan using the required Member Incentive form. All programs were approved for implementation by the DHCS. The following programs were implemented in 2021. A description of each program and outcomes are as follows:

a. **Interactive Voice Recording (IVR) Calls.** In 2021, IVR Calls were placed by a third-party vendor to members during the months of January through December. The IVR calls were placed for the following HEDIS® care gaps: Controlling High Blood Pressure (CBP), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Diabetes and Cardiovascular Disease Screening and Monitoring for

People With Schizophrenia or Bipolar Disorder (SSD), Chlamydia Screening in Women (CHL), Comprehensive Diabetes Care Eye Exam (CDC-eye), Comprehensive Diabetes Care HemoglobinA1c (CDC- HT), Childhood Immunization Status (CIS-Combo 3), Immunizations for Adolescents (IMA), Lead Screening in Children (LSC), Prenatal and Postpartum Care (PPC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children and adolescents (WCC), Well-Child Visits in the First 30 Months of Life (W30), and Child and Adolescent Well-Care Visits (WCV). Calls were placed in English and Spanish per the member's preferred language. A total of 9,141 calls were placed to eligible members. This program was expected to increase HEDIS® rates by 10%. UHCCP CA found this program to be moderately effective as calls were successfully placed to members, 22.30% contact rate. When compared against 2020 data where a total of 1,194 calls were placed to eligible members with a contact rate of 20.27%. UnitedHealthcare observed this program had a +2.03% contact rate increase. As seen in 2020, the program reporting was unable to indicate how effective the program was in connecting members to their PCP to close gaps in care. Any awareness and education, however, is helpful in messaging to members that they are due for care. UnitedHealthcare decided to no longer participate in this program for 2022 due to utilizing other live call programs.

b. **Live Calls.** In 2021, UnitedHealthcare continued to partner with a third-party vendor to conduct live calls during the calendar year for the following HEDIS® care gaps: BCS, CBP, CCS, CDC-HT, CIS, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Human Papillomavirus Infection (HPV), IMA, Lead Screening (LSC), PPC, W30, and WCV. Calls were placed in English and Spanish per the member's preferred language. A total of 26,110 calls were placed to eligible members, 2.55% net new appointment rate in 2021. This is a -0.08% decrease in the net new appointment rate when compared to 2020, where a total of 8,272 telephone calls were placed to eligible members, and the net new appointment rate was 2.63%.

c. **Member Rewards.** In 2021, the plan continued to participate in the Member Rewards program offering $50 gift card to members to close their gaps in care for the following measures: BCS, CCS, CDC-HT, CHL, CIS, IMA, LSC, PPC, and WCV. A total of 11,495 letters were mailed to eligible members, and 162, or 1.40%, of the eligible members who were sent a Member Reward mailing had redeemed their gift card. UnitedHealthcare observed a lower redemption rate in 2021 (-0.13%) compared to the 2020 redemption rate of 1.53%. This low redemption rate can be attributed to the steps required to obtain a gift card such as completing the attestation and mailing the form to the vendor. The plan will continue to participate in Member Rewards in 2022 to offer all eligible members the opportunity of redeeming a hard copy or electronic gift card.

d. **HealPros.** An In-Home A1c testing conducted by a non-clinical HealPros technologist. UnitedHealthcare eligible members receive a telephone call by a live HealPros call agent offering the in-home screenings they are due for. A HealPros non-clinical Technologist come to the eligible member's home to provide in-home screenings. HealPros targets the following HEDIS® measures: Comprehensive Diabetes Care: Eye Exam (CDC-Eye), Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (CDC-HT), Comprehensive Diabetes Care: Medical Attention for Nephropathy (CDC-Neph). The technologist will administer a retinopathy and nephropathy screening, the member self-administers a HgbA1c test with a finger stick test kit and urine test. The HealPros technologist will collect the test and return package. UHC credentialed Providers will review screening results. A results letter will be sent to the member. The member will be encouraged to go to their Primary Care Practitioner (PCP) office in-person for continued care. Additionally, a copy of

the results will be given to the member's identified PCP. Since the program launched in October 2020, 210 eligible members have been called (40.3% successful contact, 55.4% successful appointments scheduled), and a Diabetic Retinopathy Exam has been completed by 21 members for a completion rate of 67.4% and 1 A1c test resulted. This program continued in 2021 encouraging members to close their care gaps.

In 2021, 415 eligible members have been called (27.7% successful contact, 47.8% successful appointments scheduled), and a Diabetic Retinopathy Exam has been completed by 37members and 16 A1c tests have been resulted for a completion rate of 61.8%. The completed rate from 2020 to 2021 has decreased -5.6%. This can be attributed to the program only being live for 2 months in 2020 compared to a complete calendar year in 2021. This program will continue in 2022 encouraging members to close their care gaps.

e. **Healthy First Steps.** An online, interactive incentive program designed to help pregnant women and new mothers with prenatal, postpartum, and well-baby care. The Healthy First Steps digital rewards program aims to improve prenatal, postpartum, and well-baby care, drive member engagement, and close gaps in care for specific HEDIS® measures including Prenatal and Postpartum Care (PPC), Lead Screening in Children (LSC), and Well-Child Visits in the First 30 Months of Life (W30). A program mailer is sent to all eligible members encouraging them to enroll into the program, and program mailers sent to newly identified pregnant members on a weekly basis thereafter. The program rewards women for visiting the doctor and reporting the information online during their pregnancy and their baby's well-child visits. Once members sign up for Healthy First Steps, they can access an interactive board that shows their prenatal visits, along with opportunities to earn rewards for following a prenatal visit schedule, and continuous educational information provided. Using a game-like interface, members can track appointments and receive email and/or text message appointment reminders. Members are offered eight incentives for completing key visits throughout their pregnancy and their baby's well-child visits. Claims data are verified against the participants' reported online information of completed doctor visits. Additionally, system triggers are in place to flag certain activities for review.

   In 2021, the Healthy First Steps program participation rate was 57.1% (n=28; n=49 eligible members) indicating a decreased program participation rate of -19.6% from one year to the next when compared to 2020 data where the participation rate was 76.7% (n=66; n=86 eligible members). UnitedHealthcare enterprise maternity program owners attributed this decrease in participation rate in all Medicaid markets across the enterprise due to the new registration process being integrated into myuhc.com. The Healthy First Steps program is continuously monitored and reviewed at UnitedHealthcare Healthy First Steps enterprise stakeholder meetings, the Health Education and Cultural and Linguistics Committee (HECL) and Quality Management Committee (QMC). Committee and/or meeting attendees have an opportunity to review the program and discuss methods to increase participation. Additional trainings regarding the program and updates will continuously be provided to ensure program awareness and marketing efforts. In 2022, the Health Plan's Clinical Quality team will continue to integrate monitoring and quality improvement efforts with different audiences to ensure the upmost program awareness to drive increased participation rates.

f. **Early and Periodic Screening, Diagnostic and Treatment (ESPDT) IVR Calls**. UnitedHealthcare implemented EPSDT IVR calls in November 2018 targeting HEDIS® measures such as CIS, IMA, LSC, WCV, W30 and reminders for dental and eye exams. UnitedHealthcare has actively participated in the

program year over year. In 2021, UnitedHealthcare continued to monitor the program. In 2021, UnitedHealthcare achieved a contact rate of 22.03%, a -0.03% reduction rate from the 2020 contact rate of 22.06% observed. The EPSDT IVR calling answering machine rate was 55.70% compared to 51.98% in 2020. The EPSDT IVR call will continue in 2022 and the quarterly rates will continue to be reported to the Health Education and Cultural and Linguistics (HECL) Committee.

g. **Flu Vaccine Email.** This campaign is targeted to members for the influenza, or flu and COVID-19 vaccine. A member engagement digital email was sent to eligible members to remind them to get their annual flu vaccine and COVID-19 vaccine. This email is sent out two times a year, once in Quarter 4 and a reminder flu email in Quarter 1 of the following year. These emails were sent in English, Spanish, and available in other languages upon request. In January 2021 the Flu Vaccine email was sent to 4,430 members. The delivery rate was 98.76% with an open rate of 18.70%. In November 2021 the Flu vaccine email was sent to 6,955 members. The delivery rate was 98.85% with an open rate of 40.15%. When comparing 2020 data against 2021 data, specifically emails sent in November 2020 (n= 9,325, delivery rate, 82.03.%, and open rate of 26.95%), to emails sent to eligible members in November 2021, UnitedHealthcare observed a +1.09% increased delivery rate, and a +13.2% increased open rate. The increase in delivery can be attributed to two flu emails being sent in 2021 as opposed to one email sent in 2020. The emails will continue to be sent to members with an email on file in 2022.

h. **Women's Health Email.** The Women's Health Email was sent to members who were eligible for Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS) HEDIS® measures. In 2021, the email content was updated to remove the production of two emails and removed the promotion of the Healthy First Steps program. As a result of a reconciled email, the member engagement digital email was sent to eligible members to remind them to get their breast cancer screening, cervical cancer screening, and annual well woman exam. The digital email was sent to eligible members with an open care gap for the BCS and CCS HEDIS® measures. There were 2,650 emails sent out to eligible members. These emails were sent in English, Spanish, and available in other languages upon request. The delivery rate was 98.87% with an open rate of 25.08%. Compared to 2020 data, there was an +0.61% increase in the delivery rate. The plan will continue to send Women's Health emails in 2022.

i. **SameSky (formerly ConsejoSano).** In 2021, UnitedHealthcare continued its partnership with ConsejoSano, now known as SameSky, a vendor offering culturally and linguistically appropriate health education messaging to health plan members. The decision was largely in part due to the 2020 reported engagement rate, 27.44%, and the overall positive interactions expressed by the Plan's members. Similarly, in 2020, UnitedHealthcare partnered with SameSky to deliver member engagement campaigns for a series of select HEDIS® measures that did not meet the MPL in RY 2020. However, in 2021, UnitedHealthcare focused on closing care gaps for the following HEDIS® measures such as BCS, CBP, CCS, CDC-H9, CHL, CIS, IMA, W30, and WCV. SameSky performed member outreach in the form of e-mails, mailers, and live calls and strategically scheduled throughout May to December 2021.

