Volume 1 of 3

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2019–June 30, 2020

Main Report

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

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Commonly Used Abbreviations and Acronyms

- **A&I**—Audits & Investigations Division
- **AIDS**—acquired immunodeficiency syndrome
- **APL**—All Plan Letter
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems[1]
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CAP**—corrective action plan
- **CA WIC**—California Welfare and Institutions Code
- **CCC**—Children with Chronic Conditions
- **CCI**—Coordinated Care Initiative
- **CDPH**—California Department of Public Health
- **CFR**—Code of Federal Regulations
- **CHIP**—Children's Health Insurance Program
- **CMB**—California Medical Board
- **CMS**—Centers for Medicare & Medicaid Services
- **COHS**—County Organized Health System
- **COVID-19**—coronavirus disease 2019
- **DHCS**—California Department of Health Care Services
- **DMC plan**—dental managed care plan
- **EAS**—External Accountability Set
- **EDV**—Encounter Data Validation
- **EHR**—electronic health record
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FCC**—Family-Centered Care
- **FFS**—fee-for-service
- **FMEA**—failure modes and effects analysis
- **GMC**—Geographic Managed Care
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[2]
- **HIV**—human immunodeficiency virus
- **HMO**—health maintenance organization
- **HPV**—human papillomavirus
- **HSAG**—Health Services Advisory Group, Inc.

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

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

- **ID/DD**—Intellectual Disability or Developmental Disability
- **IP**—improvement plan
- **IS**—information systems
- **ISCAT**—Information Systems Capabilities Assessment Tool
- **LTC**—long-term care
- **LTCH**—long-term care hospital
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCO**—managed care organization
- **MCP**—managed care health plan
- **MDS**—Minimum Data Set
- **MEDS**—Medi-Cal Eligibility Data System
- **MLTSS**—Managed Long-Term Services and Supports
- **MLTSSP**—Managed Long-Term Services and Supports Plan
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **OB/GYN**—obstetrics/gynecology
- **PAHP**—prepaid ambulatory health plan
- **PCCM**—primary care case management
- **PCP**—primary care provider
- **PDSA**—Plan-Do-Study-Act
- **PHP**—prepaid health plan
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project
- **PMV**—performance measure validation
- **PNA**—population needs assessment
- **PSP**—population-specific health plan
- **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- **QIP**—quality improvement project
- **SHP**—specialty health plan
- **SMART**—Specific, Measurable, Achievable, Relevant, and Time-bound
- **SNF/ICF**—Skilled Nursing Facility/Intermediate Care Facility
- **SPD**—Seniors and Persons with Disabilities
- **TPM**—Two-Plan Model

1. Executive Summary

As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364 and §457.1250,[3] the California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access and quality of care for the Medicaid and Children's Health Insurance Program (CHIP) populations, including:

- A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.
- For each external quality review (EQR)-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR in accordance with §438.364(a)(6).

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Jan 26, 2021.

The review period for this *2019–20 Medi-Cal Managed Care External Quality Review Technical Report* is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond this report's review period in the *2020–21 Medi-Cal Managed Care External Quality Review Technical Report*.

Title 42 CFR §438.2 defines an MCO, in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as PAHPs. DHCS designates three of its MCOs as population-specific health plans (PSPs). DHCS' Medi-Cal Managed Care program (MCMC) has one contracted PIHP with a specialized population, which DHCS designated as a specialty health plan (SHP). Unless citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable), DHCS' PAHPs as DMC plans, and the PIHP with a specialized population as an SHP. This report will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

MCMC provides managed health care services to more than 11 million beneficiaries (as of June 2020)[4] in the State of California through a combination of contracted MCMC plans. During the review period, DHCS contracted with 25 MCPs,[5] three PSPs, and one SHP to provide health care services in all 58 counties throughout California. Additionally, DHCS contracted with three DMC plans that each operate in Los Angeles and Sacramento counties. A summary of HSAG's assessment of performance and notable results for the July 1, 2019, through June 30, 2020, review period follows.

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities, with all changes being made within either National Committee for Quality Assurance (NCQA) or CMS allowable parameters. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

This Executive Summary section provides a summary of the activities completed during the July 1, 2019, through June 30, 2020, review period as well as activities for which a final report was produced and available while HSAG was producing this EQR technical report.

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[4] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

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

DHCS Comprehensive Quality Strategy

In November 2019, DHCS posted the *State of California Department of Health Care Services Comprehensive Quality Strategy Draft Report for Public Comment*. Following receipt of the public comments, DHCS revised the DHCS Comprehensive Quality Strategy; however, to allow for inclusion of additional details related to COVID-19 and delay of implementing California Advancing and Innovating Medi-Cal (CalAIM), DHCS intends on finalizing and submitting the final comprehensive quality strategy document to CMS in 2021.

Compliance Reviews

Managed Care Health Plans, Population-Specific Health Plans, and Specialty Health Plans

In accordance with California Welfare and Institutions Code (CA WIC) §19130(b)(3), DHCS directly conducts compliance reviews of MCPs, PSPs, and SHPs, rather than contracting with the EQRO to conduct reviews on its behalf. HSAG identified the following notable conclusions based on HSAG's review and assessment of all relevant compliance-related documents provided by DHCS (i.e., audit reports, corrective action plan [CAP] responses, and final closeout letters). Note that during the review period for this report, DHCS conducted no compliance review activities for the SHP, Family Mosaic Project; therefore, the summary of notable conclusions only includes information related to MCPs and PSPs.

- Findings identified during DHCS Audits & Investigations Division (A&I) audits reflected opportunities for improvement for MCPs and PSPs in the areas of quality and timeliness of, and access to health care.
- Audit findings within the assessed areas were MCP- and PSP-specific; therefore, across all MCPs and PSPs, HSAG identified no common areas for improvement.
- As in previous years, DHCS demonstrated ongoing efforts to follow up on findings as evidenced in the audit reports, CAP responses, and final closeout letters that DHCS submitted to HSAG for review.

Due to the COVID-19 response efforts, in April 2020, DHCS A&I suspended its Medical and State Supported Services Audits of MCPs, PSPs, and the SHP; however, DHCS continued to require MCPs, PSPs, and the SHP to comply with all CAP requirements imposed prior to COVID-19.

Dental Managed Care Plans

As with MCPs, PSPs, and the SHP, DHCS directly conducts compliance reviews of DMC plans rather than contracting with the EQRO to conduct reviews on its behalf. In May 2019, DHCS A&I began conducting annual audits with DMC plans to assess the plans' compliance with the Knox-Keene Health Care Service Plan Act of 1975 requirements and compliance with the

Medi-Cal Dental Managed Care Program Contract. Before May 2019, the Department of Managed Health Care conducted the DMC plan compliance reviews.

HSAG identified the following notable conclusions based on HSAG's review and assessment of all relevant compliance-related documents provided by DHCS (i.e., audit reports, CAP responses, and final closeout letters):

- Findings identified during A&I Dental Audits reflected opportunities for improvement for DMC plans in the areas of quality and timeliness of, and access to dental care.
- Audit findings within the assessed areas were DMC plan-specific; therefore, across all DMC plans, HSAG identified no common areas for improvement.
- DHCS demonstrated ongoing efforts to follow up on findings as evidenced in the audit reports, CAP responses, and final closeout letters that DHCS submitted to HSAG for review.

Performance Measures

Managed Care Health Plans, Population-Specific Health Plans, Specialty Health Plan, and Managed Long-Term Services and Supports Plans

DHCS' Managed Care Accountability Set (MCAS) is comprehensive and includes measures that assess the quality, accessibility, and timeliness of care MCPs, PSPs, the SHP, and Managed Long-Term Services and Supports Plans (MLTSSPs) provide to their members, including screening, prevention, health care, and utilization services. HSAG auditors determined that all MCPs, PSPs, the SHP, and MLTSSPs followed the appropriate performance measure specifications to produce valid rates.

Performance measure results in this report for MCPs, PSPs, and MLTSSPs are for reporting year 2020 only, based on DHCS making changes to the performance measure requirements and age stratifications from the previous reporting year; therefore, HSAG makes no comparisons and draws no conclusions from the reporting year 2020 performance measure results. While the performance measure results for the SHP, Family Mosaic Project, are for multiple reporting years (2018, 2019, and 2020), due to the SHP's small Medi-Cal population size, HSAG was unable to assess performance or draw any conclusions from the performance measure results.

Note that while DHCS did not hold MCPs and PSPs accountable to meet minimum performance levels for reporting year 2020 due to COVID-19, DHCS supported MCPs and PSPs in continuing to assess performance on measures and implement quality improvement strategies to address areas in need of improvement.

Dental Managed Care Plans

Reporting year 2020 was the second year that DHCS required DMC plans to submit audited performance measure rates reflecting measurement year data from the previous calendar year. DHCS provided HSAG with audited performance measure rates for both reporting units for each of the DMC plans. HSAG calculated statewide weighted averages for each required measure and compared the reporting year 2020 statewide weighted averages to the reporting year 2019 statewide weighted averages to assess performance across all DMC plans.

While the statewide weighted averages show opportunity for improvement related to ensuring members receive a comprehensive oral evaluation or prophylaxis in the recommended time frame, DMC plan statewide weighted averages show that across most measures, DMC plans demonstrated significant improvement in member access to dental care services and preventive dental care from reporting year 2019 to reporting year 2020.

Performance Improvement Projects

Managed Care Health Plans, Population-Specific Health Plans, and Specialty Health Plans

During the review period, MCPs, PSPs, and the SHP completed their 2017–19 performance improvement projects (PIPs) and HSAG assigned final confidence levels to all 52 PIPs. Through HSAG's PIP training, validation, and technical assistance, MCPs, PSPs, and the SHP successfully initiated the 2019–21 PIPs on a variety of health equity and child and adolescent health topics; however, due to the challenges of conducting PIPs during the COVID-19 public health emergency, DHCS elected to end the 2019–21 PIPs as of June 30, 2020. While DHCS elected to end the PIPs, it encouraged MCPs, PSPs, and the SHP to continue improvement efforts related to their PIP topics until the next set of PIPs begin.

Dental Managed Care Plans

During the review period, DMC plans submitted their *Preventive Services Utilization* statewide quality improvement project (QIP) intervention progress report and received HSAG's feedback on their intervention progress. Through HSAG's PIP training, validation, and technical assistance, all DMC plans submitted modules 1 through 3 for their individual PIPs and two of the DMC plans progressed to the intervention testing phase; however, due to the challenges of conducting PIPs during the COVID-19 public health emergency, DHCS elected to end the DMC plans' 2019–21 individual PIPs as of June 30, 2020. While DHCS elected to end the PIPs, it encouraged DMC plans to continue improvement efforts related to their PIP topics until the next set of PIPs begin.

Validation of Network Adequacy

To assist with assessing and ensuring network adequacy across contracted MCPs, PSPs, and the SHP, DHCS contracted with HSAG on the following network adequacy activities:

- Alternative Access Standards Reporting
- Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) Experience and Distance Reporting
- Timely Access Focused Study

Alternative Access Standards Reporting

As part of DHCS' ongoing monitoring and oversight of MCPs, PSPs, and the SHP, DHCS ensures that MCPs', PSPs', and the SHP's provider networks are adequate to deliver services to members. If providers are unavailable or unwilling to service Medi-Cal beneficiaries such that an MCP, PSP, or SHP is unable to meet time and distance standards, MCPs, PSPs, and the SHP may request that DHCS allow an alternative access standard for specified provider scenarios (e.g., provider type, ZIP Code). The DHCS All Plan Letter (APL) 19-002[6] provides MCPs, PSPs, and SHPs with DHCS' clarifying guidance regarding network certification requirements, including requests for alternative access standards.

CA WIC §14197.05[7] requires DHCS' annual EQR technical report to present information related to MCPs' alternative access standard requests. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to process and report on data related to alternative access standards for MCP provider networks.

During the review period, MCPs submitted to DHCS 19,224 alternative access standard requests, and 10,629 distinct combinations of request characteristics appeared in the data supplied by DHCS. Of these combinations, 4,803 (45.2 percent) resulted in an approval from DHCS.

HSAG also conducted analyses related to the following:

- Reasons for the approval or denial of alternative access standard requests
- Distance and driving time between nearest network provider and furthest beneficiary
- Time frame for approval or denial of requests
- Consumer complaints

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[6] All Plan Letter 19-002. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-002.pdf. Accessed on: Jan 26, 2021.

[7] CA WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14197.05. Accessed on: Jan 26, 2021.

- Process of ensuring out-of-network access
- Contracting efforts
- Providers under contract

Summaries of the analyses are located in Section 14 of this report ("Validation of Network Adequacy"). The complete results of the analysis are located in *Volume 3 of 3* of this EQR technical report (Appendix HH).

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

DHCS requires that MCPs provide coordination of care for their members requiring LTC services, including services at SNFs/ICFs. The DHCS APL 17-017[8] provides MCPs with DHCS' clarifying guidance regarding requirements for LTC coordination and disenrollment from managed care, when applicable.

CA WIC §14197.05 requires DHCS' annual EQR technical report to present information related to the experience of individuals placed in SNFs/ICFs and the distance that these individuals are placed from their residences. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to develop a methodology to assess this SNF/ICF information, and HSAG subsequently worked with DHCS to obtain the necessary data and conduct the analyses.

For contract year 2019–20, HSAG calculated nursing facility population stratifications and long-stay quality measures to capture members' experiences and the driving distances between beneficiaries in SNFs/ICFs and their places of residence using Minimum Data Set (MDS) 3.0 data for Medi-Cal beneficiaries in SNFs/ICFs during calendar year 2019 (i.e., January 1, 2019, through December 31, 2019).

While all counties are represented in this analysis, only MCP reporting units operating in County Organized Health System (COHS) counties are responsible for ensuring their institutionalized members receive medically necessary covered services. The MCP reporting units operating in non-COHS counties are only responsible for the first 30 days of a member's stay in a SNF/ICF.

Skilled Nursing Facility/Intermediate Care Facility Experience Observations and Findings

The following is a summary of HSAG's notable observations and findings from the SNF/ICF experience analyses related to members' experiences while residing in a SNF/ICF. Detailed results are located in Section 14 of this report ("Validation of Network Adequacy").

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[8] All Plan Letter 17-017. Available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-017.pdf. Accessed on: Jan 26, 2021.

- HSAG identified the following notable observations based on its review of the statewide nursing facility population characteristics:
  - Approximately 68 percent of SNF/ICF residents were 65 years of age or older during calendar year 2019, which is lower than the most recently published national rate (85.1 percent) for this age group.[9] This difference is likely due to the methodology that limits the study population to Medicaid managed care members admitted to a SNF/ICF in the measurement year or year prior.
  - Approximately 47 percent of SNF/ICF residents were male in calendar year 2019, which is higher than the most recently published national rate (32.1 percent) for this gender.[10]
  - Approximately 56 percent of SNF/ICF residents had a psychiatric diagnosis during calendar year 2019.
  - Approximately 84 percent of SNF/ICF residents entered their facility from an acute hospital.
- HSAG identified the following notable findings from its assessment of the quarterly and annual statewide rates for each long-stay quality measure:
  - Seven of the 11 (63.64 percent) long-stay quality measures that could be compared to national benchmarks had better rates than the national averages.
    - One of the four (25.00 percent) adverse event measures that could be compared to national benchmarks had a rate that was better than the national average.
    - Both of the behavioral health measures that could be compared to national benchmarks had rates that were better than the national averages.
    - All four physical health measures had rates that were better than the national averages.
    - The rate for the *Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder* measure was worse than the national average.
- Of those residents who entered a SNF/ICF from either an acute hospital or long-term care hospital (LTCH), approximately 24 percent and 21 percent, respectively, had a subsequent admission to a hospital during calendar year 2019.
- HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Adverse Events* composite measure:
  - 51.87 percent of residents experienced no adverse events during calendar year 2019, while 48.13 percent of residents experienced at least one adverse event, with 13.78 percent of residents experiencing more than one adverse event during the year.
  - The most common adverse event that residents experienced was *Hospital Admissions From SNFs*, with 36.14 percent of all residents experiencing at least one hospital admission during calendar year 2019.
  - 9.56 percent of residents had a pressure ulcer.

[9] National Center for Health Statistics. Long-term Care Providers and Services Users in the United States, 2015–2016. *Vital and Health Statistics*, 2019; 3, 43. Available at: www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf. Accessed on: Jan 21, 2021.

[10] Ibid.

  - Of the residents who experienced more than one adverse event during calendar year 2019, 41.72 percent experienced both an admission to a hospital and a pressure ulcer.
- HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Behavioral Health* composite measure:
  - 69.89 percent of residents experienced no behavioral health events during calendar year 2019, while 30.11 percent of residents experienced at least one behavioral health event, with 5.50 percent of residents experiencing more than one behavioral health event during the year.
  - The most common behavioral health event that residents experienced was *Percent of Residents Who Used Antianxiety or Hypnotic Medication*, with 18.65 percent of all residents having used an antianxiety or hypnotic medication during calendar year 2019.
  - 15.35 percent of residents had behavior symptoms that affected others around them. Of the residents who experienced more than one behavioral health event during calendar year 2019, 84.59 percent experienced both the use of antianxiety or hypnotic medications and behavior symptoms that affected others.
- HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Physical Health* composite measure:
  - 57.68 percent of residents experienced no physical health events during calendar year 2019, while 42.32 percent of residents experienced at least one physical health event, with 14.09 percent of residents experiencing more than one physical health event during the year.
  - The most common physical health event that residents experienced was *Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder*, with 19.62 percent of all residents having lost control of their bowel or bladder during calendar year 2019.
  - 16.15 percent of all residents had their need for help with daily activities increase, and 15.20 percent of residents had their ability to move independently worsen.
  - Of the residents who experienced more than one physical health event during calendar year 2019, 47.28 percent experienced both a decrease in their ability to move independently and an increase in their need for help performing daily activities.

Skilled Nursing Facility/Intermediate Care Facility Distance Findings

The following is a summary of HSAG's notable findings from the SNF/ICF distance analyses. Detailed results are located in Section 14 of this report ("Validation of Network Adequacy").

- HSAG identified the following notable findings from its assessment of the county-level short-stay resident distance results:
  - While the statewide average driving distance for short-stay residents was 12.54 miles from their place of residence to the facility, at least half of all short-stay residents traveled 6.40 or fewer miles. Because 5 percent of short-stay residents traveled 37.90 miles or more from their place of residence to the facility, the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.

  - In 30 of the 51 (58.82 percent) counties with sufficient data, at least half of short-stay residents traveled fewer than 10 miles from their place of residence.
- HSAG identified the following notable findings from its assessment of the county-level long-stay resident distance results:
  - While the statewide average driving distance for long-stay residents was 16.80 miles from their place of residence to the facility, at least half of all long-stay residents traveled 7.80 or fewer miles. Because 5 percent of long-stay residents traveled 53.10 miles or more from their place of residence to the facility, the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.
  - In 24 of the 42 (57.14 percent) counties with sufficient data, at least half of long-stay residents traveled fewer than 10 miles from their place of residence.
- HSAG identified the following notable findings from its assessment of the statewide short- and long-stay distance results:
  - Long-stay residents had a longer average driving distance from their place of residence to a facility than short-stay residents.
  - Both long- and short-stay residents with the following characteristics had a longer than average driving distance from their place of residence to a facility:
    - Residents with a psychiatric diagnosis
    - Residents who entered from the community
    - Residents who entered from a psychiatric hospital
    - Residents who entered from other health care settings
  - Short- and long-stay residents who resided in rural areas had a longer average driving distance from their place of residence to a facility than residents who resided in urban areas.

Timely Access Focused Study

Beginning in contract year 2016–17, DHCS contracted with HSAG to conduct an annual focused study to evaluate the extent to which MCPs are meeting the DHCS wait time standards. In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS canceled this study for the remainder of the calendar year due to CMS granting flexibility to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of calendar year 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this report, HSAG completed the fourth quarter 2019 calls and began conducting the first quarter 2020 calls. Because in March 2020 DHCS determined to halt the Timely Access Focused Study calls and subsequently canceled the study in July 2020, HSAG did not complete the first quarter 2020 calls; therefore, HSAG includes no information regarding the calendar year 2020 Timely Access Focused Study in this report.

Comparison of Calendar Year 2018 and Calendar Year 2019 Results

HSAG identified the following notable results when comparing the calendar year 2019 non-urgent and urgent appointment time compliance rates to the calendar year 2018 compliance rates:

- ♦ The non-urgent appointment wait time standard compliance rate for the obstetrics/gynecology (OB/GYN) provider type was significantly better in calendar year 2019 compared to calendar year 2018.
- ♦ When comparing compliance rates for the following provider types, there were statistically significantly fewer providers who met the appointment wait time standards in calendar year 2019 than in calendar year 2018.
  - ■ Primary care provider (PCP)—urgent appointment wait time standards
  - ■ Specialist—both non-urgent and urgent appointment wait time standards
  - ■ All providers—both non-urgent and urgent appointment wait time standards

Calls to Managed Care Health Plan Call Centers

During calendar year 2019, HSAG made calls to each MCP's call center. Of the 1,752 total calls placed, 93.9 percent met the wait time standard of 10 minutes. Note that calendar year 2019 was the first year HSAG made calls to MCPs' call centers; therefore, HSAG has no calendar year 2018 rates to compare to calendar year 2019 rates related to call center wait time standard compliance results.

Consumer Surveys

During the review period, HSAG administered the standardized survey instrument Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS) and Children with Chronic Conditions (CCC) measurement sets to a statewide sample of CHIP members enrolled in MCPs and Medi-Cal fee-for-service (FFS).

HSAG observed the following notable results from the CHIP CAHPS survey:

General Child Population

The following reportable measures scored below the National Committee for Quality Assurance (NCQA) Medicaid national 50th percentiles:

- ♦ Global Ratings:
  - ■ *Rating of All Health Care*
  - ■ *Rating of Health Plan*
- ♦ Composite Measures:
  - ■ *Customer Service*

- *Getting Care Quickly*
- *Getting Needed Care*
- *How Well Doctors Communicate*

The following reportable measure scored above the NCQA Medicaid national 50th percentile but below the 90th percentile:

- Global Ratings:
  - *Rating of Personal Doctor*

Trend Analysis

The 2020 score was statistically significantly lower than the 2019 score for the *Getting Needed Care* composite measure. The 2020 scores were not statistically significantly higher than the 2019 scores for any measure.

Children with Chronic Conditions Population

The following reportable measures scored below the NCQA CCC Medicaid national 50th percentiles:

- Global Ratings:
  - *Rating of All Health Care*
  - *Rating of Health Plan*
  - *Rating of Personal Doctor*
- Composite Measures:
  - *Customer Service*
  - *Getting Care Quickly*
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
- CCC Composite Measures and Items:
  - *Access to Prescription Medicines*
  - *Family-Centered Care (FCC): Getting Needed Information*

The following reportable measures scored above the NCQA CCC Medicaid national 50th percentiles but below the 90th percentiles:

- Global Ratings:
  - *Rating of Specialist Seen Most Often*
- CCC Composite Measures and Items:
  - *FCC: Personal Doctor Who Knows Child*

Trend Analysis

The 2020 score was statistically significantly lower than the 2019 score for the *Getting Needed Care* composite measure. The 2020 scores were not statistically significantly higher than the 2019 scores for any measure.

Encounter Data Validation

During the review period for this EQR technical report, HSAG conducted an Encounter Data Pilot Study to determine the feasibility of selecting samples from the provider data instead of the member data for the Encounter Data Validation (EDV) Study. HSAG's analysis of the provider data identified data quality issues that DHCS would need to address before provider data could be reliably used for sample selection; therefore, DHCS determined to have HSAG follow the already-established methodology of selecting samples from the member data for the 2019–20 EDV Study.

Following completion of the Encounter Data Pilot Study, HSAG began conducting the 2019–20 EDV Study with MCPs and PSPs, which consisted of medical record review. In March 2020, to ensure that MCPs, PSPs, and their providers could focus on the COVID-19 response efforts and to not put individuals at risk by requiring travel for collection of medical record data, DHCS and HSAG temporarily halted the 2019–20 EDV Study. While the medical record procurement was on hold, HSAG continued to review the available medical records that MCPs and PSPs submitted to HSAG prior to March 2020. In July 2020, DHCS determined to cancel the 2019–20 EDV Study to allow MCPs, PSPs, and providers to continue prioritizing their COVID-19 response efforts. While HSAG reviewed the medical records MCPs and PSPs submitted prior to the 2019–20 EDV Study being canceled, due to incomplete medical record procurement, HSAG was unable to conduct analyses on the data; therefore, HSAG presents no results or findings in this report.

Focused Studies

During the review period, HSAG was in the process of conducting multiple focused studies. The following are summaries of HSAG's notable conclusions from the focused studies that HSAG either concluded during the review period or for which HSAG had concluded the analyses and finalized the reports during the production of this EQR technical report, which is outside the review period for this report. In Section 17 of this report ("Focused Studies"), HSAG includes summaries of focused studies that were in process but had not yet concluded.

Asian Subpopulations Health Disparities Analysis

To assess and improve health disparities, DHCS contracted with HSAG to conduct a health disparities study using the External Accountability Set (EAS) performance indicators reported by the 25 full-scope MCPs for reporting years 2017–2019.[11] When statewide results were analyzed across all three reporting years, the Asian group had better rates for 65 percent of all indicators compared to the reference group (i.e., the White group).[12] However, when statewide results for the EAS indicators were stratified by primary language, the rates for several of the Asian languages were lower than the rates for English speakers for certain indicators. The findings based on primary language are not consistent with the findings based on race/ethnicity. As recommended in the 2016 and 2017 Health Disparities Reports, this focused study was conducted to assess health disparities for the Asian subpopulations based on race/ethnicity and primary language.

For this analysis, when the Asian racial/ethnic group is broken out into subpopulations, HSAG found that four Asian racial/ethnic subpopulations (representing approximately 73 percent of the Asian racial/ethnic group for reporting year 2019) had rates that were better than the rates for the White group for a majority of indicators for all three reporting years:

- The Asian Indian racial/ethnic subpopulation had rates that were better than the White group for 14 of 26 indicators (54 percent).
- The Chinese racial/ethnic subpopulation had rates that were better than the White group for 19 of 26 indicators (73 percent).
- The Filipino racial/ethnic subpopulation had rates that were better than the White group for 13 of 26 indicators (50 percent).
- The Vietnamese racial/ethnic subpopulation had rates that were better than the White group for 18 of 26 indicators (69 percent).

For the remaining Asian racial/ethnic subpopulations, only the Other Asian or Pacific Islander (five indicators), Korean (three indicators), Cambodian (two indicators), Amerasian (one indicator), and Laotian (one indicator) subpopulations had any indicator rates that were better than the rates for the White group for all three reporting years. Similar to the findings within the 2018 Health Disparities Report, very few Asian racial/ethnic subpopulations had rates that were worse than the rate for the White group, as only the Laotian (three indicators), Asian Indian (one indicator), Japanese (one indicator), and Vietnamese (one indicator) racial/ethnic subpopulations had any indicator rates that were worse than the rate for the White group for all three reporting years. These findings are also true for the Asian primary language

[11] For reporting years 2017 and 2018, 23 MCPs reported EAS indicators. Aetna Better Health of California and UnitedHealthcare Community Plan were new MCPs for reporting year 2019.

[12] Health Services Advisory Group, Inc. *2018 Health Disparities Report.* Managed Care Quality and Monitoring Division: California Department of Health Care Services; February 2020. Available at: https://www.dhcs.ca.gov/Documents/CA2018-19-Health-Disparities-Report.pdf. Accessed on: Jan 22, 2021.

subpopulations, as the Cantonese and Vietnamese language groups had a majority of rates that were better than the rates for the English group for all three reporting years. This indicates that, while there are few identified health disparities for the Asian subpopulations, the high performance indicated for the Asian racial/ethnic group as a whole is not consistent among many of the smaller Asian racial/ethnic subpopulations, who have similar results to the White group.

In analyzing the performance of the subpopulations within the Asian racial/ethnic group, the high performance of this group relative to the White group was primarily driven by the relative high performance of four of the five largest Asian subpopulations (Asian Indian, Chinese, Filipino, and Vietnamese). While the smaller Asian subpopulations did not demonstrate the same high performance relative to the White group, all Asian subpopulations had rates that were better than or similar to the rates for the White group for at least 81 percent of the reported indicators. As a result, HSAG does not recommend DHCS add the Asian racial/ethnic subpopulations analyses to future health disparities analyses.

2018–19 Medi-Cal Health Disparities Analysis

For the 2018–19 Medi-Cal Health Disparities Analysis, HSAG evaluated indicator data collected for reporting year 2019 at the statewide level, which consisted of data collected during calendar year 2018 (also known as HEDIS measurement year 2018). HSAG aggregated the results from the 25 full-scope MCPs and then stratified these statewide rates for all indicators by four demographic stratifications (i.e., race/ethnicity, primary language, age, and gender); however, HSAG only identified health disparities based on statistical analysis for the race/ethnicity stratification.

The following are the overall conclusions for the Medi-Cal health disparities analysis for reporting year 2019:

- The rates for the Black or African American group were worse than those for the White group for approximately 38 percent of indicators in the analyses.
  - Indicators for which the rates for the Black or African American group were worse than the rates for the White group were related to access to care and health outcomes. This trend is commonly seen nationally in other state Medicaid programs.[13] Note that the rates for the Black or African American group were better than the rates for the White group for some process measures related to preventive care and appropriate utilization.
- The rates for the American Indian or Alaska Native group and Native Hawaiian or Other Pacific Islander group were worse than those for the White group for approximately 31 percent and 15 percent, respectively, of indicators in the analyses.
- The rates for both the Asian and Hispanic or Latino groups were better than the rates for the White group for approximately 65 percent of indicators in the analyses.

[13] Bulger J, Shubrook J, Snow R. Racial Disparities in African Americans with Diabetes: Process and Outcome Mismatch. *Am J Manag Care*. 2012 Aug;18(8):407–13.

The following are the overall conclusions for the Medi-Cal health disparities analysis for reporting year 2017 through reporting year 2019:

- Overall, for approximately 70 percent of indicators where rates for specific racial/ethnic groups were worse than the rate for the White group in reporting year 2017, the health disparities for those indicators continued to exist in reporting year 2019, demonstrating that health disparities are not improving.
- Overall, for approximately 90 percent of indicators where rates for specific racial/ethnic groups were better than the rate for the White group in reporting year 2017, the health disparities for those indicators continued to exist in reporting year 2019, demonstrating that health disparities are not improving.

2019–20 Medi-Cal Health Disparities Analysis

For the 2019–20 Medi-Cal Health Disparities Analysis, HSAG evaluated indicator data collected for reporting year 2020 at the statewide level, which consisted of data collected during calendar year 2019. HSAG aggregated the results from the 25 full-scope MCPs and then stratified these statewide rates for all indicators by two demographic stratifications (i.e., race/ethnicity and primary language); however, HSAG only identified health disparities based on statistical analysis for the race/ethnicity stratification.

Due to the impacts of COVID-19, the 2019–20 health disparities analysis only includes 10 MCAS indicators that utilize administrative data only. Additional indicators will be added in future iterations of this study once more complete data become available. The goal of the health disparities analysis is to improve health care for Medi-Cal members by evaluating the health care disparities affecting members enrolled in Medi-Cal MCPs. This analysis does not include data for FFS beneficiaries in Medi-Cal.

The following are the overall conclusions for the 2019–20 Medi-Cal Health Disparities Analysis:

- The *Chlamydia Screening in Women—Total* indicator represents an area of overall strength. For this indicator, there were no negative disparities and the rates for all racial/ethnic groups were above the minimum performance level.
- The *Asthma Medication Ratio—Total* and *Breast Cancer Screening—Total* indicators represent areas of overall opportunity for improvement. While there were no negative disparities for *Asthma Medication Ratio—Total* and only one negative disparity for *Breast Cancer Screening* (American Indian or Alaska Native), this is due to the low performance for the White racial/ethnic group rather than positive performance overall. The Asian and Other racial/ethnic groups showed positive performance, with rates that were above the minimum performance levels for both indicators; however, the rates for all other racial/ethnic groups were below the minimum performance level for both indicators.
- All racial/ethnic groups had at least one *Antidepressant Medication Management* or *Contraceptive Care* indicator rate that was worse than the rate for the White group.
  - There were four racial/ethnic groups with rates worse than the rate for the White group for both *Antidepressant Medication Management* indicators. This finding also aligns with

national data that show antidepressant medication use is higher among non-Hispanic White adults.[14]

- Only the rate for the Black or African American group fell below the minimum performance level for the *Effective Acute Phase Treatment* indicator; however, the rates for three racial/ethnic groups (Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander) fell below the minimum performance level for the *Effective Continuation Phase Treatment* indicator.
- For the *Contraceptive Care—All Women—Most or Moderately Effective Contraception* indicators, five racial/ethnic groups had negative disparities for the *Ages 15–20 Years* indicator, but only two of these negative disparities also existed for the *Ages 21–44 Years* indicator (Asian and Native Hawaiian or Pacific Islander). For the *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years* indicator, two racial/ethnic groups (Asian and Black or African American) had negative disparities. These findings suggest that most disparities related to contraceptive care are limited to the adolescent female population. These findings also align with national data which show that contraception use was higher among older and non-Hispanic White women compared to adolescent and non-Hispanic Black women.[15]
- The rates for all racial/ethnic groups for the *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15 to 20 Years* and *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21 to 44 Years* indicators were below their respective national benchmarks.[16,17]

♦ The *Developmental Screening in the First Three Years of Life—Total* indicator represents an area of overall opportunity for improvement. While the rates for three racial/ethnic groups (Asian, Native Hawaiian or Other Pacific Islander, and Other) were better than the

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[14] Brody DJ, Gu Q. Antidepressant use among adults: United States, 2015–2018. *NCHS Data Brief*. 2020; 377. Available at: https://www.cdc.gov/nchs/data/databriefs/db377-H.pdf. Accessed on: Jan 26, 2021.

[15] Daniels K, Abma JC. Current contraceptive status among women aged 15–49: United States, 2017–2019. *NCHS Data Brief*. 2020; 388. Available at: https://www.cdc.gov/nchs/data/databriefs/db388-H.pdf. Accessed on: Jan 26, 2021.

[16] Centers of Medicare & Medicaid Services. Child Health Care Quality Measures. "Performance on the Child Core Set Measures, FFY 2019." Oct. 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Jan 26, 2021.

[17] Centers for Medicare & Medicaid Services. Adult Health Care Quality Measures. "Performance on the Adult Core Set Measures, FFY 2019."Oct. 2020. Available at: www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html. Accessed on: Jan 26, 2021.

rate for the White group for this indicator, the rates for all racial/ethnic groups fell below the national benchmark.[18]

2020 Preventive Services Analysis

At the request of the Joint Legislative Audit Committee, the California State Auditor published an audit report in March 2019 regarding DHCS' oversight of the delivery of preventive services to children enrolled in Medi-Cal. The audit report recommended that DHCS expand its monitoring beyond the existing set of quality measures as a way to ensure that children in Medi-Cal managed care are receiving all of the appropriate preventive services from DHCS' contracted MCPs.[19] In response to this recommendation, DHCS worked with HSAG to develop an annual Preventive Services Report.