   As a result, SameSky conducted outreach to 9,962 unique members with an engagement rate of 31.70% indicating members were successfully contacted and/or the member opened e-mails. Engagement was defined as the number of unique members who made an appointment while on the call, or the member had already scheduled an appointment. The reported engagement rate for 2021 was 32.33%. The call reach rate was 22.31%, a reported 8.09% of members had numbers that were

disconnected or noted as incorrect by someone else answering the calls. The data indicates a +4.89% increase in the reported engagement rate when compared to 2020 data. This can be attributed to the increase in number of members outreached to and the longer lengths of campaigns.

In addition to the HEDIS® specific targeted campaigns, UnitedHealthcare engaged SameSky to also conduct established care calls in June 2021. This call campaign would indirectly make an impact to access to care and increase initial health assessments. UnitedHealthcare identified a total of 854 members to be outreached to. A total of 609 total calls were made, 12 members self-reported they had already completed an appointment with their assigned Primary Care Provider, and 10 members stated they had already made an appointment. Indicating a 2.58% success rate. Of the 609 total calls made, 134 calls were successfully connected, resulting in a 15.69% engagement rate. Only 20 telephone numbers were wrong phone numbers, and 7 members declined to participate and stay on the call. The engagement success rate was 16.42%.

Overall, SameSky's campaigns were engagement success rates for each campaign proved to be higher than other UnitedHealthcare national clinical quality programs offered by the enterprise. This is largely since live telephonic agents are fluent in San Diego County's threshold languages such as Spanish, Arabic, Farsi, Chinese, Vietnamese, and Tagalog; and are more representative of the members served. In fact, member feedback indicated satisfaction with the call agents. Specifically, one member reported how pleased he was to speak to a representative in his preferred language, Tagalog. He noted how that call agent helped him coordinate care with his Primary Care Physician. SameSky has proven to help decrease language barriers and increase access to care.

j. **Pfizer Vaccine Adherence for Kids (VAKs).** Pfizer sponsored Child Immunization interactive voice recordings (IVR) and postcards were sent to eligible members to encourage well child visits and childhood immunizations. The Pfizer Vaccine Adherence for Kids (VAKs) targets the following HEDIS® measures: CIS, IMA, W30, and WCV. In 2021, a total of 15,827 outbound calls were made, of those calls 808 were authenticated for a 5.10% contact rate. UnitedHealthcare observed that the contact rate decreased by -0.75% compared to 2020 data, where 1,043 outbound calls were made, of those calls 61 calls were authenticated for a 5.85% contact rate. In addition to the IVR calls, in 2021, 1,302 postcards were mailed to members to encourage well child visits and childhood immunizations. Compared to only 98 postcards mailed to members in 2020. However, the total number of postcards in 2020 was much lower due to the COVID-19 public health emergency and having to pause the program for nearly the entire 2020 calendar year.

In October 2021, UnitedHealthcare decided to end the Pfizer sponsored child immunization interactive voice recordings (IVR) and postcards due to two factors, including utilizing multiple vendors for live calling causing member calling exhaustion, and an updated state requirement that would impact the postcard mailing. The updated DHCS All Plan Letter (APL) 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services would no longer allow for a short non-discrimination notice on a postcard; all materials would need to include a long form discrimination. As a result of the updated requirement, the postcard mailing did not allow for enough spacing to include a long discrimination notice and would defeat the purpose of a postcard as an eye-catching and cost-effective reminder. As a result, UnitedHealthcare opted out of the program and instead focused on the use of other interventions that target the indicated HEDIS® measures.

k. **Pfizer Adolescent Immunization Program.** In 2021, UnitedHealthcare implemented the Pfizer Adolescent Immunization Program. This program is an extension of the Pfizer VAKs program; however, this program would target parents and guardians or young adult members at ages 16-17 years old and 18-23 years old monthly throughout the year assisting with closing care gaps for the HEDIS® measure IMA. The program has one reminder option, a postcard to eligible members and or parent or guardian of children ages 16-17 years old and 18-23 years old. The postcard serves to remind and encourage eligible members to schedule appointments for adolescent immunizations as recommended by the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunizations Practices (ACIP), and the American Academy of Pediatrics (AAP). Essentially reducing the rate of vaccine-preventable diseases, improve vaccination rates in the adolescent population, and help support immunization and overall health care for adolescent patients. The postcards were mailed in English and Spanish, and additional languages were available upon request.

   There were a total of 1,079 postcards sent for Adolescent program from Jan 2021 until September 2021. However, like the Pfizer VAKs program, UnitedHealthcare decided to end the program in October 2021 due to the updated state requirement that would impact the postcard mailing. The updated DHCS All Plan Letter (APL) 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services would no longer allow for a short non-discrimination notice on a postcard; all materials would need to include a long form discrimination. As a result of the updated requirement, the postcard mailing did not allow for enough spacing to include a long discrimination notice and would defeat the purpose of a postcard and cost-effective use. As a result, UnitedHealthcare opted out of the program and instead focused on the use of other interventions that target the indicated HEDIS® measure IMA.

l. **LetsGetChecked.** Offers In-Home Lead and A1c testing kits mailed to eligible members. Eligible members will receive a letter informing members that they are due for a screening. It will include information regarding why the member should receive a screening, how to order the test, and how to complete the test. The member will have the option to order the test by a phone call, text message, or online. An interactive voice recording (IVR) messaging will then prompt the member to enter an 8-digit code to complete the order. The in-home testing kit arrives at the eligible member's home with clear directions and materials to complete the sample collection. The kit is returned in a pre-paid envelope directly to the lab. The sample collection is then processed with results sent to the member and primary care provider. A Let'sGetChecked nurse follows up on the lab results. LetsGetChecked targets the following HEDIS® measures: CDC-HT and LSC. The program launched in December 2020 for Lead Screening only. Opt-In letters were sent to 242 eligible members, and 20 members opted in to participate in the program. However, no members returned the test kits resulting in a 0% participation rate. Low participation rates can be attributed to not receiving timely state approval for the program delaying the launch dates and only allowed the program to be implemented for one month in 2020. The CDC-HT testing portion of the program did not launch in 2020 due to issues with the online portal. UnitedHealthcare planned to continue the LetsGetChecked program for both In-Home Lead and A1c testing in 2021.

   As a result, the program launched in April 2021 for LetsGetChecked and opt-In letters to participate in the program were sent to 249 eligible members for the CDC-HT measure, and 18% of eligible members (45) opted in to participate in the program. However, only 14 members returned the test kits resulting in a 31.1% participation rate. Opt-In letters were also sent to 543 eligible members for the LSC

measure, and 14% or 75 members opted in to participate in the program. However, only 7 members returned the test kits resulting in a 9.3% participation rate. All results for CDC-HT and LSC measures were successfully sent to members and providers. UnitedHealthcare observed an overall increased program participation rate in 2021 compared to 2020 due to the program having launched a full calendar year for both the lead screening and hemoglobin A1c testing. UnitedHealthcare will continue to monitor the LetsGetChecked program for both In-Home lead and hemoglobin A1c testing in 2022.

F. Other Health Plan Campaigns

UHCCP CA developed a strategic plan to expand member engagement programs in 2021 as a means of increasing HEDIS® performance rates. The following were additional programs implemented by the Quality Department.

a. **Member Gift Card Program.** In December 2020, UHCCP CA observed that several HEDIS® Preventive Care measures were well below the Minimum Performance Level (MPL). UHCCP CA's Quality team received feedback from several practices requesting an incentive to encourage the member to complete preventive care screenings. In response, UHCCP CA developed an intervention to engage members and offer a $50 Wal-Mart gift card reward for completing preventive care visits. UnitedHealthcare implemented a Member Gift Card program in which gift cards are provided by the provider practice at the point of care for the following measures: CCS, BCS, CHL, CDC-HT, W30, WCV, CIS, IMA. Since the program launch in December 2020, there were a total of six participating provider practices and nine gift cards distributed. Due to the program only launching for one month in 2020, the number of gift cards distributed was not substantial. At the time of program implementation there were 2,420 eligible members among the participating practices. The rate of distribution in 2020 was 0.37% compared to UnitedHealthcare enterprise national *Member Rewards* program that previously had a 1.7% distribution rate in 2019. The gift card program was monitored through 2021 and has been open to additional provider offices interested in participating.

As a result, in 2021, the program had a total of 13 participating practices and 313 gift cards were distributed among the practices. There were 3,614 eligible members among the participating practices. The rate of distribution in 2021 was 8.7% compared to UnitedHealthcare enterprise national *Member Rewards* program that previously had a 1.40% distribution rate in 2021. The program added 7 additional practices in 2021, which increased the number of gift cards distributed. Additionally, in September 2021, the plan extended the Member Gift Card program to include the Access to Care (ACC) measure. The program launched on September 14, 2021, as a pilot program with one provider site. The members eligible to participate in this program are newly enrolled UnitedHealthcare members in need of an initial visit within 180 days of enrollment. The member must schedule an appointment with their assigned Primary Care Provider and complete the initial visit withing the 180 days of enrollment. During the months of September 2021 through December 2021 the pilot provider site distributed 23 gift cards. The program was successful during the 3-month-period that the addition of the ACC measure was extended to another provider site interested in participating with the additional measure for 2022.

The member gift card program will continue through 2022 and will be open to additional provider offices interested in participating.

HEDIS® Preventive Letters. In November 2021, UnitedHealthcare sent out HEDIS® Preventive Letters to eligible adult and pediatric members with an open care gap. The preventive letter engages the member, alerts the member of any outstanding care gap(s), and provides instructions on how to close their open care gaps. Members whose preferred language was noted as English or Spanish and who have existing care gaps as of July 2021 were included in this mailing. The HEDIS® Preventive Letters targeted the following HEDIS® measures: ACE, ARB, AMR, BCS, CBP, CCS, CDC-H9, CIS, DIU, IMA, W30, WCV, WCC. A total of 10,098 letters were mailed to members, and 840 (8.31%) letters returned. The mailing was much larger in 2021 compared to 2020 with a total of 5,005 letters sent to members at that time, and a higher returned rate, 493 (9%) letters returned. Further, UnitedHealthcare will conduct a post mailing evaluation to determine if the preventive letters mailing made an impact on care gap closure. The data run-out report will be available in July 2022.