DHCS collaborated with the California Department of Public Health (CDPH) to link available blood lead screening laboratory data with Medi-Cal data; however, these efforts were delayed due to COVID-19 and its impact on CDPH operations. While DHCS released the information for the *Blood Lead Screening* indicators, as well as MCP-specific results for each indicator, as an addendum to the *2020 Preventive Services Report* in February 2021, based on the production schedule for this EQR technical report, HSAG was unable to include a summary of the addendum in this report. HSAG will include a summary of the addendum in the 2020–21 EQR technical report.

DHCS selected three existing MCAS indicators reported by the 25 full-scope MCPs and six HSAG-calculated indicators for inclusion in the *2020 Preventive Services Report*. The following nine indicators were included in the analysis:

MCP-Calculated MCAS Indicators

- *Chlamydia Screening in Women—16 to 20 Years*
- *Developmental Screening in the First Three Years of Life—Total*
- *Screening for Depression and Follow-Up Plan*

HSAG-Calculated Indicators

- *Alcohol Use Screening*
- *Child and Adolescent Well-Care Visits*

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[18] Centers of Medicare & Medicaid Services. Child Health Care Quality Measures. "Performance on the Child Core Set Measures, FFY 2019." Oct. 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Jan 26, 2021.

[19] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Jan 26, 2021.

- *Dental Fluoride Varnish*
- *Tobacco Use Screening*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* (two indicators)

Based on its evaluation of the nine indicators listed previously, HSAG identified five key findings and provided conclusions and considerations for each finding. The following are the high-level descriptions of the five findings. A more detailed description of the findings, conclusions, and considerations is located under the "2020 Preventive Services Analysis" heading in Section 17 of this report ("Focused Studies").

- Key Finding 1: Performance is regional.
- Key Finding 2: Statewide performance varies based on race/ethnicity and primary language.
- Key Finding 3: Overall performance across California's six largest counties is high for a majority of indicators, but improvement is needed for well-child visits.
- Key Finding 4: A majority of younger children receive well-care visits, but improvement is needed for developmental screenings and the provision of dental fluoride varnish.
- Key Finding 5: Adolescent rates for well-care visits are lower than rates for younger children.

Regional Model Access

To ensure that MCMC beneficiaries in the Regional Model counties have reasonable access to care, Recommendation 10 of the California State Auditor Report 2018-122 (Auditor Report) required DHCS to conduct an analysis to determine the specific causes of the reported inability of MCPs operating under the Regional Model to provide reasonable access to care in the Regional Model counties. The MCPs operating under the Regional Model are Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan (Anthem Blue Cross) and California Health & Wellness Plan (CHW). The Regional Model counties are Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

DHCS contracted with HSAG to conduct a focused study to identify the specific causes of provider network issues identified in the Auditor Report. The purpose of this analysis was two-fold:

- Identify the specific Regional Model counties in which provider network coverage issues exist for each of these MCPs and each provider type.
- Identify specific causes of provider network issues identified in the Auditor Report.

Overall, the results of the HSAG analyses suggest that the driving factor underlying the reported inability of the MCPs operating under the Regional Model to meet access standards is

a lack of providers in rural areas. This situation is not unique to California, as a shortage of providers in rural counties is a recognized issue nationwide.

Technical Assistance

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

Technical Assistance Activity for Performance Measures

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each technical assistance request to ensure the most efficient provision of technical assistance with the greatest likelihood of resulting in enhanced skills and, ultimately, improved performance. As a result of the technical assistance that HSAG provided to DHCS, MCPs, PSPs, and the SHP:

- DHCS has a better understanding of performance measures, which will enable DHCS to make informed decisions regarding future MCAS requirements.
- DHCS has more in-depth understanding of the various EQR activities.
- DHCS gained information to assist in making informed decisions regarding how to best move forward with various EQR activities during the COVID-19 pandemic and to best provide guidance to MCPs, PSPs, and the SHP related to EQR activities impacted by COVID-19.
- MCPs under CAPs became more proficient conducting the rapid-cycle PIP process and strengthened their quality improvement efforts.
- MCPs have a better understanding of the CAHPS survey process.

Technical Assistance Activity for Quality Improvement Collaboration

Under the Technical Assistance Activity for Quality Improvement Collaboration, HSAG coordinated with DHCS to plan and facilitate quarterly collaborative discussions with MCPs, PSPs, and the SHP to support MCPs', PSPs', and the SHP's quality improvement efforts. During the review period, DHCS and HSAG facilitated successful collaborative discussions and engaged MCPs, PSPs, and the SHP to actively participate by sharing their own experiences, challenges, and lessons learned from their quality improvement efforts. All presenters shared helpful information that generated valuable conversation among participants. One of the collaborative discussions focused on the impact COVID-19 was having on PIPs, which was helpful in alleviating MCPs', PSPs' and the SHP's anxiety about PIP requirements.

Technical Assistance Activity for Quality Conference

DHCS contracted HSAG to organize and facilitate a quality conference, *Health Equity: Promoting Quality and Access for All; Building Skills to Bridge the Health Divide*, on October 30, 2019, in Sacramento, California. The conference provided MCPs, PSPs, and the SHP the opportunity to build skills to bridge the health divide. Presentations focused on strategies related to addressing health equity gaps and ensuring access to health care for all Medi-Cal members.

Based on evaluation results, the 2019 Quality Conference was very well received, with most of the conference attendees agreeing that as a result of the conference presentations, they gained knowledge and skills to apply to their quality improvement work to bridge the health care divide. Most conference attendees also agreed that the presenters were effective in presenting the content and that they met their presentation objectives.

Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of members. The PNA identifies member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues. MCP and PSP contractual requirements related to the PNA are based on Title 22 of the California Code of Regulations, sections 53851(b)(2), 53851(e), 53853(d), 53876(a)(4), 53876(c), and 53910.5(a)(2), and Title 42 CFR §438.206(c)(2), §438.242(b)(2), and §438.330(b)(4) .

Each MCP's and PSP's PNA must address the special needs of the Seniors and Persons with Disabilities (SPD) population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and must take action to address these opportunities.

DHCS' PNA report review process included the opportunity for feedback and resubmission by MCPs and PSPs to ensure they met DHCS' expectations and requirements. DHCS provided HSAG with a summary of its assessment of the PNA reports that reflected DHCS' thorough review of the reports. Upon review of all submissions and resubmissions, DHCS approved all 25 MCPs' and three PSPs' PNA reports.

Recommendations across All Assessed Activities

Based on HSAG's 2019–20 EQR, HSAG makes the following recommendations to DHCS:

Performance Measure Validation

- Consider allowing MCPs and PSPs to choose the methodology for measure reporting (i.e., administrative or hybrid) for measures with specifications that allow for both methods. This would allow MCPs and PSPs to select the methodology that both maximizes performance and best uses resources.
- To support collection of information for performance measurement reporting, develop a process to gather information about the current use and barriers to use of supplemental data sources from clinical-based electronic health records (EHRs) by MCPs and PSPs to increase integration of supplemental data sources from EHRs.

Managed Long-Term Services and Supports Plan Performance Measures

- Obtain input from MLTSSPs and other stakeholders regarding adding MLTSS-specific measures from CMS' MLTSSP measure list to the DHCS MLTSSP required measure set.[20]

Validation of Network Adequacy

Alternative Access Standards Reporting

- Identify alternative resources and technologies that could be leveraged by MCPs to provide access to members living in remote locations that prevent meeting time and distance standards.
  - With the expansion of telehealth services and technology during calendar year 2020 in response to the COVID-19 public health emergency, HSAG recommends that DHCS and its contracted MCPs explore ways that these technologies may be used to minimize the impact of sparse provider networks and reduce travel costs for members, providers, and plans.
- Develop and maintain a list of provider practice locations statewide to facilitate the calculation of the percentage of Medi-Cal contracted providers within each county.
  - One of the reporting elements required under CA WIC §14197.05 is the percentage of providers in a plan service area, by provider and specialty type, that are under contract with an MCP. Due to data limitations, HSAG was unable to accurately identify a complete list of county-level physician practices. Developing and maintaining a list of identified Medi-Cal contracted provider practice locations will improve DHCS' ability to provide MCPs with more accurate and current information regarding eligible providers.

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[20] Center for Medicaid and CHIP Services. Centers for Medicare & Medicaid Services. *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual (May 2019).* Available at: https://www.medicaid.gov/media/3396. Accessed on: Jan 14, 2021.

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

- Consider utilizing administrative data sources in addition to MDS data to calculate risk-adjusted outcome measures, like CMS' *Long-Term Services and Supports (LTSS) Successful Transition After Long-Term Institutional Stay* and *Minimizing Institutional Length of Stay* measures, in order to capture the experiences for both SNF and ICF residents.[21] Further, DHCS could consider working with HSAG to calculate MCP-level rates for these measures.
- Work with HSAG to investigate the high usage of hypnotic/antianxiety and antipsychotic medications among Medi-Cal beneficiaries in SNFs, especially residents with dementia, to determine if high usage of hypnotic/antianxiety and antipsychotic medications is regional or concentrated to certain SNFs. Based on the findings of this investigation, DHCS could then leverage the information to request outlier facilities to submit information related to their high utilization of hypnotic/antianxiety and antipsychotic medications, along with the facilities' plans for reducing the utilization of these medications.
- Work with HSAG to assess how often beneficiaries are placed in a SNF/ICF closest to their place of residence, as well as how often beneficiaries transfer to a different SNF/ICF during the measurement year. Further, DHCS should consider assessing the additional factors associated with the distance between the beneficiary's place of residence and the SNF/ICF (e.g., understanding whether beneficiaries are placed in a SNF/ICF further away from their place of residence due to specific physical or behavioral health care needs).
- Consider working with HSAG to assess the distances beneficiaries travel from their place of residence to a SNF/ICF at the MCP level. By assessing distance at the MCP level, DHCS can better understand the care coordination MCPs provide to beneficiaries when they are placed in a SNF/ICF. Further, by performing the analysis at the MCP level, DHCS could leverage the results of both the regional and MCP analyses to set future time and distance performance standards for MCPs.

Additional details regarding each recommendation are located in Section 14 of this report ("Validation of Network Adequacy")

Consumer Surveys

- While the decline in the 2020 CHIP CAHPS Survey scores for the *Getting Needed Care* composite measure compared to the prior year for both populations may be due to COVID-19, DHCS should work with MCPs to determine the causes for the statistically significant decline from 2019 to 2020 for this measure and identify strategies to ensure that members' access to care does not continue to decline.

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[21] Centers for Medicare & Medicaid Services. Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual, May 2019. Available at: https://www.medicaid.gov/media/3396. Accessed on: Jan 26, 2021.

Focused Studies

- Work with HSAG when planning for the 2020–21 Medi-Cal Health Disparities Analysis to prioritize which items for consideration to incorporate from the 2018–19 Medi-Cal Health Disparities Analysis, 2019–20 Asian Subpopulations Health Disparities Analysis, and 2019–20 Medi-Cal Health Disparities Analysis.

2. Introduction

Purpose of Report

As required by 42 CFR §438.364 and §457.1250,[22] DHCS contracts with HSAG, an EQRO, to prepare an annual, independent, technical report that summarizes findings on access and quality of care related to the health care services provided by MCMC plans, including opportunities for quality improvement.

Note: Title 42 CFR §438.2 defines an MCO, in part, as "an entity that has, or is seeking to qualify for, a comprehensive risk contract." CMS designates DHCS-contracted MCPs as MCOs and DMC plans as PAHPs. DHCS designates three of its MCOs as PSPs. MCMC has one PIHP with a specialized population, which DHCS designated as an SHP. Unless citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable), DHCS' PAHPs as DMC plans, and the PIHP with a specialized population as an SHP. This report will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

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

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

[22] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Jan 26, 2021.

quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.

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

Quality, Access, and Timeliness

CMS requires that the EQR evaluate the performance of MCOs, PIHPs, PAHPs, and PCCM entities related to the quality and timeliness of, and access to care they deliver. §438.320 indicates that quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through:

- Its structural and operational characteristics.
- The provision of services consistent with current professional, evidence-based knowledge.
- Interventions for performance improvement.

Additionally, §438.320 indicates that access, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).

This report includes conclusions drawn by HSAG related to MCMC plans' strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to MCMC plan members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. While quality, access, and timeliness are distinct aspects of care, most MCMC plan activities and services cut across more than one area. Collectively, all MCMC plan activities and services affect the quality, access, and timeliness of care delivered to MCMC plan members. In this report, when applicable, HSAG indicates instances in which MCMC plan performance affects one specific aspect of care more than another.

Summary of Report Content

This report is divided into three volumes that include the following content:

Volume 1—Main Report

- An overview of Medi-Cal Managed Care.
- A description of DHCS' Comprehensive Quality Strategy report.

- A description of the scope of EQR activities for the period of July 1, 2019, through June 30, 2020, including the methodology used for data collection and analysis; a description of the data for each activity; and an aggregate assessment of MCMC plan performance related to each activity, as applicable.
- A description of HSAG's assessment related to the four federally mandated EQR-related activities, three of the six optional EQR-related activities, and the technical assistance provided to MCMC plans as set forth in 42 CFR §438.358:
  - Mandatory activities:
    - Health plan compliance reviews
    - Validation of performance measures
    - Validation of PIPs
    - Validation of network adequacy
  - Optional activities:
    - Administration of consumer surveys
    - Encounter data validations
    - Focused studies
  - Technical assistance

Volume 2—Plan-Specific Evaluation Reports and Alternate Reporting Methods for Reporting Year 2020 Hybrid Measures

- MCMC plan-specific evaluation reports (appendices A through FF). Each MCMC plan-specific evaluation report provides an assessment of the MCMC plan's strengths and weaknesses with respect to the quality and timeliness of, and access to health care services as well as recommendations to the MCMC plan for improving quality of health care services for its members.
- A summary of MCPs that chose to report hybrid measures using DHCS-approved alternate methods (Appendix GG).

Volume 3—Alternative Access Standards Tables

- Tables presenting key reporting elements defined in CA WIC section 14197.05 regarding alternative access standards requests for provider networks (Appendix HH).

The EQR technical report and MCMC plan-specific evaluation reports all align to the same review period—July 1, 2019, through June 30, 2020.

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on COVID-19 response efforts. Additionally, DHCS changed its requirements related to some EQR activities, with all changes being made within either NCQA or CMS allowable parameters. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or

changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Overview

In the State of California, DHCS administers the Medicaid program (Medi-Cal) through its FFS and managed care delivery systems. In California, the CHIP population is included in Medi-Cal.

MCMC provides managed health care services to more than 11 million beneficiaries (as of June 2020)[23] in the State of California through a combination of contracted MCMC plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its MCMC plans, making improvements to care and services, and ensuring that MCMC plans comply with federal and State standards.

During the review period, DHCS contracted with 25 MCPs,[24] three PSPs, and one SHP to provide health care services in all 58 counties throughout California and contracted with three DMC plans to provide dental services in Los Angeles and Sacramento counties. DHCS operates MCMC through a health care delivery system that encompasses seven models of managed care for its full-scope services as well as a model for PSPs, a model for SHPs, and two model types for DMC plans. DHCS monitors MCMC plan performance across model types. The MCMC county map, which depicts the location of each model type, is located at https://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf.

Following is a description of each managed care model type, including the number of beneficiaries served by each model type as of June 2020. HSAG obtained the enrollment information from the *Medi-Cal Managed Care Enrollment Report*.[23]

County Organized Health System (COHS) model. A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission. A COHS model has been implemented in 22 counties and operates in each as a single, county-operated health plan. This model does not offer FFS Medi-Cal. As of June 2020, the COHS model was serving more than 2.1 million beneficiaries through six health plans in 22 counties.

Two-Plan Model (TPM). Under a TPM, beneficiaries may choose between two MCPs; typically, one MCP is a local initiative and the other a commercial plan. DHCS contracts with both plans. The local initiative is established under authority of the local government with input

[23] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on Jul 15, 2020.

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

from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The commercial plan is a private insurance plan that also provides care for Medi-Cal beneficiaries. As of June 2020, the TPM was serving more than 6.8 million beneficiaries through 12 health plans in 14 counties. Note that Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan serves as a local initiative in Tulare County and a commercial plan in all other TPM counties.

Geographic Managed Care (GMC) model. Under a GMC model, DHCS allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county). As of June 2020, the GMC model had five health plans serving more than 435,000 beneficiaries in Sacramento County and seven health plans serving more than 688,000 beneficiaries in San Diego County.

Regional model. This model consists of three commercial health plans that provide services to beneficiaries in the rural counties of the State, primarily in northern and eastern California. As of June 2020, the Regional model was serving more than 295,000 beneficiaries in 18 counties.

Imperial model. This model operates in Imperial County with two commercial health plans. As of June 2020, this model was serving more than 76,000 beneficiaries.

San Benito model. This model operates in San Benito County and provides services to Medi-Cal beneficiaries through a commercial plan and FFS Medi-Cal. As of June 2020, the San Benito model was serving more than 8,000 beneficiaries. San Benito is California's only county where enrollment in managed care is not mandatory.

Population-Specific Health Plan model. The PSP model operates in Los Angeles, Riverside, San Bernardino, and San Diego counties. The following three MCOs are designated as a "Population-Specific Health Plan" model because of their specialized populations:

- AIDS Healthcare Foundation—provides services in Los Angeles County, primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). As of June 2020, AIDS Healthcare Foundation was serving 632 members.
- Rady Children's Hospital—San Diego provides pediatric care services in San Diego County. As of June 2020, Rady Children's Hospital—San Diego was serving 370 members.
- SCAN Health Plan provides services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties. As of June 2020, SCAN Health Plan was serving 14,090 members.

Specialty Health Plan model. SHPs provide health care services to specialized populations. During the review period, DHCS held a contract with one SHP, Family Mosaic Project. This SHP provides intensive case management and wraparound services in San Francisco County for MCMC children and adolescents at risk of out-of-home placement. As of June 2020, Family Mosaic Project's number of members was too small to report based on the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Dental Managed Care Plans. Three DMC plans provide dental services in Los Angeles and Sacramento counties. In Los Angeles County, DMC plans operate as prepaid health plans (PHPs). In this county, Medi-Cal beneficiaries have the option to enroll in a DMC plan or to access dental benefits through the dental FFS delivery system. In Sacramento County, the DMC plans operate under a GMC model in which DMC enrollment is mandatory. As of June 2020, DMC plans were serving more than 366,000 members in Los Angeles County and more than 425,000 members in Sacramento County.

Table 2.1 shows MCMC plan names, model types, reporting units, and the counties in which they provide Medi-Cal services. MCMC plans submit data for some EQR activities at the plan level and submit data for other activities at the reporting unit level. The bundling of counties into a single reporting unit allows a population size to support valid rates.

Table 2.1—Medi-Cal Managed Care Health Plan Names, Model Types, Reporting Units, and Counties as of June 30, 2020

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

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
Managed Care Health Plans			
Aetna Better Health of California	GMC	Sacramento	Sacramento
		San Diego	San Diego
Alameda Alliance for Health	TPM—Local Initiative	Alameda	Alameda
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	GMC	Sacramento	Sacramento
	Regional	Region 1	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
		Region 2	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba
	San Benito	San Benito	San Benito
	TPM—CP	Alameda	Alameda
		Contra Costa	Contra Costa
		Fresno	Fresno
		Kings	Kings
		Madera	Madera
		San Francisco	San Francisco
		Santa Clara	Santa Clara
	TPM—Local Initiative	Tulare	Tulare
Blue Shield of California Promise Health Plan (known as Care1st Health Plan prior to January 1, 2019)	GMC	San Diego	San Diego
California Health & Wellness Plan	Imperial	Imperial	Imperial
	Regional	Region 1	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama
		Region 2	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba
CalOptima	COHS	Orange	Orange
CalViva Health		Fresno	Fresno
		Kings	Kings

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
	TPM—Local Initiative	Madera	Madera
CenCal Health	COHS	San Luis Obispo	San Luis Obispo
		Santa Barbara	Santa Barbara
Central California Alliance for Health	COHS	Merced	Merced
		Monterey/Santa Cruz	Monterey, Santa Cruz
Community Health Group Partnership Plan	GMC	San Diego	San Diego
Contra Costa Health Plan	TPM—Local Initiative	Contra Costa	Contra Costa
Gold Coast Health Plan	COHS	Ventura	Ventura
Health Net Community Solutions, Inc.	GMC	Sacramento	Sacramento
		San Diego	San Diego
	TPM—CP	Kern	Kern
		Los Angeles	Los Angeles
		San Joaquin	San Joaquin
		Stanislaus	Stanislaus
		Tulare	Tulare
Health Plan of San Joaquin	TPM—Local Initiative	San Joaquin	San Joaquin
		Stanislaus	Stanislaus
Health Plan of San Mateo	COHS	San Mateo	San Mateo
Inland Empire Health	TPM—Local Initiative	Riverside/San Bernardino	Riverside, San Bernardino
Kaiser NorCal (KP Cal, LLC)*	GMC	KP North	Sacramento
	Regional	KP North	Amador, El Dorado, Placer
Kaiser SoCal (KP Cal, LLC)	GMC	San Diego	San Diego

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
Kern Health Systems, DBA Kern Family Health Care	TPM—Local Initiative	Kern	Kern
L.A. Care Health Plan	TPM—Local Initiative	Los Angeles	Los Angeles
Molina Healthcare of California	GMC	Sacramento	Sacramento
		San Diego	San Diego
	Imperial	Imperial	Imperial
	TPM—CP	Riverside/San Bernardino	Riverside, San Bernardino
Partnership HealthPlan of California	COHS	Northeast	Lassen, Modoc, Shasta, Siskiyou, Trinity
		Northwest	Del Norte, Humboldt
		Southeast	Napa, Solano, Yolo
		Southwest	Lake, Marin, Mendocino, Sonoma
San Francisco Health Plan	TPM—Local Initiative	San Francisco	San Francisco
Santa Clara Family Health Plan	TPM—Local Initiative	Santa Clara	Santa Clara
UnitedHealthcare Community Plan	GMC	San Diego	San Diego

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
Population-Specific Health Plans			
AIDS Healthcare Foundation	PSP	Los Angeles	Los Angeles
Rady Children's Hospital—San Diego	PSP	San Diego	San Diego
SCAN Health Plan	PSP	Los Angeles/ Riverside/San Bernardino	Los Angeles, Riverside, San Bernardino
Specialty Health Plan			
Family Mosaic Project	SHP	San Francisco	San Francisco
Dental Managed Care Plans			
Access Dental Plan	PAHP	Los Angeles	Los Angeles
	PAHP—GMC	Sacramento	Sacramento
Health Net of California, Inc.	PAHP	Los Angeles	Los Angeles
	PAHP—GMC	Sacramento	Sacramento
LIBERTY Dental Plan of California, Inc.	PAHP	Los Angeles	Los Angeles
	PAHP—GMC	Sacramento	Sacramento

For enrollment information about each county, go to https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report.

3. DHCS Comprehensive Quality Strategy

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

In the *Medi-Cal Managed Care External Quality Review Technical Report—July 1, 2018–June 30, 2019*, HSAG indicated that in November 2019, DHCS posted the *State of California Department of Health Care Services Comprehensive Quality Strategy Draft Report for Public Comment*. Following receipt of the public comments, DHCS revised the DHCS Comprehensive Quality Strategy; however, to allow for inclusion of additional details related to COVID-19 and delay of implementing CalAIM, DHCS intends on finalizing and submitting the final comprehensive quality strategy document to CMS in 2021.

The most up-to-date information on DHCS' Comprehensive Quality Strategy is located at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx. Information regarding CalAIM is located at https://www.dhcs.ca.gov/calaim.

4. Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Compliance Reviews

In accordance with 42 CFR §438.358, the state or its designee must conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM entity's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

Background

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

In accordance with CA WIC §19130(b)(3), DHCS directly conducts compliance reviews of MCPs, PSPs, and SHPs, rather than contracting with the EQRO to conduct reviews on its behalf. DHCS applies the Generally Accepted Government Auditing Standards, also known as the Yellow Book. DHCS has determined that its auditing tools are proprietary; therefore, HSAG is unable to review the tools. While HSAG cannot determine whether DHCS' tools assess compliance with all federal and State requirements, in 2020, DHCS provided HSAG with a document that listed the categories and standards DHCS audits to determine MCP, PSP, and SHP compliance with federal Medicaid regulations and numerous state-specific requirements, as well as the frequency at which DHCS reviews each standard. HSAG analyzed the information in this document and reviewed the associated State regulations. Additionally, HSAG evaluated DHCS' MCMC contract requirements cited in the document and noted that the contract includes the requirements articulated in 42 CFR §438 Subpart D and 42 CFR §438.330, with few exceptions, which HSAG communicated to DHCS.

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

Under DHCS' monitoring protocols, DHCS oversees the CAP process to ensure that MCPs, PSPs, and SHPs address all deficiencies identified in the compliance reviews conducted (i.e., Medical Audits and State Supported Services Audits) by DHCS A&I. DHCS issues final closeout letters to these plans once they have submitted supporting documentation to substantiate that they have fully remediated all identified deficiencies and that the deficiencies are unlikely to recur. However, if corrective action requires more extensive changes to MCP, PSP, and SHP operations and full implementation cannot be reasonably achieved without additional time, DHCS may close some deficiencies on the basis that sufficient progress has

been made toward meeting set milestones. In these instances, DHCS may issue closeout letters to these plans with the understanding that progress on full implementation of corrective actions will be assessed in the next audit.

Compliance Reviews

Following are descriptions of the two types of DHCS A&I compliance reviews, including areas assessed and frequency of the reviews.

DHCS Audits & Investigations Division Medical Audits

To meet the requirements of CA WIC §14456, DHCS A&I annually conducts on-site medical audits of each MCP, PSP, and SHP, alternating between comprehensive full-scope and reduced-scope audits. Additionally, DHCS A&I conducts annual follow-up on the previous year's CAP. DHCS A&I Medical Audits cover the following review categories:

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

State Supported Services

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

Objectives

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

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

Methodology

As part of the EQR technical report production, DHCS submitted to HSAG all audit reports and CAP closeout letters for audits DHCS conducted within the previous three-year period and that HSAG had not already reported on in previous EQR technical reports.

HSAG determined, by assessing the dates of each plan's review, whether DHCS conducted compliance monitoring reviews for all MCPs, PSPs, and the SHP at least once within the three-year period prior to the review dates for this report. Unless noted, HSAG excluded from its analysis information from compliance reviews conducted earlier than July 1, 2016, (i.e., three years prior to the start of the review period) and later than June 30, 2020, (i.e., the end of the review period).

HSAG reviewed all compliance-related information to assess the degree to which MCPs, PSPs, and the SHP are meeting the standards that DHCS A&I assessed as part of the compliance review process. Additionally, HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about overall plan performance in providing quality, accessible, and timely health care and services to members.

In addition to summarizing the aggregated results, HSAG also summarized MCP-, PSP-, and SHP-specific results, including HSAG's recommendations. Plan-specific compliance review results and HSAG's recommendations are included in the applicable appendices included in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

Results—Compliance Reviews

Due to the COVID-19 response efforts, in April 2020, DHCS A&I suspended its Medical and State Supported Services Audits of MCPs, PSPs, and the SHP; however, DHCS continued to require MCPs, PSPs, and the SHP to comply with all CAP requirements imposed prior to COVID-19, as applicable.

To ensure DHCS' compliance with 42 CFR §438.358, HSAG reviewed the dates on which DHCS conducted its most recent compliance reviews of MCPs, PSPs, and the SHP and determined that DHCS conducted a compliance review no earlier than three years from the start of the review period for this report (July 1, 2019) and no later than the end of the review period for this report (June 30, 2020) for all MCPs, PSPs, and the SHP.

The following is a summary of notable results from HSAG's assessment of the compliance review information submitted by DHCS to HSAG for production of the 2019–20 MCP-, PSP-, and SHP-specific evaluation reports and this EQR technical report. The summary includes new information not reported on in previous review periods. During the review period for this report, DHCS conducted no compliance review activities for the SHP, Family Mosaic Project; therefore, the summary of notable results only includes information related to MCPs and PSPs.

- DHCS provided evidence to HSAG of DHCS' ongoing follow-up with MCPs and PSPs regarding findings A&I identified during audits. DHCS provided documentation to HSAG of its follow-up with MCPs and PSPs on CAPs as well as finding-related documentation from these MCPs and PSPs. DHCS determined that the documentation from MCPs and PSPs was detailed and reflected changes to policies and procedures to ensure compliance with all DHCS contract requirements.
- HSAG received results from 27 A&I State Supported Services Audits of MCPs and PSPs. A&I identified no findings in 23 of the 27 audits (85 percent), reflecting full compliance with the State Supported Services contract and regulations.
- HSAG received results from 29 A&I Medical Audits of MCPs and PSPs. A&I identified a finding in at least one review area (e.g., Utilization Management, Member's Rights) in all but two of the Medical Audits. For both Health Plan of San Joaquin and Partnership HealthPlan of California, A&I identified no findings during the Medical Audit.
- Findings were MCP- and PSP-specific; therefore, HSAG identified no common areas for improvement across these entities.

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

Conclusions—Compliance Reviews

Findings identified during A&I audits reflected opportunities for improvement for MCPs and PSPs in the areas of quality and timeliness of, and access to health care. Audit findings within the assessed areas were MCP- and PSP-specific; therefore, across all MCPs and PSPs, HSAG identified no common areas for improvement. As in previous years, DHCS demonstrated ongoing efforts to follow up on findings as evidenced in the audit reports, CAP responses, and final closeout letters that DHCS submitted to HSAG for review.

Recommendations—Compliance Reviews

HSAG has no recommendations for DHCS related to compliance reviews of MCPs, PSPs, and the SHP.

5. Dental Managed Care Plan Compliance Reviews

As indicated in the previous section of this report ("Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Compliance Reviews"), in accordance with 42 CFR §438.358, the state or its designee must conduct a review within the previous three-year period to determine each MCO's, PIHP's, PAHP's, or PCCM entity's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. Also as indicated previously, the EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

Background

As with the MCPs, PSPs, and the SHP, DHCS directly conducts compliance reviews of DMC plans rather than contracting with the EQRO to conduct reviews on its behalf. In May 2019, DHCS A&I began conducting annual audits with DMC plans to assess the plans' compliance with the Knox-Keene Health Care Service Plan Act of 1975 requirements and compliance with the Medi-Cal Dental Managed Care Program contracts. Before May 2019, the Department of Managed Health Care conducted the DMC plan compliance reviews.

As indicated in Section 4 of this report ("Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Compliance Reviews"), HSAG is unable to review DHCS' proprietary compliance review tools to determine whether the tools assess compliance with all federal and State requirements.

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

Under DHCS' monitoring protocols, DHCS oversees the CAP process to confirm that DMC plans address all deficiencies identified in the compliance reviews conducted (i.e., A&I Dental Audit). DHCS issues final closeout letters to these plans once they have submitted supporting documentation to substantiate that they have fully remediated all identified deficiencies and that the deficiencies are unlikely to recur. However, if corrective action requires more extensive changes to DMC plan operations and full implementation cannot be reasonably achieved without additional time, DHCS may close some deficiencies on the basis that sufficient progress has been made toward meeting set milestones. In these instances, DHCS may issue closeout letters to these plans with the understanding that progress on full implementation of corrective actions will be assessed in the next audit.

Compliance Reviews

DHCS Audits & Investigations Division Dental Audits

The purpose of the Dental Audit is for DHCS A&I to determine whether the dental services the DMC plan is providing to members comply with federal and State laws, Medi-Cal regulations and guidelines, and the State's GMC and PHP contracts. During the audit, A&I reviews the DMC plan's contract with DHCS, policies for providing services, and procedures the DMC plan uses to implement the policies. A&I also performs verification studies of the implementation and effectiveness of the policies. Finally, A&I reviews DMC plan documents and conducts interviews with the DMC plan's administrators and staff members. DHCS A&I Dental Audits cover the following review categories:

- Utilization Management
- Case Management and Coordination of Care
- Access and Availability of Care
- Member's Rights
- Quality Management

Objectives

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

- DHCS' compliance with conducting reviews with all DMC plans within the three-year period prior to the review dates for this report.
- DMC plans' compliance with the areas that DHCS reviewed as part of the compliance review process.

Methodology

As part of the EQR technical report production, DHCS submitted to HSAG all audit reports and CAP closeout letters for the most recent reviews for each DMC plan.

HSAG determined, by assessing the dates of each DMC plan's review, whether DHCS conducted compliance monitoring reviews for all DMC plans at least once within the three-year period prior to the review dates for this report. Unless noted, HSAG excluded from analysis information from compliance reviews conducted earlier than July 1, 2016, (i.e., three years prior to the start of the review period) and later than June 30, 2020, (i.e., the end of the review period).

HSAG reviewed all compliance-related information to determine the degree to which DMC plans are meeting the standards assessed as part of the compliance review process.

Additionally, HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about overall DMC plan performance in providing quality, accessible, and timely dental care services to members.

In addition to summarizing the aggregated results, HSAG also summarized DMC plan-specific results, including HSAG's recommendations. DMC plan-specific compliance review results and HSAG's recommendations are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

Results—Compliance Reviews

Due to the COVID-19 response efforts, in April 2020, DHCS A&I suspended its Dental Audits of DMC plans; however, DHCS continued to require DMC plans to comply with all CAP requirements imposed prior to COVID-19.

To assess DHCS' compliance with 42 CFR §438.358, HSAG reviewed the dates on which DHCS conducted its most recent compliance reviews of DMC plans and determined that DHCS conducted a compliance review no earlier than three years from the start of the review period for this report (July 1, 2019) and no later than the end of the review period for this report (June 30, 2020) for all DMC plans.

The following is a summary of notable results from HSAG's assessment of the compliance review information submitted by DHCS to HSAG for production of the 2019–20 DMC plan-specific evaluation reports and this EQR technical report. The summary includes new information not reported in previous review periods.

- DHCS provided evidence to HSAG of DHCS' ongoing follow-up with DMC plans regarding findings A&I identified during audits. DHCS provided documentation to HSAG of its follow-up with two DMC plans on CAPs as well as finding-related documentation from these DMC plans. DHCS determined that the documentation from the two DMC plans was detailed and reflected changes to policies and procedures to comply with all DHCS contract requirements.
- HSAG received Dental Audit results for all three DMC plans. A&I identified a finding in at least two review areas (e.g., Utilization Management, Member's Rights) in all three Dental Audits. Findings within the review areas were DMC plan-specific, with no findings cutting across all three DMC plans.

For the most up-to-date A&I Dental Audit reports, go to: https://www.dhcs.ca.gov/services/Pages/Dentalmanagedcare.aspx.

Conclusions—Compliance Reviews

Findings identified during A&I Dental Audits reflected opportunities for improvement for DMC plans in the areas of quality and timeliness of, and access to dental care. Audit findings within the assessed areas were DMC plan-specific; therefore, across all DMC plans, HSAG identified no common areas for improvement. DHCS demonstrated ongoing efforts to follow up on findings as evidenced in the audit reports, CAP responses, and final closeout letters that DHCS submitted to HSAG for review.

Recommendations—Compliance Reviews

HSAG has no recommendations for DHCS related to compliance reviews of DMC plans.

6. Performance Measure Validation

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of those entities' quality assessment and performance improvement programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(1)(ii) and (b)(2). The EQR technical report must include information on the validation of MCO, PIHP, PAHP, and PCCM entity performance measures (as required by the state) or MCO, PIHP, PAHP, and PCCM entity performance measures calculated by the state during the preceding 12 months.

Background

To comply with §438.358, DHCS contracted with HSAG to conduct an independent audit, in alignment with NCQA's HEDIS Compliance Audit™,[25] standards, policies, and procedures to assess the validity of the DHCS-selected performance measures calculated and submitted by MCPs, PSPs, and the SHP. Additionally, DHCS contracted with HSAG to conduct an independent audit of the DHCS-selected performance measures calculated and submitted by MLTSSPs, which are part of California's Coordinated Care Initiative (CCI). During each audit, HSAG evaluates two aspects of performance measures for each MCP, PSP, MLTSSP, and the SHP. First, HSAG assesses the validity of each plan's data using CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[26] Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about these plans' performance in providing quality, accessible, and timely care and services to their members.

Objectives

The purpose of HSAG's performance measure validation (PMV) is to ensure that each MCP, PSP, MLTSSP, and the SHP calculates and reports performance measures consistent with the established specifications and that the results can be compared to one another.

HSAG conducts HEDIS Compliance Audits and PMV, and analyzes performance measure results to:

- Evaluate the accuracy of the performance measure data collected.

[25] HEDIS Compliance Audit™ is a trademark of NCQA.
[26] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 26, 2021.

- Determine the extent to which each MCP, PSP, MLTSSP, and the SHP followed the established specifications for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

Note: MCPs, PSPs, the SHP, and MLTSSPs must calculate and report DHCS' required performance measure rates annually for a measurement year (January through December) at the reporting unit level. DHCS defines a "reporting unit level" as a single county, a combined set of counties, or a region as determined and pre-approved by DHCS.

Methodology

HSAG adheres to NCQA's *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information System (IS) Capabilities Assessment and an evaluation of compliance with performance measure specifications for a plan. All of HSAG's lead auditors are certified HEDIS compliance auditors.

Performance Measure Validation Activities

PMV involved three phases: audit validation, audit review, and follow-up and reporting. The following provides a summary of HSAG's activities with MCPs, PSPs, the SHP, and MLTSSPs, as applicable, within each of the audit phases. Throughout all audit phases, HSAG actively engages with MCPs, PSPs, the SHP, and MLTSSPs to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support these entities in understanding all audit requirements and in being able to report valid rates for all required performance measures.

Audit Validation Phase (October 2019 through May 2020)

- Forwarded HEDIS 2020 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Conducted annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled audit review (on-site or virtual) dates.
- Conducted kick-off calls to introduce the audit team; discuss the audit review agenda; provide guidance on HEDIS Compliance Audit and PMV processes; and ensure that MCPs, PSPs, the SHP, and MLTSSPs were aware of important deadlines.
- Reviewed completed HEDIS Roadmaps and Information Systems Capabilities Assessment Tool (ISCAT) to assess compliance with the audit standards and provided the IS standard tracking report that listed outstanding items and areas that required additional clarification.

- Reviewed source code used for calculating the HEDIS performance measure rates to ensure compliance with the technical specifications, unless the MCP, PSP, SHP, or MLTSSP used a vendor with HEDIS Certified Measures℠.[27]
- Reviewed source code used for calculating the non-HEDIS performance measure rates to ensure compliance with the specifications required by the State.
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation to ensure the integrity of medical record review processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Phase (January 2020 through April 2020)

- Conducted audit reviews (on-site or virtual) to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Note that starting in March 2020, under guidance from NCQA and in response to the public health and safety concerns surrounding the spread of COVID-19, HSAG coordinated and conducted remote, web-based virtual audit reviews in lieu of on-site visits. All required audit review activities, whether completed virtually or on-site, met NCQA's requirements.

Follow-Up and Reporting Phase (May 2020 through July 2020)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS 2019 Audit Means, Percentiles, and Ratios. The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Compared the final rates to the Patient Level Detail files required by DHCS, ensuring that data matched the final rate submission and met DHCS requirements.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

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

Description of Data Obtained

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

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

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

Performance Measure Results Analyses

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

HSAG assessed MCPs' and PSPs' performance in comparison to high performance levels and minimum performance levels and identified strengths; opportunities for improvement; and recommendations based on its assessment of MCP, PSP, SHP, and MLTSSP performance.

Aggregate MCP, PSP, SHP, and MLTSSP performance measure results, findings, and recommendations are included in Section 7, Section 8, Section 9, and Section 10 of this report ("Managed Care Health Plan Performance Measures," "Population-Specific Health Plan Performance Measures," "Specialty Health Plan Performance Measures," and "Managed Long-Term Services and Supports Plan Performance Measures," respectively).

Performance Measure Validation Results

In reporting year 2020, HSAG conducted 29 PMVs, with 28 of those being NCQA HEDIS Compliance Audits. The exception was Family Mosaic Project, an SHP that reported non-HEDIS measures and underwent PMV consistent with CMS protocols. These 29 MCPs, PSPs, and the SHP represented 60 separate data submissions for performance measure rates at the reporting unit level. HSAG also conducted PMVs with 25 MCPs for a select set of measures that DHCS required MCPs to stratify by the SPD and non-SPD populations, and with 13 MLTSSPs for their MLTSS populations.

Each PMV included preparation for the virtual or on-site audit review, Roadmap review, data systems review, supplemental data validation if applicable, source code review, a virtual or on-site audit review, medical record review validation when appropriate, primary source validation, query review, preliminary and final rate review, and initial and final audit reports production.

Of the 28 MCPs and PSPs that underwent NCQA HEDIS Compliance Audits, 26 used vendors with HEDIS Certified Measures to calculate and produce HEDIS measure rates. All seven vendors that represented these MCPs and PSPs each achieved full NCQA Measure Certification[SM, 28] status for the reported HEDIS measures. HSAG reviewed and approved the source code that Family Mosaic Project developed internally for calculation of the required non-HEDIS measures and the source code that Kaiser NorCal and Kaiser SoCal each developed internally for calculation of the required HEDIS measures. In addition, HSAG reviewed and approved source code used to calculate the required non-HEDIS measures for all MCPs and PSPs.

Note the following regarding PMV results:

- Aetna Better Health of California:
  - Reported a small number of members for its MLTSS population for San Diego County; however, there were not enough eligible members to report valid rates; therefore, HSAG assigned an audit designation of Not Applicable (NA) to both required MLTSSP measures in this reporting unit.
  - Did not have any eligible members for its MLTSS population in Sacramento County; therefore, HSAG includes no MLTSSP PMV results for this reporting unit.
- UnitedHealthcare Community Plan did not have any eligible members for its MLTSS population in San Diego County; therefore, HSAG includes no MLTSSP PMV results for this reporting unit.

Strengths—Performance Measure Validation

HSAG auditors identified the following strengths during the PMV process:

- Although they experienced challenges associated with COVID-19, all MCPs, PSPs, and the SHP were able to fully engage in the audit process and produce valid performance measure rates for all required MCAS measures.
- Auditors noted that in general, with few exceptions, MCPs, PSPs, and the SHP have integrated teams which include key staff members from both quality and information technology departments. Auditors observed that both areas worked closely together and had a sound understanding of the NCQA HEDIS Compliance Audit process. This multidisciplinary approach is crucial for reporting accurate and timely performance measure rates.

[28] NCQA Measure Certification[SM] is a service mark of NCQA.

- MCPs, PSPs, and the SHP used enrollment data as the primary data source for determining the eligible population for most measures. The routine data transfer and longstanding relationship between MCPs/PSPs/the SHP and DHCS continued to support implementation of best practices and stable processes for acquiring membership data. In addition to smooth and accurate processing by MCPs, PSPs, and the SHP, the data included fewer issues compared to previous years and fewer retrospective enrollment concerns.
- In reporting year 2020, the majority of MCPs and PSPs continued to increase use of supplemental data sources. These additional data sources offered MCPs and PSPs the opportunity to more accurately capture the services provided to their members. Moreover, reporting hybrid measures along with supplemental data reduced the burden and resources that MCPs and PSPs had to expend to abstract the clinical information.
- MCPs and PSPs had rigorous editing processes in place to ensure accurate and complete pharmacy data.
- Generally, and with few exceptions, MCPs and PSPs receive most claims data electronically and have a very small percentage of claims that require manual data entry, minimizing the potential for errors.

Opportunities for Improvement—Performance Measure Validation

Due to the continued increase in the number of supplemental data sources used for performance measure rate calculations, MCPs and PSPs have the opportunity to ensure that comprehensive and ongoing oversight processes are in place.

HSAG auditors identified MCP-, PSP-, and SHP-specific challenges and opportunities for improvement and provided feedback to these entities, as applicable, regarding the challenges and opportunities for improvement. While HSAG identified instances of some MCPs and PSPs being partially compliant with an IS standard, HSAG auditors determined that the identified issues had a minimal impact on performance measure reporting.

Recommendations—Performance Measure Validation

HSAG recommends the following to DHCS regarding PMV:

- Consider allowing MCPs and PSPs to choose the methodology for measure reporting (i.e., administrative or hybrid) for measures with specifications that allow for both methods. This would allow MCPs and PSPs to select the methodology that both maximizes performance and best uses resources.
- To support collection of information for performance measurement reporting, develop a process to gather information about the current use and barriers to use of supplemental data sources from clinical-based EHRs by MCPs and PSPs to increase integration of supplemental data sources from EHRs.

MCP-, PSP-, SHP-, and MLTSSP-specific PMV findings and recommendations are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

7. Managed Care Health Plan Performance Measures

Requirements

To comply with 42 CFR §438.330, DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets). Some of these measures are also HEDIS measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. MCPs must report county or regional rates unless otherwise approved by DHCS.

Medi-Cal Managed Care Accountability Set

DHCS' reporting year[29] 2020 MCAS consisted of a combination of HEDIS and CMS Adult and Child Core Set measures. Several required measures include more than one indicator, bringing the total number of performance measure rates required for MCP reporting to 52. In this report, HSAG uses "performance measure" or "measure" (rather than indicator) to reference required MCAS measures. Collectively, performance measure results reflect the quality and timeliness of, and access to care provided by MCPs to their members.

Table 7.1 lists the reporting year 2020 MCAS measures by measure domain. HSAG organized the measures into measure domains based on the health care areas they affect. Organizing the measures by domains allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS.

Additionally, Table 7.1 indicates the data capture method DHCS required MCPs to use for reporting year 2020 MCAS measures. For performance measures reported using the hybrid methodology, MCPs are required to procure medical record data. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCMC plans the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

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[29] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 7.1—Reporting Year 2020 (Measurement Year 2019) Managed Care Accountability Set Measures

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

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

Measure	Method of Data Capture
Children's Health Domain	
Adolescent Well-Care Visits	Hybrid
Childhood Immunization Status—Combination 10	Hybrid
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	Admin
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	Admin
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	Admin
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	Admin
Developmental Screening in the First Three Years of Life—Total	Admin
Immunizations for Adolescents—Combination 2	Hybrid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Body Mass Index (BMI) Percentile Documentation—Total	Hybrid

Measure	Method of Data Capture
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	Hybrid
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid
Women's Health Domain	
Breast Cancer Screening—Total	Admin
Cervical Cancer Screening	Hybrid
Chlamydia Screening in Women—Ages 16–20 Years	Admin
Chlamydia Screening in Women—Ages 21–24 Years	Admin
Chlamydia Screening in Women—Total	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	Admin
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	Admin
Contraceptive Care—All Women—LARC—Ages 21–44 Years	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	Admin
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	Admin
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	Admin
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	Admin
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	Admin

Measure	Method of Data Capture
Prenatal and Postpartum Care—Postpartum Care	Hybrid
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Hybrid
Behavioral Health Domain	
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	Admin
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	Admin
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication—Initiation Phase	Admin
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	Admin
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	Admin
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	Admin
Screening for Depression and Follow-Up Plan—Ages 65+ Years	Admin
Acute and Chronic Disease Management Domain	
Adult BMI Assessment—Total	Hybrid
Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total	Admin
Asthma Medication Ratio—Total	Admin
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total	Hybrid
Comprehensive Diabetes Care—HbA1c Testing—Total	Hybrid
Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years	Admin
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years	Admin
Controlling High Blood Pressure—Total	Hybrid
HIV Viral Load Suppression—Ages 18–64 Years	Admin
HIV Viral Load Suppression—Ages 65+ Years	Admin
Plan All-Cause Readmissions—Observed Readmissions—Total	Admin
Plan All-Cause Readmissions—Expected Readmissions—Total	Admin
Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total	Admin

Measure	Method of Data Capture
Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years	Admin

Seniors and Persons with Disabilities Performance Measure Stratification

In addition to requiring MCPs to report rates for MCAS measures in reporting year 2020, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department Visits per 1,000 Member Months*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *Plan All-Cause Readmissions*

DHCS-Established Performance Levels

To create a uniform standard for assessing MCPs on performance measures, DHCS established a high performance level and minimum performance level for each HEDIS measure within the reporting year 2020 MCAS, except the three *Plan All-Cause Readmissions* measures. DHCS established no high performance level and minimum performance level for these measures because no comparable benchmarks exist. DHCS uses the established high performance levels as performance goals and recognizes MCPs for outstanding performance. MCPs are contractually required to perform at or above DHCS-established minimum performance levels.

To establish the high performance levels and minimum performance levels for the reporting year 2020 MCAS HEDIS measures, DHCS used NCQA's Quality Compass®,[30] HEDIS 2019 Medicaid health maintenance organization (HMO) benchmarks. The Quality Compass HEDIS 2019 Medicaid HMO benchmarks reflect the previous year's benchmark percentiles (calendar year 2018). DHCS based the high performance levels for reporting year 2020 on NCQA's Quality Compass HEDIS 2019 Medicaid HMO 90th percentiles and the minimum performance levels for reporting year 2020 on the national Medicaid 50th percentiles.

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

DHCS initially determined to hold MCPs accountable to meet the minimum performance levels for 13 hybrid and five administrative measures; however, in April 2020, due to COVID-19 response efforts, DHCS made a decision to only hold MCMC plans accountable to meet the minimum performance levels for administrative measures. Additionally, in August 2020, DHCS determined not to impose CAPs or sanctions on any MCMC plan for failing to meet the minimum performance level for any MCAS measure in reporting year 2020, including both administrative and hybrid measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

DHCS assessed each MCP's reporting year 2019 performance measure rates against the established minimum performance levels and required MCPs to submit to DHCS an IP for each measure with a rate below the minimum performance level (unless the MCP was reporting a rate for the measure for the first time). An IP generally consisted of an MCP's submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a PIP for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. DHCS reviewed each IP submission (including PDSA Cycle Worksheets and SWOT analysis) for design soundness and anticipated intervention effectiveness, and HSAG validated the PIP submissions.

The IP process was one way that DHCS and MCPs engaged in efforts to improve the quality and timeliness of, and access to care for members, including targeting key quality improvement areas as outlined in DHCS' Comprehensive Quality Strategy (i.e., immunizations of two-year-olds, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs used structured quality improvement resources and a rapid-cycle approach (including the PDSA cycle process) to strengthen these key quality improvement areas. As a result, DHCS may not have required an MCP to submit IPs for all measures with rates below the minimum performance levels. However, MCPs continue to be contractually required to meet minimum performance levels for select MCAS measures.

Note that in April 2020, to allow MCMC plans to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP submissions related to reporting year 2019 performance measure results.

DHCS provided HSAG with a summary of MCPs' reporting year 2019 IPs for inclusion in the EQR technical report and in MCP-specific evaluation reports.

Reporting Year 2019 Corrective Action Plans

Based on reporting year 2019 performance measure results, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or if DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

Note that in April 2020, to allow MCMC plans to focus efforts on the COVID-19 response, DHCS waived requirements for remaining CAP PDSA cycle submissions related to reporting year 2019 performance measure results.

DHCS provided HSAG with a summary of MCPs' reporting year 2019 CAPs for inclusion in the EQR technical report and in MCP-specific evaluation reports.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 Quality Improvement Plan and a six-month progress update.

Sanctions

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

If an MCP continually fails to meet the established minimum performance levels or fails to submit the required information requested by DHCS during the CAP process, DHCS may:

- Impose additional monetary sanctions.
- Assign an MCP monitor or consultant.
- Terminate the MCP contract.

Note that based on DHCS not holding MCMC plans accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

MCMC Weighted Average Calculation Methodologies

For all but three measures, HSAG calculated the reporting year 2020 MCMC weighted averages according to CMS' methodology.[31] Based on DHCS allowing MCPs three options for reporting hybrid measure rates for reporting year 2020, some MCPs used their MCP-level reporting year 2019 rates for all or some of their reporting unit rates; therefore, HSAG modified the MCMC weighted average calculations for the following measures:

- *Adult BMI Assessment—Total*
- *Childhood Immunization Status—Combination 10*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*

The following is a summary of how HSAG modified the methodology for calculating the reporting year 2020 MCMC weighted averages for these three measures:

Adult BMI Assessment—Total

Anthem Blue Cross used the measurement year 2018 (reporting year 2019) MCP-level rate for every reporting unit for this measure; therefore, HSAG only used Anthem Blue Cross' MCP-level rate once to represent all 12 Anthem Blue Cross reporting units when calculating the reporting year 2020 MCMC weighted average for this measure.

Molina Healthcare of California (Molina) used the measurement year 2018 (reporting year 2019) MCP-level rates for two of its four reporting units (Riverside/San Bernardino counties and Sacramento County) and measurement year 2019 (reporting year 2020) reporting unit rates for the other two reporting units (Imperial County and San Diego County). HSAG only used Molina's MCP-level rate once when calculating the reporting year 2020 MCMC weighted

[31] Centers for Medicare & Medicaid Services. Technical Assistance Brief: Calculating State-Level Rates Using Data from Multiple Reporting Units. March 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf. Accessed on: Jan 26, 2021.

average for this measure; however, HSAG estimated the eligible population to represent the Riverside/San Bernardino counties and Sacramento County reporting units by removing the eligible populations of the two reporting units that did not use the measurement year 2018 (reporting year 2019) MCP-level rates (San Diego County and Imperial County).

Childhood Immunization Status—Combination 10

For the reporting units for which Anthem Blue Cross and Molina used their respective measurement year 2018 (reporting year 2019) *Childhood Immunization Status—Combination 3* measure MCP-level rates, HSAG used the eligible populations from the measurement year 2018 (reporting year 2019) reporting unit rates for the *Childhood Immunization Status—Combination 3* measure when calculating the reporting year 2020 MCMC weighted average. HSAG used the eligible population from the *Childhood Immunization Status—Combination 3* measure since it was the only *Childhood Immunization Status* measure DHCS required for reporting year 2019 and because it has the exact same eligible population as the *Childhood Immunization Status—Combination 10* measure.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total

Anthem Blue Cross used the measurement year 2018 (reporting year 2019) MCP-level rate for all 12 reporting units for this measure; therefore, HSAG only used Anthem Blue Cross' MCP-level rate once to represent all 12 Anthem Blue Cross reporting units when calculating the reporting year 2020 MCMC weighted average for this measure.

Results—Managed Care Health Plan Performance Measures

Table 7.2 through Table 7.5 present the reporting year 2020 performance measure results grouped by measure domains. The tables present reporting year 2020 MCMC weighted averages only, based on DHCS making changes to the performance measure requirements and age stratifications from the previous reporting year. HSAG will display performance measure rate comparisons in the 2020–21 EQR Technical Report and trending in the 2021–22 EQR Technical Report.

Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures due to the COVID-19 public health emergency, HSAG only presents the performance measure results and does not make conclusions or recommendations related to MCPs' reporting year 2020 performance measure results.

Children's Health Domain

Table 7.2 presents the reporting year 2020 MCMC weighted averages for measures within the Children's Health domain.

Table 7.2—Children's Health Domain Reporting Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	52.95%
Childhood Immunization Status—Combination 10	38.32%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.69%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	85.75%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.88%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	85.88%
Developmental Screening in the First Three Years of Life—Total	25.42%
Immunizations for Adolescents—Combination 2	43.57%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total	86.71%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	54.62%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.07%

Women's Health Domain

Table 7.3 presents the reporting year 2020 MCMC weighted averages for measures within the Women's Health domain.

Table 7.3—Women's Health Domain—Reporting Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	62.19%
Cervical Cancer Screening	64.67%
Chlamydia Screening in Women—Ages 16–20 Years	60.49%

Measure	Reporting Year 2020 Rate
Chlamydia Screening in Women—Ages 21–24 Years	69.52%
Chlamydia Screening in Women—Total	64.83%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.74%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.43%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.58%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.82%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.73%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.24%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.99%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	34.68%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	1.66%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.31%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	13.36%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.85%
Prenatal and Postpartum Care—Postpartum Care	77.55%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.86%

Behavioral Health Domain

Table 7.4 presents the reporting year 2020 MCMC weighted averages for measures within the Behavioral Health domain.

Table 7.4—Behavioral Health Domain—Reporting Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.36%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.12%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	39.92%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	47.21%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	15.18%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	9.72%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	11.85%

Acute and Chronic Disease Management Domain

Table 7.5 presents the reporting year 2020 MCMC weighted averages for measures within the Acute and Chronic Disease Management domain.

Table 7.5—Acute and Chronic Disease Management Domain—Reporting Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	92.46%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	44.82
Asthma Medication Ratio—Total	61.49%

Measure	Reporting Year 2020 Rate
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	34.23%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.77%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.60%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	11.00%
Controlling High Blood Pressure—Total	65.10%
HIV Viral Load Suppression—Ages 18–64 Years	7.32%
HIV Viral Load Suppression—Ages 65+ Years	6.36%
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.91%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.58%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.93
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.25%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	2.77%

Results—Seniors and Persons with Disabilities

Table 7.6 presents the SPD and non-SPD MCMC weighted averages, a comparison of the SPD and non-SPD MCMC weighted averages, and the total MCMC weighted averages for all measures MCPs stratified by SPD and non-SPD populations for reporting year 2020.

Table 7.6—Reporting Year 2020 (Measurement Year 2019) Medi-Cal Managed Care Weighted Averages Comparison and Results for Measures Stratified by the SPD Population

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

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

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

Reporting year 2020 total rates are based on the total statewide results, including the SPD and non-SPD populations. Please note, if no data are available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	72.70	42.63	Not Tested	44.82
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.41%	93.69%	-0.28	93.69%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	89.12%	85.68%	3.44	85.75%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.07%	87.81%	2.26	87.88%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.68%	85.85%	0.83	85.88%
*Plan All-Cause Readmissions—Total***	11.30%	8.04%	3.26	8.91%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable comparisons between the MCMC weighted averages for the SPD population and MCMC weighted averages for the non-SPD population in reporting year 2020:

- The reporting year 2020 MCMC weighted averages for the SPD population were significantly better than the reporting year 2020 MCMC weighted averages for the non-SPD population for the following measures:

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*

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

HEDIS Improvement Plans—Results

During the review period, six of the 25 MCPs that reported rates in reporting year 2019 (24 percent) had IPs in progress for performance measures with rates below the minimum performance levels in reporting year 2019. MCPs submitted PDSA Cycle Worksheets or SWOT analysis summaries to DHCS describing efforts to improve their performance on measures with rates below the minimum performance levels or conducted PIPs to improve performance. Triennially, at minimum, DHCS monitored MCPs on quality improvement activities and progress being made on improving performance. Additionally, DHCS provided technical assistance to MCPs as needed, in collaboration with HSAG.

Detailed summaries of the MCPs' IP activities (including PIPs) are included in their individual MCP-specific evaluation reports, located in the following appendices found in *Volume 2 of 3* of this EQR technical report:

- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Appendix E
- Blue Shield of California Promise Health Plan—Appendix F
- CalViva Health—Appendix I
- Inland Empire Health Plan—Appendix T
- Kern Health Systems, DBA Kern Family Health Care—Appendix W
- Molina Healthcare of California—Appendix Z

Based on DHCS not holding MCPs accountable to meet minimum performance levels in reporting year 2020 for any measures due to the COVID-19 public health emergency, HSAG was unable to assess if MCPs' quality improvement efforts resulted in improved performance on measures included in their IPs.

Note that as stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, all MCPs will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 Quality Improvement Plan that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

HEDIS Corrective Action Plans—Results

DHCS had four MCPs under HEDIS CAPs during the review period for this report. All four MCPs conducted comprehensive quality improvement activities that included provider- and member-level strategies. Detailed summaries of the MCPs' CAP activities are included in their individual MCP-specific evaluation reports, located in the following appendices included in *Volume 2 of 3* of this EQR technical report:

- California Health & Wellness Plan—Appendix G
- Health Net Community Solutions, Inc.—Appendix P
- Health Plan of San Joaquin—Appendix R
- Partnership HealthPlan of California—Appendix AA

As with the IPs, based on DHCS not holding MCPs accountable to meet minimum performance levels in reporting year 2020 for any measures due to the COVID-19 public health emergency, HSAG was unable to assess if MCPs' quality improvement efforts resulted in improved performance on measures included in their CAPs.

In September 2020, DHCS notified the four MCPs listed previously that DHCS was closing their CAPs, which were based on DHCS' previous performance measure set (EAS). As previously noted, all MCPs will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 Quality Improvement Plan that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. To ensure continued monitoring of the four MCPs following the CAP closures, DHCS will require these MCPs to meet quarterly via telephone with their assigned DHCS nurse consultant. While DHCS notified the MCPs of their CAP closures outside the review period for this EQR technical report, HSAG includes the information because it was available prior to this report being finalized.

Conclusions—Managed Care Health Plan Performance Measures

DHCS' MCAS is comprehensive and includes measures that assess the quality, accessibility, and timeliness of care MCPs provide to their members, including screening, prevention, health care, and utilization services. While DHCS did not hold MCPs accountable to meet minimum performance levels for reporting year 2020 due to COVID-19, DHCS supported MCPs in continuing to assess performance on measures and implement quality improvement strategies to address areas in need of improvement.

Throughout the review period, DHCS supported MCPs' efforts to provide quality, accessible, and timely health care to their members, including:

- Allowed MCPs flexibility related to performance measure requirements in response to the challenges associated with COVID-19 and provided ongoing guidance to MCPs regarding the provision of services in the midst of the public health emergency.
- Provided technical assistance to MCPs in collaboration with HSAG on implementation of rapid-cycle quality improvement strategies for measures with rates below the minimum performance levels and measures with year-over-year declining rates.
- Assisted MCPs with prioritizing areas in need of improvement and identifying performance measures for MCPs to use as focus areas for PIPs and IPs.
- Conducted monthly technical assistance calls and quarterly in-person leadership meetings with MCPs on CAPs to improve performance related to measures for which these MCPs had multiple years of performance below the minimum performance levels.
- Conducted technical assistance calls for MCPs not engaged in a CAP, as needed.
- Provided opportunities through quarterly collaborative discussions for DHCS and other State agencies (e.g., CDPH) to provide MCPs with information on resources and for MCPs to share information with each other about quality improvement efforts, successes, and lessons learned.
- Produced and disseminated to MCPs quality improvement briefs and postcards highlighting MCP promising practices, educational information, and resources related to:
  - Immunizations for adolescents, with an emphasis on the human papillomavirus (HPV) vaccination.
  - Providing preventive care to pregnant and postpartum members during the COVID-19 public health emergency.
  - Conducting well-child visits and administering immunizations for infants and young children during the COVID-19 public health emergency.
  - Managing members with diabetes during the COVID-19 public health emergency.
  - Managing members with hypertension during the COVID-19 public health emergency.
    - When sending this postcard to MCPs, DHCS included a list of quality improvement interventions being conducted by MCPs throughout California, as well as interventions other states, agencies, and organizations are implementing to promote safe access to preventive care during COVID-19.
- Conducted the annual MCP quality improvement survey to obtain feedback to help improve DHCS' quality improvement processes, including DHCS' strategies for providing relevant quality improvement technical assistance and support to MCPs.
- Continued updating the Quality Improvement Toolkit, which provides information about resources, promising practices to improve quality of care, ways to improve performance on measures, and ways to promote health equity.
- Hosted the *Health Equity: Promoting Quality and Access for All* quality improvement conference in October 2019 to provide the opportunity for MCPs to discuss health equity and learn about best practices for identifying health disparities and inequities and addressing barriers preventing members from receiving care.

In addition to supporting MCPs, DHCS contracted with HSAG to conduct analytic studies based on performance measure results to assess Medi-Cal beneficiaries' access to care and better understand health disparities affecting Medi-Cal beneficiaries. Summaries of the activities HSAG conducted using performance measure results are included in the "Focused Studies" section of this report.

Recommendations—Managed Care Health Plan Performance Measures

Based on reporting year 2020 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG has no recommendations for DHCS in the area of performance measures related to MCPs.

MCP-specific performance measure results and recommendations are included in the applicable appendices found in in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

8. Population-Specific Health Plan Performance Measures

Requirements

To comply with 42 CFR §438.330, DHCS selects performance measures to evaluate the quality of care PSPs delivered to their members. AIDS Healthcare Foundation, Rady Children's Hospital—San Diego, and SCAN Health Plan provide services to specialized populations; DHCS therefore has different performance measure requirements for these PSPs than exist for the MCPs or the SHP.

Beginning with reporting year 2020, DHCS modified its required performance measure set and renamed it MCAS (formerly called EAS). For reporting year 2020, DHCS required PSPs to report a set of measures specific to their population. The 2020 MCAS consisted of only select CMS Adult and Child Core set measures, some of which are also HEDIS measures. Based on the specialized populations served by the PSPs, HSAG does not calculate statewide weighted averages for any PSP measures; therefore, HSAG includes the individual PSP-specific performance measure results in this section of the EQR technical report. Note that HSAG only displays reporting year 2020 rates based on changes in performance measures and age stratifications from the previous reporting year. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019. HSAG will display performance measure rate comparisons in the 2020–21 EQR Technical Report and trending beginning in the 2021–22 EQR Technical Report.

Note that as with MCPs, DHCS allowed PSPs to choose from three options for hybrid measure reporting for reporting year 2020 due to travel restrictions, quarantines, and potential risk to PSP and provider staff members related to COVID-19. For reporting year 2020, all PSPs reported hybrid measure rates using measurement year 2019 data and following the hybrid methodology.

AIDS Healthcare Foundation

Table 8.1 lists the reporting year 2020 MCAS measures by measure domain and indicates the data capture method DHCS required AIDS Healthcare Foundation to use.

Table 8.1—AIDS Healthcare Foundation Reporting Year 2020 (Measurement Year 2019) Managed Care Accountability Set Measures

Admin = administrative method, which requires that PSPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, PSPs derive the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. PSPs may not use medical records to retrieve information. When using the administrative method, PSPs use the entire eligible population as the denominator.

Hybrid = hybrid method, which requires that PSPs identify the eligible population using administrative data, then extract a systematic sample of members from the eligible population,

which becomes the denominator. PSPs use administrative data to identify services provided to these members. When administrative data do not show evidence that PSPs provided the service, PSPs review medical records for those members to derive the numerator.

Measure	Method of Data Capture
Women's Health Domain	
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	Admin
Contraceptive Care—All Women—LARC—Ages 21–44 Years	Admin
Behavioral Health Domain	
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	Admin
Screening for Depression and Follow-Up Plan—Ages 65+ Years	Admin
Acute and Chronic Disease Management Domain	
Adult BMI Assessment—Total	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total	Hybrid
Comprehensive Diabetes Care—HbA1c Testing—Total	Hybrid
Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years	Admin
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years	Admin
Controlling High Blood Pressure—Total	Hybrid
HIV Viral Load Suppression—Ages 18–64 Years	Admin
HIV Viral Load Suppression—Ages 65+ Years	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years	Admin

Rady Children's Hospital—San Diego

Table 8.2 lists the reporting year 2020 MCAS measures by measure domain and indicates the data capture method DHCS required Rady Children's Hospital—San Diego to use.

Table 8.2—Rady Children's Hospital—San Diego Reporting Year 2020 (Measurement Year 2019) Managed Care Accountability Set Measures

Admin = administrative method, which requires that PSPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, PSPs derive the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. PSPs may not use medical records to retrieve information. When using the administrative method, PSPs use the entire eligible population as the denominator.

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

Measure	Method of Data Capture
Children's Health Domain	
Adolescent Well-Care Visits	Hybrid
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	Admin
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	Admin
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	Admin
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	Admin
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total	Hybrid
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid
Women's Health Domain	
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	Admin
Contraceptive Care—All Women—LARC—Ages 15–20 Years	Admin

Measure	Method of Data Capture
Acute and Chronic Disease Management Domain	
Ambulatory Care—ED Visits per 1,000 Member Months—Total	Admin

SCAN Health Plan

Table 8.3 lists the reporting year 2020 MCAS measures by measure domain and indicates the data capture method DHCS required SCAN Health Plan to use.

Table 8.3—SCAN Health Plan Reporting Year 2020 (Measurement Year 2019) Managed Care Accountability Set Measures

Admin = administrative method, which requires that PSPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, PSPs derive the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. PSPs may not use medical records to retrieve information. When using the administrative method, PSPs use the entire eligible population as the denominator.

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

Measure	Method of Data Capture
Women's Health Domain	
Breast Cancer Screening—Total	Admin
Behavioral Health Domain	
Screening for Depression and Follow-Up Plan—Ages 65+ Years	Admin
Acute and Chronic Disease Management Domain	
Adult BMI Assessment—Total	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total	Hybrid
Comprehensive Diabetes Care—HbA1c Testing—Total	Hybrid
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years	Admin
Controlling High Blood Pressure—Total	Hybrid

Measure	Method of Data Capture
Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years	Admin

DHCS-Established Performance Levels

Like MCPs, PSPs are contractually required to perform at or above DHCS-established minimum performance levels; and DHCS uses the established high performance levels as performance goals, recognizing PSPs for outstanding performance. PSPs are subject to the same quality monitoring, corrective action, and sanction processes as MCPs. See the description of these processes in Section 7 of this report ("Managed Care Health Plan Performance Measures").

As indicated in Section 7, in April 2020, due to COVID-19 response efforts, DHCS initially made a decision to only hold MCMC plans accountable to meet the minimum performance levels for administrative measures. Additionally, in August 2020, DHCS determined not to impose CAPs or sanctions on any MCMC plan for failing to meet the minimum performance level for any MCAS measure in reporting year 2020, including both administrative and hybrid measures. Instead, DHCS required all PSPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in Section 7.

Results—Population-Specific Health Plan Performance Measures

Table 8.4 through Table 8.6 display the reporting year 2020 performance measure results for the three PSPs. Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures due to the COVID-19 public health emergency, HSAG only presents the performance measure results and does not make conclusions or recommendations related to PSPs' reporting year 2020 performance measure results.

AIDS Healthcare Foundation

Table 8.4—Reporting Year 2020 Performance Measure Results
AIDS Healthcare Foundation—Los Angeles County

* A lower rate indicates better performance for this measure.

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Women's Health Domain	
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	NA
Contraceptive Care—All Women—LARC—Ages 21–44 Years	NA
Behavioral Health Domain	
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.00%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	NA
Acute and Chronic Disease Management Domain	
Adult BMI Assessment—Total	97.03%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total**	S
Comprehensive Diabetes Care—HbA1c Testing—Total	95.35%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years**	26.23%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	NA
Controlling High Blood Pressure—Total	60.00%
HIV Viral Load Suppression—Ages 18–64 Years	93.56%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years**	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	NA

Rady Children's Hospital—San Diego

Table 8.5—Reporting Year 2020 Performance Measure Results
Rady Children's Hospital—San Diego—San Diego County

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

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

Measure	Reporting Year 2020 Rate
Children's Health Domain	
Adolescent Well-Care Visits	42.62%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	73.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	72.73%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	66.67%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	99.46%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.91%
Women's Health Domain	
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	NA
Contraceptive Care—All Women—LARC—Ages 21–44 Years	NA
Acute and Chronic Disease Management Domain	
*Ambulatory Care—ED Visits—Total**	73.86

SCAN Health Plan

Table 8.6—Reporting Year 2020 Performance Measure Results
SCAN Health Plan—Los Angeles/Riverside/San Bernardino Counties

* A lower rate indicates better performance for this measure.