Additionally, UnitedHealthcare observed in 2021 that the HEDIS® preventive letters was a much larger mailing than in years prior. The process proved to be more expensive and tedious than years prior due to the larger membership. As a result, UnitedHealthcare has decided to end the manual in-house mass mailings; and instead, the health plan has opted into participating in UnitedHealthcare's enterprise national clinical quality annual preventive letter. An annual preventive letter is mailed to all HEDIS® eligible households to educate and encourage the importance of scheduling and/or receiving appropriate screenings and well child visits. The preventive letter specifically reinforces the importance of screenings and encourages members to schedule an appointment with their doctor. The national clinical quality program will adopt and utilize the health plan's California customized adult and pediatric letters and send them to eligible members with open care gaps to encourage an annual physical or wellness visit at least once a year. The mailings are scheduled to launch in March 2022.

Blood Pressure Monitors Mailing. In 2020, the Plan identified low utilization rates for routine medical visits due to COVID-19. As a result, the Plan identified opportunities to better support members with diagnosed with Hypertension. Some of the barriers identified included members reporting challenges to completing medical visits due to fear of contracting COVID-19; Providers unable to assess blood pressure values in a telehealth visit; and telehealth visits served as an innovative solution to combat access challenges but presented unique challenges to patient care as key components of the visit were missing. In response UHCCP CA developed a Program to assist members in monitoring blood pressure from a remote setting. The goals of the blood pressure monitor mailing included supporting telehealth visits, promote self-management, increase controlled blood pressure HEDIS® rates for the measure CBP, and improve member health outcomes.

UnitedHealthcare analyzed demographic data for the CBP measure reviewing member level data dated as of November 2020. UnitedHealthcare identified a total of 548 members and an analysis was conducted to identify further demographic characteristics including language, age, gender and race/ethnicity. The profile was compared to the overall membership to identify differences in this population. Results indicated the following: 1) the top 3 languages are consistent with overall membership: English (n=376, 68.6%), Spanish (n=82, 15.0%), followed by Mandarin (n=26, 4.7%); 2) The most prominent age band identified is members between the ages of 55-64 years of age (n=231, 42.2%), while overall adult membership is predominantly 25-34 (n=4,798, 34%); 3) There was a slightly higher percentage of females (n=277, 50.5%) than males (n=271, 49.5%) consistent with overall membership; and 4) The Unknown race category was mostly reported (n=372, 67.9%), and Not Hispanic or Latino (n=432, 78.8%).

Further, among the eligible members, UnitedHealthcare identified a total of 527 blood pressure monitors to be sent to eligible members. A blood pressure monitor would be sent to eligible members, regardless of compliance status, based on MLD data from September 2020. The mailing would include a letter introducing the device and a health education instruction on how to check blood pressure, how to interpret results, a log to track blood pressure readings, and a postcard with a link to the product manual available in English and Spanish. Providers were also notified of the mass mailing and provided with the materials for reference. The mailing was launched in January 2021. Subsequent orders were placed in the following months for members requesting a larger blood pressure cuff or other device issue(s) encountered.

Following the mailing, Quality Department staff conducted a total of 510 phone calls that were made between January and March 2021. Of the total members called; 114 (22.4%) answered the phone, 280 (54.9%) members were left a voicemail message requesting a call back, 116 (22.7%) did not answer and a voicemail was unable to be left. Some reasons noted for being unable to reach some members were: the number was not in service, a voicemail was not set up yet, or the voicemail was full. Overall, we received very positive feedback from members who were able to answer the phone call. Below are some member anecdotes obtained while on the phone calls:

- Member stated he needed a blood pressure monitor desperately and since receiving it he has been checking it daily. Last week his BP went high, and he ended up going to the hospital. He was so thankful and said that without it he wouldn't have known his blood pressure was high and something bad could have happened. He thanked United many times during the call.
- Member has been able to use monitor and was appreciative of the mailing.
- Member stated she has been using the monitor and was very grateful for receiving it.
- Member is going in for an appointment due to high blood pressure. She stated the machine has come in handy for checking it daily.
- Member received monitor and has been using it. He stated he appreciates it.

Additionally, UnitedHealthcare conducted a post mailing analysis and found that the overall final compliance rate for CBP decreased by 8.48% from 2019 (64.44%) to 2020 (55.96%). However, there were significant challenges noted that hindered improvement many measures in 2020 such as continued barriers due to the COVID-19 Public Health Emergency. Despite not meeting the goal of 61.80% for the CBP measure for 2020, the Plan still observed favorable statistically significant improvement when comparing compliance rates pre versus post mailing to consider this project a successful intervention. Due to member and provider program popularity, the Plan launched another blood pressure monitor mailing in December 2021. The Plan will conduct a post mailing evaluation of the second mass mailing when available in July 2022.

Mom's Meals. UnitedHealthcare implemented the Mom's Meals program offering tailored meals based on personal health needs conveniently delivered to the eligible member's doorstep. The intent of the program is to address social determinants of health among our maternal health population following their delivery. This program provides postpartum women with meals for 14 days following their delivery. The team at Mom's Meals uses high-quality ingredients to create dishes that taste great and are healthy as well. Mom's Meals are fully prepared and refrigerated meals that can easily be placed in the microwave. When the Mom's Meals package arrives, members can simply put the meals in their refrigerator. They will last up to 14 days from delivery. UnitedHealthcare expects the program to

increase member satisfaction and address social determinants of health, such as, mobility issues, transportation, and food insecurity. Additionally, the program serves as a kick start to encourage access to healthy meal options, demonstrate that healthy food can taste good, and provide resources for continued healthy eating.

The Mom's Meals program was originally planned for implementation in 2020; however, this was deferred to be implemented in 2021 instead, due to the COVID-19 public health emergency. UnitedHealthcare continued to develop and plan the program launch in 2021. The program officially launched on January 7, 2022, with a member mailing included in the monthly Healthy First Steps packet to eligible members, followed by outreach calls begun on February 1, 2022. The program launch delay was due to internal vendor contracting challenges encountered by the Quality Department. Further, since the program launch, there have been a total of 171 eligible members and 15 additional eligible members identified from an ad-hoc hospital discharge report. Among the 171 eligible members outreached via mail, a total of 144 members have been outreached via telephone; 5 members have been successfully referred to the program; 2 members have been successfully scheduled to receive their meals; and 2 members have already received their delivered meals. UnitedHealthcare anticipates member participation rates to increase over time as we continue to monitor the program in 2022.

Our assessment of the interventions we put in place to impact our population assessed to have access to preventive care, understanding of the importance of preventive health care, efforts to reduce the impact of the COVID-19 pandemic on limiting utilization of healthcare services, diabetes care, and hypertension care are summarized. Despite best efforts made to provide health education classes to our members for select topics, classes were poorly attended and have not been a useful mechanism to increase member education about healthy lifestyles or preventive care. UnitedHealthcare national clinical quality programs offered have proven to be less effective when compared to external vendors, such as SameSky, who provide a more wrap around service that includes live calling, mailing, and email. Additionally, the success of the program is largely due to live telephonic agents' fluency in San Diego County's threshold languages such as Spanish, Arabic, Farsi, Chinese, Vietnamese, and Tagalog. They are more representative of the members served and member feedback confirming their satisfaction with the call agents who are more representative of our membership. UnitedHealthcare noted that culturally appropriate outbound call campaigns were most effective in increasing preventive care visits. Additionally, the health plan's point-of-care gift card program proved to be more successful than UnitedHealthcare's Member Rewards program. Members receive their gift card upon completion of their visit versus having to wait over 90 days to receive a gift card. Further, UnitedHealthcare also implemented the Heal Pros and Let's Get Checked programs, offering a more engaging approach by offering in-person and/or at-home testing; however, the participation rates were notably low. Finally, distribution of blood pressure monitors was very popular among our provider network and our members; however, they did not result in an overall improved hypertension management. UnitedHealthcare continue to observe low CBP rates during the first year of implementing the program.

With multiple programs running at the same time, UnitedHealthcare observed limitations to program reporting and was unable to truly indicate which program was more effective than the other, and which program made a greater impact on our members' care gap closure rates. Thus, UnitedHealthcare relied heavily on tracking and trending program participation and member engagement rates for each program to evaluate the results of our changes and make the decision to adopt, adapt, or abandon a program. Further, any awareness and education proved to be helpful in the multi-channel messaging approach the health plan

implemented for our members that are due for care. UnitedHealthcare will continue to monitor our quality improvement programs and make any necessary changes throughout 2022 based on our members' needs.

G. Other

a) Discrimination, Cultural and Linguistics Grievances and Appeals

The Plan's Quality Department Clinical Quality Manager and Clinical Quality Analyst work closely and engage with the Appeals and Grievance teams to manage these grievances, monitor these closely and have a process in place to route and close all issues appropriately. Discrimination, cultural and linguistics grievances, and appeals are presented at the Health Education, Cultural and Linguistics Committee, and Quality Management Committee at least quarterly. The Plan monitors complaints and grievances related to language services and looks for trends on a quarterly basis. These are also included in routine quarterly reporting of total complaints and grievances to the DMHC. During calendar year 2021, there were zero (0) grievances identified in the category of *Cultural, Linguistic, or Discrimination*. UnitedHealthcare will continue to monitor discrimination, cultural and linguistics grievances and appeals and present a summary at the Health Education, Cultural and Linguistics Committee, and Quality Management Committee at least quarterly.

b) Disenrollment Survey

As part of UnitedHealthcare's member satisfaction and growth strategies, the Plan surveys members who have disenrolled with the Plan, and tracks and trends disenrollment reasons over time. Below are the top disenrollment reasons members opted to leave UnitedHealthcare and tracked for calendar year 2021:

Table 41. Disenrollment Survey 2021

2021 Disenrollment Reasons by Month														
Reason	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Grand Total**	**Rate**
Beneficiary Preference-HP Did Not Cover Bene Needs	1	39	59	70	40	36	46	42	50	30	23	26	462	**28.77%**
Could Not Choose Doctor I Wanted	0	32	25	35	40	26	31	35	38	27	26	23	338	**21.05%**
Did Not Choose This Plan	0	16	10	31	9	10	10	9	8	14	12	3	132	8.22%
Doctor Did Not Meet Beneficiary Needs	0	5	8	6	10	6	11	5	6	7	9	6	79	4.92%
Emergency Disenroll	12	9	12	7	12	10	10	17	10	11	11	4	125	7.78%
Indian Health Coverage	0	0	1	4	0	1	1	0	2	0	1	2	12	0.75%
Medical Exemption	0	1	0	0	0	0	1	2	1	0	0	2	7	0.44%
Medical/Dental Exemption	0	0	0	1	0	0	0	0	0	0	0	0	1	0.06%
Moving Out Of County	0	4	2	0	1	6	4	4	6	1	2	1	31	1.93%
No Reason Checked	0	28	29	20	24	17	25	12	25	18	18	19	235	**14.63%**

Other Reason	0	8	13	14	18	23	11	12	12	5	21	19	156	9.71%
System Generated	0	0	2	1	0	0	1	1	0	1	0	0	6	0.37%
Too Far To Go	0	4	3	1	1	0	5	2	3	1	1	1	22	1.37%
Grand Total	**13**	**146**	**164**	**190**	**155**	**135**	**156**	**141**	**161**	**115**	**124**	**106**	**1606**	**100.00 %**

Data Source: Disenrollment Data Report January 2021 to December 2021

The data indicates that the top three reasons for disenrolling with UnitedHealthcare are consistent with the reasons and data trend identified in 2020, including reasons for "Beneficiary Preference- HP Did Not Cover Beneficiary's Needs," 28.77% compared to 24.04% in 2020; "Could Not Choose Doctor I Wanted," 21.05% compared to 19.73% in 2020; and "No Reason Checked," 14.63% compared to 19.67% in 2020. Also noted, is that January 2021 counts are low; however, this is due to the date range of the report that is based on "effective date". Limitations to this data were identified including not capturing reasons for all type of reasons for disenrollment, only those identified by the DHCS with Maximus system for tracking, and that it only provides the count of responses and nothing further.

c) Language Line Interpreter Utilization

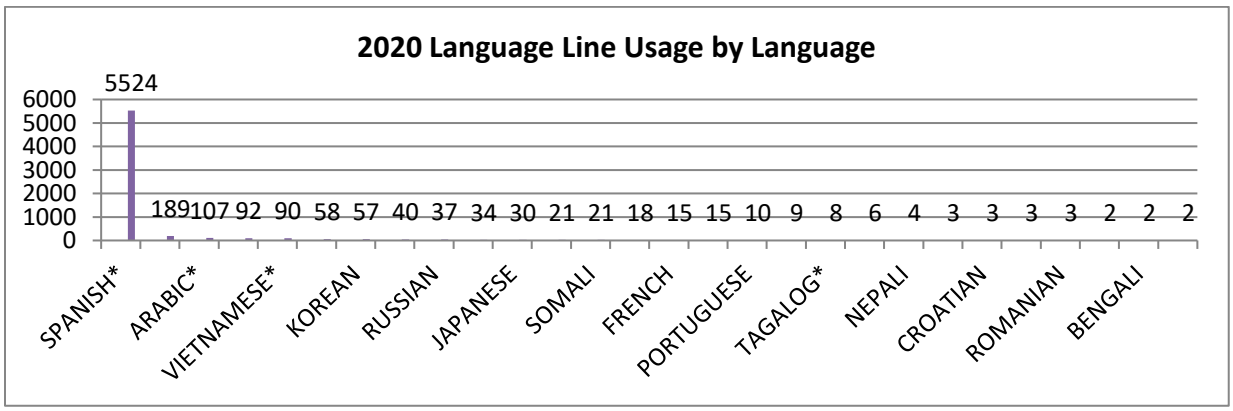
1. **Telephone Calls**

UnitedHealthcare contracts with the external vendor LanguageLine Solutions, who employs certified interpreters. Employees are assessed for language proficiency skills and are required to participate in an interpreter certification program to provide interpretation services. LanguageLine Solutions assess, track, and monitor employee proficiency testing and training. LanguageLine Solutions is the only provider who has a true certification program validated through external industry experts and who maintains a documented process for certifying medical interpreters through testing and training.

UnitedHealthcare monitors LanguageLine Solutions usage by language and presents the data to the Health Education and Cultural and Linguistics Committee on a quarterly basis. The tables below represent comparison data from 2020 (January 1, 2020 to December 31, 2020) and 2021 (January 1, 2021 to December 31, 2021).

In 2020, data indicates that the top three languages handled by LangaugeLine Solutions are predominantly for Spanish calls (n=5,524), followed by Arabic (n=189), and Cantonese (n=92).

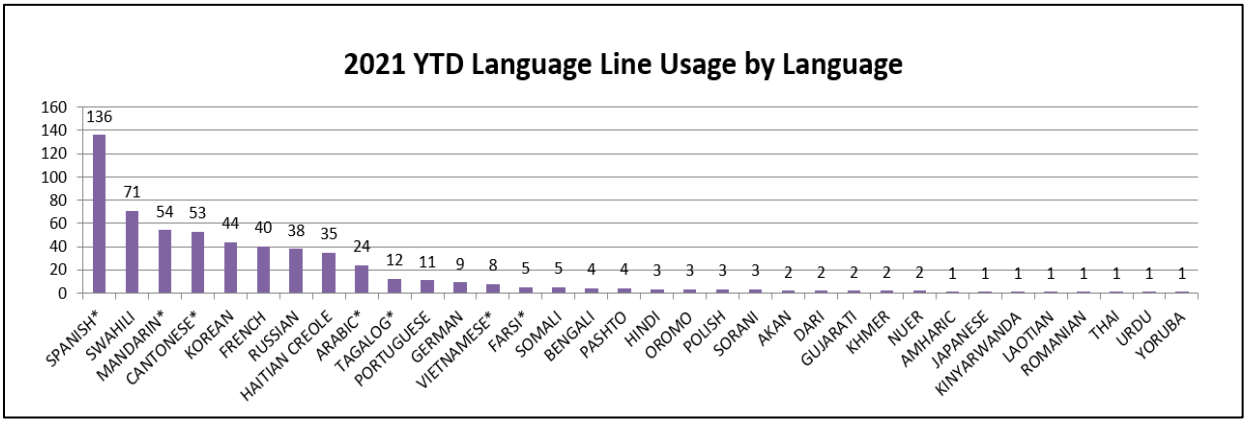
Figure 3. 2020 Language Line Usage by Language



Data Source: Language Line Usage Reports

By comparison, in 2021, data indicates that the top three languages handled by LanguageLine Solutions are predominantly for Spanish calls (n=136), followed by Swahili (n=71), and Mandarin (n=54).

Figure 4. 2021 Language Line Usage by Language



Data Source: Language Line Usage Reports

As was noted in the previous PNA RY 2021, data indicates unreliable sources of information as reported on LanguageLine reports. Trends were investigated and the causes have been unexplained to date. The Member Services team identified a gap entailing that the team involved in this data collection has been disbanded. They worked diligently to identify a new team to champion this data set moving forward. In 2021, UnitedHealthcare continued to monitor this data closely with the understanding that the unreliability of data means that comparison of year over year is not reasonable.

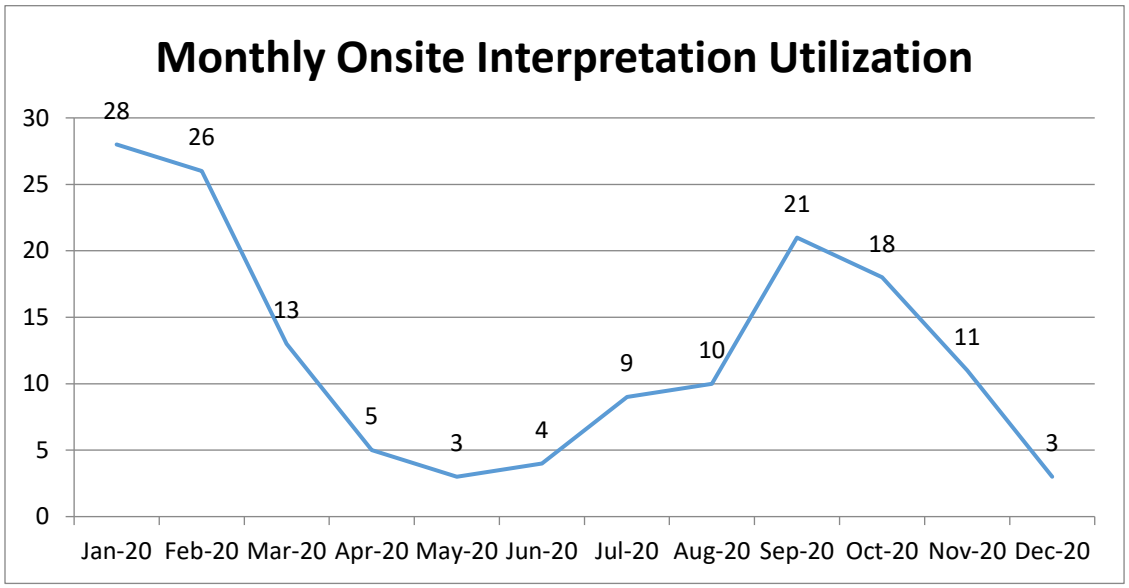
Through the Plan's quarterly reporting, the HECL committee noted higher call utilization for Language Line when compared to volume of calls handled by bilingual Member Services Advocates.

During Quarter 4 2021, a workgroup was held to explore other options for additional reporting to better understand if this observation is indicative of a missed opportunity. Member Services confirmed that bilingual agents take more English calls than Spanish calls due to agent availability in the queue, which is typical of other markets across the enterprise. Member Services also confirmed calls in other non-English languages are captured in the telephonic Language Line reports.

2. **Onsite Interpretation**

To improve access to care in the provider office, UnitedHealthcare offers onsite interpretation. The table below demonstrates the monthly onsite interpretation utilization from January 2020 to December 2020. Data indicates that utilization of onsite interpreters fluctuated over time. At its highest peak in January 2020, utilization was at 28 onsite interpreters provided for the month, and at its lowest utilization, 3 onsite interpreters were utilized during the month of December 2020.