Measure	Reporting Year 2020 Rate
Women's Health Domain	
Breast Cancer Screening—Total	83.48%
Behavioral Health Domain	
Screening for Depression and Follow-Up Plan—Ages 65+ Years	17.81%
Acute and Chronic Disease Management Domain	
Adult BMI Assessment—Total	98.78%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total**	14.11%
Comprehensive Diabetes Care—HbA1c Testing—Total	94.89%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	13.27%
Controlling High Blood Pressure—Total	70.32%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	1.94%

Conclusions—Population-Specific Health Plan Performance Measures

DHCS' required performance measures for each PSP are specific to the PSP's unique population. While DHCS did not hold PSPs accountable to meet minimum performance levels for reporting year 2020 due to COVID-19, DHCS supported PSPs in continuing to assess performance on measures and implement quality improvement strategies to address areas in need of improvement.

Under the "Conclusions—Managed Care Health Plan Performance Measures" heading in Section 7 of this report, HSAG lists ways that DHCS supported MCPs' efforts to provide quality, accessible, and timely health care to their members. DHCS also supported PSPs in providing quality, accessible, and timely health care to their members through these efforts.

Recommendations—Population-Specific Health Plan Performance Measures

Based on reporting year 2020 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG has no recommendations for DHCS in the area of performance measures related to PSPs.

PSP-specific performance measure results and recommendations are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

9. Specialty Health Plan Performance Measures

Requirements

To comply with 42 CFR §438.330, DHCS selects performance measures to evaluate the quality of care delivered by the contracted SHPs to their members. Due to the specialized populations that SHPs serve, rather than requiring SHPs to report rates for the MCAS measures, DHCS collaborates with each SHP to select two measures appropriate to the SHP's Medi-Cal population. SHPs may select HEDIS measures or develop SHP-specific measures. SHPs must report county or regional rates unless otherwise approved by DHCS.

In reporting year 2020, DHCS held a contract with one SHP, Family Mosaic Project. Due to Family Mosaic Project's specialized population, DHCS determined that no HEDIS or CMS Core Set measures were appropriate for the SHP to report; therefore, DHCS required Family Mosaic Project to continue to report the two measures the SHP designed in collaboration with DHCS and HSAG to evaluate performance elements specific to the SHP.

Table 9.1 lists the reporting year 2020 performance measures DHCS required Family Mosaic Project to report.

Table 9.1—Reporting Year 2020 (Measurement Year 2020) Family Mosaic Project Performance Measures

Specialty Health Plan	Measure
Family Mosaic Project	*Promotion of Positive Pro-Social Activity*
	School Attendance

DHCS-Established Performance Levels

No national benchmarks exist for the SHP-developed measures; therefore, DHCS did not establish performance levels for Family Mosaic Project.

Results—Specialty Health Plan Performance Measures

Table 9.2 displays FMP's performance measure results for reporting years 2018, 2019, and 2020. The reporting year is the year in which the SHP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year.

Table 9.2—Multi-Year Performance Measure Results
Family Mosaic Project—San Francisco County

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Reporting year 2020 rates reflect measurement data from January 1, 2019, through December 31, 2019.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
School Attendance	NA	NA	NA	Not Comparable
Promotion of Positive Pro-Social Activity	NA	NA	NA	Not Comparable

Recommendations—Specialty Health Plan Performance Measures

Based on SHP reporting year 2020 performance measure results, HSAG draws no conclusions and has no recommendations for DHCS in the area of SHP performance measures.

SHP-specific performance measure results, findings, and recommendations are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

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

As part of the CCI, DHCS holds contracts with 13 MLTSSPs to provide long-term support services and Medicare wraparound benefits to dual-eligible beneficiaries who have opted out of or who are not eligible for Cal MediConnect.[32] Table 10.1 lists MLTSSPs and the counties in which they operate.

Table 10.1—Managed Long-Term Services and Supports Plans

Managed Long-Term Services and Supports Plans	Counties
Aetna Better Care of California	Sacramento and San Diego
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Santa Clara
Blue Shield of California Promise Health Plan (known as Care1st Health Plan prior to January 1, 2019)	San Diego
CalOptima	Orange
Community Health Group Partnership Plan	San Diego
Health Net Community Solutions, Inc.	Los Angeles and San Diego
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	Riverside and San Bernardino
Kaiser SoCal (KP Cal, LLC)	San Diego
L.A. Care Health Plan	Los Angeles
Molina Healthcare of California	Riverside, San Bernardino, and San Diego
Santa Clara Family Health Plan	Santa Clara
UnitedHealthcare Community Plan	San Diego

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

Requirements

Table 10.2 lists the four MCAS performance measures that DHCS required MLTSSPs to report for reporting year 2020 and indicates the data capture method DHCS required MLTSSPs to use. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Table 10.2—Reporting Year 2020 (Measurement Year 2019) Managed Long-Term Services and Supports Plan Performance Measures

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

Measure	Method of Data Capture
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	Admin
Plan All-Cause Readmissions—Observed Readmissions—Total	Admin
Plan All-Cause Readmissions—Expected Readmissions—Total	Admin
Plan All-Cause Readmissions—O/E Ratio—Total	Admin

Results—Managed Long-Term Services and Supports Plan Performance Measures

Table 10.3 presents the MLTSSP weighted averages for each reporting year 2020 required performance measure. Table 10.3 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. HSAG will display performance measure rate comparisons in the 2020–21 EQR Technical Report and trending beginning in the 2021–22 EQR Technical Report. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 10.3—Reporting Year 2020 Statewide Weighted Average Performance Measure Results for Managed Long-Term Services and Supports Plans

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	51.52
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.71%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.32%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.94

Recommendations—Managed Long-Term Services and Supports Plan Performance Measures

When DHCS evaluates the MLTSSP performance measure requirements, HSAG recommends that DHCS obtain input from MLTSSPs and other stakeholders regarding adding MLTSS-specific measures from CMS’ MLTSSP measure list to the DHCS MLTSSP required measure set.[33]

MLTSSP-specific performance measure results, findings, and recommendations are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

[33] Center for Medicaid and CHIP Services. Centers for Medicare & Medicaid Services. Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual (May 2019). Available at: https://www.medicaid.gov/media/3396. Accessed on: Jan 14, 2021.

11. Dental Managed Care Plan Performance Measures

Requirements

DHCS requires DMC plans to submit quarterly self-reported performance measure rates for each reporting unit (i.e., Los Angeles County and Sacramento County). To provide DHCS with ongoing, consistent comparison over time, DMC plans use a rolling 12-month methodology to display rates for a full year within each quarterly performance measure rate report.

Reporting year 2019 was the first year that DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year data from the previous calendar year. In May 2020, DMC plans submitted to DHCS both reporting units' reporting year 2020 performance measure audited rates reflecting measurement year 2019 data (i.e., January 1, 2019, through December 31, 2019).

Results—Dental Managed Care Plan Performance Measures

Table 11.1 presents the reporting year 2019 and 2020 DMC plan statewide weighted averages for each required performance measure. To allow HSAG to provide meaningful display of DMC plan performance, HSAG organized the performance measures according to health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Table 11.1—Reporting Years 2019 and 2020 Statewide Weighted Average Performance Measure Results for Dental Managed Care Plans

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

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

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Access to Care			
Annual Dental Visits—Ages 0–20 Years	39.28%	40.72%	1.44
Annual Dental Visits—Ages 21+ Years	18.95%	19.78%	0.83
Continuity of Care—Ages 0–20 Years	63.68%	53.87%	-9.81
Continuity of Care—Ages 21+ Years	32.21%	21.91%	-10.31
Exam/Oral Health Evaluations—Ages 0–20 Years	34.48%	35.94%	1.46
Exam/Oral Health Evaluations—Ages 21+ Years	14.08%	14.68%	0.61
General Anesthesia—Ages 0–20 Years	65.17%	60.56%	-4.61
General Anesthesia—Ages 21+ Years	34.84%	22.47%	-12.36
Overall Utilization of Dental Services–One Year—Ages 0–20 Years	42.57%	44.12%	1.55
Overall Utilization of Dental Services–One Year—Ages 21+ Years	19.17%	20.04%	0.87
Use of Dental Treatment Services—Ages 0–20 Years	19.52%	21.19%	1.67
Use of Dental Treatment Services—Ages 21+ Years	12.56%	13.26%	0.70
Usual Source of Care—Ages 0–20 Years	32.93%	33.72%	0.79
Usual Source of Care—Ages 21+ Years	8.80%	10.04%	1.23
Preventive Care			
Preventive Services to Filling—Ages 0–20 Years	82.51%	84.54%	2.03
Preventive Services to Filling—Ages 21+ Years	36.01%	37.96%	1.95
Sealants to Restoration Ratio (Surfaces)—Ages 6–9 Years	5.42	5.88	0.46

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Sealants to Restoration Ratio (Surfaces)—Ages 10–14 Years	2.39	2.29	-0.10
Treatment/Prevention of Caries—Ages 0–20 Years	29.90%	31.85%	1.95
Treatment/Prevention of Caries—Ages 21+ Years	7.48%	8.21%	0.73
Use of Preventive Services—Ages 0–20 Years	33.61%	35.50%	1.89
Use of Preventive Services—Ages 21+ Years	7.84%	8.56%	0.72
Use of Sealants—Ages 6–9 Years	13.75%	14.18%	0.43
Use of Sealants—Ages 10–14 Years	6.76%	7.08%	0.32

Findings—Dental Managed Care Plan Performance Measures

HSAG observed the following notable aggregate DMC plan performance measure results for reporting year 2020:

- The DMC plan statewide weighted averages for 16 of 24 measures (67 percent) improved significantly from reporting year 2019 to reporting year 2020.
- The DMC plan statewide weighted averages for the two *Continuity of Care* measures (8 percent of all measures reported) declined significantly from reporting year 2019 to reporting year 2020.

Conclusions—Dental Managed Care Plan Performance Measures

While the statewide weighted averages show opportunity for improvement related to ensuring members receive a comprehensive oral evaluation or prophylaxis in the recommended time frame, DMC plan statewide weighted averages show that across most measures, DMC plans demonstrated significant improvement in ensuring member access to dental care services and providing preventive dental care from reporting year 2019 to reporting year 2020.

Recommendations—Dental Managed Care Plan Performance Measures

Based on reporting year 2020 aggregate DMC plan performance measure results, HSAG has no recommendations for DHCS in the area of performance measures related to DMC plans. While HSAG has no recommendations for DHCS, in the DMC plan-specific evaluation reports, HSAG made recommendations to the DMC plans with performance measure rates that declined significantly from reporting year 2019 to reporting year 2020.

DMC plan-specific performance measure results, findings, and recommendations are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

12. Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Performance Improvement Projects

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

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

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

Background

To comply with the CMS requirements, since 2008 DHCS has contracted with HSAG to conduct an independent validation of PIPs submitted by MCPs, PSPs, and the SHP. HSAG uses a two-pronged approach. First, HSAG provides training and technical assistance to these plans on how to design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. Then, HSAG assesses the validity and reliability of PIP submissions to draw conclusions about the quality and timeliness of, and access to care furnished by these plans.

Rapid-Cycle Performance Improvement Projects

HSAG's rapid-cycle PIP approach places emphasis on improving both health care outcomes and processes through the integration of quality improvement science. This approach guides MCMC plans through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of changes requires fewer resources and allows more flexibility for adjusting throughout the improvement process. By piloting changes on a smaller scale, MCMC plans have opportunities to determine the effectiveness of several changes prior to expanding the successful interventions.

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. The following modules guide these plans through the rapid-cycle PIP approach:

- Module 1: PIP Initiation
- Module 2: Intervention Determination
- Module 3: Intervention Testing
- Module 4: PIP Conclusions

While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for MCMC plans to test interventions. Modules 1 through 3 create the basic infrastructure to help MCMC plans identify interventions to test. Through an iterative process, these plans have opportunities to revise modules 1 through 3 to achieve all validation criteria. Once the plans achieve all validation criteria for modules 1 through 3, they test interventions using a series of PDSA cycles. For each intervention it tests on a small scale using the PDSA cycle, each MCMC plan must submit a separate PDSA worksheet and determine the next steps based on results and lessons learned.

Once MCMC plans complete intervention testing, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was unsuccessful and should be stopped (abandon). MCMC plans complete Module 4 after testing all interventions and finalizing analyses of the PDSA cycles. Module 4 summarizes the results of the tested interventions. At the end of the PIP, the plans identify successful interventions that may be implemented on a larger scale to achieve the desired health care outcomes.

Requirements

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

2017–19 Performance Improvement Projects

For PIPs that began in July 2017, DHCS set two categories of PIP topic selection for MCPs, PSPs, and the SHP. For MCPs, DHCS required that the first PIP topic involve an identified health disparity (Disparity PIP). DHCS required that the second PIP topic be related to the MCP's performance on a metric related to one of the four MCMC quality strategy priority areas (DHCS-priority PIP). DHCS set the following DHCS-priority PIP topic selection criteria:

- DHCS required an MCP to choose *Childhood Immunizations—Combination 3* as its topic if the MCP performed below the minimum performance level on the measure in reporting year 2017 or performed below the statewide MCMC average, with declining performance on the measure having occurred in reporting year 2017.

  If the MCP was not required to choose *Childhood Immunizations—Combination 3* as a topic based on the criteria listed above, DHCS required that the MCP focus the DHCS-priority PIP topic on:

  - *Controlling High Blood Pressure, Comprehensive Diabetes Care,* or *Prenatal and Postpartum Care—Postpartum Care* if the MCP performed below the minimum performance levels on any of these measures in reporting year 2017. If an MCP performed below the minimum performance levels for more than one of these measures in reporting year 2017, DHCS required that the MCP choose the measure for which it has performed below the minimum performance level for consecutive years or the measure for which the MCP's performance has been significantly declining for consecutive years;

  Or:

  - If in reporting year 2017 an MCP performed above the minimum performance level and MCMC average for *Childhood Immunizations—Combination 3* and above the minimum performance levels for *Controlling High Blood Pressure, Comprehensive Diabetes Care,* and *Prenatal and Postpartum Care—Postpartum Care*, DHCS required that the MCP choose a PIP topic for any area in need of improvement.

For PSPs and the SHP, when Disparity PIP topics were not applicable, DHCS required that PSPs and the SHP identify two topics using the topic selection criteria for DHCS-priority PIPs.

The 2017–19 PIPs for MCPs, PSPs, and the SHP concluded on June 30, 2019.

2019–21 Performance Improvement Projects

For PIPs that began in July 2019, DHCS set two new categories of PIP topic selection for MCPs, PSPs, and the SHP. For MCPs and PSPs, DHCS continued to require that the first PIP topic involve an identified health disparity (Health Equity PIP). For the second PIP topic, DHCS required that MCPs and PSPs identify an area in need of improvement related to child and adolescent health (Child and Adolescent Health PIP). For PSPs that do not serve the child and adolescent populations, DHCS required that the PSPs choose a PIP topic for any area in need of improvement, supported by plan-specific data. DHCS required the SHP to identify two PIP topics on a clinical or nonclinical area for which improvement would have a favorable impact on health outcomes or member satisfaction.

The SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date for the 2019–20 PIPs is June 30, 2021.

Objectives

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

HSAG evaluates two key components of each PIP:

- Technical structure, to determine whether a PIP's initiation (i.e., topic rationale, PIP team, global aim, SMART aim, key driver diagram, and data collection methodology) is based on sound methodology and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- Conducting of quality improvement activities. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing, evaluation using PDSA cycles, sustainability, and spreading successful change. This component evaluates how well MCPs, PSPs, and the SHP execute quality improvement activities and whether the PIP achieves and sustains the desired aim.

Methodology

Based on the agreed-upon timeline, MCPs, PSPs, and the SHP submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to these plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. HSAG conducts PIP validation in accordance with the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[34] Following are the validation criteria that HSAG uses for each module:

Module 1—PIP Initiation

- The narrowed focus was supported by the data.
- The SMART Aim measure baseline specifications and data collection methodology supported the rapid-cycle process and included the following:
  - Data source(s).
  - Step-by-step process.
  - SMART Aim baseline data.

[34] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 26, 2021.

- The SMART Aim was stated accurately and included all required components and rationale (narrowed focus, baseline percentage, goal percentage, and end date)
- The SMART Aim run chart included the titles, goal percentage, baseline percentage, and data collection interval.
- The MCMC plan confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.

Module 2—Intervention Determination

- The MCMC plan included a process map(s) that clearly illustrated the step-by-step flow of the current process for the narrowed focus.
- The steps in the process map(s) identified as gaps or opportunities for improvement were clearly labeled.
- The steps documented in the failure modes and effects analysis (FMEA) table aligned with the steps in the process map that were identified as gaps or opportunities for improvement.
- The failure mode(s), failure cause(s), and failure effect(s) were logically linked to the listed step(s) in the FMEA table.
- The MCMC plan prioritized the listed failure modes and ranked them from highest to lowest in the Failure Mode Priority Ranking table.
- The drivers and interventions in the key driver diagram were clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

Module 3—Intervention Testing

- The Intervention Plan included at least one key driver and failure mode.
- The MCMC plan included all required components for the Intervention Plan.
- The Intervention Effectiveness Measure(s) was appropriate for the intervention.
- The data collection process was appropriate for the intervention effectiveness measure(s).

Module 4—PIP Conclusions

- The rolling 12-month data collection methodology was followed for the SMART Aim measure for the duration of the PIP.
- The SMART Aim goal was achieved as illustrated in the final SMART Aim run chart.
- If the SMART Aim goal was achieved, the improvement can be clearly linked to at least one tested intervention.
- The MCMC plan completed the PDSA worksheet(s), and the interpretation of testing results and data were accurate.
- The narrative summary of the overall PIP findings was complete and accurate.
- If the SMART Aim goal was achieved, the MCMC plan documented a plan for sustaining the improvement beyond the SMART Aim end date.

- If an intervention(s) was successful, the MCMC plan documented the plan for spreading the intervention(s) beyond the scope of the narrowed focus.

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

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to at least one intervention tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to at least one intervention tested; however, the MCMC plan did not accurately summarize the key findings.
- Low confidence—the PIP was methodologically sound; however, one of the following occurred:
  - The PIP did not achieve the SMART Aim goal.
  - The PIP achieved the SMART Aim goal; however, the demonstrated improvement could not be linked to any of the tested interventions.
- Reported PIP results were not credible (referred to in this report as "not credible")—the SMART Aim measure and/or the approved rapid-cycle PIP process was not followed through the SMART Aim end date.

After validating each PIP module, HSAG provides written feedback to MCMC plans summarizing HSAG's findings and whether the plans achieved all validation criteria. Once MCMC plans achieve all validation criteria for modules 1 through 3, the plans test intervention(s) through the end of the SMART Aim end date. HSAG requests status updates from the plans throughout the intervention testing phase of the PIP process and, when needed, provides technical assistance.

HSAG validated up to the point of PIP progression for each MCP, PSP, and the SHP as of June 30, 2020; results of the validation activities completed by June 30, 2020, are included in this report. Note that in March 2020, HSAG encouraged MCPs, PSPs, and the SHP to notify DHCS and HSAG of any impact on PIP activities due to the COVID-19 response efforts. HSAG provided technical assistance and granted PIP module submission extensions based on individual MCMC plan circumstances. In June 2020, due to challenges MCPs, PSPs, and the SHP were continuing to experience in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020.

MCP-, PSP-, and SHP-specific PIP activities are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

Results—Performance Improvement Projects

2017–19 Performance Improvement Projects

During the review period, MCPs, PSPs, and the SHP submitted modules 4 and 5 for the 2017–19 PIPs, which had a SMART Aim end date of June 30, 2019. HSAG validated 79 Module 4 submissions and 52 Module 5 submissions, and notified MCPs, PSPs, the SHP, and DHCS of the validation findings.

Based on HSAG's assessment of the validity and reliability of the 2017–19 PIP results, following is a breakdown of the final confidence levels HSAG assigned to the 52 PIPs that MCPs, PSPs, and the SHP concluded by June 30, 2019:

- *High Confidence*: 2 (4 percent)
- *Confidence*: 7 (13 percent)
- *Low Confidence*: 42 (81 percent)
- *Not Credible*: 1 (2 percent)

Overall, the two PIPs with a *High Confidence* rating:

- Followed the approved PIP methodology.
- Presented the findings clearly and accurately, in alignment with the approved methodology.
- Achieved the SMART Aim goal.
- Documented data to clearly link improvement in the SMART Aim measure to tested interventions.

The majority of the PIPs with a *Low Confidence* rating received the rating due to not achieving the SMART Aim goal. During technical assistance calls with HSAG and in the Module 5 submissions, MCPs, PSPs, and the SHP provided information about factors they believed contributed to the PIPs not progressing as planned, to being unable to achieve the SMART Aim goal, or to being unable to link the tested interventions to the demonstrated improvement. The following are notable factors identified by MCPs, PSPs, and the SHP:

- Organizational Factors
  - Staffing changes, including the lead for the PIP going on leave and PIP team members quitting.
  - Unexpected delays in obtaining or distributing data.
  - Inaccuracy of the data.
  - Inability to reach members with outreach and the intervention due to having inaccurate contact information or members declining the intervention.
  - Not receiving timely approval from the State for member-facing materials.

- Provider Factors
  - Staffing not consistently sufficient to accommodate the intervention while also handling normal business operations.
  - Providers having scheduling conflicts and competing priorities.
  - Difficulty implementing a new process into the clinic workflow.

Despite well-executed quality improvement efforts, MCPs, PSPs, and the SHP may not achieve the SMART Aim goals due to other confounding factors. Through the PIP process, however, MCPs, PSPs, and the SHP may have small successes, standardize processes, determine successful interventions, and identify lessons learned that they can apply to future improvement projects.

Across all 2017–19 PIPs, MCPs, PSPs, and the SHP tested interventions targeting members and providers. MCP-, PSP-, and SHP-specific intervention testing validation and SMART Aim measure attainment results, along with information on whether or not MCPs, PSPs, and the SHP decided, based on intervention testing results, to adopt, adapt, or abandon the interventions are included in the MCP-, PSP-, and SHP-specific evaluation reports found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

2019–21 Performance Improvement Projects

Prior to beginning the 2019–21 PIPs, DHCS required MCPs, PSPs, and the SHP to submit proposals for both the Health Equity PIP and Child and Adolescent Health PIP topics. With HSAG's input, DHCS approved 58 PIP topics.

Upon receiving PIP topic approvals, MCPs, PSPs, and the SHP initiated the 2019–21 PIPs. During the review period, HSAG conducted trainings on rapid-cycle PIP Version 5 modules 1 through 4 submission forms and requirements. HSAG validated the following modules and notified MCPs, PSPs, the SHP, and DHCS of the validation findings:

- Module 1—58 initial submissions and 66 resubmissions
- Module 2—54 initial submissions and 42 resubmissions
- Module 3—34 initial submissions and 23 resubmissions

As previously noted, starting in March 2020, HSAG provided technical assistance and granted PIP module submission extensions based on the impact of COVID-19 response efforts on PIP activities. In June 2020, due to challenges MCPs, PSPs, and the SHP were continuing to experience in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. DHCS encouraged MCPs, PSPs, and the SHP to continue improvement efforts related to their PIP topics until DHCS announces next steps for resuming PIPs.

Performance Improvement Projects Topics

Table 12.1 lists MCPs', PSPs', and the SHP's 2017–19 PIPs and 2019–21 PIP topics.

Table 12.1—Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Performance Improvement Project Topics

* PIP conducted as part of CAP process.

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

MCP, PSP, or SHP Name	2017–19 PIP Topics	2019–21 PIP Topics
Managed Care Health Plans		
Aetna Better Health of California	No PIP conducted (MCP began providing services starting January 1, 2018, after the start of the 2017–19 PIPs)	*Cervical Cancer Screening Among White Women* (Health Equity PIP)
		Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Alameda Alliance for Health	*Children/Adolescent Access to Primary Care Physicians*	*Well-Child Visits in the First 15 months of Life Among African-American Infants* (Health Equity PIP)
	Diabetes Care HbA1c Testing Among African-American Males (Disparity PIP)	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	*Asthma Medication Ratio Among African Americans* (Disparity PIP)	*Childhood Immunizations—Combination 10*
	Postpartum Care	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life Among African-American Children* (Health Equity PIP)
Blue Shield of California Promise Health Plan	*Childhood Immunization Status—Combination 3 Among Non-Hispanic Children* (Disparity PIP)	*Childhood Immunization Status—Combination 3 Among Non-Hispanic Children* (Health Equity PIP)
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

MCP, PSP, or SHP Name	2017–19 PIP Topics	2019–21 PIP Topics
California Health & Wellness Plan	*Childhood Immunization Status—Combination 3**	*Cervical Cancer Screening Among Members in Region 2** (Health Equity PIP)
	*Controlling Blood Pressure Among Hispanic Members** (Disparity PIP)	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**
CalOptima	*Adult's Access to Preventive/Ambulatory Health Services*	*Primary Care Provider Visits Among Members Experiencing Homelessness* (Health Equity PIP)
	Diabetes Care Poor HbA1c Control in Santa Ana City (Disparity PIP)	*Well-Child Visits in the First 15 Months of Life*
CalViva Health	*Childhood Immunization Status—Combination 3**	*Breast Cancer Screening Among Hmong-Speaking Members* (Health Equity PIP)
	*Postpartum Care in Fresno County** (Disparity PIP)	*Childhood Immunization Status—Combination 10*
CenCal Health	*Childhood Immunization Status—Combination 3*	*Postpartum Care Among Members in San Luis Obispo County* (Health Equity PIP)
	Human Papillomavirus Vaccination Among Adolescents in Santa Barbara County (Disparity PIP)	*Well-Child Visits in the First 15 Months of Life*
Central California Alliance for Health	*Childhood Immunization Status—Combination 3*	*Adolescent Well-Care Visits Among Members in Merced County* (Health Equity PIP)
	Opioid Overdose Deaths Among Members in Merced County (Disparity PIP)	*Childhood Immunization Status—Combination 10*
Community Health Group Partnership Plan	*Annual Provider Visits Among Males 20 to 30 Years of Age* (Disparity PIP)	*Adolescent Well-Care Visits*
	Childhood Immunization Status—Combination 3	*Cervical Cancer Screening Among Members in Cities of Lemon Grove, Spring Valley, and La Mesa* (Health Equity PIP)

MCP, PSP, or SHP Name	2017–19 PIP Topics	2019–21 PIP Topics
Contra Costa Health Plan	*Controlling Blood Pressure Among African-American Members* (Disparity PIP)	*Diabetes Control Among Spanish-Speaking Hispanic/Latino Members* (Health Equity PIP)
	Diabetes Nephropathy Screening	*Well-Child Visits in the First 15 Months of Life*
Gold Coast Health Plan	*Childhood Immunization Status—Combination 3*	*Adolescent Well-Care Visits*
	Diabetes Care Poor HbA1c Control Among Non-English-Speaking Hispanic/Latino Members (Disparity PIP)	*Cervical Cancer Screening Among Members in Area 5* (Health Equity PIP)
Health Net Community Solutions, Inc.	*Cervical Cancer Screening Among Mandarin-Speaking Chinese Members** (Disparity PIP)	*Cervical Cancer Screening Among Members in Sacramento County** (Health Equity PIP)
	*Childhood Immunization Status—Combination 3**	*Childhood Immunization Status—Combination 10**
Health Plan of San Joaquin	*Cervical Cancer Screening Among White Women 24 to 64 Years of Age in Stanislaus County** (Disparity PIP)	*Adolescent Well-Care Visits**
	*Childhood Immunization Status—Combination 3**	*Cervical Cancer Screening Among White Women 24 to 64 Years of Age in Stanislaus County** (Health Equity PIP)
Health Plan of San Mateo	*Asthma Medication Ratio*	*Adolescent Well-Care Visits*
	Cervical Cancer Screening Among English-Speaking Members (Disparity PIP)	*Cervical Cancer Screening Among Members Living with Disabilities* (Health Equity PIP)
Inland Empire Health Plan	*Asthma Medication Ratio*	*Adolescent Well-Care Visits Among Members in City of Victorville* (Health Equity PIP)
	Childhood Immunization Status—Combination 10 Among African-American Members in Riverside County (Disparity PIP)	*Well-Child Visits in the First 15 Months of Life*

MCP, PSP, or SHP Name	2017–19 PIP Topics	2019–21 PIP Topics
Kaiser NorCal	*Contraception Use Among Adolescent Women in South Sacramento* (Disparity PIP)	*Adolescent Well-Care Visits*
	Initial Health Assessment	*Hypertension Control Among African-American Members in South Sacramento* (Health Equity PIP)
Kaiser SoCal	*Adolescent Vaccinations*	*Adolescent Well-Care Visits*
	Depression Screening Among Hispanic/Latino Members (Disparity PIP)	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (Health Equity PIP)
Kern Health Systems, DBA Kern Family Health Care	*Childhood Immunization Status—Combination 3 Among African-American Members* (Disparity PIP)	*Asthma Medication Ratio*
	Use of Imaging Studies for Lower Back Pain	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life Among Members in Central Bakersfield* (Health Equity PIP)
L.A. Care Health Plan	*Childhood Immunization Status—Combination 3*	*Asthma Medication Ratio Among Members in Service Planning Area 6* (Health Equity PIP)
	Diabetes Medication Adherence Among African-American Members (Disparity PIP)	*Childhood Immunization Status—Combination 10*
Molina Healthcare of California	*Childhood Immunization Status—Combination 3*	*Childhood Immunization Status—Combination 10*
	Postpartum Care Among African-American Members in Riverside/San Bernardino Counties (Disparity PIP)	*Diabetes Testing Among Members in Sacramento County* (Health Equity PIP)
Partnership HealthPlan of California	*Childhood Immunization Status—Combination 3**	*Well-Child Visits in the First 15 Months of Life Among Hispanic/Latino Members** (Health Equity PIP)
	*Diabetes Nephropathy Screening in Southwest Region** (Disparity PIP)	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**

MCP, PSP, or SHP Name	2017–19 PIP Topics	2019–21 PIP Topics
San Francisco Health Plan	*Immunizations for Adolescents—Combination 2*	*Breast Cancer Screening Among African-American Members* (Health Equity PIP)
	Postpartum Care Among African-American Members (Disparity PIP)	*Well-Child Visits in the First 15 Months of Life*
Santa Clara Family Health Plan	*Childhood Immunization Status—Combination 3 Among Vietnamese Members* (Disparity PIP)	*Adolescent Well-Care Visits Among Members in Network 20* (Health Equity PIP)
	Controlling High Blood Pressure	*Well-Child Visits in the First 15 Months of Life*
UnitedHealthcare Community Plan**	No PIP conducted (MCP began providing services starting January 1, 2018, after the start of the 2017–19 PIPs)	*Cervical Cancer Screening*
		Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Population-Specific Health Plans		
AIDS Healthcare Foundation**	*Colorectal Cancer Screening*	*Controlling High Blood Pressure*
	Diabetes Retinal Eye Exam	*Diabetes Retinal Eye Exam*
Rady Children's Hospital—San Diego**	No PIP conducted (PSP began providing services starting January 1, 2018, after the start of the 2017–19 PIPs)	*Diabetes Control*
		Flu Vaccination
SCAN Health Plan	*Cholesterol Medication Adherence*	*Breast Cancer Screening*
	Statin Use in Persons with Diabetes in San Bernardino County (Disparity PIP)	*Diabetes Control Among Spanish-Speaking Members* (Health Equity PIP)
Specialty Health Plan		
Family Mosaic Project**	*Improving Client Access and Use of Recreational Activities*	*Improving Family Functioning*
	Reducing Physical Health Issues	*Reducing Anxiety Symptoms*

Conclusions—Performance Improvement Projects

During the review period, MCPs, PSPs, and the SHP completed their 2017–19 PIPs and HSAG assigned final confidence levels to all 52 PIPs. Through HSAG's PIP training, validation, and technical assistance, MCPs, PSPs, and the SHP successfully initiated the 2019–21 PIPs on a variety of health equity and child and adolescent health topics; however, due to the challenges of conducting PIPs during the COVID-19 public health emergency, DHCS elected to end the 2019–21 PIPs as of June 30, 2020. While DHCS elected to end the PIPs, it encouraged MCPs, PSPs, and the SHP to continue improvement efforts related to their PIP topics until the next set of PIPs begin, projected to launch in October 2020.

Recommendations—Performance Improvement Projects

Based on the 2017–19 PIP outcomes, HSAG has no recommendations for DHCS in the area of PIPs.

HSAG includes MCP-, PSP-, and SHP-specific PIP recommendations, as applicable, in appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

13. Dental Managed Care Plan Performance Improvement Projects

As indicated in Section 12 of this report ("Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Performance Improvement Projects"), validating PIPs is one of the mandatory EQR activities described at 42 CFR §438.358(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction, and (2) focuses on clinical and/or nonclinical areas that involve the following:

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

Also as indicated previously, the EQR technical report must include information on the validation of PIPs required by the state and underway during the preceding 12 months.

Background

Beginning in January 2019, DHCS contracted with HSAG to work on QIPs with DHCS and the DMC plans. DHCS requested that HSAG provide technical assistance to DMC plans and DHCS related to the statewide QIP. Additionally, DHCS requested that HSAG conduct DMC plan training about HSAG's rapid-cycle PIP process so that DMC plans could begin conducting their individual QIPs using HSAG's rapid-cycle PIP process.

Requirements

DHCS requires DMC plans to conduct or participate in two QIPs each year, one of which is the statewide QIP. DMC plans must consult with DHCS about the second individual QIP topic.

Statewide Quality Improvement Project

DHCS requires DMC plans to conduct a statewide QIP to increase preventive services among children ages 1 to 20 by 10 percentage points by the end of 2023. Beginning in February 2019, DHCS required DMC plans to submit two reports annually—one intervention progress report to HSAG and an annual QIP submission to DHCS.

Individual Performance Improvement Project

Beginning in February 2019, DHCS required DMC plans to convert their individual QIPs to rapid-cycle PIPs and to follow HSAG's rapid-cycle PIP process as described in Section 12 of this report. With the transition of DMC plans' individual QIPs to HSAG's rapid-cycle PIP process, HSAG refers to DMC plans' individual QIPs as individual PIPs.

Objectives

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

HSAG evaluates two key components of each PIP:

- ♦ Technical structure, to determine whether a PIP's initiation (i.e., topic rationale, PIP team, global aim, SMART aim, key driver diagram, and data collection methodology) is based on sound methodology and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- ♦ Conducting of quality improvement activities. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing, evaluation using PDSA cycles, sustainability, and spreading successful change. This component evaluates how well DMC plans execute quality improvement activities and whether the PIP achieves and sustains the desired aim.

Methodology

Statewide Quality Improvement Project

DMC plans submit two reports annually for the statewide QIP—one intervention progress report to HSAG, and an annual QIP submission to DHCS.

Individual Performance Improvement Project

Based on the agreed-upon timeline, DMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to these plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. HSAG conducts PIP validation in accordance with the CMS Protocol 1, cited in the previous section. See Section 12 of this report ("Managed Care Health Plan, Population-Specific Plan, and Specialty Health Plan Performance Improvement Projects") for HSAG's module validation criteria and PIP confidence level assignment.