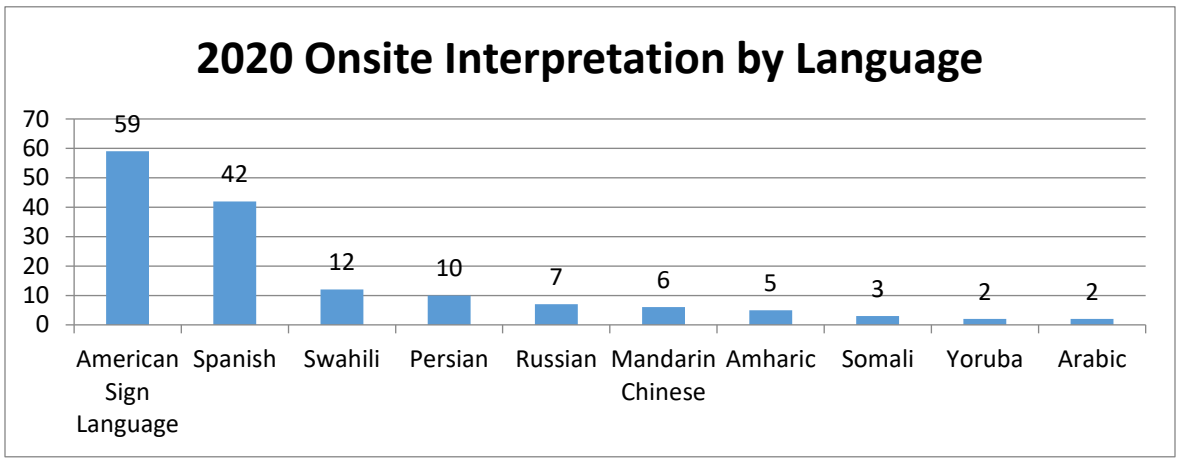
Figure 5. Monthly Onsite Interpretation Utilization



Data Source: Language Line Usage Reports

Data for all of 2020 indicates that the largest onsite interpreter languages requested were for American Sign Language(n=59), Spanish (n=42), and Swahili (n=12).

Figure 6. 2020 Onsite Interpretation by Language



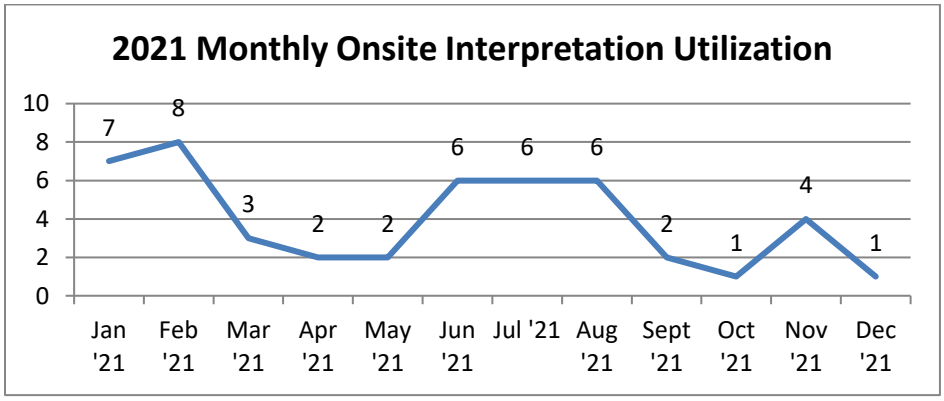
Data Source: Language Line Usage Reports

By comparison, utilization fluctuated during the 2021 calendar year. At its highest peak in 2021, utilization was eight (8) onsite interpreters, and at its lowest utilization, one (1) onsite interpreter was requested. The average for onsite interpreter services was 4 per month. Overall utilization decreased compared to 2020 where the average was 12.6 per month. The notable downward trend observed could still likely be due to the COVID-19 public emergency.

Data indicates that the largest onsite interpreter languages requested were American Sign Language (ASL) 58.3% (n=28), Spanish 25.0% (n=12), and Mandarin 8.3% (n=4). When comparing to 2020, the top two (2) languages are consistent. Another notable observation is that due to the decrease in utilization from the prior year there was a decrease in total number of languages requested, six (6) in 2021 versus 13 in 2020.

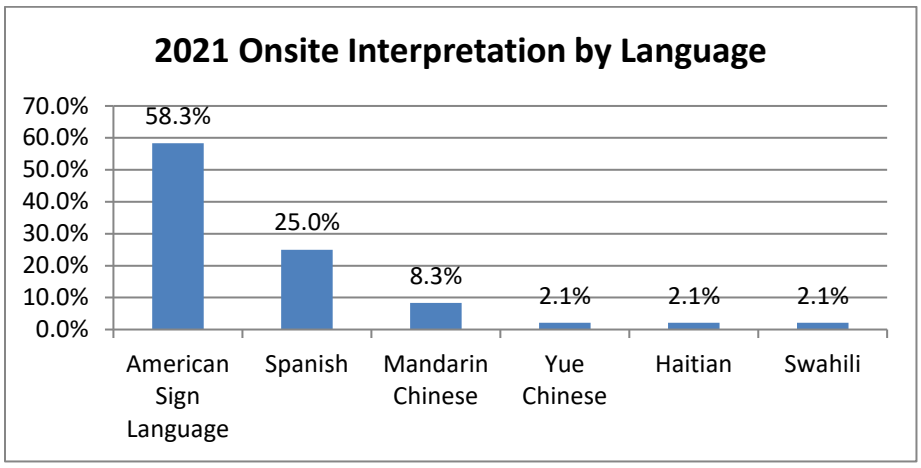
The figures below demonstrate the monthly onsite interpretation utilization for calendar year 2021.

Figure 7. 2021 Monthly Onsite Interpretation Utilization



Data Source: Language Line Usage Reports

Figure 8. 2021 Onsite Interpretation by Language



Data Source: Language Line Usage Reports

Furthermore, UnitedHealthcare did not have any member grievances or provider complaints reported related to onsite interpreter services. Although we did not have any complaints through the formal process, we did have concerns raised throughout the year. The first concern was related to a provider office reporting that an interpreter did not show up for the appointment as scheduled. This was investigated and the HECL team met with the vendor liaison for Language Line to discuss the current process and the mitigation consisted of creating a standard operating procedure to ensure the Plan receives details on how issues reported to the vendor are resolved on an individual basis, as well as the vendor enhancing their monthly reports with more details on resolution on a month-to-month basis. The second concern raised was from a provider office having difficulty scheduling onsite interpreters through our Provider Services phone line. The HECL team confirmed the process with the Provider Services team and identified a training issue which has since been resolved.

Currently it is unclear if these concerns raised had a direct impact on the decrease in utilization for 2021. However, UnitedHealthcare will continue to monitor utilization in 2022 and rectify any issues that may arise.

IV. Action Plan

1) Action Plan Table

UnitedHealthcare will focus on the following Action Plan as outlined below to improve health outcomes for Plan members. The Plan identified opportunities to address Key Findings as presented in this report. The proposed programs will be designed to impact health disparities among targeted eligible members. The 2022 PNA Action Plan table objectives and strategies remain unchanged from the 2021 PNA Action Plan table provided in the PNA RY2021 report, as data is currently limited.

UnitedHealthcare will continue to monitor the programs and make any improvements to the strategies throughout the year as needed.

2022 PNA Action Plan Table
HEDIS® Preventive Care Campaigns Addressing Health Disparities
Objective: UnitedHealthcare will deliver culturally appropriate member campaigns to reach a larger percent of the member population (whose preferred language is that other than English) increasing the total number of HEDIS® measures meeting the MPL for Measurement Year from 8 total measures in 2020 to 10 total measures in 2021 by June 1, 2022. **Data Source:** HEDIS® member level data and SameSky Utilization Reports
Strategies
1.) Develop a series of Member Engagement programs in partnership with SameSky to address awareness of preventive care services that may impede the member's ability to complete a PCP visit.
2.) Develop culturally and linguistically appropriate member outreach campaigns including member materials and telephone scripts translated into the County Threshold languages.
3.) Target eligible members (in their preferred language) with an open care gap and coordinate appointment scheduling.
Mom's Meals, a food insecurity project
Objective: Increase the PPC HEDIS® measure by 10%, from 79.86% [HEDIS® MY2020] to 89.86% by supporting food security for postpartum care for the maternal health population with the utilization of Mom's Meals by December 31, 2022. **Data Source:** HEDIS® member level data and Mom's Meals Utilization Reports
Strategies
1.) Offer Mom's Meals to eligible members with a delivery discharge in 2021-2022.
2.) Provide home delivered meals to high-need members who are most likely to suffer negative health outcomes due to poor nutrition or food insecurity including health education messaging to complete the post-partum visit.
3.) Provide health education to all members receiving services, reiterating the importance of the post-partum visit.
Integrate Population Health Management Focus (Hypertension)
Objective: Increase the CBP HEDIS® measure by 10%, from 55.96% [HEDIS® MY2020] to 65.96% by implementing a more integrated population health management approach to our members by December 31, 2022. **Data Source:** HEDIS® member level data and HEDIS® Prospective Reports
Strategies
1.) Create member engagement materials and health education self-management materials and tools.
2.) Connect members to available resources as needed by offering interpretation services, transportation to the member's appointment, and/or address any other social determinant of health need, such as meals or other priority needs.
3.) Conduct member and provider outreach to coordinate care based on condition and individual needs such as preventive care visits, medication verification, lab standing orders, and alternative visits such as telemedicine visits, home visits, and in-home lab test kits.

4.) Integrate Pharmacist review of clinical measures to assess medication history and opportunities to inform providers of medication history and pharmacy fill activities.

2) Action Plan Review and Update Table

The table below presents an update from the Action Plan as documented in the Population Needs Assessment RY2021.

2021 PNA Action Plan Review and Update Table	
HEDIS® Preventive Care Campaigns Addressing Health Disparities	
Objective. 1.) UnitedHealthcare will deliver culturally appropriate member campaigns to reach a larger percent of the member population (whose preferred language is that other than English) increasing the total number of HEDIS® measures meeting the MPL for Measurement Year from 8 total measures in 2020 to 10 total measures in 2021 by June 1, 2022. **Data source:** HEDIS® member level data	**Progress Measure:** ***UnitedHealthcare partnered with vendor, SameSky (formerly known as ConsejoSano), who performed cultural and linguistically appropriate member outreach in the form of e-mails, mailers, and live calls in 2020 and 2021. SameSky conducted outreach to 5,223 unique members in 2020, with an engagement rate of 37.79% indicating members were successfully contacted and/or the member opened e-mails. The reported engagement rate for 2020 was 27.44%. A reported 9.55% of members had numbers that were disconnected or noted as incorrect by someone else answering the calls. UnitedHealthcare was unable to conduct a thorough analysis of the program last PNA RY2021 as the HEDIS® run out report was not available until after Q2 2021 and was not included in last year's PNA Action Plan Review and Update Table. As a result, UnitedHealthcare conducted a thorough analysis of the HEDIS care gap closure rate and the effectiveness of the program in Q1 2022. Additionally, UnitedHealthcare increased the total number of HEDIS® measures meeting the MPL for measurement year from 8 total measures in 2020 to 10 total measures in 2021. However, in 2022, only 8 total measures were met. A slight decline was observed when compared to the previous measurement year.*** **Data source:** HEDIS® member level data and SameSky Utilization Reports
	Progress Toward Objective: In 2020, UnitedHealthcare partnered with SameSky to deliver a *HEDIS® Preventive Care Campaigns Addressing Health Disparities* program. SameSky is a vendor offering culturally and linguistically appropriate health education messaging to health plan members. SameSky would deliver member engagement campaigns for a series of select HEDIS® measures that did not meet the MPL in RY 2019 such as CCS, CDC, CBP, and Well-Child Visits. However, due to the COVID-

	19 pandemic and competitive priorities, the program successfully launched in Q4 2020. Due to the delayed launch and limited data, UnitedHealthcare was unable to determine the effectiveness of the program. Thus, UnitedHealthcare continued to partner with SameSky in 2021. An in-depth analysis of the effectiveness of the program was conducted in Q1 2022. The results of the analysis will be noted in the Strategies section as these results were not available at the time the PNA RY2021 was due. UnitedHealthcare plans to continue to partner with SameSky in 2022.
Strategies	
Strategy 1.) Develop a series of Member Engagement programs in partnership with SameSky to address awareness of preventive care services that may impede the member's ability to complete a PCP visit.	**Progress Discussion:** In 2021, UnitedHealthcare developed a series of member engagement programs in partnership with SameSky to address awareness of preventive care services that may impede the member's ability to complete a PCP visit. These member engagement programs include Preventive Call Campaigns, a Call Campaign for members who have not yet established their care with the Plan, HEDIS® Call Campaigns focused on well-child care, women's health, and chronic disease measures. UnitedHealthcare would meet with SameSky to ensure implementation of planned activities and continuous monitoring.
Strategy 2.) Develop culturally and linguistically appropriate member outreach campaigns including member materials and telephone scripts translated into the County Threshold languages.	**Progress Discussion:** In partnership with SameSky, member materials and telephone scripts were developed for each member outreach campaigns in the County threshold languages including English, Spanish, Arabic, Farsi, Chinese, Vietnamese and Tagalog. UnitedHealthcare and SameSky developed new materials for the not yet established care campaign and new measures added to the repository of HEDIS® measures. These materials were submitted to the state for formal review and approval before the campaign launch.
Strategy 3.) Target eligible members (in their preferred language) with an open care gap and coordinate appointment scheduling.	**Progress Discussion:** UnitedHealthcare provided SameSky with a targeted list for eligible members with an open care gap for the select HEDIS® measures. SameSky performed member outreach in the form of e-mails, mailers, and live calls in 2020 and 2021. In 2020, SameSky conducted outreach to 5,223 unique members, with an engagement rate of 37.79% indicating members were successfully contacted and/or the member opened e-mails. Engagement was defined as the number of unique members who made an appointment while on the call, or they had already

scheduled an appointment. The reported engagement rate for 2020 was 27.44%. A reported 9.55% of members had numbers that were disconnected or noted as incorrect by someone else answering the calls.

The following table, Table 4. Increase in Gap Closure Rates, displays the changes in care gap closure at implementation, October 2020, and conclusion December, 2020 of the campaigns.

Increase in Gap Closure Rates

		Oct 2020	Nov 2020	Dec 2020	+/-
PEDIATRIC WELLNESS	Well Child 0-15mo (W15)	1.74% (4/230)	1.76% (6/340)	NA (0/0)	+0.02%
	Well Child 3-6 years (W34)	16.96% (321/1,362)	16.48% (313/1,899)	NA (0/0)	-0.48%
	Under 2 Immunizations (CIS-10)	29.90% (157/525)	29.40% (234/796)	NA (0/0)	-0.50%
Adolescent Well Care	Adolescent Well Care 12-21 (AWC)	10.70% (278/2,597)	10.69% (417/3,901)	NA (0/0)	-0.01%
	Adolescent Immunizations – Combo 2 (IMA-2)	3.85% (6/156)	4.00% (9/225)	NA (0/0)	+0.15%
WELL WOMAN	Breast Cancer Screening (BCS)	11.11% (24/216)	11.44% (46/402)	NA (0/0)	+0.33%
	Cervical Cancer Screening (CCS)	12.86% (533/4,148)	13.02% (741/5,692)	NA (0/0)	+0.16%
	Chlamydia Screening (CHL)	23.59% (71/301)	24.57% (115/468)	NA (0/0)	+0.98%
DIABETES	Comprehensive Diabetes Care – HbA1c Testing (CDC-HT)	40.43% (114/282)	40.13% (128/319)	NA (0/0)	-0.30%
	Comprehensive Diabetes Care – HbA1c Poor Control >9.0% (CDC-H9)	22.12% (119/538)	21.95% (135/615)	NA (0/0)	-0.17%
MATERNAL HEALTH	Postpartum Care (PPCP)	14.63% (24/164)	14.85% (20/202)	15.30% (41/268)	+0.67%
	Prenatal Visits (PPCT)	21.28% (10/47)	22.22% (12/54)	22.86% (16/70)	+1.58%
ANNUAL WELL	Controlling High Blood Pressure (CBP)	5.63% (44/817)	6.06% (60/990)	NA (0/0)	+0.43%

Unitedhealthcare noted SameSky not only assisted with closing care gaps for the specified HEDIS® measures, but they also exceeded the original goal of closing care gaps for 10% of eligible members for most measures, as demonstrated in Table 4.

UnitedHealthcare also analyzed program effectiveness and care gap closure by campaign modality including outgoing calls made to members (n=8,906), emails sent (n=1,348), and mail sent (n=5,226) to 5,223 unique members with 5,795 total open care gaps. Outgoing calls, emails and mail indicate that SameSky successfully contacted over 10% of all members outreached to, resulting in an overall 13.98% success rate.

Overall, outcome rates were higher than those reported by comparable vendors in which the Plan collaborates to offer similar programs. This influenced the decision to continue the Plan's partnership with SameSky for 2021.

In 2021, UnitedHealthcare focused on closing care gaps for 10 total HEDIS® measures. SameSky performed member outreach in the form of e-mails, mailers, and live calls and

	strategically scheduled throughout May to December 2021. As a result, SameSky conducted outreach to 9,962 unique members with an engagement rate of 31.70% indicating members were successfully contacted and/or the member opened e-mails. Engagement was defined as the number of unique members who made an appointment while on the call, or the member had already scheduled an appointment. The reported engagement rate for 2021 was 32.33%. The call reach rate was 22.31%, a reported 8.09% of members had numbers that were disconnected or noted as incorrect by someone else answering the calls. The data indicates a +4.89% increase in the reported engagement rate when compared to 2020 data. This can be attributed to the increase in number of members outreached to and the longer lengths of campaigns. In addition to the HEDIS® specific targeted campaigns, UnitedHealthcare engaged SameSky to also conduct established care calls in June 2021. This call campaign would indirectly make an impact to access to care and increase initial health assessments. UnitedHealthcare identified a total of 854 members to be outreached to. A total of 609 total calls were made, 12 members self-reported they had already completed an appointment with their assigned Primary Care Provider, and 10 members stated they had already made an appointment. Indicating a 2.58% success rate. Of the 609 total calls made, 134 calls were successfully connected, resulting in a 15.69% engagement rate. Only 20 telephone numbers were wrong phone numbers, and 7 members declined to participate and stay on the call. The engagement success rate was 16.42%. UnitedHealthcare analyzed overall care gap closure rate for MY2021(RY2022) and identified the following measures were met or did not meet the state MPL including: BCS (44.56%, not met); CBP (55.23%, not met); CCS(46.47%, not met); CDC-H9 (39.66%, met); CHL (67.42%, met); CIS-10 (38.93%, met); IMA (25.57% not met); W30 - Well-Child Visits in the First 15 Months (24.20%, not met); W30 - Well-Child Visits for age 15 Months to 30 months (50.62%, not met); and WCV (39.42%, not met). UnitedHealthcare plans to continue to partner with SameSky in 2022.
Mom's Meals, a food insecurity project	
Objective 1.) Increase the PPC HEDIS® measure by 10%, from 79.86% [HEDIS® MY2020] to 89.86% by supporting food	**Progress Measure:** ***The Mom's Meals food insecurity project was originally planned for implementation in 2020; however, this was deferred to be implemented in 2021 due to the COVID-19 public health emergency and shifted priorities due***

security for postpartum care for the maternal health population with the utilization of Mom's Meals by December 31, 2022. **Data Source:** HEDIS® member level data and Mom's Meals Utilization Reports	***to member needs. UnitedHealthcare continued to plan the program launch in 2021. The project officially launched on January 7, 2022. Thus, due to the delayed project implementation, limited data is available to determine correlation between an increase PPC HEDIS® care gap closure rate and the effectiveness of Mom's Meals.*** **Data source:** HEDIS® member level data and Mom's Meals Utilization Reports
	Progress Toward Objective: UnitedHealthcare successfully planned and implemented the Mom's Meals food insecurity project in 2022. The project officially launched on January 7, 2022, with a member mailing included in the monthly Healthy First Steps packet to eligible members, followed by outreach calls begun on February 1, 2022. The project launch delay was due to internal vendor contracting challenges encountered by the Quality Department.
Strategies	
Strategy 1.) Offer Mom's Meals to eligible members with a delivery discharge in 2021-2022.	**Progress Discussion:** UnitedHealthcare mailed a letter inviting eligible members to participate in the Mom's Meals food insecurity project. A total of 171 eligible members were identified, and an additional 15 members were identified from an ad-hoc hospital discharge report. These members received a letter of invitation on January 7, 2022, followed by an outreach telephone call to 144 eligible members with a correct telephone number on file on February 1, 2022. UnitedHealthcare continues to offer the Mom's Meals food insecurity project monthly via mail and telephone call outreach attempts.
Strategy 2.) Provide home delivered meals to high-need members who are most likely to suffer negative health outcomes due to poor nutrition or food insecurity including health education messaging to complete the post-partum visit.	**Progress Discussion:** Since the program launch, a total of 5 members have been successfully referred into the program, 2 members have been successfully scheduled to receive their meals, and 2 members have successfully received their home-delivered meals. UnitedHealthcare anticipates member participation rates to increase over time as we continue to invite eligible members to participate into the program and monitor utilization rates throughout 2022.