After validating each PIP module, HSAG provides written feedback to DMC plans summarizing HSAG's findings and whether or not the plans achieved all validation criteria. Once these plans achieve all validation criteria for modules 1 through 3, the plans test intervention(s) through the end of the SMART Aim end date. HSAG requests status updates from the plans throughout the intervention testing phase of the PIP process and, when needed, provides technical assistance.

HSAG validated up to the point of PIP progression for each DMC plan as of June 30, 2020; results of the validation activities completed by June 30, 2020, are included in this report. Note that in March 2020, HSAG encouraged DMC plans to notify DHCS and HSAG of any impact on PIP activities due to the COVID-19 response efforts. HSAG provided technical assistance and granted PIP module submission extensions based on individual DMC plan circumstances. In June 2020, due to DHCS' decision to end the 2019–21 PIPs for MCPs, PSPs, and the SHP, DHCS also ended the DMC plans' 2019–21 individual PIPs effective June 30, 2020.

DMC plan-specific PIP activities are included in the applicable appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

Results—Performance Improvement Projects

Statewide Quality Improvement Project

In January 2020, DMC plans submitted to HSAG their individual statewide *Preventive Services Utilization* QIP intervention progress reports that included a summary of identified barriers and interventions they conducted as of December 31, 2019. HSAG reviewed the progress reports and provided feedback to each DMC plan in February 2020.

Individual Performance Improvement Project

During the review period, HSAG conducted trainings on rapid-cycle PIP Version 5 modules 1 through 4 to provide DMC plans with information about the key concepts of the rapid-cycle PIP framework as well as submission requirements and validation criteria for PIP modules. HSAG validated the following modules and notified DMC plans and DHCS of the validation findings:

- Module 1—three initial submissions and five resubmissions
- Module 2—three initial submissions and two resubmissions
- Module 3—three initial submissions

As noted previously, due to DHCS' decision to end the 2019–21 PIPs for MCPs, PSPs, and the SHP, DHCS also ended the DMC plans' 2019–21 individual PIPs effective June 30, 2020. As with the MCPs, PSPs, and SHP, DHCS encouraged DMC plans to continue improvement efforts related to their PIP topics until DHCS announces next steps for resuming PIPs.

Table 13.1 lists DMC plans' individual PIP topics.

Table 13.1—Dental Managed Care Plan Performance Improvement Project Topics

DMC Plan Name	PIP Topic
Access Dental Plan	*Increasing an Annual Dental Visit for Children, Ages 5–18*
Health Net of California, Inc.	*Dental Care among Members Living with Diabetes*
LIBERTY Dental Plan of California, Inc.	*Dental Care among Members Living with Diabetes*

Conclusions—Performance Improvement Projects

During the review period, DMC plans submitted their *Preventive Services Utilization* statewide QIP intervention progress report and received HSAG's feedback on their intervention progress. Through HSAG's PIP training, validation, and technical assistance, all DMC plans submitted modules 1 through 3 for their individual PIPs, and two of the DMC plans progressed to the intervention testing phase; however, due to the challenges of conducting PIPs during the COVID-19 public health emergency, DHCS elected to end the DMC plans' 2019–21 individual PIPs as of June 30, 2020. While DHCS elected to end the PIPs, it encouraged DMC plans to continue improvement efforts related to their PIP topics until the next set of PIPs begin.

Recommendations—Performance Improvement Projects

HSAG has no recommendations for DHCS related to DMC plan PIPs.

HSAG includes DMC plan-specific PIP recommendations, as applicable, in appendices found in *Volume 2 of 3* of this EQR technical report (appendices A through FF).

14. Validation of Network Adequacy

Validation of network adequacy is a mandatory EQR activity; and states must begin conducting this activity, described at 42 CFR §438.358(b)(1)(iv), no later than one year from CMS' issuance of the associated EQR protocol. While CMS originally planned to release the protocol in 2018, it had not yet been released at the time that this EQR technical report was produced.

To assist with assessing and ensuring network adequacy across contracted MCPs, PSPs, and the SHP, DHCS contracted with HSAG on the following network adequacy activities:

- Alternative Access Standards Reporting
- SNF/ICF Experience and Distance Reporting
- Timely Access Focused Study

Alternative Access Standards Reporting

As part of DHCS' ongoing monitoring and oversight of MCPs, PSPs, and the SHP, DHCS ensures that MCPs', PSPs', and the SHP's provider networks are adequate to deliver services to members. If providers are unavailable or unwilling to service Medi-Cal beneficiaries such that an MCP, PSP, or SHP is unable to meet time and distance standards, MCPs, PSPs, and the SHP may request that DHCS allow an alternative access standard for specified provider scenarios (e.g., provider type, ZIP Code). The DHCS APL 19-002[35] provides MCPs, PSPs, and SHPs with DHCS' clarifying guidance regarding network certification requirements, including requests for alternative access standards.

Due to their delivery structure, some MCPs may be eligible to petition DHCS to consider an alternative to the time and distance standard.[36] This alternative is used by Kaiser NorCal, Kaiser SoCal, and the PSPs (AIDS Healthcare Foundation, Rady Children's Hospital—San Diego, and SCAN Health Plan), as this process allows each MCP and PSP to justify its capability to deliver the appropriate level of care within its specialized delivery structure. If DHCS agrees that the MCP and PSP are delivering the appropriate level of care at that time, there would be no need for the MCP or PSP to submit additional data regarding the network for time and distance standards.

DHCS reviews each MCP's and PSP's alternative access standard request to determine that the requesting MCP or PSP has adequately described its delivery structure to exhibit a

[35] All Plan Letter 19-002. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-002.pdf. Accessed on: Jan 21, 2021.

[36] CA WIC §14197(e)(1)(B). Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14197.&lawCode=WIC. Accessed on: Jan 25, 2021.

clinically integrated health care model/network consisting of, but not limited to either of the following:

- Medical Home: A team-based health care delivery model led by a health care team in a centralized facility to provide comprehensive and continuous medical care to patients with a goal to obtain maximal health outcomes.
- Specialty Services for Specialty Population: A limited but comprehensive network that renders services specific to the diagnoses of the beneficiaries and ensures that care coordination and support services are available across the continuum of care regardless of location.

This alternative to the time and distance standard does not preclude MCPs, PSPs, or the SHP from meeting the other Annual Network Certification components. DHCS reserves the right to revoke an approved alternative access standard request if concerns regarding quality of care are discovered through avenues including but not limited to grievances and appeals reporting and timely access survey results.

Additionally, CA WIC §14197.05[37] requires DHCS' annual EQR technical report to present information related to MCPs' alternative access standard requests. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to process and report on data related to alternative access standards for MCP provider networks.

Reporting Elements

The following reporting elements are defined by CA WIC §14197.05 for inclusion in the annual EQR technical report:

- The number of requests for alternative access standards in the plan service area for time and distance, categorized by all provider types, including specialists, and by adult and pediatric.
- The number of allowable exceptions for the appointment time standard, if known, categorized by all provider types, including specialists, and by adult and pediatric.
- Distance and driving time between the nearest network provider and ZIP Code of the beneficiary furthest from that provider for requests for alternative access standards.
- The approximate number of beneficiaries impacted by alternative access standards or allowable exceptions.
- Percentage of providers in the plan service area, by provider and specialty type, which are under a contract with a Medi-Cal MCP.

[37] CA WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14197.05. Accessed on: Jan 26, 2021.

- The number of requests for alternative access standards approved or denied by ZIP Code and provider and specialty type, and the reasons for the approval or denial of the request for alternative access standards.
- The process of ensuring out-of-network access.
- Descriptions of contracting efforts and explanation for why a contract was not executed.
- Time frame for approval or denial of a request for alternative access standards by DHCS.
- Consumer complaints, if any.

Methodology

To compile information for each reporting element, HSAG used the following data supplied by DHCS:

- MCPs' alternative access standards request data.[38]
- DHCS' alternative access standards administrative data (i.e., a Microsoft Excel workbook).
- DHCS' quarterly grievance reports data from 2019 Quarter 3 through 2020 Quarter 2 on beneficiaries' complaints related to access to providers (e.g., no providers in the area who accept the beneficiary's MCP, the beneficiary is unable to obtain an appointment with a contracted provider).
- Medi-Cal Managed Care Office of the Ombudsman data on beneficiary grievances and appeals related to access to providers, and specifically to time and distance standards (e.g., no providers in the area who accept the beneficiary's MCP, the beneficiary is unable to obtain an appointment with a contracted provider). The reporting period for the Ombudsman data is February 1, 2019, through January 31, 2020.
- DHCS' modified 274 Provider Demographic data for June 2019 on the physical locations of providers and the MCPs with which providers are contracted in each county.

MCPs were required to submit alternative access standard requests to DHCS no later than March 18, 2019, for those standards to be effective on July 1, 2019. Approved alternative access standards are valid for the July 1, 2019, through June 30, 2020, contract year. The analysis is based on alternative access standard requests submitted to DHCS between February 1, 2019, and January 31, 2020.

Note that MCPs did not invoke the advanced access exception during the reporting period; therefore, no exceptions for the appointment time standard exist, and this reporting element is not included in the analysis.

Additionally, the calculation of the percentage of providers in a plan service area under contract with a Medi-Cal MCP requires the number of MCP providers as defined in the 274 Provider Demographic data to identify the numerator for the percentage. The denominator for the percentage requires a count of the number of providers practicing in a given service area.

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[38] MCPs are allowed to use the Alternative Access Standard Request Template for time and distance standards only.

HSAG's review of the California Medical Board (CMB) licensing data determined that these data do not contain adequate information about providers' practice locations to be a reliable estimate of the total number of providers for a specific county. Further, the 274 Provider Demographic data and CMB licensing data could not be linked by a National Provider Identifier or license number to ensure that providers identified in the 274 file were also identified in the CMB data. For these reasons, the available data are limited in their ability to identify the denominator as defined above. The total number of providers practicing in a service area will be larger than the number of Medi-Cal contracted providers, making the actual percentage of providers under contract with a Medi-Cal MCP smaller than what is reported. The results in Table 7.1 through Table 7.58, included in *Volume 3 of 3* of this EQR technical report (Appendix HH), indicate the percentage of all Medi-Cal contracted providers located within a service area who are contracted with each MCP serving that area.

Results—Alternative Access Standards Reporting

Number of Requests, Approvals, and Denials

The alternative access standard requests were tabulated and stratified by the following characteristics: MCP, county, ZIP Code, provider type (including specialty), and adult or pediatric focus.[39] For each combination of the strata, HSAG tabulated the total number of requests submitted, and then identified the final disposition of the request as approved or denied. Regardless of the number of requests submitted for a given MCP, county, ZIP Code, provider type, or adult or pediatric combination, there is only one final approval or denial for that combination of characteristics.

There were 19,224 requests submitted to DHCS, and 10,629 distinct combinations of request characteristics appeared in the data supplied by DHCS. Of these combinations, 4,803 (45.2 percent) resulted in an approval from DHCS. The complete results of the analysis of the total number of requests submitted and the number approved or denied are located in *Volume 3 of 3* of this EQR technical report (Appendix HH).

Reasons for the Approval or Denial of Alternative Access Standard Requests

DHCS approves or denies alternative access standard requests for multiple reasons. The most common reasons for DHCS to approve or deny an alternative access standard request include:

- Approval Reasons
  - The alternative access standards request is within five miles of the standard.
  - No closer in-network or out-of-network provider was located than the MCP indicated in its request.

[39] DHCS identified an adult/pediatric designation for mental health (non-psychiatry) outpatient services, core specialists, OB/GYNs, and PCPs. Hospitals, pharmacies, and OB/GYN PCPs were identified with an N/A for the adult/pediatric designation.

- DHCS identified closer providers, yet all had been contacted by the MCP and the MCP clearly explained why those providers could not be added to its network.
- The alternative access standards request is for a PCP or a mental health provider and is in a designated Health Professional Shortage Area.

♦ Denial Reasons
- An in-network or out-of-network provider existed within the time or distance standard.
- An in-network provider existed outside the time or distance standard yet was closer than the alternative access standard request.
- An out-of-network provider existed outside the time or distance standard yet was closer than the alternative access standard request, as long as the closer provider found was not one of the providers the MCP contacted and clearly explained why those providers could not be added to the MCP's network.
- The alternative access standard request is incomplete or insufficient.
- The alternative access standard request is a PO Box or a unique ZIP Code (i.e., a high-volume mail receiver that receives mail in one location and distributes the mail internally such as a large organization, government building, or university).
- The alternative access standard request was no longer needed as the MCP was meeting time and distance standards.
- The alternative access standard request was sent in error or a duplicate request was submitted.

Distance and Driving Time Between Nearest Network Provider and Furthest Beneficiary

For each MCP and ZIP Code for which alternative access standard requests were submitted, HSAG calculated the median distance and drive time between the nearest network provider and the beneficiary ZIP Code furthest from that network provider, as well as the median number of beneficiaries impacted. Because each MCP and ZIP Code combination may have multiple requests across provider types, HSAG also calculated the range of distances, drive times, and beneficiaries impacted across requests. The medians for each data element were calculated using all requests submitted, and not using only the approved requests. DHCS did not approve all requests included in this analysis, nor did DHCS approve all requests with the distance and drive times initially submitted.

The shortest median distance was 0.0 miles for Alameda Alliance for Health and ZIP Code 94578 and Molina and ZIP Code 92024, while the longest median distance was 160.5 miles for Anthem Blue Cross and ZIP Code 92389. The shortest median drive time was 0.0 minutes for Alameda Alliance for Health and ZIP Code 94578, while the longest median drive time was 236 minutes for Inland Empire Health Plan and ZIP Code 92309. The smallest median number of impacted beneficiaries was 0.0 individuals in 62 combinations of MCPs and ZIP Codes, while the largest median number of impacted beneficiaries was 18,540 individuals for CenCal Health and ZIP Code 93458. The complete results for the analysis of distances, drive times, and impacted beneficiaries are located in *Volume 3 of 3* of this EQR technical report (Appendix HH).

Time Frame for Approval or Denial of Requests

For each MCP, HSAG calculated the time between the initial alternative access standard request submitted by the MCP and the first decision for approval or denial made by DHCS. For each MCP, HSAG then determined the median number of days to approval or denial. Denials include alternative access standard requests for which the initial disposition was "denial," "partial approval," or "no longer needed."

In accordance with WIC 14197(e)(3), DHCS must approve or deny an alternative access standard request within 90 days of submission. DHCS may stop the 90-day review time frame on one or more occasions as necessary if an incomplete MCP submission is received or if additional information is needed from the MCP. Upon submission of the additional information to DHCS, the 90-day time frame would resume at the same point in time it was previously stopped, unless fewer than 30 days remain. In these instances, DHCS must approve or deny the alternative access standard request within 30 days of submission of the additional information.

Across all MCPs, the median number of days to approval or denial across all requests was 116 days for requests submitted between March 1, 2019, and June 30, 2019, for their initial submission and 168 days for requests submitted between July 1, 2019, and January 31, 2020, for their CAP submission. The complete results for the analysis of the time between an alternative access standard request and approval or denial are located in *Volume 3 of 3* of this EQR technical report (Appendix HH).

Consumer Complaints

HSAG reviewed two sources of data for consumer complaints: the number of calls made to the Medi-Cal Managed Care Office of the Ombudsman, and DHCS' quarterly grievance reports from 2019 Quarter 3 through 2020 Quarter 2 on beneficiaries' complaints related to access to providers, and specifically to time and distance standards. HSAG reviewed the ombudsman's data stratified by MCP; however, the data did not include a county-level identifier for the location of the beneficiary. The ombudsman's data identified counts of calls associated with "Access to Care." In contrast, the DHCS grievance data included a county-level identifier and were stratified according to MCP and county. The grievance data identified counts of beneficiaries noting a lack of PCP or specialist availability.

On average, the Ombudsman Office received 4.8 calls for each MCP, with a low of 1.0 calls and a high of 22.0 calls. On average, there were 259.9 grievances for each MCP and county. The lowest number of grievances was 1.0, and the highest number of grievances was 8,111. The complete results for the analysis of consumer complaints are located in *Volume 3 of 3* of this EQR technical report (Appendix HH).

Process of Ensuring Out-of-Network Access

DHCS sets the requirements for MCPs to provide out-of-network access. Specifically, MCPs must provide for out-of-network access if their network is unable to provide medically

necessary covered services within timely access standards. Additionally, MCPs must provide for the completion of covered services by a terminated or out-of-network provider at the request of a beneficiary in accordance with the continuity of care requirements in the California Health and Safety Code Section 1373.96. In addition to the aforementioned requirements, MCPs that are under a CAP for failing to meet time and distance standards must also ensure subcontractors and delegated entities adhere to the out-of-network access requirements, submit a policy or procedure to ensure there is a consistent process for out-of-network access compliance, and demonstrate their ability to effectively provide out-of-network access information to beneficiaries.

HSAG reviewed the data submitted by MCPs in the alternative access standard requests related to processes to ensure out-of-network access. The following processes not included in the DHCS-defined approach were described by MCPs:

- Providing transportation to an out-of-network provider when beneficiaries' needs cannot be met for time and distance, appointment time, or cultural and linguistic needs.
- Providing behavioral health services through LiveHealth Online, with direct access to behavioral health providers through an online/mobile application.
- Plan will authorize out-of-network care.

Contracting Efforts

MCPs engage in a variety of different contracting efforts to ensure network adequacy related to time and distance standards across geography, provider specialties, and adult and pediatric care. HSAG reviewed the alternative access standard request data for information provided by MCPs about contracting efforts and synthesized this information with data provided by DHCS on themes and trends in contracting efforts.

The contracting efforts that MCPs reported to DHCS include the following:

- Provider was unwilling to accept the MCP contract or Medi-Cal FFS rates.
- Provider refused to contract with the MCP.
- Provider did not meet the MCP's professional standards or credentialing requirements, or had a disqualifying quality of care issue.
- Provider was currently in contracting negotiations with the MCP.[40]

The contracting efforts that MCPs reported in the alternative access standard requests in response to DHCS' analysis of their request included the following:

- Provider could not be found.
- Provider retired.
- Provider was deceased.

[40] If applicable, the rationale must detail the targeted time frame for execution.

- Plan will be performing outreach to an alternate provider for contracting.
- Provider specializes in different services than needed.
- Provider delivers limited services.
- Population too sparse to find providers.
- Very small number of beneficiaries impacted (e.g., 1 percent of membership).
- Providers cannot contract due to competing contracts.
- Closest provider is already contracted with plan.
- Closer providers are not much closer than currently contracted provider.
- Closer provider is not within time and distance standards.

Providers Under Contract

MCPs contract with providers located within their plan service areas, and some MCPs contract outside their plan service areas when a particular specialty is needed in the network or a provider outside of the service area is able to meet the time and distance standards. To understand the scope of each MCP's network in a service area, HSAG calculated the percentage of Medi-Cal contracted providers located within a given county who are contracted with each MCP serving that county. Note that because the available data do not provide reliable information on the practice locations of all providers (e.g., under Medi-Cal contract or not), the actual percentage of all providers contracted with each MCP in a service area will be smaller than what is reported in the results of this analysis. The following is a summary of the results of these calculations.

- Across all MCPs, the median percentage of contracted providers across counties and across provider types is 52.7 percent. This indicates that MCPs typically contract with just over half of the providers who are contracted with any MCP, across counties and provider types.
- The MCPs with the highest median percentage of contracted providers across counties and provider types are Gold Coast Health Plan and Partnership HealthPlan of California (both 100.0 percent). These MCPs typically contract with a higher proportion of providers located within the counties they serve than other MCPs.
- The MCP with the lowest median percentage of contracted providers across counties and provider types is Aetna Better Health of California (6.3 percent). This MCP typically contracts with a lower proportion of providers located within the counties it serves than other MCPs.
- The provider type with the highest median percentage of contracted providers across counties and MCPs is Pharmacy (75.5 percent). MCPs typically contract with a higher proportion of providers of this type located within the counties they serve compared to other types of providers.
- The provider types with the lowest median percentage of contracted providers across counties and MCPs are Adult Dermatology and Adult OB/GYN PCP (both 0 percent). MCPs typically contract with a lower proportion of providers of these types located within the counties they serve compared to other types of providers.

The complete results for the analysis of the number of providers contracted with an MCP within each county for each provider and specialty type as a percentage of all providers in that county are located in *Volume 3 of 3* of this EQR technical report (Appendix HH).

Recommendations—Alternative Access Standards Reporting

HSAG identified the following recommendations for DHCS that may improve access and alternative access reporting:

- Identify alternative resources and technologies that could be leveraged by MCPs to provide access to members living in remote locations that prevent meeting time and distance standards.
  - With the expansion of telehealth services and technology during calendar year 2020 in response to the COVID-19 public health emergency, HSAG recommends that DHCS and its contracted MCPs explore ways that these technologies may be used to minimize the impact of sparse provider networks and reduce travel costs for members, providers, and plans.
- Develop and maintain a list of provider practice locations statewide to facilitate the calculation of the percentage of Medi-Cal contracted providers within each county.
  - One of the reporting elements required under CA WIC §14197.05 is the percentage of providers in a plan service area, by provider and specialty type, that are under contract with an MCP. Due to data limitations, HSAG was unable to accurately identify a complete list of county-level physician practices. Developing and maintaining a list of identified Medi-Cal contracted provider practice locations will improve DHCS' ability to provide MCPs with more accurate and current information regarding eligible providers.

Based on the analyses, HSAG identified an opportunity for DHCS to collect data on MCPs' barriers to successful contracting using a structured data element instead of unstructured text. A structured data element would help DHCS identify key areas on which to focus to improve access. HSAG is aware that DHCS began collecting this information in 2020; therefore, HSAG makes no formal recommendation regarding collection of barrier information.

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

DHCS requires that MCPs provide coordination of care for their members requiring LTC services, including services at SNFs/ICFs. The DHCS APL 17-017[41] provides MCPs with DHCS' clarifying guidance regarding requirements for LTC coordination and disenrollment from managed care, when applicable.

[41] All Plan Letter 17-017. Available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-017.pdf. Accessed on: Jan 26, 2021.

CA WIC §14197.05 requires DHCS' annual EQR technical report to present information related to the experience of individuals placed in SNFs/ICFs and the distance that these individuals are placed from their residences. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to develop a methodology to assess this SNF/ICF information, and HSAG subsequently worked with DHCS to obtain the necessary data and conduct the analyses.

For contract year 2019–20, HSAG calculated nursing facility population stratifications and long-stay quality measures to capture members' experiences and the driving distances between beneficiaries in SNFs/ICFs and their places of residence using MDS 3.0 data for Medi-Cal beneficiaries in SNFs/ICFs during calendar year 2019 (i.e., January 1, 2019, through December 31, 2019).

While all counties are represented in this analysis, only MCP reporting units operating in COHS counties are responsible for ensuring their institutionalized members receive medically necessary covered services. The MCP reporting units operating in non-COHS counties are only responsible for the first 30 days of a member's stay in a SNF/ICF.

Methodology

Following is a high-level description of the DHCS-approved analytic methodology, including a summary of the data sources and analyses used for both the SNF/ICF Experience and Distance analyses.

Data Sources

HSAG received demographic, eligibility, and enrollment files from DHCS that were extracted from the Medi-Cal Eligibility Data System (MEDS) and contained a record for each month a beneficiary was eligible for Medi-Cal during calendar years 2018 and 2019. HSAG used data from the MDS 3.0 national database to evaluate nursing facility performance on all quality measures. The MDS 3.0 data consist of resident assessments covering a core set of screening, clinical, and functional status items used by CMS to facilitate care management in SNFs.[42]

Combining Data

HSAG combined the demographic file provided by DHCS with the MDS 3.0 data file by using a matching methodology that uses different combinations of the Medi-Cal client identification number, beneficiary Social Security number, beneficiary date of birth, and beneficiary name fields. Once HSAG combined the MDS 3.0 data with the demographic file, HSAG then linked the SNF/ICF residents to the enrollment and eligibility files by Medi-Cal ID.

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[42] Centers for Medicare & Medicaid Services. MDS 3.0 Technical Information. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation. Accessed on: Jan 26, 2021.

Identifying Long- and Short-Stay Residents

Using the MDS 3.0 assessments for residents whom HSAG matched to a Medi-Cal ID, HSAG limited the MDS 3.0 data to assessments for episodes that began, ended, or occurred during the measurement year (i.e., January 1, 2019, through December 31, 2019). HSAG further limited the MDS 3.0 data to residents who were admitted to the SNF during the measurement year or the year prior to the measurement year and who were enrolled in Medi-Cal managed care at the time of their admission to the SNF. After determining stays and episodes, HSAG identified long- and short-stay residents following the *MDS 3.0 Quality Measures User's Manual* v12.1.[43] Residents are considered long-stay if their most recent episode in the facility is more than 100 days, and residents are considered short-stay if their most recent episode in the facility is 100 days or fewer.

Skilled Nursing Facility/Intermediate Care Facility Experience Analysis

HSAG calculated statewide nursing facility population characteristics and 14 quarterly long-stay quality measures for all matched long-stay Medi-Cal beneficiaries following the *MDS 3.0 Quality Measures User's Manual* v12.1.[44] HSAG also calculated two additional MDS 3.0 measures, one developed by Pharmacy Quality Alliance and one developed by HSAG that captures hospital admissions. HSAG aggregated the quarterly quality measure rates to obtain an annual rate for each quality measure. Table 14.1 displays the statewide nursing facility population characteristics, and Table 14.2 displays the long-stay quality measures included in the experience analysis. HSAG also performed a cross-measure analysis at the statewide level for applicable long-stay quality measures. HSAG grouped the long-stay quality measures into three composite measures (*Adverse Events, Behavioral Health*, and *Physical Health*) as displayed in Table 14.2. For the cross-measure analysis, HSAG first determined if a beneficiary was numerator positive in any of the four quarters for each measure included in the composite measure. HSAG then determined how many beneficiaries had no events, one event, or more than one event for each composite measure during the measurement year.

Skilled Nursing Facility/Intermediate Care Facility Distance Analysis

Using the MDS 3.0 assessments for residents whom HSAG matched to a Medi-Cal ID, HSAG determined the beneficiaries' place of residence prior to the SNF/ICF admission using the monthly demographic data provided by DHCS and determined the SNF/ICF address information using the California MDS 3.0 facility file provided by CDPH. HSAG used Quest Analytics Suite software (Quest) to geocode the addresses for all beneficiaries in SNFs/ICFs and for the SNF/ICF facilities, assigning each address an exact geographic location (i.e.,

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[43] Centers for Medicare & Medicaid Services. *MDS 3.0 Quality Measures User's Manual* (v12.1). Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-USERS-MANUAL-v121.pdf. Accessed on: Jan 13, 2021.

[44] Ibid.

latitude and longitude). HSAG then used Quest to calculate the driving distance between the beneficiaries in SNFs/ICFs and their place of residence prior to the SNF/ICF admission.

Results and Findings—Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

Skilled Nursing Facility/Intermediate Care Facility Experience Results and Findings

To better understand the experiences of SNF/ICF residents, it is important to understand the population characteristics of these residents. Table 14.1 presents the annual statewide facility population characteristics, stratified by age, gender, resident characteristic, discharge planning status, location from which the resident entered the facility, and resident entry date.

Table 14.1—Statewide Nursing Facility Population Characteristics

S indicates fewer than 11 cases exist in the numerator; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard.

Stratification	Count	Percent
Age		
<25 Years	484	0.72%
25–54 Years	8,285	12.39%
55–64 Years	12,509	18.71%
65–74 Years	15,200	22.73%
75–84 Years	14,331	21.43%
85+ Years	16,055	24.01%
Gender		
Male	31,283	46.79%
Female	35,581	53.21%
Resident Characteristics		
Residents with a Psychiatric Diagnosis	37,114	55.51%
Residents with Intellectual Disability or Developmental Disability (ID/DD) indicated	24	0.04%
Hospice Residents	3,795	5.68%
Residents with Life Expectancy of Less Than 6 Months	3,231	4.83%

Stratification	Count	Percent
Discharge Planning for Residents		
Discharge planning is already occurring for the resident to return to the community	15,599	23.33%
Location from Which the Resident Entered the Facility		
Community	2,844	4.25%
Another Nursing Home or Swing Bed	4,107	6.14%
Acute Hospital	56,087	83.88%
Psychiatric Hospital	2,811	4.20%
Inpatient Rehabilitation Facility	175	0.26%
ID/DD Facility	S	S
Hospice	287	0.43%
LTCH	174	0.26%
Other	S	S
Resident Entry Date		
Resident with Entry Date on or After January 1, 2018	66,789	99.89%

HSAG identified the following notable observations based on its review of the statewide nursing facility population characteristics:

- Approximately 68 percent of SNF/ICF residents were 65 years of age or older during calendar year 2019, which is lower than the most recently published national rate (85.1 percent) for this age group.[45] This difference is likely due to the methodology that limits the study population to Medicaid managed care members admitted to a SNF/ICF in the measurement year or year prior.
- Approximately 47 percent of SNF/ICF residents were male in calendar year 2019, which is higher than the most recently published national rate (32.1 percent) for this gender.[46]
- Approximately 56 percent of SNF/ICF residents had a psychiatric diagnosis during calendar year 2019.
- Approximately 84 percent of SNF/ICF residents entered their facility from an acute hospital.

[45] National Center for Health Statistics. Long-Term Care Providers and Services Users in the United States, 2015–2016. *Vital and Health Statistics*, 2019; 3, 43. Available at: www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf. Accessed on: Jan 21, 2021.

[46] Ibid.

Long-Stay Quality Measure Results

Adverse events, mental health status, and physical health status can all impact residents' experiences within a SNF and overall quality of life.[47] To better understand these impacts, HSAG calculated quarterly and annual long-stay quality measures. Table 14.2 presents the quarterly and annual statewide rates for each long-stay quality measure. The annual rates include shading for comparisons to the national averages, where applicable, which were derived from *Nursing Home Compare's Four Quarter Average Score* for calendar year 2019.[48]

Table 14.2—Long-Stay Quality Measures

Quarter 1 2019 represents the January 1, 2019, through March 31, 2019, measurement period.

Quarter 2 2019 represents the April 1, 2019, through June 30, 2019, measurement period.

Quarter 3 2019 represents the July 1, 2019, through September 30, 2019, measurement period.

Quarter 4 2019 represents the October 1, 2019, through December 31, 2019, measurement period.

2019 Annual represents the January 1, 2019, through December 31, 2019, measurement period.

indicates an applicable national average value is available for the measure.

indicates the rate was better than the national average.

*indicates a lower rate is better for this measure.

^The *Antipsychotic Use in Persons with Dementia* measure was developed by the Pharmacy Quality Alliance.

^^The *Hospital Admissions from SNFs* measure is a custom measure developed by HSAG.

[47] Degenholtz HB, Resnick AL, Bulger N, et al. Improving quality of life in nursing homes: the structured resident interview approach. *Journal of Aging Research*. 2014:892679. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4209834/. Accessed on: Feb 25, 2021.

[48] Centers for Medicare & Medicaid Services. MDS Quality Measures. *Data.Medicare.gov*, 2020. Available at: https://data.medicare.gov/Nursing-Home-Compare/MDS-Quality-Measures/djen-97ju. Accessed on: Jan 21, 2021.

Long-Stay Quality Measures	Quarter 1 2019 Rate	Quarter 2 2019 Rate	Quarter 3 2019 Rate	Quarter 4 2019 Rate	2019 Annual Rate
Adverse Events Composite Measures					
Antipsychotic Use in Persons with Dementia,^*	9.50%	9.09%	8.79%	8.60%	8.94%
Hospital Admissions from SNFs,^^*	22.68%	21.43%	20.95%	21.42%	21.55%
*Percent of High-Risk Residents With Pressure Ulcers**	10.60%	9.84%	9.42%	9.10%	9.66%
*Percent of Residents Experiencing One or More Falls with Major Injury**	1.74%	1.84%	1.91%	1.79%	1.82%
*Percent of Residents Who Inappropriately Received an Antipsychotic Medication**	3.90%	3.37%	3.17%	2.86%	3.28%
*Percent of Residents Who Were Physically Restrained**	0.37%	0.47%	0.35%	0.33%	0.38%
*Percent of Residents with a Urinary Tract Infection**	1.49%	1.64%	1.46%	1.19%	1.43%
*Inappropriate Use of Antianxiety/Hypnotic Medication**	5.32%	5.07%	5.07%	4.88%	5.07%
Behavioral Health Composite Measures					
*Percent of Residents Who Have Depressive Symptoms**	0.74%	0.64%	0.79%	1.91%	1.07%
*Percent of Residents Who Used Antianxiety or Hypnotic Medication**	16.51%	15.66%	15.28%	15.13%	15.58%
*Prevalence of Behavior Symptoms Affecting Others**	12.90%	13.03%	12.53%	12.92%	12.84%

Long-Stay Quality Measures	Quarter 1 2019 Rate	Quarter 2 2019 Rate	Quarter 3 2019 Rate	Quarter 4 2019 Rate	2019 Annual Rate
Physical Health Composite Measures					
*Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder**	30.05%	29.24%	29.43%	28.92%	29.37%
*Percent of Residents Who Lose Too Much Weight**	4.85%	4.59%	4.73%	4.51%	4.66%
*Percent of Residents Whose Ability to Move Independently Worsened**	12.48%	12.01%	11.68%	11.79%	11.96%
*Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased**	8.45%	8.77%	8.90%	9.06%	8.82%
Other Long-Stay Quality Measures					
*Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder**	2.60%	2.49%	2.16%	2.19%	2.34%

HSAG identified the following notable findings from its assessment of the quarterly and annual statewide rates for each long-stay quality measure:

- Seven of the 11 (63.64 percent) long-stay quality measures that could be compared to national benchmarks had better rates than the national averages.
  - One of the four (25.00 percent) adverse event measures that could be compared to national benchmarks had a rate that was better than the national average.
  - Both of the behavioral health measures that could be compared to national benchmarks had rates that were better than the national averages.
  - All four physical health measures had rates that were better than the national averages.
  - The rate for the *Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder* measure was worse than the national average.

Hospital admissions from a SNF are considered an adverse event given the disruption to the resident's care and potential exposure to health risks (e.g., falls, infections) while in the hospital. Further, national studies indicate that many hospitalizations from SNFs are preventable/avoidable.[49] As a result, it is important to understand whether hospital admissions from SNFs are occurring. Table 14.3 displays the *Hospital Admissions from SNFs* measure rates stratified by each member's admission source.

Table 14.3—Hospital Admissions from SNFs—Stratified Results

S indicates fewer than 11 cases exist in the numerator; therefore, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

Entered Facility From	Quarter 1 2019 Rate	Quarter 2 2019 Rate	Quarter 3 2019 Rate	Quarter 4 2019 Rate	2019 Annual Rate
Community	4.07%	4.57%	3.73%	5.76%	4.60%
Another Nursing Home or Swing Bed	9.35%	8.04%	8.70%	7.32%	8.30%
Acute Hospital	25.73%	24.32%	23.64%	24.24%	24.40%
Psychiatric Hospital	5.90%	4.24%	3.83%	2.61%	4.05%
Inpatient Rehabilitation Facility	S	S	S	S	S
ID/DD Facility	S	S	S	S	S
Hospice	S	S	S	S	S
LTCH	35.00%	S	S	S	20.93%
Other	S	S	S	S	6.41%

As presented in Table 14.1, more than 84 percent of residents entered their SNF/ICF from either an acute hospital or LTCH. Of these residents, approximately 24 percent and 21 percent, respectively, had a subsequent admission to a hospital during calendar year 2019.