Strategy 3.) Provide health education to all members receiving services, reiterating the importance of the post-partum visit.	**Progress Discussion:** In partnership with Mom's Meals, UnitedHealthcare developed a letter of invitation introducing Mom's Meals to eligible members. The letter is included in our larger Healthy First Steps mailing packet to eligible members. The letter includes health education messaging to complete a post-partum visit. In addition to the letter, a telephone call script was developed to outreach to our members following the mailing. The telephone call script includes health education messaging reiterating the importance of the post-partum visit. The Quality Department Associate Business Analyst has an opportunity to invite the member into the program and highlight the importance of seeing their primary care provider for follow-up care after delivery.
Integrate Population Health Management Focus (Hypertension)	
Objective 1.) Increase the CBP HEDIS® measure by 10%, from 55.96% [HEDIS® MY2020] to 65.96% by implementing a more integrated population health management approach to our members by December 31, 2022. **Data Source:** HEDIS® member level data and HEDIS® prospective reports	**Progress Measure:** ***Limited data is available to infer a correlation between an increase in HEDIS® care gap closure rate and an integrated population health management approach to our members diagnosed with hypertension.*** **Data source:** HEDIS® member level data and HEDIS® prospective reports
	Progress Toward Objective: In 2020, UnitedHealthcare identified low utilization rates for routine medical visits due to COVID-19. As a result, the Plan identified opportunities to better support members diagnosed with Hypertension. Some of the barriers identified included members reporting challenges to completing medical visits due to fear of contracting COVID-19; Providers unable to assess blood pressure values in a telehealth visit; and telehealth visits served as an innovative solution to combat access challenges in 2020-2021 but presented unique challenges to patient care as key components of the visit were missing. In response, UnitedHealthcare developed a program to assist members in monitoring blood pressure from a remote setting. The goals of the blood pressure monitor mailing included supporting telehealth visits, promoting self-management, increasing controlled blood pressure HEDIS® rates for the measure CBP, and improving overall member health outcomes. The blood pressure monitor mailing was implemented on January 5, 2021.
Strategies	

1.) Create member engagement materials and health education self-management materials and tools.	**Progress Discussion:** The Plan worked with UnitedHealthcare's National Marketing Department to request and develop new materials in English and Spanish (the Plan's two top languages among members with a hypertension diagnosis) catered for the intent of this project. 1. Cover Letter: A letter was created to explain the reason the member was receiving the monitor and description of the contents of the package. Additionally, the letter also included a direct phone line and email address for members to contact for general questions with the option to request a larger sized cuff if necessary, and a reminder to keep their appointments with their doctor and share their reading results. 2. Blood Pressure Log and Flyer: A flyer was created with helpful tips for members on how to check and manage their blood pressure at home (American Heart Association and Heart) including a chart with key readings to look for, when to call the doctor, and a sample log as a manual option to keep track of blood pressure readings if preferred.
2.) Connect members to available resources as needed by offering interpretation services, transportation to the member's appointment, and/or address any other social determinant of health need, such as meals or other priority needs.	**Progress Discussion:** UnitedHealthcare ensured the cover letter introducing the blood pressure monitor project and included a direct phone line and email address for members to contact for general questions about the project. The direct phone line and email address would connect to the Quality Department Associate Business Analyst assigned to the project. Members had the opportunity to connect with the Associate Business Analyst for interpretation or translation services, transportation to the member's appointment, and/or address any other social determinant of health need, such as meals or other priority needs.
3.) Conduct member and provider outreach to coordinate care based on condition and individual needs such as preventive care visits, medication verification, lab standing orders, and alternative visits such as telemedicine visits, home visits, and in-home lab test kits.	**Progress Discussion:** UnitedHealthcare was unable to integrate member and provider outreach to coordinate care based on condition and individual needs such as preventive care visits, medication verification, lab standing orders, and alternative visits such as telemedicine visits, home visits, and in-home lab test kits due to staffing resources and limitations.

4.) Integrate Pharmacist review of clinical measures to assess medication history and opportunities to inform providers of medication history and pharmacy fill activities.	**Progress Discussion:** UnitedHealthcare was unable to integrate Pharmacist review of clinical measures to assess medication history and opportunities to inform providers of pharmacy fill activities due to report limitations and the lack of Pharmacist resources to conduct the clinical review for this ad-hoc project.

V. Stakeholder Engagement

The Plan utilizes Stakeholder Engagement to impact the PNA. Groups such as the Community Advisory Committee, Provider Advisory Committee, and Public Policy Committee are engaged and provide valuable feedback from a member and provider perspective.

1) Community Advisory Committee (CAC)

UnitedHealthcare provides the Community Advisory Committee (CAC) with an opportunity to provide input on various health plan activities that may impact the PNA. UnitedHealthcare provides findings of the PNA, solicits input from the CAC, discusses opportunities for improvement for health plan activities and provides updates to the CAC with progress made towards PNA goals.

In 2021, UnitedHealthcare CAC meetings were engaged to provide feedback on some of the health plan activities that would impact results to the PNA. UnitedHealthcare's Director, Marketing and Community Outreach held a total of three (3) CAC meetings hosted in English and Spanish. These meetings were held on October 6, 2021, in-person in English and Spanish, and December 10, 2021 in English via Microsoft Teams, a web-based meeting platform.

At each CAC meeting, the Clinical Quality Manager had the opportunity to provide an update on current health education and cultural and linguistics programs. In October 2021, The Clinical Quality Manager provided updates on the California Smokers' Helpline, or 1-800-No-Butts rebranding to Kick It California and provided new contact information. Additionally, the Clinical Quality Manager provided an overview of the virtual health education classes in partnership with Champions for Health and took the opportunity to garner feedback from CAC members and asked what other topics they would like to learn about in calendar year 2022, how the health plan can better encourage members to attend the classes, and how we can do better the following year. Members stated that they would like to have a class offered on Medi-Cal benefits, understand the referral and authorization process, and how to navigate Medi-Cal as a larger topic. They also mentioned that they would likely participate if the classes were in-person versus virtual and suggested to mail health education flyers regularly to encourage members to participate in the classes.

At the December 2021 CAC meeting, the Quality Department Clinical Quality Analyst educated members on the annual CAHPS® survey that UnitedHealthcare conducts and encouraged CAC members to respond to the survey if selected. Clinical Quality Manager had the opportunity to present the annual PNA findings to CAC members. An overview of the findings and results were provided, including the Action Plan for 2021 to 2022 activities to identify opportunities and/or programs to impact health disparities among targeted eligible members. Findings shared included the active outreach to members to close their care gap through our partnership with ConsejoSano, now known as SameSky; an infant formula delivery initiative to

our pediatric members during the pandemic; and the population health approach to identify childbirth disparities among African American women. The Clinical Quality Manager allowed the opportunity for questions, feedback, or suggestions regarding the PNA results. The CAC members did not have any feedback.

2) Provider Advisory Committee (PAC)

UnitedHealthcare ensures contracted health care providers, practitioners, and allied health care personnel receive pertinent information regarding the PNA findings and member needs through the PAC and HEDIS® monthly meetings held with all FQHC's contracted with the Plan.

In 2021, UnitedHealthcare conducted four (4) PAC meetings held on the following dates: February 17, 2021, May 19, 2021, August 11, 2021, and November 10, 2021. UnitedHealthcare's Clinical Quality Manager had the opportunity to present on all health education and cultural and linguistic programs updates that are pertinent to PNA findings and member needs. Some of the regular agenda items discussed throughout the year include cultural, linguistics, health education programs such as Diabetes Prevention Program, and member engagement program updates. Below are some of the meeting discussion and feedback received from the PAC meetings.

During the Quarter 1, 2021 meeting (February 17, 2021), the Clinical Quality Manager provided a summary of the Diabetes Prevention Program participation updates and additional metrics among participants. Additionally, the Clinical Quality Manager provided a summary of our partnership with SameSky and targeted culturally diverse member-facing campaigns that provide personalized engagement, navigation, and education services to members on a scheduled basis. The Clinical Quality Manager included an update on the email, mail and telephone call campaigns launched to date and allowed the opportunity for open discussion and questions or concerns about the programs offered.

During the Quarter 2, 2021 meeting (May 19, 2021), the Director of Clinical Quality and Health Equity provided a summary of the new DHCS All Plan Letter 21-004 Standards for Determining Threshold Languages, 1557 Non-Discrimination Requirements, and Language Assistance Services newly released at on April 8, 2021, highlighted the addition of two threshold languages in San Diego County and the new non-discrimination notice that would be updated to all member informing letters. Additionally, the Director of Clinical Quality and Health Equity presented the new program UnitedHealthcare would launch, the Mom's Meals Program, targeting postpartum members who have just delivered a member. An overview of the program was provided along with the progress toward the launch date. A summary of regular agenda items including the Diabetes Prevention Program updates and all member engagement programs were provided to the committee.

During the Quarter 3, 2021 meeting (August 11, 2021), the Clinical Quality Manager presented an overview of the PNA RY2021 findings and results, including the Action Plan for 2021 to 2022 activities to identify opportunities and/or programs to impact health disparities among targeted eligible members. Findings shared included the active outreach to members to close their care gap through our partnership with ConsejoSano, now known as SameSky; an infant formula delivery initiative to our pediatric members during the pandemic; and the population health approach to identify childbirth disparities among African American women. The Clinical Quality Manager allowed the opportunity for questions, feedback, or suggestions regarding the PNA results. The PAC members did not have any feedback. Additionally, a

summary of regular agenda items including the Diabetes Prevention Program updates and all member engagement programs were provided to the committee.