[49] Medicare Payment Advisory Commission. Chapter 9: Hospital and SNF use by Medicare beneficiaries who reside in nursing facilities, June 2017. Available at: http://www.medpac.gov/docs/default-source/reports/jun17_ch9.pdf?sfvrsn=0. Accessed on: Feb 25, 2021.

Cross-Measure Analysis Results

To better understand members' experiences in SNFs/ICFs, HSAG assessed how many Medi-Cal residents experienced an adverse, behavioral health, or physical health event. Table 14.4 through Table 14.6 present the percentage of residents experiencing no events, at least one event, and more than one event for each quarter and annually for each composite measure (*Adverse Events*, *Behavioral Health*, and *Physical Health*).

Table 14.4—Statewide Cross-Measure Results for the *Adverse Events* Composite Measure

Quarter 1 2019 represents the January 1, 2019, through March 31, 2019, measurement period.

Quarter 2 2019 represents the April 1, 2019, through June 30, 2019, measurement period.

Quarter 3 2019 represents the July 1, 2019, through September 30, 2019, measurement period.

Quarter 4 2019 represents the October 1, 2019, through December 31, 2019, measurement period.

2019 Annual represents the January 1, 2019, through December 31, 2019, measurement period.

Number of Events	Quarter 1 2019 Rate	Quarter 2 2019 Rate	Quarter 3 2019 Rate	Quarter 4 2019 Rate	2019 Annual Rate
Residents Experiencing No Events	67.19%	68.22%	68.95%	68.91%	51.87%
Residents Experiencing At Least One Event	32.81%	31.78%	31.05%	31.09%	48.13%
Residents Experiencing More Than One Event	7.59%	6.96%	6.68%	6.06%	13.78%

HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Adverse Events* composite measure:

- 51.87 percent of residents experienced no adverse events during calendar year 2019, while 48.13 percent of residents experienced at least one adverse event, with 13.78 percent of residents experiencing more than one adverse event during the year.
- The most common adverse event that residents experienced was *Hospital Admissions From SNFs*, with 36.14 percent of all residents experiencing at least one hospital admission during calendar year 2019.
- 9.56 percent of residents had a pressure ulcer.

- Of the residents who experienced more than one adverse event during calendar year 2019, 41.72 percent experienced both an admission to a hospital and a pressure ulcer.

Table 14.5—Statewide Cross-Measure Results for the *Behavioral Health* Composite Measure

Quarter 1 2019 represents the January 1, 2019, through March 31, 2019, measurement period.

Quarter 2 2019 represents the April 1, 2019, through June 30, 2019, measurement period.

Quarter 3 2019 represents the July 1, 2019, through September 30, 2019, measurement period.

Quarter 4 2019 represents the October 1, 2019, through December 31, 2019, measurement period.

2019 Annual represents the January 1, 2019, through December 31, 2019, measurement period.

Number of Events	Quarter 1 2019 Rate	Quarter 2 2019 Rate	Quarter 3 2019 Rate	Quarter 4 2019 Rate	2019 Annual Rate
Residents Experiencing No Events	76.57%	77.02%	77.50%	76.73%	69.89%
Residents Experiencing At Least One Event	23.43%	22.98%	22.50%	23.27%	30.11%
Residents Experiencing More Than One Event	2.81%	2.71%	2.77%	3.09%	5.50%

HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Behavioral Health* composite measure:

- 69.89 percent of residents experienced no behavioral health events during calendar year 2019, while 30.11 percent of residents experienced at least one behavioral health event, with 5.50 percent of residents experiencing more than one behavioral health event during the year.
- The most common behavioral health event that residents experienced was *Percent of Residents Who Used Antianxiety or Hypnotic Medication*, with 18.65 percent of all residents having used an antianxiety or hypnotic medication during calendar year 2019.
- 15.35 percent of residents had behavior symptoms that affected others around them. Of the residents who experienced more than one behavioral health event during calendar year 2019, 84.59 percent experienced both the use of antianxiety or hypnotic medications and behavior symptoms that affected others.

Table 14.6—Statewide Cross-Measure Results for the *Physical Health* Composite Measure

Quarter 1 2019 represents the January 1, 2019, through March 31, 2019, measurement period.

Quarter 2 2019 represents the April 1, 2019, through June 30, 2019, measurement period.

Quarter 3 2019 represents the July 1, 2019, through September 30, 2019, measurement period.

Quarter 4 2019 represents the October 1, 2019, through December 31, 2019, measurement period.

2019 Annual represents the January 1, 2019, through December 31, 2019, measurement period.

Number of Events	Quarter 1 2019 Rate	Quarter 2 2019 Rate	Quarter 3 2019 Rate	Quarter 4 2019 Rate	2019 Annual Rate
Residents Experiencing No Events	71.33%	72.11%	72.68%	72.82%	57.68%
Residents Experiencing At Least One Event	28.67%	27.89%	27.32%	27.18%	42.32%
Residents Experiencing More Than One Event	5.13%	5.03%	4.77%	4.32%	14.09%

HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Physical Health* composite measure:

- 57.68 percent of residents experienced no physical health events during calendar year 2019, while 42.32 percent of residents experienced at least one physical health event, with 14.09 percent of residents experiencing more than one physical health event during the year.
- The most common physical health event that residents experienced was *Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder*, with 19.62 percent of all residents having lost control of their bowel or bladder during calendar year 2019.
- 16.15 percent of all residents had their need for help with daily activities increase, and 15.20 percent of residents had their ability to move independently worsen.
- Of the residents who experienced more than one physical health event during calendar year 2019, 47.28 percent experienced both a decrease in their ability to move independently and an increase in their need for help performing daily activities.

Skilled Nursing Facility/Intermediate Care Facility Distance Results and Findings

Table 14.7 and Table 14.8 present the statewide and county-level average driving distances and the 25th, 50th, and 75th percentile driving distances between beneficiaries in SNFs/ICFs and their place of residence prior to SNF/ICF admission, as well as the number of SNF/ICF short- and long-stay residents, respectively.

Table 14.7—County-Level Short-Stay Resident Distance Results

^ Residents who have more than one episode during the measurement year are counted multiple times (once for each episode) in the Number of Residents column.

* The average distance and percentile values are distances presented in miles.

N/A indicates that the distances could not be calculated since there were no SNF/ICF residents residing in the county.

S indicates fewer than 11 SNF/ICF residents reside in the county; therefore, HSAG suppresses displaying the rates in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

County	Number of Residents^	Average Distance*	25th Percentile*	50th Percentile*	75th Percentile*
Statewide	78,945	12.54	3.00	6.40	12.70
Alameda	1,964	8.03	2.40	4.50	8.40
Alpine	0	N/A	N/A	N/A	N/A
Amador	21	22.65	9.10	20.10	31.70
Butte	96	38.93	2.10	3.45	24.95
Calaveras	S	S	S	S	S
Colusa	S	S	S	S	S
Contra Costa	1,145	13.14	3.40	9.30	16.00
Del Norte	53	127.40	2.80	22.70	263.20
El Dorado	18	57.54	10.90	29.30	61.90
Fresno	955	20.85	4.10	7.60	16.80
Glenn	15	31.61	16.80	20.80	32.50
Humboldt	221	75.58	6.60	15.90	156.60
Imperial	255	63.10	19.40	82.60	89.20
Inyo	S	S	S	S	S
Kern	621	21.61	3.70	7.80	27.20
Kings	94	35.98	6.80	21.00	42.40

County	Number of Residents^	Average Distance*	25th Percentile*	50th Percentile*	75th Percentile*
Lake	361	41.60	10.80	40.00	54.60
Lassen	15	90.31	84.50	95.00	123.00
Los Angeles	26,961	9.48	2.90	6.00	11.40
Madera	94	21.24	1.70	13.00	30.40
Marin	391	12.91	3.00	5.30	11.10
Mariposa	13	58.48	28.40	37.00	52.00
Mendocino	288	50.22	2.75	38.20	76.85
Merced	1,149	17.63	2.60	8.30	20.10
Modoc	22	80.43	1.10	5.40	110.70
Mono	S	S	S	S	S
Monterey	850	13.88	2.50	4.60	16.80
Napa	220	9.49	1.50	3.00	12.50
Nevada	37	24.93	2.80	19.80	44.70
Orange	8,468	8.22	3.10	5.65	9.70
Placer	89	22.76	6.50	11.80	19.90
Plumas	S	S	S	S	S
Riverside	5,680	14.97	3.80	9.80	19.00
Sacramento	1,791	13.24	4.30	7.10	12.40
San Benito	12	42.99	35.30	40.95	52.55
San Bernardino	4,522	14.74	3.80	8.30	18.60
San Diego	8,410	10.21	3.20	6.40	11.40
San Francisco	893	9.24	1.90	3.50	6.20
San Joaquin	994	11.26	2.70	4.60	10.00
San Luis Obispo	422	25.73	3.20	10.50	20.10
San Mateo	1,138	11.19	2.80	5.80	12.50
Santa Barbara	805	22.16	2.10	4.80	21.20

County	Number of Residents^	Average Distance*	25th Percentile*	50th Percentile*	75th Percentile*
Santa Clara	3,388	9.13	3.10	5.90	9.60
Santa Cruz	610	14.13	1.80	4.50	15.60
Shasta	652	40.51	2.70	6.60	15.80
Sierra	S	S	S	S	S
Siskiyou	82	62.66	11.60	31.05	82.60
Solano	866	15.63	2.30	7.60	20.10
Sonoma	951	15.55	2.90	6.60	16.70
Stanislaus	773	12.93	3.40	6.20	12.50
Sutter	50	29.46	2.50	3.90	31.60
Tehama	22	48.08	1.40	19.65	38.30
Trinity	37	74.65	34.60	37.90	58.90
Tulare	482	20.16	1.90	7.35	19.20
Tuolumne	39	45.84	28.30	45.80	51.90
Ventura	1,405	11.12	2.40	5.30	12.70
Yolo	386	11.24	2.10	6.85	13.30
Yuba	85	31.62	5.30	13.10	35.70

HSAG identified the following notable findings from its assessment of the county-level short-stay resident distance results:

- While the statewide average driving distance for short-stay residents was 12.54 miles from their place of residence to the facility, at least half of all short-stay residents traveled 6.40 or fewer miles. Because 5 percent of short-stay residents traveled 37.90 miles or more from their place of residence to the facility, the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.
- In 30 of the 51 (58.82 percent) counties with sufficient data, at least half of short-stay residents traveled fewer than 10 miles from their place of residence.

Table 14.8—County-Level Long-Stay Resident Distance Results

^ Residents who have more than one episode during the measurement year are counted multiple times (once for each episode) in the Number of Residents column.

* The average distance and percentile values are distances presented in miles.

N/A indicates that the distances could not be calculated since there were no SNF/ICF residents residing in the county.

S indicates fewer than 11 SNF/ICF residents reside in the county; therefore, HSAG suppresses displaying the rates in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

County	Number of Residents^	Average Distance*	25th Percentile*	50th Percentile*	75th Percentile*
Statewide	28,929	16.80	3.20	7.80	16.80
Alameda	518	11.89	3.10	5.20	10.50
Alpine	0	N/A	N/A	N/A	N/A
Amador	S	S	S	S	S
Butte	19	78.03	3.10	6.70	66.20
Calaveras	S	S	S	S	S
Colusa	S	S	S	S	S
Contra Costa	301	16.18	3.20	9.40	17.60
Del Norte	35	104.47	0.90	2.70	129.60
El Dorado	S	S	S	S	S
Fresno	313	35.37	4.00	9.30	30.60
Glenn	S	S	S	S	S
Humboldt	155	68.89	5.20	14.90	97.10
Imperial	67	74.63	59.00	84.80	94.10
Inyo	S	S	S	S	S
Kern	195	31.83	3.40	8.10	42.50
Kings	19	42.72	2.80	36.00	55.20
Lake	113	46.08	5.50	20.10	56.00
Lassen	21	45.40	0.70	25.00	83.20
Los Angeles	12,816	10.78	2.80	6.90	13.90
Madera	17	48.30	1.60	22.70	37.30
Marin	212	21.31	3.20	8.75	22.50

County	Number of Residents^	Average Distance*	25th Percentile*	50th Percentile*	75th Percentile*
Mariposa	S	S	S	S	S
Mendocino	115	63.10	3.10	38.50	96.20
Merced	251	24.32	1.80	8.80	24.50
Modoc	19	10.77	1.00	1.50	9.70
Mono	0	N/A	N/A	N/A	N/A
Monterey	282	25.09	3.00	8.60	23.90
Napa	121	27.61	0.30	2.50	21.00
Nevada	S	S	S	S	S
Orange	2,641	11.83	3.10	6.90	12.90
Placer	22	48.30	5.80	14.60	41.50
Plumas	S	S	S	S	S
Riverside	1,591	23.05	6.20	15.70	30.10
Sacramento	411	25.48	5.70	9.70	16.80
San Benito	S	S	S	S	S
San Bernardino	1,606	19.25	4.40	10.30	25.40
San Diego	2,162	12.83	3.70	8.35	15.20
San Francisco	300	14.46	3.30	4.95	9.90
San Joaquin	210	29.78	3.30	6.00	20.60
San Luis Obispo	146	32.38	4.40	12.80	24.40
San Mateo	512	15.77	4.10	10.25	18.70
Santa Barbara	307	35.73	2.30	6.50	46.00
Santa Clara	1,170	14.65	3.70	6.55	10.80
Santa Cruz	188	22.28	1.80	4.35	19.90
Shasta	217	79.91	3.50	9.50	80.30
Sierra	S	S	S	S	S
Siskiyou	37	128.21	30.40	51.20	180.40

County	Number of Residents^	Average Distance*	25th Percentile*	50th Percentile*	75th Percentile*
Solano	357	22.48	3.20	16.10	27.30
Sonoma	390	31.78	2.90	11.00	27.70
Stanislaus	160	27.66	4.40	10.45	27.20
Sutter	13	31.89	10.60	34.50	40.90
Tehama	S	S	S	S	S
Trinity	S	S	S	S	S
Tulare	107	26.93	2.20	8.30	24.30
Tuolumne	S	S	S	S	S
Ventura	551	16.48	3.20	9.40	18.00
Yolo	153	22.79	1.20	9.30	19.20
Yuba	18	34.50	17.10	27.15	39.00

HSAG identified the following notable findings from its assessment of the county-level long-stay resident distance results:

- While the statewide average driving distance for long-stay residents was 16.80 miles from their place of residence to the facility, at least half of all long-stay residents traveled 7.80 or fewer miles. Because 5 percent of long-stay residents traveled 53.10 miles or more from their place of residence to the facility, the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.
- In 24 of the 42 (57.14 percent) counties with sufficient data, at least half of long-stay residents traveled fewer than 10 miles from their place of residence.

Table 14.9 presents the statewide average driving distance for short- and long-stay residents, along with the aggregate average driving distance (i.e., short- and long-stay residents combined), stratified by key resident characteristics, location from which the resident entered the facility, and whether the resident lived in a rural or urban area.

Table 14.9—Statewide Short- and Long-Stay Distance Results

The average distances are presented in miles.

N/A indicates that the distances could not be calculated since there were no SNF/ICF residents in this group.

Stratification	Short-Stay Resident Average Distance	Long-Stay Resident Average Distance	Aggregate Average Distance
Statewide			
Statewide Average Distance	12.54	16.80	13.68
Resident Characteristics			
Residents With Alzheimer's Disease Diagnosis	10.92	13.32	12.35
Residents With a Psychiatric Diagnosis	13.97	19.02	15.77
Residents With ID/DD Indicated	11.35	19.44	14.79
Hospice Residents	13.66	15.12	14.43
Residents With Life Expectancy of Less Than 6 Months	13.99	15.42	14.75
Location from Which the Resident Entered the Facility			
Community	12.86	18.41	15.30
Another Nursing Home or Swing Bed	N/A	N/A	N/A
Acute Hospital	12.38	15.51	13.17
Psychiatric Hospital	27.63	36.56	33.78
Inpatient Rehabilitation Facility	N/A	N/A	N/A
ID/DD Facility	N/A	N/A	N/A
Hospice	N/A	N/A	N/A
LTCH	N/A	N/A	N/A
Other	29.14	34.91	32.77
Rural/Urban			
Rural	23.97	34.37	26.52
Urban	10.13	13.60	11.08

HSAG identified the following notable findings from its assessment of the statewide short- and long-stay distance results:

- Long-stay residents had a longer average driving distance from their place of residence to a facility than short-stay residents.
- Both long- and short-stay residents with the following characteristics had longer than average driving distances from their place of residence to a facility:
  - Residents with a psychiatric diagnosis
  - Residents who entered from the community
  - Residents who entered from a psychiatric hospital
  - Residents who entered from other health care settings
- Short- and long-stay residents who resided in rural areas had a longer average driving distance from their place of residence to a facility than residents who resided in urban areas.

Recommendations—Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

Given that the 2019–20 contract year was the first time HSAG performed the SNF/ICF Experience and Distance Reporting analysis, the results and findings are a baseline for future analyses. As a result, HSAG recommends that DHCS consider the following recommendations for future analyses in order to further understand the experiences of those placed in SNFs/ICFs and the distance they are placed from their residence:

- Although some facilities may be licensed as both a SNF and an ICF, MDS data do not capture the experiences of ICF residents. As a result, DHCS should consider utilizing additional administrative data sources to calculate risk-adjusted outcome measures, like CMS' *Long-Term Services and Supports (LTSS) Successful Transition After Long-Term Institutional Stay* and *Minimizing Institutional Length of Stay* measures, in order to capture the experiences for both SNF and ICF residents.[50] Further, DHCS could consider working with HSAG to calculate MCP-level rates for these measures.
- While the statewide rate for the *Percent of Residents Who Were Physically Restrained* measure was lower than 0.4 percent in calendar year 2019, the statewide rates for the *Antipsychotic Use in Persons with Dementia*, *Percent of Residents Who Inappropriately Received an Antipsychotic Medication*, and *Inappropriate Use of Antianxiety/Hypnotic Medication* measures were greater than 8 percent, 3 percent, and 5 percent, respectively. These results indicate that never events (i.e., events that should not be happening) are occurring in SNFs/ICFs. The Food and Drug Administration has not approved any atypical antipsychotics for the treatment of neuropsychiatric symptoms of dementia, and

[50] Center for Medicaid and CHIP Services. Centers for Medicare & Medicaid Services. *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual, May 2019.* Available at: https://www.medicaid.gov/media/3396. Accessed on: Jan 26, 2021.

antipsychotic use is associated with an increased risk of death and cerebrovascular events for elderly people with dementia.[51] As a result, DHCS should work with HSAG to investigate the high usage of hypnotic/antianxiety and antipsychotic medications among Medi-Cal beneficiaries in SNFs, especially residents with dementia, to determine if high usage of hypnotic/antianxiety and antipsychotic medications is regional or concentrated to certain SNFs. Based on the findings of this investigation, DHCS could then leverage the information to request outlier facilities to submit information related to their high utilization of hypnotic/antianxiety and antipsychotic medications, along with the facilities' plans for reducing the utilization of these medications.

- DHCS should work with HSAG to assess how often beneficiaries are placed in a SNF/ICF closest to their place of residence, as well as how often beneficiaries transfer to a different SNF/ICF during the measurement year. Further, DHCS should consider assessing the additional factors associated with the distance between the beneficiary's place of residence and the SNF/ICF (e.g., understanding whether beneficiaries are placed in a SNF/ICF further away from their place of residence due to specific physical or behavioral health care needs).
  - These analyses would provide further information into the behavior of the SNF/ICF resident population and would provide further insight into which factors, other than distance, the SNF/ICF resident population considers when choosing a SNF/ICF facility. Additionally, this would allow DHCS to understand the differences in the distances residents travel based on their county of residence and provide further information as to whether long travel distances for residents are related to an inadequate network or due to additional factors (e.g., beneficiaries chose a facility further away from their place of residence due to specific health care needs). Since MCPs are responsible for care coordination for SNF/ICF residents (e.g., ensuring beneficiaries are placed in a facility that provides the appropriate level of care for their health care needs), these results may also provide further insight into MCP performance in this area.
- DHCS should consider working with HSAG to assess the distances beneficiaries travel from their place of residence to a SNF/ICF at the MCP level. By assessing distance at the MCP level, DHCS can better understand the care coordination MCPs provide to beneficiaries when they are placed in a SNF/ICF. Further, by performing the analysis at the MCP level, DHCS could leverage the results of both the regional and MCP analyses to set future time and distance performance standards for MCPs.

Timely Access Focused Study

DHCS requires MCPs to ensure that participating providers offer appointments that meet the wait time standards described in Table 14.10. Beginning in contract year 2016–17, DHCS contracted with HSAG to conduct an annual focused study to evaluate the extent to which MCPs are meeting the DHCS wait time standards. In March 2020, to ensure MCPs and their

[51] Steinberg M, Lyketsos CG. Atypical antipsychotic use in patients with dementia: managing safety concerns. Am J Psychiatry. 2012;169(9):900–906. doi:10.1176/appi.ajp.2012.12030342

providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS canceled this study for the remainder of the calendar year due to CMS granting flexibility to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of calendar year 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this report, HSAG completed the fourth quarter 2019 calls and began conducting the first quarter 2020 calls. Because in March 2020 DHCS determined to halt the Timely Access Focused Study calls and subsequently canceled the study in July 2020, HSAG did not complete the first quarter 2020 calls; therefore, HSAG includes no information regarding the calendar year 2020 Timely Access Focused Study in this report.

Table 14.10 lists the DHCS wait time standards and shows the provider type and specialty criteria that HSAG used for each appointment type for the calendar years 2018 and 2019 Timely Access Focused Study analyses.

Table 14.10—California Department of Health Care Services Timely Access Standards

Appointment Type	Criteria for Provider Type/Specialty	Wait Time Standard	
		Non-Urgent Appointments	**Urgent Appointments**
Primary care appointment (adult and pediatric)	PCPs and PCP extenders	10 business days	48 hours
Specialist appointment (adult and pediatric)	Cardiologists/interventional cardiologists; dermatologists; endocrinologists; gastroenterologists; general surgeons; hematologists; HIV/AIDS specialists and infectious disease specialists; nephrologists; neurologists; oncologists; ophthalmologists; orthopedic surgeons; otolaryngologists and ear, nose, and throat (ENT) specialists; physical medicine and rehabilitation specialists; psychiatrists; and pulmonologists	15 business days	96 hours
Appointment with a mental health care provider who is not a	Nonphysician mental health providers (PhD and above	10 business days	96 hours

Appointment Type	Criteria for Provider Type/Specialty	Wait Time Standard	
		Non-Urgent Appointments	Urgent Appointments
physician (adult and pediatric)	[including psychologists] and master's degree providers)		
First prenatal visits	OB/GYN and midwife (certified nurse midwife and licensed nurse midwife)	10 business days	Not applicable
Appointment with ancillary providers	Physical therapy appointments, magnetic resonance imaging (MRI) appointments, mammogram appointments	15 business days	Not applicable

Since 2016–17, the scope of the Timely Access Focused Study has expanded to include evaluation of:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

Methodology

Note: The following methodology description includes the processes DHCS and HSAG follow when HSAG is actively conducting the Timely Access Focused Study. Once DHCS determines to restart this study, HSAG and DHCS will follow these processes and assess whether any changes are needed.

HSAG routinely conducts the Timely Access Focused Study to evaluate MCPs' wait time standard compliance and provider and call center knowledge of interpretation service requirements. HSAG collaborates with DHCS to perform the following key quarterly activities that are primarily based on the most recent provider data submitted to DHCS by MCPs:

- Submit a data requirement document to DHCS for provider data extraction.
- Review provider data extracted by DHCS; and collaborate with DHCS to define the study population (i.e., eligible providers for each appointment type), as appropriate.
- Select sample providers.
- Conduct telephone surveys to sample providers and call centers.
- Calculate results for the study indicators.
- Submit deliverables to DHCS.

Calls to Providers

Annually, HSAG surveys a sample of 411 providers across all provider types and specialties per MCP reporting unit, with approximately 25 percent of the total sample being surveyed each quarter.

Quarterly, during standard operating hours (i.e., 9 a.m. to 5 p.m. Pacific Time), HSAG's trained callers make phone calls to all selected provider offices. During the calls, the callers follow tightly regulated scripts with designed response options to various questions that may arise from the provider office. This allows data collection to be controlled and accurate. If a provider is selected for more than one reporting unit, HSAG's methodology includes processes to minimize interruptions to provider offices. The calls are monitored consistently and on a regular schedule via audio and visual monitoring systems. At least 10 percent of all calls made are reviewed by a full-time monitoring staff member, and information collected during the phone calls is saved in an electronic tool for further analysis.

HSAG has a separate process for collecting appointment availability information from Kaiser NorCal and Kaiser SoCal providers due to these MCPs' automated appointment scheduling systems.

Calls to Managed Care Health Plan Call Centers

HSAG makes 73 calls to each MCP's call center annually. To minimize the interruption to the call centers, HSAG makes 19 calls per MCP for the first quarter, then 18 calls per quarter for the remaining three quarters. For each quarter, the survey calls are made over a six-week period; therefore, HSAG's trained callers make a call to each call center no more than once per day during normal business hours (i.e., 9 a.m. to 5 p.m. Pacific Time), with the call time varying from day to day. The callers end the call if the hold time reaches 10 minutes.

Study Indicators

Following telephone survey completion each quarter, HSAG exports the abstraction data from the electronic tool, reviews the data, and conducts the analyses. For calendar years 2018 and 2019, HSAG used the following measures to assess and report survey results at the statewide, MCP, and reporting unit levels:

- Measure 1—Percentage of sampled providers not meeting the study population criteria based on the calls and the distribution of reasons not meeting the study population criteria
- Measure 2—Percentage of providers with "Accepting New Patient" status in DHCS' 274 provider data confirmed by the calls
- Measure 3—Percentage of providers accepting new patients
- Measure 4—Percentage of providers with appointment times collected and the distribution of reasons why appointment times were not collected
- Measure 5—Percentage of providers meeting wait time standards based on the first, second, and third appointment times
- Measure 6—Minimum, median, maximum, and mean waiting times based on the first, second, and third appointment times

- Measure 7—Percentage of providers contracted with other MCPs in the same county or region
- Measure 8—Percentage of providers in DHCS' provider data, but not contracted with an MCP according to the survey
- Measure 9—Percentage of providers contracted with an MCP according to the survey but not in DHCS' provider data
  - Note: This measure is only applicable to a reporting unit if one or more reporting units are operating in the same county or region.
- Measure 10—Percentage of providers with different appointment times for adults and children
- Measure 11—Percentage of providers who are aware that patients are entitled to receive interpretation of services in any language according to the survey response
- Measure 12—Percentage of providers with site language(s) in DHCS' 274 provider data confirmed according to the survey response and the distribution of reasons why site language(s) were not confirmed
- Measure 13—Percentage of providers with provider language(s) in DHCS' 274 provider data confirmed according to the survey response and the distribution of reasons why provider language(s) were not confirmed
- Call Center Measure 1—Percentage of calls meeting the wait time standard of 10 minutes
- Call Center Measure 2—Percentage of calls to the call centers where the call center staff are aware that beneficiaries are entitled to receive interpretation services in any language

  Call Center Measure 3—List of languages the call center speaks according to the survey response

Results—Timely Access Focused Study

As indicated previously, in July 2020, DHCS canceled the Timely Access Focused Study for the remainder of the calendar year due to CMS granting flexibility to allow MCPs and their providers to continue prioritizing COVID-19 response efforts. Since HSAG conducted only a portion of the first quarter 2020 provider calls, HSAG did not conduct any analyses on the results of these calls; therefore, HSAG includes no 2020 results in this report. This section provides a summary of the calendar year 2019 call results, which were completed during the review period for this report, including a comparison of calendar year 2019 call results to calendar year 2018 call results, as applicable.

Calls to Providers

For calendar years 2018 and 2019, Table 14.11 and Table 14.12 present providers' compliance results for non-urgent and urgent appointment wait times, respectively. Providers for which HSAG obtained at least one appointment have been included. The rate is determined by the total number of providers with an appointment time obtained for the designated appointment that met the appointment wait time standards. The tables also compare the calendar year 2019 rates to the calendar year 2018 rates based on the Chi-square test of statistical significance, with *p*-value of <0.05.

Table 14.11—Calendar Years 2018 and 2019 Timely Access Focused Study Statewide Provider Compliance for Non-Urgent Appointment Wait Time Standards

[green] = Statistical testing result indicates that the calendar year 2019 rate is significantly better than the calendar year 2018 rate.

[red] = Statistical testing result indicates that the calendar year 2019 rate is significantly worse than the calendar year 2018 rate.

Provider Type	Non-Urgent Appointment		
	Calendar Year 2018 Rate	Calendar Year 2019 Rate	Calendar Years 2018–19 Rate Difference
PCP	90.8%	90.5%	-0.3%
Specialist	78.7%	73.4%	-5.3%
Non-Physician Mental Health Provider	92.0%	89.4%	-2.6%
OB/GYN	86.7%	89.1%	2.4%
Ancillary Provider	95.5%	94.5%	-1.0%
All Providers	**88.4%**	**87.0%**	**-1.4%**

Table 14.12—Calendar Years 2018 and 2019 Timely Access Focused Study Statewide Provider Compliance for Urgent Appointment Wait Time Standards

[green] = Statistical testing result indicates that the calendar year 2019 rate is significantly better than the calendar year 2018 rate.

[red] = Statistical testing result indicates that the calendar year 2019 rate is significantly worse than the calendar year 2018 rate.

Provider Type	Urgent Appointment		
	Calendar Year 2018 Rate	Calendar Year 2019 Rate	Calendar Years 2018–19 Rate Difference
PCP	85.0%	81.2%	-3.8%
Specialist	72.7%	67.2%	-5.5%
Non-Physician Mental Health Provider	86.5%	83.5%	-3.0%
All Providers	**81.7%**	**77.0%**	**-4.6%**

HSAG identified the following notable results when comparing the calendar year 2019 non-urgent and urgent appointment time compliance rates to the calendar year 2018 compliance rates:

- The non-urgent appointment wait time standard compliance rate for the OB/GYN provider type was significantly better in calendar year 2019 compared to calendar year 2018.
- When comparing compliance rates for the following provider types, there were statistically significantly fewer providers who met the appointment wait time standards in calendar year 2019 than in calendar year 2018.
  - PCP—urgent appointment wait time standards
  - Specialist—both non-urgent and urgent appointment wait time standards
  - All Providers—both non-urgent and urgent appointment wait time standards

Calls to Managed Care Health Plan Call Centers

During calendar year 2019, HSAG made calls to each MCP's call center. Of the 1,752 total calls placed, 93.9 percent met the wait time standard of 10 minutes. Note that calendar year 2019 was the first year HSAG made calls to MCPs' call centers; therefore, HSAG has no calendar year 2018 rates to compare to calendar year 2019 rates related to call center wait time standard compliance results.

Quarterly Reports and Raw Data

Following completion of the calls each quarter, HSAG produces and submits to DHCS reports and raw data files at the statewide aggregate and MCP levels.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requiring the MCPs to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential issues with data quality, member services and/or provider training and access to services provided, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews the response and provides feedback to each MCP, then determines whether the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow the MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

Network Hotspots Focused Study

Based on the calendar years 2018 and 2019 Timely Access Study results, DHCS requested that HSAG conduct the Network Hotspots Focused Study to identify each MCP's network hotspots (i.e., clusters of providers who have failed to meet standards and expectations with respect to various elements of access, timeliness, and data quality). Once HSAG identifies the network hotspots for each MCP, DHCS intends to request that MCPs prioritize their improvement efforts on those provider clusters. At the time this EQR technical report was

produced, the Network Hotspots Focused Study final report was not available. HSAG will include the Network Hotspots Focused Study results in the 2020–21 EQR technical report.

Recommendations—Timely Access Focused Study

Based on prior years' Timely Access Focused Study results, DHCS contracted with HSAG to conduct the Network Hotspots Focused Study; therefore, HSAG has no recommendations for DHCS related to the Timely Access Focused Study.

15. Consumer Surveys

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

Background

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

The *2020 CHIP CAHPS Survey Summary Report* includes the detailed methodology, results, conclusions, and recommendations. Following is a summary for the 2020 CHIP CAHPS Survey.

Objective

The primary objective of the CAHPS surveys was to obtain information about how CHIP beneficiaries experienced or perceived key aspects of their health care services.

Methodology

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

Table 15.1 lists the global ratings, composite measures, and CCC composite measures and items included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the CCC measurement set.

Table 15.1—CAHPS Measures

Global Ratings	Composite Measures	CCC Composite Measures
Rating of Health Plan	*Getting Needed Care*	*Access to Specialized Services*
Rating of All Health Care	*Getting Care Quickly*	*FCC: Personal Doctor Who Knows Child*
Rating of Personal Doctor	*How Well Doctors Communicate*	*Coordination of Care for CCC*

Global Ratings	Composite Measures	CCC Composite Measures
Rating of Specialist Seen Most Often	*Customer Service*	*Access to Prescription Medicines*
		FCC: Getting Needed Information

Survey Sampling Procedures

The members eligible for sampling included those who were CHIP members at the time the sample was drawn and who were continuously enrolled in the same MCP or FFS for at least five of the last six months of 2019 (July through December). The members eligible for sampling included those who were 17 years of age or younger (as of December 31, 2019). Based on administrative data DHCS provided in the CHIP sample frame, HSAG identified the entire population of CHIP members eligible for sampling. HSAG selected a random sample of all eligible CHIP members for inclusion in the survey.

All child members within the sample frame file were given a chronic condition prescreen status code of 1 or 2. A prescreen code of 1 indicated that the member had claims or encounters which did not suggest that the member had a greater probability of having a chronic condition. A prescreen code of 2 (also known as a positive prescreen status code) indicated that the member had claims or encounters which suggested that the member had a greater probability of having a chronic condition. After selecting CHIP members for the general child sample (i.e., 3,065 child members), HSAG selected a CCC supplemental sample of 3,615 CHIP members with a prescreen code of 2 (i.e., the population of children who were more likely to have a chronic condition).[52] HSAG drew the supplemental sample to ensure an adequate number of responses from children with chronic conditions.

Survey Administration

In previous years, HSAG administered a mixed-mode methodology (i.e., mail followed by telephone follow-up); however, due to guidelines outlined by President Donald Trump's declaration of a national emergency in March 2020 in response to the COVID-19 outbreak in the United States, HSAG updated the survey administration protocol from a mixed-mode methodology to a mail-only methodology, with a third questionnaire and cover letter being mailed to non-respondents.

[52] The general child sample included an oversample of 1,415 child members, and the CCC supplemental sample included an oversample of 1,775 child members.

Survey Analyses

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS 2020, Volume 3: Specifications for Survey Measures*. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed the following analyses to comprehensively assess member experience:

- Response Rates
- Respondent Analysis
- Top-Box Scores[53]
- Trend Analysis

Results—Consumer Surveys

Response Rates

HSAG mailed 6,680 child surveys to the CHIP sample of members selected for surveying. Of these, 1,532 child surveys were completed for the CHIP sample. HSAG used these completed surveys to calculate the CAHPS survey results. Detailed results are available in the *2020 CHIP CAHPS Survey Summary Report*.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members in the sample. If the parent/caretaker of the CHIP member appropriately answered at least three of five NCQA-specified questions in the survey instrument, HSAG counted the survey as complete.