During the Quarter 4, 2021 meeting (November 10, 2021), the Clinical Quality Manager provided the committee with regular standing agenda items discussed throughout the year such as the Diabetes Prevention Program and member engagement programs updates. Additionally, the Clinical Quality Manager prepared a brief survey to ask providers for their feedback on the use of video interpreter services for their patients, if they found the video interpreter services valuable for their patients, if they had a preference in how to access video interpreter services and how we can improve to better provide interpreter services via telephone, onsite, or virtual modalities. The committee meeting ran over the allotted times, and the Clinical Quality Manager was unable to gather feedback during the meeting. The Clinical Quality Manager followed up with the discussion, developed a brief survey via Qualtrics, and distributed the link to PAC committee members and additional Provider Network contacts via email after the meeting to allow for more responses. However, no survey responses were received. The Clinical Quality Manager will bring the agenda item back to the PAC committee in Quarter 1 2022.

3) Public Policy Committee

UnitedHealthcare conducts a standing Public Policy Committee (PPC). The committee meets at least quarterly throughout the year. Members and UnitedHealthcare contract network providers can attend the PPC meetings to learn about the plan, county and DHCS state policy updates. PPC meeting attendees can provide input, feedback regarding the PNA activities, findings, and any member needs. There were four (4) PPC meetings held on March 11, 2021, June 10, 2021, September 9, 2021, and December 9, 2021. During all PPC meetings, the Clinical Quality Manager can provide health education and cultural and linguistics updates regarding the Diabetes Prevention Program, health education resource library, interpreter, and translation services, and DHCS all plan policy letters (APLs). Below are some of the meeting discussion items and updates received from the PPC meetings.

During the Quarter 1, 2021 meeting (March 11, 2021), the Clinical Quality Manager presented on the blood pressure monitor program that was launched by the health plan Quality Department to support telehealth visits, self-management and increase controlled blood pressure to improve overall member health outcomes. The Clinical Quality Manager provided an overview of the mailing packet which included instructions for when to check blood pressure, how to interpret results, health education insert, log to track blood pressure readings, and a postcard with a link to the product manual available in English and Spanish. The blood pressure monitor functionality and cover letter were also discussed. Additional topics covered by the Clinical Quality Manger included a telephone call campaign for members who have not established care in partnership with SameSky (previously known as ConsejoSano), in addition to planned HEDIS® member engagement campaigns. Sample letters were presented to PPC committee members. These member engagement programs were highlighted to the PPC committee as part of the PNA action plan progress.

During the Quarter 2, 2021 meeting (June 10, 2021), the Director of Clinical Quality and Health Equity provided a summary of the new DHCS All Plan Letter 21-004 Standards for Determining Threshold Languages, 1557 Non-Discrimination Requirements, and Language Assistance Services newly released at on April 8, 2021, highlighted the addition of two threshold languages in San Diego County and the new non-discrimination notice that would be updated to all member informing letters. The Director of Clinical Quality

and Health Equity also provided a summary on the state required Pediatric Call Campaign. The state required the managed care plans to contact all members ages 7-21 who haven't had a well child visit within the last six months. The eligible members would receive reminder phone calls and letters would be sent to those members aging out on how to select an adult care provider. A PPC committee member provided feedback on the calls she has received concerning reminders for her daughter's visits stating the calls are a bit aggressive. She suggested that the tone should be more helpful and include acknowledgment on the COVID pandemic impact on in-person doctor visits. UnitedHealthcare, took this feedback into consideration for all active live call campaigns to our members. Another topic covered during the PPC meeting included the 2021 Health and Wellness Member Calendar. The Quality Department Clinical Quality Analyst provided an overview of the calendar and its topics. The calendar includes health reminders, covered benefit information, health plan customer service information, and stickers. An evaluation of the calendar was conducted, and results were shared to PPC committee members. The evaluation would include members who received the calendar and provided feedback on how to improve the product going forward. Overall evaluation results indicated that health plan members found the member calendar helpful for health reminders and recommended that the calendars continue to be sent to each year. They would also like to see more variety of stickers. The calendars need to be delivered to members before the start of the calendar year. This feedback would be taken into consideration for the 2022 Health and Wellness Member Calendar.

During the Quarter 3, 2021 meeting (September 9, 2021) the Director of Clinical Quality and Health Equity provided a summary on a new DHCS All Plan Letter (APL)- Medi-Cal COVID-19 Vaccination Incentive Program released in August. The Director of Clinical Quality and Health Equity provided an overview of UnitedHealthcare's state approved Vaccine Response Plan in response to the APL. The twenty-one-element strategy included a multi-tiered member, provider, tribal partner, and community-based organization (CBO) partnership focused on outreach. The plan would include evidence based and culturally appropriate information disseminated to help build trust in the vaccine; member incentives offered, coordination of vaccine appointments, transportation to vaccine appointments; television and radio campaigns offered in Spanish; a mobile vaccine unit funded; vaccine clinics funded for multiple Walgreen's locations; monetary donations to several FQHC's designated as official vaccine distribution centers; direct outreach to members concerning vaccine hesitancy; and identifying unvaccinated members offering direct outreach and education. The 2022 Health and Wellness Member Calendar was also presented and discussed. The Quality Department Clinical Quality Analyst provided a summary of the upcoming interactive calendar that would include resources, tips, stickers, and a cover letter. It's availability in English and Spanish. The calendar will reinforce key health behaviors and promote healthy living by providing education topics, influencing individual positive health behavior, and impower members with tools for self-management of health status. The calendar would also include feedback gathered from a member focus group including feedback was gathered on the calendar monthly topics, graphic design, sticker sheet, new interactive ideas, and the 2022 calendar name. Finally, the Clinical Quality Manager provided an update on UnitedHealthcare's health education programs including the rebranding of the California Smokers' Helpline to Kick It California, provide the phone numbers and website launch date. The Clinical Quality Manager would also provide an update on the upcoming health education classes. Including class schedule highlighting the additional topics such as meditation and mindfulness, provided as feedback by the committee.

During the Quarter 4, 2021 meeting (December 9, 2021) UnitedHealthcare invited the DHCS Chief Quality Officer to the PPC to provide a summary and overview of the state's Quality and Health Equity Strategy to PPC committee members. The presentation focused on the state's goals, guiding principles on eliminating health disparities in the three main areas identified to have gaps in care, and the future state of population health management. Furthermore, executive leadership provide an update on key areas of focus for the health plan including the COVID-19 Pandemic response, CalAim implementation, community partnerships and solutions, and the upcoming request for proposal (RFP) re-bid for Commercial Plans in

San Diego County. Clinical leadership provided updates on the following topics including behavioral health access to service barriers, international claims, and San Diego County COVID-19 and vaccine updates.

VI. PNA Reporting and Oversight

Results and key findings of the PNA will be presented to the UnitedHealthcare Quality Management Committee and Health Education and Cultural and Linguistics Committee in Quarter 3, 2022. The Clinical Quality Manager will manage the 2022-2023 PNA Action Plan, updating outcomes as they become available. A summary of the PNA will be presented to the Provider Advisory Committee, Community Advisory Committee, and Public Policy Committee. Members and providers will have an opportunity to provide feedback to enhance the delivery of population health management programs. UnitedHealthcare will incorporate feedback into the RY 2023 PNA as applicable.

VII. References

1. County of San Diego, Health and Human Services Agency, Live Well San Diego, Community Health Assessment Fiscal Year 2019-2021. Retrieved from Community Health Assessments (sandiegocounty.gov)
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3. Live Well San Diego, South Region Community Health Assessment (2014). Retrieved from CHA_Final-10-22-14_South-Region.pdf (livewellsd.org)
4. National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases: Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity (2022). Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html
5. United States Census Bureau (2022). Quick Facts: Chula Vista city, California. Retrieved from U.S. Census Bureau QuickFacts: Chula Vista city, California

VIII. Appendix

California Department of Health Care Services

Medi-Cal Managed Care Accountability Set (MCAS)

Updated May 12, 2021

MCAS for Medi-Cal Managed Care Health Plans (MCPs)

Measurement Year 2020 | Reporting Year 2021

Based on Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Sets for Reporting Year 2020

Total Number of Measures = 33 (10 Hybrid. and 23 Administrative)

MPL means Minimum Performance Level

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL**
1	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	Yes
2	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	Yes
3	Asthma Medication Ratio [ii]	AMR	Administrative	Yes [iii]
4	Breast Cancer Screening	BCS	Administrative	Yes
5	Cervical Cancer Screening	CCS	Hybrid/Admin*	Yes
6	Child and Adolescent Well-Care Visits	WCV	Administrative	Yes [iv]
7	Childhood Immunization Status: Combination 10	CIS-10	Hybrid/Admin*	Yes
8	Chlamydia Screening in Women [ii]	CHL	Administrative	Yes [iii]

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#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL**
9	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CDC-H9	Hybrid/Admin*	Yes
10	Controlling High Blood Pressure	CBP	Hybrid/Adm	Yes [iv]
11	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	Yes
12	Immunizations for Adolescents: Combination 2	IMA-2	Hybrid/Admin*	Yes
13	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	Yes
14	Prenatal and Postpartum Care: Postpartum Care	PPC-Pst	Hybrid/Admin*	Yes
15	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-Pre	Hybrid/Admin*	Yes
16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	WCC-BMI	Hybrid/Admin*	Yes
17	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	WCC-N	Hybrid/Admin*	Yes
18	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	WCC-PA	Hybrid/Admin*	Yes
19	Well-Child Visits in the First 30 Months of Life	W30	Administrative	Yes [iv]
20	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED [i]	Administrative	No
21	Concurrent Use of Opioids and Benzodiazepines	COB	Administrative	No

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#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL**
22	Contraceptive Care—All Women: Long Acting Reversible Contraception (LARC) [ii]	CCW-LARC	Administrative	No
23	Contraceptive Care—All Women: Most or Moderately Effective Contraception [ii]	CCW-MMEC	Administrative	No
24	Contraceptive Care—Postpartum Women: LARC—3 Days [ii]	CCP-LARC3	Administrative	No
25	Contraceptive Care—Postpartum Women: LARC—60 Days [ii]	CCP-LARC60	Administrative	No
26	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days [ii]	CCP-MMEC3	Administrative	No
27	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days [ii]	CCP-MMEC60	Administrative	No
28	Developmental Screening in the First Three Years of Life	DEV	Administrative	No
29	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
30	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
31	Plan All-Cause Readmissions	PCR [i]	Administrative	No
32	Screening for Depression and Follow-Up Plan [ii]	CDF	Administrative	No
33	Use of Opioids at High Dosage in Persons Without Cancer	OHD	Administrative	No