Table 15.2 presents the total number of CHIP members sampled, the number of ineligible and eligible members, the number of surveys completed, and the response rate for the CHIP population selected for surveying. The survey dispositions and response rates are based on the responses of parents/caretakers of children in the general child and CCC supplemental populations. The CHIP response rate of 23.03 percent was greater than the national child Medicaid response rate reported by NCQA for 2019, which was 18.40 percent. In 2019, the CHIP response rate was 24.93 percent, which was 1.9 percentage points higher than the 2020 CHIP response rate. HSAG has observed a steady decline in response rates to the CAHPS surveys over the past several years, so this small decline falls in line with national trends. The change in survey protocol to a mail-only methodology did not seem to have a major effect on the response rate for the CHIP population.

[53] The percentage of survey respondents who chose the most positive score for a given item's response scale.

Table 15.2—2020 CHIP CAHPS Survey Total Number of Respondents and Response Rate

Response rate is calculated as Number of Completed Surveys/Eligible Sample.

Population	Total Sample Size	Ineligible Sample	Eligible Sample	Completed Surveys	Response Rate
General Child Sample	3,065	15	3,050	670	21.97%
CCC Supplemental Sample	3,615	14	3,601	862	23.94%
CHIP	**6,680**	**29**	**6,651**	**1,532**	**23.03%**

Performance Highlights

General Child Performance Highlights

Differences in scores should be evaluated from a clinical perspective. While the CHIP general child population results may be above or below the national averages, differences in scores may not be important from a clinical point of view. HSAG observed the following:

- The gaps between the NCQA Medicaid national 50th and 90th percentiles were on average 3.6 percentage points for the general child population, indicating that the distributions of national performance were close together.
- The differences between the NCQA Medicaid national averages and the NCQA Medicaid national 50th percentiles ranged from -0.2 percentage points to 0.7 percentage points, with an average difference of 0.4 percentage points. In other words, the NCQA Medicaid national averages were similar to the NCQA Medicaid national 50th percentiles.
- The differences between the CHIP general child population scores and the NCQA Medicaid national averages ranged from 0.8 percentage points above the NCQA Medicaid national average to 8.9 percentage points below the NCQA Medicaid national average, with an average of 3.6 percentage points below the NCQA Medicaid national averages for the general child population.

Top-Box Scores

The following reportable measures scored below the NCQA Medicaid national 50th percentiles:

- Global Ratings:
  - *Rating of All Health Care*
  - *Rating of Health Plan*

- Composite Measures:
  - *Customer Service*
  - *Getting Care Quickly*
  - *Getting Needed Care*
  - *How Well Doctors Communicate*

The following reportable measure scored above the NCQA Medicaid national 50th percentile but below the 90th percentile:

- Global Ratings:
  - *Rating of Personal Doctor*

Trend Analysis

The 2020 score was statistically significantly lower than the 2019 score for the *Getting Needed Care* composite measure. The 2020 scores were not statistically significantly higher than the 2019 scores for any measure.

CCC Performance Highlights

Differences in scores should be evaluated from a clinical perspective. While the CHIP CCC population results may be above or below the national averages, differences in scores may not be important from a clinical point of view. HSAG observed the following:

- The gaps between the NCQA CCC Medicaid national 50th and 90th percentiles were on average 3.5 percentage points for the CCC population, indicating that the distributions of national performance were close together.
- The differences between the NCQA CCC Medicaid national averages and the NCQA CCC Medicaid national 50th percentiles ranged from -0.5 percentage points to 0.9 percentage points, with an average difference of 0.1 percentage points. In other words, the NCQA CCC Medicaid national averages were similar to the NCQA CCC Medicaid national 50th percentiles.
- The differences between the CHIP CCC population scores and the NCQA CCC Medicaid national averages ranged from 2.2 percentage points above the NCQA CCC Medicaid national averages to 8.8 percentage points below the NCQA CCC Medicaid national averages, with an average of 2.3 percentage points below the NCQA CCC Medicaid national averages for the CCC population.

Top-Box Scores

The following reportable measures scored below the NCQA CCC Medicaid national 50th percentiles:

- Global Ratings:
  - *Rating of All Health Care*

- *Rating of Health Plan*
- *Rating of Personal Doctor*

- Composite Measures:
  - *Customer Service*
  - *Getting Care Quickly*
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
- CCC Composite Measures and Items:
  - *Access to Prescription Medicines*
  - *FCC: Getting Needed Information*

The following reportable measures scored above the NCQA CCC Medicaid national 50th percentiles but below the 90th percentiles:

- Global Ratings:
  - *Rating of Specialist Seen Most Often*
- CCC Composite Measures and Items:
  - *FCC: Personal Doctor Who Knows Child*

Trend Analysis

The 2020 score was statistically significantly lower than the 2019 score for the *Getting Needed Care* composite measure. The 2020 scores were not statistically significantly higher than the 2019 scores for any measure.

Conclusions—Consumer Surveys

For both the general child and CCC populations, HSAG observed a statistically significant decline from 2019 to 2020 for the *Getting Needed Care* composite measure scores, which reflect parents' or caretakers' experiences with easily getting the care, tests, or treatment they needed for their child and getting an appointment for their child to see a specialist as soon as their child needed.

Recommendations—Consumer Surveys

While HSAG understands that the difference in the 2020 scores for the *Getting Needed Care* composite measure compared to the prior year for both populations may be due to COVID-19, HSAG suggests that DHCS work with the MCPs to determine the causes for the statistically significant decline and identify strategies to ensure that members' access to care does not continue to decline.

16. Encounter Data Validation

Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity is one of the optional EQR activities described at 42 CFR §438.310(c)(2).

Background

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DHCS requires MCPs and PSPs to submit high-quality encounter data. DHCS relies on the quality of the encounter data to accurately and effectively monitor and improve quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS' overall management and oversight of MCMC.

Objective

The objective of the 2019–20 EDV Study (EDV Study) was to examine, through a review of medical records, the completeness and accuracy of the professional encounter data submitted to DHCS by the 25 MCPs and two PSPs included in the study for services rendered between January 1, 2018, and December 31, 2018.

Encounter Data Pilot Study

During the review period of July 1, 2019, through June 30, 2020, HSAG conducted an Encounter Data Pilot Study to determine the feasibility of selecting samples from the provider data instead of the member data for the EDV Study. HSAG's analysis of the provider data identified data quality issues that DHCS would need to address before provider data could be reliably used for sample selection; therefore, DHCS determined to have HSAG follow the already-established methodology of selecting samples from the member data for the EDV Study.

Status of Encounter Data Validation Study

During the review period of July 1, 2019, through June 30, 2020, HSAG began conducting the EDV Study with MCPs and PSPs, which consisted of medical record review. In March 2020, to ensure that MCPs, PSPs, and their providers could focus on the COVID-19 response efforts and to not put individuals at risk by requiring travel for collection of medical record data, DHCS and HSAG temporarily halted the EDV Study. While the medical record procurement was on hold, HSAG continued to review the available medical records that MCPs and PSPs submitted to HSAG prior to March 2020. In July 2020, DHCS determined to cancel the EDV Study to

allow MCPs, PSPs, and providers to continue prioritizing their COVID-19 response efforts. While HSAG reviewed the medical records MCPs and PSPs submitted prior to the EDV Study being canceled, due to incomplete medical record procurement, HSAG was unable to conduct analyses on the data; therefore, HSAG presents no results or findings in this report.

17. Focused Studies

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

Background

DHCS contracts with HSAG to conduct focused studies to gain better understanding of and identify opportunities for improving care provided to beneficiaries. HSAG conducted activities related to the following focused studies during the review period:

- Asian Subpopulations Health Disparities
- CAHPS
- EDV Pilot Study (Note that information on the activities related to the EDV Pilot Study is included in Section 16 of this report [“Encounter Data Validation”]).
- Health Disparities
- Homelessness
- Preventive Services Analysis
- Regional Model Access
- Timely Access (Note that information on the activities related to the Timely Access Focused Study is included in Section 14 of this report [“Validation of Network Adequacy”]).

HSAG’s Approach to Focused Studies

HSAG conducts each focused study in accordance with the CMS *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*. October 2019.[54]

Study Design

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

[54] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*. October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 26, 2021.

details the technical specification for these measures to ensure methodological soundness and reliable calculability for the populations under study.

Data Collection

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

Data Analyses

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

Final Report

At the end of each focused study, HSAG produces a report in the format and with the content approved by DHCS. In addition to presenting the findings associated with the study question(s), the report discusses the implications of the results in light of the policy environment within the State and presents actionable recommendations to improve the delivery of health care to beneficiaries.

Focused Study Summaries

In this section of the EQR technical report, HSAG includes high-level summaries of the focused study activities completed during the review period. HSAG also includes high-level summaries of final focused study reports that were available during the EQR technical report production process, even if the focused study reports were finalized outside the review period for this report. References to the final focused study reports are included, as applicable, and publicly posted reports are located at
https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

Asian Subpopulations Health Disparities Analysis

A health disparity is the difference in health outcomes between groups within a population.[55] To assess and improve health disparities, DHCS contracted with HSAG to conduct a health disparities study using the EAS performance indicators reported by the 25 full-scope MCPs for reporting years 2017–2019.[56] When statewide results were analyzed across all three reporting years, the Asian group had better rates for 65 percent of all indicators compared to the reference group (i.e., the White group).[57] However, when statewide results for the EAS indicators were stratified by primary language, the rates for several of the Asian languages were lower than the rates for English speakers for certain indicators. The findings based on primary language are not consistent with the findings based on race/ethnicity. As recommended in the 2016 and 2017 Health Disparities Reports, this focused study was conducted to assess health disparities for the Asian subpopulations based on race/ethnicity and primary language. DHCS requested HSAG to perform three analyses using data from the Health Disparities Reports for reporting years 2017–2019. These exploratory analyses examined the potential health disparities for the Asian subpopulations in the following areas:

1. Compared the rates for the individual Asian racial/ethnic subpopulations to the rates for the White group
2. Compared the rates for the primary language subpopulations to the rates for the English group
3. Compared the rates for each individual Asian subpopulation's dominant non-English primary language to the rates for English speakers within that Asian subpopulation (e.g., the rates for Korean speakers within the Korean racial/ethnic subpopulation to be compared to the rates for English speakers within the Korean racial/ethnic subpopulation)

The *Asian Subpopulations Health Disparities Report, September 2020* includes the detailed methodology, study results, and conclusions. Following are high-level summaries of the study methodology and key findings.

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[55] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

[56] For reporting years 2017 and 2018, 23 MCPs reported EAS indicators. Aetna Better Health of California and UnitedHealthcare Community Plan were new MCPs for reporting year 2019.

[57] Health Services Advisory Group, Inc. *2018 Health Disparities Report.* Managed Care Quality and Monitoring Division: California Department of Health Care Services; February 2020. Available at: https://www.dhcs.ca.gov/Documents/CA2018-19-Health-Disparities-Report.pdf. Accessed on: Jan 22, 2021.

Methodology—Asian Subpopulations Health Disparities Analysis

For the 2019–20 Asian Subpopulations Health Disparities Analysis, HSAG evaluated indicator data collected for reporting years 2017–2019 at the statewide level. HSAG aggregated results from 25 full-scope MCPs and then stratified these statewide rates by the Asian racial/ethnic subpopulations, primary language subpopulations, and the Asian subpopulation's dominant non-English language. Of these three stratifications, HSAG only identified health disparities based on statistical analysis for the Asian racial/ethnic subpopulations and the primary language subpopulations. To ensure the methodology with national standards, HSAG used the CMS' *Racial Ethnic, and Gender Disparities in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[58] For the Asian subpopulation dominant non-English language analysis, HSAG examined each Asian racial/ethnic subpopulation and compared the rates for English speakers within that Asian subpopulation to the dominant non-English language speakers of that subpopulation.

Key Findings—Asian Subpopulations Health Disparities Analysis

Note that HSAG uses "majority" throughout the findings to refer to at least 50 percent.

Asian Racial/Ethnic Subpopulation Health Disparities

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group's rate, then no health disparity was identified. Overall, the Asian racial/ethnic subpopulation health disparities analysis showed:

- The following Asian racial/ethnic groups had rates that were better than the rates for the White group for the majority of indicators in one or more domains for all three reporting years:
  - Asian Indian
  - Chinese
  - Filipino
  - Other Asian or Pacific Islander
  - Vietnamese
- The following Asian racial/ethnic groups had rates that were similar to the rates for the White group for the majority of indicators in all domains for all three reporting years:
  - Amerasian
  - Cambodian
  - Japanese
  - Korean
  - Laotian

[58] CMS Office of Minority Health and RAND Corporation. *Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage*. Baltimore, MD. 2019.

- No Asian racial/ethnic groups had rates that were worse than the rates for the White group for the majority of indicators in one or more domains for all three reporting years.

Primary Language Subpopulation Health Disparities

Health disparities were identified when indicator rates for primary language groups were better than or worse than the rates for the English group (i.e., the reference group). If a primary language group's indicator rate was similar to the English group's rate, then no health disparity was identified. Overall, the primary language subpopulation health disparities analysis showed:

- The following Asian primary language groups had rates that were better than the rates for the English group for the majority of indicators in one or more domains for all three reporting years:
  - Arabic
  - Cantonese
  - Other Non-English
  - Tagalog
  - Vietnamese
- The following Asian racial/ethnic groups had rates that were similar to the rates for the English group for the majority of indicators in all domains for all three reporting years:
  - Armenian
  - Cambodian
  - Farsi
  - Hmong
  - Ilocano
  - Japanese
  - Korea
  - Lao
  - Mandarin
  - Mien
  - Other Chinese
  - Russian
  - Thai
- No Asian primary language groups had rates that were worse than the rates for the English group for the majority of indicators in one or more domains for all three reporting years.

Asian Subpopulation Dominant Non-English Language

HSAG examined each of the 10 Asian racial/ethnic subpopulations to identify the most commonly spoken non-English primary language for beneficiaries within the racial/ethnic group. For all racial/ethnic groups, a majority of beneficiaries listed English as their primary language. HSAG then compared the rates for English speakers within each Asian subpopulation to the

dominant non-English language speakers of that subpopulation for each indicator for all three reporting years. Overall, the dominant non-English language analysis showed:

- The following dominant non-English language speaker groups had rates that were higher than the rates for their respective English language speaker groups for the majority of indicators in one or more domains for all three reporting years:
  - Chinese race/ethnicity—Cantonese language speakers
  - Filipino race/ethnicity—Tagalog language speakers
  - Other Asian or Pacific Islander race/ethnicity—All Other Language speakers
  - Vietnamese race/ethnicity—Vietnamese language speakers
- No dominant non-English language speaker groups had rates that were lower than the rates for their respective English language speaker groups for the majority of indicators in one or more domains for all three reporting years.

Conclusions—Asian Subpopulations Health Disparities Analysis

The results presented in the *2018 Health Disparities Report* showed that the rate for the Asian racial/ethnic group was better than the rate for the White group for 17 of the 26 indicators (65 percent). The rate for the Asian racial/ethnic group was worse than the rate for the White group for only one indicator, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*. Additionally, the results in the *2018 Health Disparities Report* showed that a majority of the indicator rates for the Asian racial ethnic group were better than the rates for the White group within three of the four domains: Preventive Screening and Children's Health, Preventive Screening and Women's Health, and Care for Chronic Conditions domains. For this analysis, when the Asian racial/ethnic group is broken out into subpopulations, HSAG found that four Asian racial/ethnic subpopulations (representing approximately 73 percent of the Asian racial/ethnic group for reporting year 2019) had rates that were better than the rates for the White group for a majority of indicators for all three reporting years:

- The Asian Indian racial/ethnic subpopulation had rates that were better than the White group for 14 of 26 indicators (54 percent).
- The Chinese racial/ethnic subpopulation had rates that were better than the White group for 19 of 26 indicators (73 percent).
- The Filipino racial/ethnic subpopulation had rates that were better than the White group for 13 of 26 indicators (50 percent).
- The Vietnamese racial/ethnic subpopulation had rates that were better than the White group for 18 of 26 indicators (69 percent).

For the remaining Asian racial/ethnic subpopulations, only the Other Asian or Pacific Islander (five indicators), Korean (three indicators), Cambodian (two indicators), Amerasian (one indicator), and Laotian (one indicator) subpopulations had any indicator rates that were better than the rates for the White group for all three reporting years. Similar to the findings within the *2018 Health Disparities Report*, very few Asian racial/ethnic subpopulations had rates that were worse than the rate for the White group, as only the Laotian (three indicators), Asian Indian

(one indicator), Japanese (one indicator), and Vietnamese (one indicator) racial/ethnic subpopulations had any indicator rates that were worse than the rate for the White group for all three reporting years. These findings are also true for the Asian primary language subpopulations, as the Cantonese and Vietnamese language groups had a majority of rates that were better than the rates for the English group for all three reporting years. This indicates that, while there are few identified health disparities for the Asian subpopulations, the high performance indicated for the Asian racial/ethnic group as a whole is not consistent among many of the smaller Asian racial/ethnic subpopulations, who have similar results to the White group.

In analyzing the performance of the subpopulations within the Asian racial/ethnic group, the high performance of this group relative to the White group was primarily driven by the relative high performance of four of the five largest Asian subpopulations (Asian Indian, Chinese, Filipino, and Vietnamese). While the smaller Asian subpopulations did not demonstrate the same high performance relative to the White group, all Asian subpopulations had rates that were better than or similar to the rates for the White group for at least 81 percent of the reported indicators. As a result, HSAG does not recommend DHCS add the Asian racial/ethnic subpopulations analyses to future health disparities analyses.

Items for Consideration—Asian Subpopulations Health Disparities Analysis

While the 2016, 2017, and 2018 health disparities reports have historically focused on health disparities related to racial/ethnic groups and have consistently found similar racial/ethnic health disparities year-over-year, the reports did not analyze health disparities related to primary language. In analyzing the performance of the primary language subpopulations, there are identified health disparities among these subpopulations. HSAG suggests that DHCS consider investigating health disparities related to the threshold primary languages in future health disparities analyses. Once HSAG is able to identify health disparities related to the threshold primary languages, then DHCS should consider determining the root cause of the primary language health disparities.

CAHPS Focused Study

During contract year 2019–20, DHCS contracted with HSAG to conduct a survey of MCPs to gather promising initiatives and strategies to improve MCPs' results for the following nine CAHPS Health Plan Survey global ratings and composite measures:

- *Customer Service*
- *Getting Care Quickly*
- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Health Plan*

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Shared Decision Making*

At the time of this EQR technical report production, the CAHPS Focused Study final report was not available. HSAG will include a summary of the CAHPS Focused Study in the 2020–21 EQR technical report.

2018–19 Medi-Cal Health Disparities Analysis

To assess and improve health disparities, DHCS contracted with HSAG to conduct a health disparities study using the EAS measures reported by the 25 full-scope MCPs for reporting year 2019 with data derived from calendar year 2018.[59] The *2018 Health Disparities Report* includes the detailed study methodology and findings. Following are high-level summaries of the study methodology and findings.

Methodology—2018–19 Medi-Cal Health Disparities Analysis

For the 2018–19 Medi-Cal Health Disparities Analysis, HSAG evaluated indicator data collected for reporting year 2019 at the statewide level, which consisted of data collected during calendar year 2018 also known as HEDIS measurement year 2018. HSAG aggregated the results from the 25 full-scope MCPs and then stratified these statewide rates for all indicators by demographic stratifications (i.e., race/ethnicity, primary language, age, and gender).

Although HSAG stratified all indicators by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. To ensure the methodology aligned with national standards, HSAG used CMS' *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[60]

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[59] Aetna Better Health of California and UnitedHealthcare Community Plan were new MCPs for reporting year 2019; therefore, the MCPs were not able to report all reporting year 2019 measures and were not included in the aggregate rates for reporting years 2017 or 2018.

[60] CMS Office of Minority Health and RAND Corporation. *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage*. Baltimore, MD. 2017.

Key Findings—2018–19 Medi-Cal Health Disparities Analysis

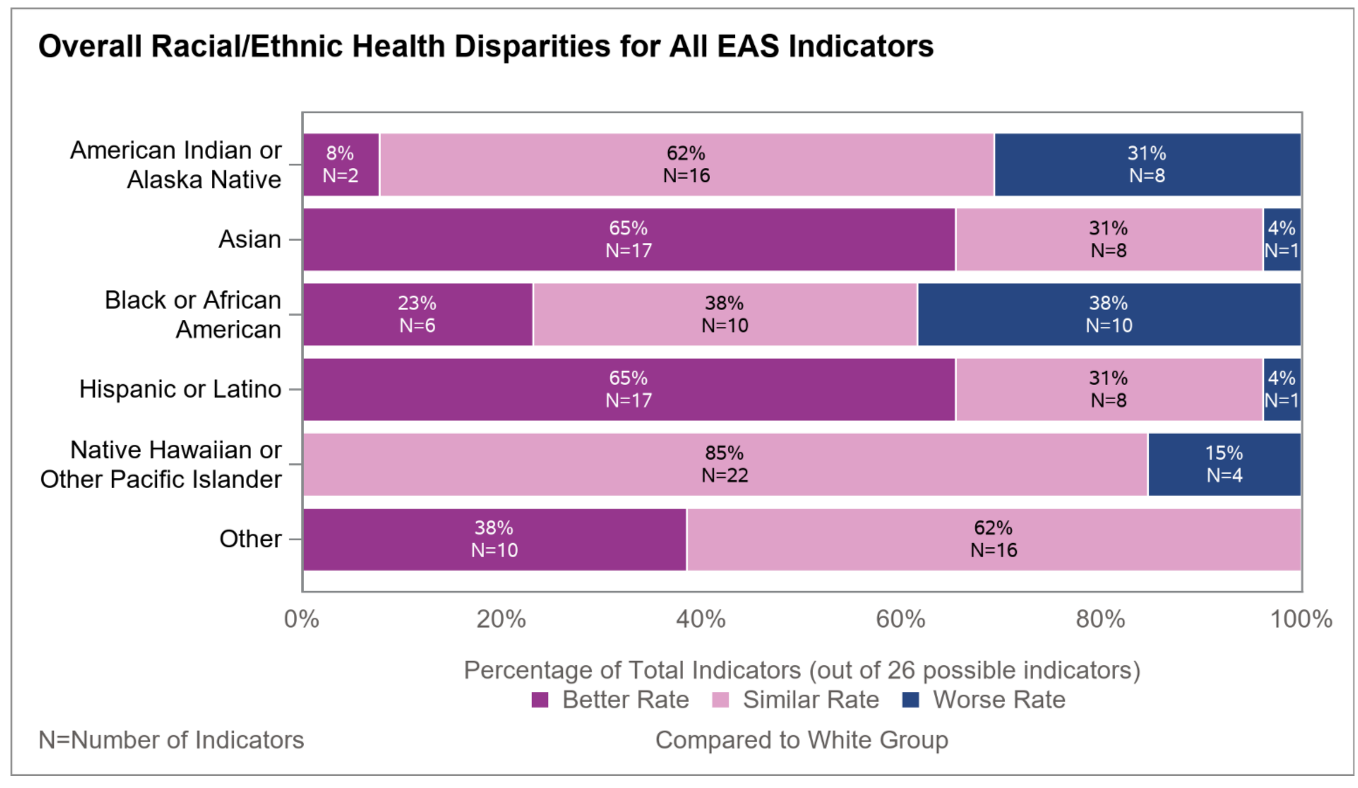
Reporting Year 2019 Findings

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 17.1 displays the percentage and number of indicators (out of 26 possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

Figure 17.1—Overall Racial/Ethnic Health Disparities for All Indicators

Note: The *Ambulatory Care* indicators were not included in the racial/ethnic health disparities analysis.

Due to rounding, the percentage of total indicators may not equal 100 percent for some racial/ethnic groups.



American Indian or Alaska Native

- For the Appropriate Treatment and Utilization domain, a majority of the indicator rates for the American Indian or Alaska Native group were better than the rates for the White group.
- For the Preventive Screening and Women's Health domain, a majority of the indicator rates for the American Indian or Alaska Native group were worse than the rates for the White group.

Asian

- For the following domains, a majority of the indicator rates for the Asian group were better than the rates for the White group:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
  - Care for Chronic Conditions
- There were no domains where a majority of the indicator rates for the Asian group were worse than the rates for the White group.

Black or African American

- For the Appropriate Treatment and Utilization domain, a majority of the indicator rates for the Black or African American group were better than the rates for the White group.
- For the Preventive Screening and Children's Health domain, a majority of the indicator rates for the Black or African American group were worse than the rates for the White group.

Hispanic or Latino

- For the following domains, a majority of the indicator rates for the Hispanic or Latino group were better than the rates for the White group:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
  - Care for Chronic Conditions
- There were no domains where a majority of the indicator rates for the Hispanic or Latino group were worse than the rates for the White group.

Native Hawaiian or Other Pacific Islander

- There were no domains where a majority of the indicator rates for the Native Hawaiian or Other Pacific Islander group were better than the rates for the White group.
- There were no domains where a majority of the indicator rates for the Native Hawaiian or Other Pacific Islander group were worse than the rates for the White group.

Other

- For the following domains, a majority of the indicator rates for the Other group were better than the rates for the White group:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
- There were no domains where a majority of the indicator rates for the Other group were worse than the rates for the White group.

Reporting Years 2017–2019 Findings

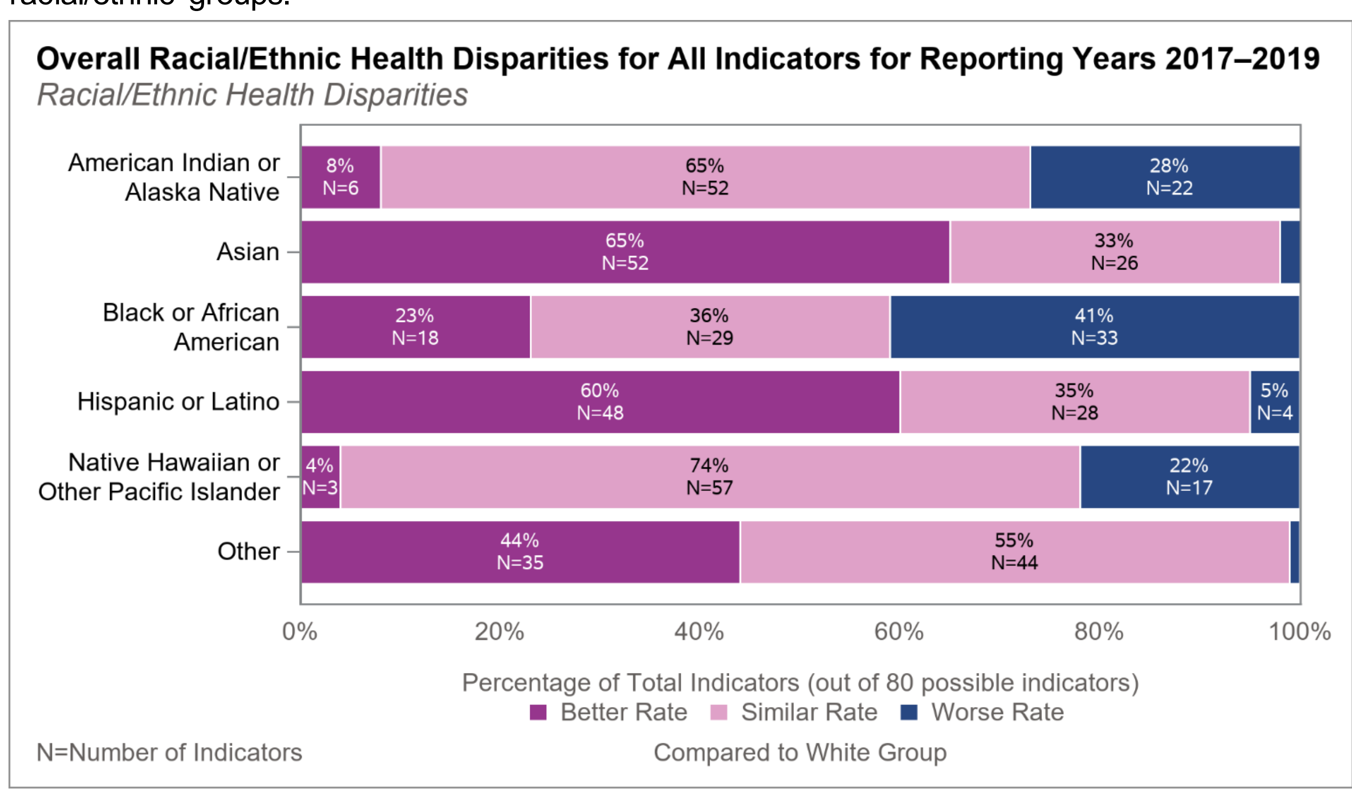
For reporting years 2017–2019, health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 17.2 displays the overall percentage and number of indicators for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group when all three reporting years are combined.

Figure 17.2—Overall Racial/Ethnic Health Disparities for All Indicators for Reporting Years 2017–2019

Note: The Ambulatory Care indicators were not included in the racial/ethnic health disparities analysis.

The Native Hawaiian or Other Pacific Islander group had a total of 77 indicators for reporting years 2017–2019.

Due to rounding, the percentage of total indicators may not equal 100 percent for some racial/ethnic groups.



American Indian or Alaska Native

- When all three reporting years were combined, there were no domains where a majority of indicator rates for the American Indian or Alaska Native group were better than the rates for the White group.

- When all three reporting years were combined, a majority of the indicator rates for the American Indian or Alaska Native group in the Preventive Screening and Women's Health domain were worse than the rates for the White group.

Asian

- When all three reporting years were combined, a majority of the indicator rates for the Asian group were better than the rates for the White group for the following domains:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
  - Care for Chronic Conditions
- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Asian group were worse than the rates for the White group.

Black or African American

- When all three reporting years were combined, the majority of indicator rates for the Black or African American group in the Appropriate Treatment and Utilization domain were better than the rates for the White group.
- When all three reporting years were combined, a majority of the indicators rates for the Black or African American group in the Preventive Screening and Women's Health domain were worse than the rates for the White group.

Hispanic or Latino

- When all three reporting years were combined, a majority of the indicator rates for the Hispanic or Latino group were better than the rates for the White group for the following domains:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Hispanic or Latino group were worse than the rates for the White group.

Native Hawaiian or Other Pacific Islander

- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Native Hawaiian or Other Pacific Islander group were better than or worse than the rates for the White group.

Other

- When all three reporting years were combined, the majority of indicator rates for the Other group in the Preventive Screening and Women's Health domain were better than the rates for the White group.

- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Other group were worse than the rates for the White group.

Conclusions—2018–19 Medi-Cal Health Disparities Analysis

The following are the overall conclusions for the Medi-Cal health disparities analysis for reporting year 2019:

- The rates for the Black or African American group were worse than those for the White group for approximately 38 percent of indicators in the analyses.
  - Indicators for which the rates for the Black or African American group were worse than the rates for the White group were related to access to care and health outcomes. This trend is commonly seen nationally in other state Medicaid programs.[61] Note that the rates for the Black or African American group were better than the rates for the White group for some process measures related to preventive care and appropriate utilization.
- The rates for the American Indian or Alaska Native group and Native Hawaiian or Other Pacific Islander group were worse than those for the White group for approximately 31 percent and 15 percent, respectively, of indicators in the analyses.
- The rates for both the Asian and Hispanic or Latino groups were better than the rates for the White group for approximately 65 percent of indicators in the analyses.

The following are the overall conclusions for the Medi-Cal health disparities analysis for reporting years 2017–2019:

- Overall, for approximately 70 percent of indicators where rates for specific racial/ethnic groups were worse than the White group in reporting year 2017, the health disparities for those indicators continued to exist in reporting year 2019, demonstrating that health disparities are not improving.
- Overall, for approximately 90 percent of indicators where rates for specific racial/ethnic groups were better than the White group in reporting year 2017, the health disparities for those indicators continued to exist in reporting year 2019, demonstrating that health disparities are not improving.

Items for Consideration—2018–19 Medi-Cal Health Disparities Analysis

Based on the overall conclusions for the 2018–19 Medi-Cal Health Disparities Analysis, DHCS should consider the following:

- For the racial/ethnic groups with rates that were better than or worse than the rates for the White group for all three reporting years, DHCS should prioritize addressing health disparities related to those select indicators, where possible.

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[61] Bulger J, Shubrook J, Snow R. Racial Disparities in African Americans with Diabetes: Process and Outcome Mismatch. *Am J Manag Care*. 2012 Aug;18(8):407–13.

- For the racial/ethnic groups with rates that were better than the rates for the White group for all three reporting years (i.e., the Asian and Hispanic or Latino groups), DHCS, in collaboration with MCPs, should consider analyzing health disparities further to determine the additional factors that may be associated with higher rates.
- For the racial/ethnic groups with rates that were worse than the rates for the White group across all three reporting years, DHCS should consider opportunities to increase MCP member-level engagement to identify contributors to health disparities and strategies to address these disparities where possible.

♦ Given that the Hispanic or Latino group rates were better than the rates for the White group for a majority of indicators across all three reporting years and that the Hispanic or Latino group is consistently larger than the White group for almost all indicators, DHCS should consider using the Hispanic or Latino group as the reference group in the future. As DHCS continues to analyze health disparities, especially when additional indicators may be included in the analysis, there may be an opportunity to use the Hispanic or Latino group as the reference group in the future.

2019–20 Medi-Cal Health Disparities Analysis

To identify and understand health disparities affecting Medi-Cal beneficiaries, it is important to consider the population mix of the Medi-Cal managed care program. In 2019, the racial/ethnic distribution of the Medi-Cal managed care population consisted of the following racial/ethnic groups: Hispanic or Latino (49 percent), White (19 percent), Other or Unknown (13 percent), Asian (9 percent), Black or African American (8 percent), and Native Hawaiian or Other Pacific Islander (2 percent). In addition, the Medi-Cal managed care program's age distribution in 2019 was 18-year-olds and younger (42 percent), 19-to-64-year-olds (49 percent), and 65 and older (9 percent).[62] According to the *2003 National Healthcare Quality and Disparities Report*, disparities in access to care and quality of care were identified for the Black or African American group and Hispanic or Latino group when compared to the White group.[63] Although some disparities have narrowed since 2000, disparities continue to persist for these racial/ethnic groups as evidenced by the *2018 National Healthcare Quality and Disparities Report*, which showed that the Black or African American group and the Hispanic or Latino group experienced worse access to care when compared to the White group for 42.9 percent and 75.0 percent, respectively, of access to care indicators.[64] For quality measures, the

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[62] Managed Care Performance Monitoring Dashboard Report, January 2020. Available at: https://www.dhcs.ca.gov/services/Documents/MMCD/Jan9-2020Release.pdf. Accessed on: Jan 26, 2021.

[63] U.S. Department of Health & Human Services. Agency for Healthcare Research and Quality. National Healthcare Disparities Report, 2003. Rockville, MD: August 2007. Available at: https://archive.ahrq.gov/qual/nhqr03/nhqr03.htm. Accessed on: Jan 26, 2021.

[64] U.S. Department of Health & Human Services. Agency for Healthcare Research and Quality. 2018 National Healthcare Quality and Disparities Report. Rockville, MD: April 2020. Available at: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html. Accessed on: Jan 26, 2021.

Hispanic or Latino group and the Black or African American group experienced worse quality of care when compared to the White group for 34.7 percent and 40.0 percent, respectively, of quality care indicators. Given national findings on demographic disparities and to improve health care for Medi-Cal beneficiaries, DHCS contracted with HSAG to conduct a health disparities study using the MCAS measures reported by the 25 full-scope MCPs for reporting year 2020 with data derived from calendar year 2019.

Due to the impacts of COVID-19, the 2019–20 Medi-Cal Health Disparities Analysis only included 10 MCAS indicators that utilize administrative data only. Additional indicators will be added in future iterations of this study once more complete data become available. The goal of the health disparities analysis is to improve health care for Medi-Cal members by evaluating the health care disparities affecting members enrolled in MCPs. This analysis does not include data for FFS beneficiaries in Medi-Cal.

The *2019 Health Disparities Report* includes the detailed study methodology and findings. Following are high-level summaries of the study methodology and findings.

Methodology—2019–20 Medi-Cal Health Disparities Analysis

For the 2019–20 Medi-Cal Health Disparities Analysis, HSAG evaluated indicator data collected for reporting year 2020 at the statewide level, which consisted of data collected during calendar year 2019 also known as HEDIS measurement year 2019. HSAG aggregated the results from the 25 full-scope MCPs and then stratified these statewide rates for all indicators by demographic stratifications (i.e., race/ethnicity and primary language).

Although HSAG stratified all indicators by race/ethnicity and primary language, HSAG only identified health disparities based on statistical analysis for the race/ethnicity stratification. To ensure the methodology aligned with national standards, HSAG used CMS' *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[65]

Medi-Cal Managed Care Program and Health Disparities

DHCS' vision is to preserve and improve the health of all Californians.[66] DHCS focuses on three interconnected goals to advance this strategy:

- ♦ Improve the health of all Californians.
- ♦ Enhance quality, including the patient care experience, in all DHCS programs.
- ♦ Reduce DHCS' per capita health care program costs.

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[65] CMS Office of Minority Health and RAND Corporation. *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage*. Baltimore, MD. 2017.

[66] California Department of Healthcare Services. DHCS Strategy for Quality Improvement in Health Care. Jan 2017. Available at: https://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2017.pdf. Accessed on: Jan 26, 2021.

One of the seven priorities identified by DHCS for improving and maintaining overall health and well-being of Californians is the elimination of disparities in health care among Californians. The health disparities analysis is a step toward reaching that goal by assessing the nature and extent of health disparities across the State and between subdivisions of the Medi-Cal population.

While the scope of the 2019–20 Health Disparities Report is limited due to the impacts of COVID-19, DHCS is committed to reporting on identified health disparities and eliminating those health disparities. DHCS' efforts aimed at the identification and elimination of health disparities include, but are not limited to, the following:

- ♦ Expanding the health disparities reports over time to include trending, when possible, and assess subpopulations with identified health disparities (e.g., *Asian Subpopulation Health Disparities Report, September 2020*).
- ♦ Hosting a quality conference with MCPs in October 2019 to discuss health equity and solicit MCP feedback on best practices for identifying health disparities and inequities and addressing barriers preventing members from receiving care.
- ♦ Requiring each MCP to have one PIP that targets a health care disparity.
- ♦ Continuing to have collaborative discussions with MCPs about best practices for addressing and improving health disparities.
- ♦ Highlighting innovative practices through brief quality improvement "Postcards" and additional supplemental resources that can be searched by various topics (e.g., social determinants of health) for MCPs to find resources to help them assist and support vulnerable members and communities of color experiencing health inequities during COVID-19.
- ♦ Developing the *Preventive Services Report*, which will help DHCS identify patterns of underutilization of pediatric preventive services and implement targeted improvement strategies. The first *Preventive Services Report* was published in December 2020.
- ♦ Requiring MCPs to use the annual health disparities data provided by DHCS to help drive the strategic plan developed in MCPs' annual PNAs.
- ♦ Requiring MCPs to post notices of non-discrimination and accessibility requirements and provide written translation of these requirements and all other member information materials.
- ♦ Requesting MCPs to submit their health equity projects to DHCS annually to be considered for the Health Equity Award.

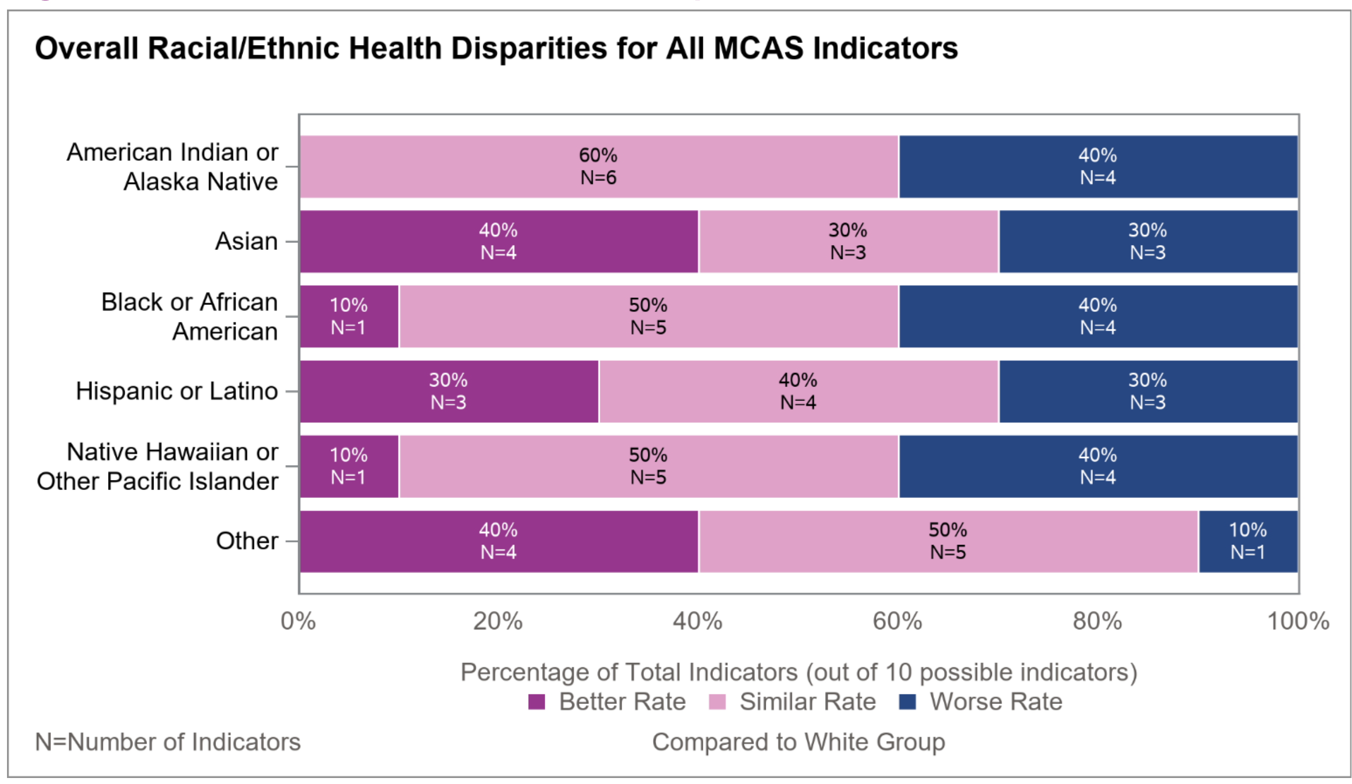
Key Findings—2019–20 Medi-Cal Health Disparities Analysis

Note that HSAG uses "majority" throughout the findings to refer to at least 50 percent.

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group's rate, then no health disparity was identified. Figure 17.3 displays the percentage and number of indicators (out of 10 possible indicators) for

which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

Figure 17.3—Overall Racial/Ethnic Health Disparities for All Indicators



American Indian or Alaska Native

- No rates for the American Indian or Alaska Native group were better than the rates for the White group.
- For the following indicators, the rates for the American Indian or Alaska Native group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*
  - *Breast Cancer Screening*
  - *Developmental Screening in the First Three Years of Life—Total*

Asian

- For the following indicators, the rates for the Asian group were better than the rates for the White group:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
- For the following indicators, the rates for the Asian group were worse than the rates for the White group:
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years*

Black or African American

- For *Chlamydia Screening in Women—Total*, the rate for the Black or African American group was better than the rate for the White group.
- For the following indicators, the rates for the Black or African American group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years*

Hispanic or Latino

- For the following indicators, the rates for the Hispanic or Latino group were better than the rates for the White group:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women—Total*
- For the following indicators, the rates for the Hispanic or Latino group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*

Native Hawaiian or Other Pacific Islander

- For *Developmental Screening in the First Three Years of Life—Total*, the rate for the Native Hawaiian or Other Pacific Islander group was better than the rate for the White group.
- For the following indicators, the rates for the Native Hawaiian or Other Pacific Islander group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years*

Other

- For the following indicators, the rates for the Other group were better than the rates for the White group:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
- For C*ontraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*, the rate for the Other group was worse than the rate for the White group.

Conclusions—2019–20 Medi-Cal Health Disparities Analysis

The following are the overall conclusions for the 2019–20 Medi-Cal Health Disparities Analysis:

- The *Chlamydia Screening in Women—Total* indicator represents an area of overall strength. For this indicator, there were no negative disparities and the rates for all racial/ethnic groups were above the minimum performance level.
- The *Asthma Medication Ratio—Total* and *Breast Cancer Screening—Total* indicators represent areas of overall opportunity for improvement. While there were no negative disparities for *Asthma Medication Ratio—Total* and only one negative disparity for *Breast Cancer Screening* (American Indian or Alaska Native), this is due to the low performance for the White racial/ethnic group rather than positive performance overall. The Asian and Other racial/ethnic groups showed positive performance, with rates that were above the minimum performance levels for both indicators; however, the rates for all other racial/ethnic groups were below the minimum performance level for both indicators.
- All racial/ethnic groups had at least one *Antidepressant Medication Management* or *Contraceptive Care* indicator rate that was worse than the rate for the White group.
  - There were four racial/ethnic groups with rates worse than the rate for the White group for both *Antidepressant Medication Management* indicators. This finding also aligns with national data that show antidepressant medication use is higher among non-Hispanic White adults.[67]
  - Only the rate for the Black or African American group fell below the minimum performance level for the *Effective Acute Phase Treatment* indicator; however, the rates for three racial/ethnic groups (Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander) fell below the minimum performance level for the *Effective Continuation Phase Treatment* indicator.
  - For the *Contraceptive Care—All Women—Most or Moderately Effective Contraception* indicators, five racial/ethnic groups had negative disparities for the *Ages 15–20 Years* indicator but only two of these negative disparities also existed for the *Ages 21–44 Years* indicator (Asian and Native Hawaiian or Pacific Islander). For the *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years* indicator, two racial/ethnic groups (Asian and Black or African American) had negative disparities. These findings suggest that most disparities related to contraceptive care are limited to the adolescent female population. These findings also align with national data which show that contraception use was higher among older and non-Hispanic White women compared to adolescent and non-Hispanic Black women.[68]

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[67] Brody DJ, Gu Q. Antidepressant use among adults: United States, 2015–2018. *NCHS Data Brief*. 2020; 377. Available at: https://www.cdc.gov/nchs/data/databriefs/db377-H.pdf. Accessed on: Jan 26, 2021.

[68] Daniels K, Abma JC. Current contraceptive status among women aged 15–49: United States, 2017–2019. *NCHS Data Brief*. 2020; 388. Available at: https://www.cdc.gov/nchs/data/databriefs/db388-H.pdf. Accessed on: Jan 26, 2021.

- The rates for all racial/ethnic groups for the *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15 to 20 Years* and *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21 to 44 Years* indicators were below their respective national benchmarks.[69,70]

- ♦ The *Developmental Screening in the First Three Years of Life—Total* indicator represents an area of overall opportunity for improvement. While the rates for three racial/ethnic groups (Asian, Native Hawaiian or Other Pacific Islander, and Other) were better than the rate for the White group for this indicator, the rates for all racial/ethnic groups fell below the national benchmark.[71]

Items for Consideration—2019–20 Medi-Cal Health Disparities Analysis

Based on the overall conclusions for the 2019–20 Medi-Cal Health Disparities Analysis, DHCS should consider the following:

- ♦ For the racial/ethnic groups with rates that were worse than the rates for the White group for the *Antidepressant Medication Management* and *Contraceptive Care* indicators, DHCS should consider analyzing health disparities further to determine the additional factors that may be associated with lower rates for these indicators. While these findings align with national data,[72,73] DHCS should work with MCPs to determine the root cause (e.g., lack of access to providers, provider behavior, cultural barriers, possible incomplete data sources)

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[69] Centers of Medicare & Medicaid Services. Child Health Care Quality Measures. "Performance on the Child Core Set Measures, FFY 2019." Oct. 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Jan 26, 2021.

[70] Centers for Medicare & Medicaid Services. Adult Health Care Quality Measures. "Performance on the Adult Core Set Measures, FFY 2019." Oct. 2020. Available at: www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html. Accessed on: Jan 26, 2021.

[71] Centers of Medicare & Medicaid Services. Child Health Care Quality Measures. "Performance on the Child Core Set Measures, FFY 2019." Oct. 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Jan 26, 2021.

[72] Brody DJ, Gu Q. Antidepressant use among adults: United States, 2015–2018. *NCHS Data Brief*. 2020; 377. Available at: https://www.cdc.gov/nchs/data/databriefs/db377-H.pdf. Accessed on: Jan 26, 2021.

[73] Daniels K, Abma JC. Current contraceptive status among women aged 15–49: United States, 2017–2019. *NCHS Data Brief*. 2020; 388. Available at: https://www.cdc.gov/nchs/data/databriefs/db388-H.pdf. Accessed on: Jan 26, 2021.

driving the health disparities for antidepressant and contraceptive medications within California.

- DHCS should ensure that MCPs are working with providers to ensure that members with persistent asthma are prescribed the necessary medication to manage their asthma and women receive appropriate breast cancer screenings.
- DHCS should consider using the Hispanic or Latino group as the reference group for future reports, given that the Hispanic or Latino group rates were better than or similar to the rates for the White group for a majority of indicators and that the Hispanic or Latino group is larger than the White group for all indicators.

Homelessness Focused Study

DHCS contracted with HSAG to evaluate the feasibility for identifying homeless beneficiaries enrolled in Medi-Cal during calendar year 2018 based on administrative data sources only and to recommend whether disparities in care for homeless beneficiaries enrolled in MCMC should be included in future iterations of the annual health disparities analysis. During the review period for this EQR technical report, DHCS and HSAG had discussions about the scope of work for this focused study and HSAG submitted the draft study methodology for DHCS' review and feedback. While the methodology was finalized prior to EQR technical report production, HSAG had not yet completed the analyses. HSAG will include the results of the 2019–20 Homelessness Focused Study in the 2020–21 EQR technical report.

2020 Preventive Services Analysis

At the request of the Joint Legislative Audit Committee, the California State Auditor published an audit report in March 2019 regarding DHCS' oversight of the delivery of preventive services to children enrolled in Medi-Cal managed care. The audit report recommended that DHCS expand its monitoring beyond the existing set of quality measures as a way to ensure that children in Medi-Cal managed care are receiving all of the appropriate preventive services from DHCS' contracted MCPs.[74] In response to this recommendation, DHCS worked with HSAG to develop an annual Preventive Services Report. While the *2020 Preventive Services Report* was released in December 2020, which is outside the review dates for this EQR technical report, HSAG includes a summary of information from the report because it was available at the time this report was produced.

DHCS collaborated with CDPH to link available blood lead screening laboratory data with Medi-Cal data; however, these efforts were delayed due to COVID-19 and its impact on CDPH operations. While DHCS released the information for the *Blood Lead Screening* indicators, as well as MCP-specific results for each indicator, as an addendum to the *2020 Preventive*

[74] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Jan 26, 2021.

Services Report in February 2021, based on the production schedule for this EQR technical report, HSAG was unable to include a summary of the addendum in this report. HSAG will include a summary of the addendum in the 2020–21 EQR technical report.

The *2020 Preventive Services Report* includes the detailed study methodology and findings. Following are high-level summaries of the study methodology and findings.

Methodology

Performance Indicators

DHCS selected three existing MCAS indicators reported by the 25 full-scope MCPs and six HSAG-calculated indicators for inclusion in the *2020 Preventive Services Report*. The following nine indicators were included in the analysis:

MCP-Calculated MCAS Indicators

- ♦ *Chlamydia Screening in Women—16 to 20 Years*
- ♦ *Developmental Screening in the First Three Years of Life—Total*
- ♦ *Screening for Depression and Follow-Up Plan*

HSAG-Calculated Indicators

- ♦ *Alcohol Use Screening*
- ♦ *Child and Adolescent Well-Care Visits*
- ♦ *Dental Fluoride Varnish*
- ♦ *Tobacco Use Screening*
- ♦ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* (two indicators)

For each MCP-calculated MCAS indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the HEDIS specification for the Medicaid population or by the CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). For the HSAG-calculated indicators, HSAG developed specifications for three of the indicators and followed the applicable technical specifications for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* indicators.

Data Sources

For the MCP-calculated MCAS indicators listed previously, HSAG received the CA-required patient-level detail file from each Medi-Cal MCP for each HEDIS reporting unit. The reporting year 2020 patient-level detail files followed HSAG's patient-level detail file instructions and included the Medi-Cal client identification number, date of birth, and member months for

members included in the audited MCP-calculated MCAS indicator rates. Additionally, the patient-level detail files indicated whether a member was included in the numerator and/or denominator for each applicable MCP-calculated MCAS indicator. HSAG validated the patient-level detail files to ensure the numerator and denominator counts matched what was reported by MCPs in the audited HEDIS IDSS files and non-HEDIS Microsoft Excel reporting files. HSAG used these patient-level detail files, along with supplemental files (e.g., demographic data provided by DHCS), to perform the measure analysis.

For the HSAG-calculated indicators listed previously, HSAG received claims/encounter data; member enrollment, eligibility, and demographic data; and provider files from DHCS. Upon receipt of the data from DHCS, HSAG evaluated the data files and performed preliminary file validation. HSAG verified that the data were complete and accurate by ensuring correct formatting, confirming reasonable value ranges for critical data fields, assessing monthly enrollment and claim counts, and identifying fields with a high volume of missing values.

Statistical Analysis

Using the MCP-calculated and HSAG-calculated data sources, HSAG performed statewide-level and regional-level analyses for the applicable indicators. The detailed statistical analysis methodology includes stratification group definitions which are located in the *2020 Preventive Services Report.*

Key Findings and Items for Consideration

The *2020 Preventive Services Report* includes the results from the analysis of nine indicators that assess the utilization of preventive services by pediatric Medi-Cal managed care members at the statewide and regional levels, as well as by key demographic characteristics (i.e., race/ethnicity, primary language, gender, and age). The 2019 California State Auditor Report highlighted DHCS' oversight of the provision of well-child visits for several age ranges in the pediatric population. To address these findings, DHCS, with stakeholder input, added newly revised well-child indicators to the measure set which allow DHCS to fully track and monitor the provision of well-child visits from birth through age 21. Additionally, DHCS also included several indicators that align with the American Academy of Pediatrics (AAP) Bright Futures recommendations in the *2020 Preventive Services Report*, and DHCS will continue to add indicators to the report that align with national recommendations as more data become available.

Overall, the Preventive Services Report will be an additional tool that DHCS can use to identify and monitor appropriate utilization of preventive services for children in Medi-Cal managed care. DHCS will leverage findings from the Preventive Services Report to work with MCPs and other stakeholders to implement targeted improvement strategies that can drive positive change and ensure Medi-Cal managed care children receive the right care at the right time.

During the development of the Preventive Services Report, DHCS and HSAG determined that three MCAS indicators with a hybrid reporting option, originally planned for inclusion and in-depth analysis, did not yield reliable rates due to the analyses' reliance on administrative data only. HSAG excluded the results for these three indicators (i.e., *Childhood Immunization*

Status—Combination 10, *Immunizations for Adolescents—Combination 2*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index [BMI] Assessment for Children/Adolescents*) due to the incompleteness of the administrative data available. The rates for these MCAS indicators are provided in Section 7 of this EQR technical report ("Managed Care Health Plan Performance measures"). Some MCAS indicators will likely be added to the Preventive Services Report in the future once MCPs resume standardized reporting for the MCAS measures.

Based on an evaluation of the nine indicators listed previously, the following are the key findings and considerations from the 2020 Preventive Services Analyses.

Key Finding 1: Performance is regional.

- The highest performance is seen in the Central Coast region of California (i.e., Monterey, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura counties) and in the San Francisco Bay Area (i.e., Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, and Sonoma counties). These counties account for approximately 14 percent of the pediatric Medi-Cal managed care population.
  - These 12 counties had at least half of their reportable indicator rates fall into the top two quintiles (i.e., at or above the 60th percentile of statewide performance).
  - Nine of these 12 counties (75.0 percent) in these high-performing geographic regions also had a larger percentage of non-English primary language speakers when compared to statewide non-English primary language speakers.
- The lowest performance was seen in the more rural counties in Northern California (i.e., Butte, Del Norte, Humboldt, Lassen, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity counties) and in San Joaquin Valley (i.e., Alpine, Amador, Inyo, Mariposa, Mono, and Tuolumne counties).
  - All 18 counties with the lowest performance had at least half of their reportable indicator rates fall into the bottom two quintiles (i.e., below the 40th percentile of statewide performance), and 16 of the 18 counties (88.9 percent) were predominantly rural.
  - Seventeen of the 18 counties (94.4 percent) had a larger proportion of White members, and nine of the 18 counties (50.0 percent) had a larger proportion of American Indian or Alaska Native members.
  - All 18 counties had substantially fewer non-English speakers when compared to statewide non-English speakers.

Conclusions and Considerations for Key Finding 1

- To increase awareness and availability for preventive services, DHCS and all its contracted MCPs initiated a Preventive Services Outreach campaign during 2020. The campaign provided educational materials and calls to the parents/guardians of children to help them understand the services available to them through Medi-Cal.
  - As a result of this new effort, DHCS anticipates that more members and their families will be better informed regarding the timing and availability of necessary preventive

services. Improvement in the utilization of preventive services is expected in measurement year 2021 results.[75]

- Given the low performance of predominantly rural Northern California and the San Joaquin Valley counties, MCPs operating in those counties may consider coordinated provider and targeted member education efforts to improve performance.
- MCPs operating in lower-performing rural counties should consider expanding the use of telehealth visits, where appropriate, and assess ways to expand the managed care provider networks to improve performance.
- MCPs can leverage quality improvement efforts from successful rural counties and expand similar activities as best practices in lower-performing rural counties to drive improvement.

Key Finding 2: Statewide performance varies based on race/ethnicity and primary language.

- Three of nine indicator rates (33.3 percent) for the Asian and Other racial/ethnic groups were higher than the statewide aggregate by more than a 10 percent relative difference.
- The majority of indicator rates for the American Indian and Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White racial/ethnic groups were lower than the statewide aggregate by more than a 10 percent relative difference.
- Although the rates for the Hispanic or Latino racial/ethnic group were generally above the statewide aggregate, this racial/ethnic group also represents approximately 56 percent of the pediatric Medi-Cal managed care population, making it unlikely that rates for the group would be above the statewide aggregate by more than a 10 percent relative difference.
- The rates for the Arabic, Chinese, Hmong, Spanish, and Vietnamese primary language groups were consistently higher than the statewide aggregate, while the rates for the Armenian and Russian primary language groups were lower than the statewide aggregate.
- Although the rates for the English primary language group were generally lower than the statewide aggregate, this primary language group also represents approximately 63 percent of the pediatric Medi-Cal managed care population, making it unlikely that rates for the group would be below the statewide aggregate by more than a 10 percent relative difference.

Conclusions and Considerations for Key Finding 2

- MCPs operating in counties or regions with lower rates for certain racial/ethnic or primary language groups have opportunities to use this information to address lower rates in their PNA process.
- DHCS requires MCPs to conduct a PNA to improve health outcomes for members and ensure that MCPs are meeting the needs of their members. The PNA must address the special needs of the Seniors and Persons with Disabilities population, children with special

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[75] Improvement in the utilization of preventive services is not expected until measurement year 2021 results given the anticipated impact of COVID-19 on measurement year 2020 results.

health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and racial/ethnic backgrounds.

- DHCS requires MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health; information from the Preventive Services Report can assist MCPs in their PIP processes.
- DHCS also requires MCPs to conduct a PIP focusing on an identified health disparity; information from the Preventive Services Report can assist MCPs in their PIP processes for addressing health disparities.

Key Finding 3: Overall performance across California's six largest counties is high for a majority of indicators, but improvement is needed for well-child visits.

- Six counties in California (Los Angeles, San Bernardino, Riverside, San Diego, Orange, and Sacramento counties) account for approximately 60 percent of the pediatric Medi-Cal managed care population.
- Overall, each of these six counties besides Riverside County demonstrated high performance across the indicators analyzed in the *2020 Preventive Services Report* (i.e., at least half of their reportable indicator rates are in the top two quintiles).
- Opportunities exist to improve performance on the *Well-Child Visits in the First 30 Months of Life* indicators given that none of the six counties had rates in the top quintile (i.e., above the 80th percentile of statewide performance) for either the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* or the *Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits* indicators.
  - San Bernardino, Riverside, and Orange counties had indicator rates that fell into the bottom two quintiles (i.e., below the 40th percentile of statewide performance) for both *Well-Child Visits in the First 30 Months of Life* indicators.

Conclusions and Considerations for Key Finding 3

- Implementing efforts to improve well-child visits within the six largest counties may contribute to substantial improvement for California overall.
- DHCS' Preventive Services Outreach campaign is expected to have a positive impact across all counties.

Key Finding 4: A majority of younger children receive well-care visits, but improvement is needed for developmental screenings and the provision of dental fluoride varnish.

- A 2019 audit conducted by the California State Auditor found that lower utilization of well-care visits was identified for some age groups within the pediatric population. HSAG's analysis identified positive findings in that the majority of Medi-Cal managed care children received a well-care visit.
  - Approximately 70 percent of Medi-Cal managed care children 15 months old and younger had at least four of the six recommended comprehensive well-care visits during calendar year 2019.

- Approximately 85 percent of Medi-Cal managed care children ages 15 to 30 months had at least one comprehensive well-care visit during calendar year 2019.
- Approximately 68 percent of Medi-Cal managed care children 3 to 6 years of age had at least one comprehensive well-care visit during calendar year 2019.
- Approximately 50 percent of Medi-Cal managed care children 7 to 11 years of age had at least one comprehensive well-care visit during calendar year 2019.

♦ The rates of well-care visits declined for children in older age groups. While 68 percent of children 3 to 6 years of age had at least one comprehensive well-care visit during calendar year 2019, only 26 percent of adolescents 18 to 21 years of age had at least one comprehensive well-care visit during calendar year 2019.

♦ Approximately 25 percent of children received a developmental screening in the first three years of life, which is substantially lower than the national benchmark of approximately 33 percent.

♦ The provision of dental fluoride varnish by non-dental providers is fairly low statewide, with only 9 percent of children 6 months to 5 years of age receiving dental fluoride varnish from a non-dental provider.

Conclusions and Considerations for Key Finding 4

♦ The benefits of receiving well-child visits include the prevention of illness through immunizations; tracking growth and development; allowing parents to raise concerns regarding their child with the child's physician; and building strong relationships among the pediatrician, parents, and child.[76]

♦ Based on the results presented in the *2020 Preventive Services Report*, MCPs have an opportunity to increase the number of well-care visits that children receive prior to 30 months of age.

♦ MCPs should leverage the anticipated increase in member utilization of preventive services (due to increased member education) by educating providers on the importance of administering comprehensive preventive care during these visits, including the provision of developmental screening and application of dental fluoride in a clinical setting by a PCP.

♦ DHCS requires MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health; information from the Preventive Services Report can assist MCPs in their PIP processes.

♦ DHCS initiated a Value Based Payment (VBP) program to incentivize the provision of certain preventive services, including well-child visits and dental fluoride varnish, to increase provider participation and delivery of these key pediatric services.

- This effort is expected to result in improvement in the provision of these key services in the reporting year in which incentive payments are first applied.

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[76] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Jan 26, 2021.

Key Finding 5: Adolescent rates for well-care visits are lower than rates for younger children.

- Approximately 51 percent of adolescents ages 12 to 17 years had at least one comprehensive well-child visit during calendar year 2019.
- Approximately 26 percent of adolescents ages 18 to 21 years had at least one comprehensive well-child visit during calendar year 2019.

Conclusions and Considerations for Key Finding 5

- Given that adolescents ages 12 to 21 years account for 45 percent of the pediatric Medi-Cal managed care population, there are opportunities for MCPs to work with providers to ensure that as children get older, they still continue to receive comprehensive well-care visits and receive the recommended screenings.
- According to the AAP and U.S. Preventive Services Task Force, alcohol and tobacco use and depression can lead to life-long detrimental health complications, and early screening is necessary to prevent chronic health and social issues.[77,78,79]
- Opportunities exist to improve the provision of critical adolescent screenings (i.e., screenings for depression and alcohol and tobacco use) in ages 18 to 21 years. These screenings may be accomplished during comprehensive well-care visits with PCPs and OB/GYNs.
- DHCS' VBP program includes measures related to tobacco use, alcohol use, and depression screenings, and DHCS expects to see a positive impact on screenings due to this incentive program.
- MCPs should work with providers to improve billing practices to capture alcohol and tobacco screenings.
- DHCS requires MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health; information from the Preventive Services Report can assist MCPs in their PIP processes.

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[77] Knight J, Roberts T, Gabrielli J, et al. Adolescent Alcohol and Substance Use and Abuse, Performing Preventive Services: A Bright Futures Handbook, American Academy of Pediatrics. Available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/Screening.pdf#search=alcohol%20screening. Accessed on: Jan 26, 2021.

[78] American Academy of Pediatrics. Teens and Tobacco Use. Available at: https://www.healthychildren.org/English/ages-stages/teen/substance-abuse/Pages/Teens-and-Tobacco-Use.aspx. Accessed on: Jan 26, 2021.

[79] Siu A (on behalf of the US Preventive Services Task Force). Screening for Depression in Children and Adolescents: US Preventive Services Task Force Recommendation Statement, *Pediatrics*. Available at: https://pediatrics.aappublications.org/content/early/2016/02/04/peds.2015-4467. Accessed on: Jan 26, 2021.

Items for Consideration—2020 Preventive Services Analysis

Based on ongoing communication with DHCS, HSAG is aware that DHCS is actively working to incorporate HSAG's identified items for consideration from the 2020 Preventive Services Analysis. Additionally, in spring 2021, DHCS and HSAG will begin discussing the methodology for the 2021 Preventive Services Analysis, incorporating findings and lessons learned from the 2020 analyses. Based on DHCS already taking action on HSAG's items for consideration, as part of the EQR technical report process HSAG has no recommendations for DHCS related to the Preventive Services Analysis.

Regional Model Access Focused Study

To ensure that MCMC beneficiaries in the Regional Model counties have reasonable access to care, Recommendation 10 of the California State Auditor Report 2018-122 (Auditor Report) required DHCS to conduct an analysis to determine the specific causes of the reported inability of MCPs operating under the Regional Model to provide reasonable access to care in the Regional Model counties. The MCPs operating under the Regional Model are Anthem Blue Cross and CHW. The Regional Model counties are Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

DHCS contracted with HSAG to conduct a focused study to identify the specific causes of provider network issues identified in the Auditor Report. The purpose of this analysis was two-fold:

- Identify the specific Regional Model counties in which provider network coverage issues exist for each MCP operating under the Regional Model (i.e., Anthem Blue Cross and CHW) and each provider type.
- Identify specific causes of provider network issues identified in the Auditor Report.

The *2019–20 Regional Model Access Focused Study Report* includes the detailed methodology, study results, and conclusions. Following are high-level summaries of the study methodology and key findings.

Methodology—Regional Model Access Focused Study

HSAG implemented a two-phase approach to determine the location and specific causes of Anthem Blue Cross' and CHW's inability to provide "reasonable access to care." Phase 1 involved HSAG gathering information through interviews conducted with Anthem Blue Cross and CHW and conducting a preliminary time and distance analysis, by MCP, provider type, and Regional Model county. Phase 2 involved additional analyses investigating MCP contracting practices relative to available providers within each county as well as determining the impact of MCPs contracting with hypothetical provider networks on beneficiary access to care.

HSAG evaluated Anthem Blue Cross' and CHW's overall network coverage in each of the Regional Model counties. For Regional Model counties in which HSAG identified a shortage in network coverage (by MCP and provider type), HSAG conducted the following additional analyses to identify causes of the network shortage:

- Distance to the nearest identified service provider who has demonstrated a willingness to provide services to Medi-Cal beneficiaries (i.e., FFS and MCMC).
- Distance to the nearest identified service provider who has demonstrated a willingness to provide services to MCMC beneficiaries.
- Percentage of all available providers having contracted with Anthem Blue Cross or CHW.
- Percentage of all providers who have demonstrated a willingness to provide services to Medi-Cal beneficiaries having contracted with Anthem Blue Cross or CHW.
- Percentage of providers that contracted with Anthem Blue Cross only, CHW only, and both MCPs in the Regional Model counties.

Key Findings—Regional Model Access Focused Study

The analyses revealed that all Regional Model counties except Sutter and Yuba counties had multiple provider types that do not meet the time or distance access to care standards. Access to care can be improved if all providers who have demonstrated a willingness to provide services to Medi-Cal beneficiaries were included in the MCMC provider network for both MCPs. However, even if all these providers were included, the improvement in access to care would generally not be sufficient for the plans to meet the time and distance standards for most of the provider specialty/county combinations for which HSAG identified issues.

Key Analysis Results

If Anthem Blue Cross and CHW included all providers currently contracted to provide services to Medi-Cal FFS or MCMC beneficiaries (i.e., willing Medi-Cal providers) in the Regional Model counties in their networks, the greatest distance a beneficiary would have to travel to access care could be reduced in a substantial number of the 73 provider specialty/county combinations assessed (64 for Anthem Blue Cross, 57 for CHW). However, in only four specialty/county combinations would the reduction be sufficient to meet the travel time and distance standard.

If the MCPs included all providers currently contracted to provide services to MCMC beneficiaries in the Regional Model counties in their networks, the greatest distance a beneficiary would have to travel to access care could be reduced in a smaller number of the 73 provider specialty/county combinations assessed (46 for Anthem Blue Cross, 22 for CHW). However, for only two specialty/county combinations would the reduction in maximum travel time be sufficient to meet the minimum travel time and distance standard. Since the combined MCMC provider network is smaller than the hypothetical willing Med-Cal provider network, which includes all current MCMC and FFS providers, it is expected that fewer specialty/county combinations would meet the standard.

HSAG also examined the percentage of all providers with which each MCP contracts. HSAG found three notable results. In the counties that failed to meet the standards for Ear, Nose, and Throat/otolaryngology, hematology, oncology, and pulmonology, there were no available providers within the county borders with whom the MCPs could contract. For one provider specialty, each MCP contracts with 100 percent of the available providers in the counties in which it failed to meet the time and distance standards for that specialty (endocrinology for Anthem Blue Cross, dermatology for CHW). In the counties where both MCPs failed to meet the standards for physical medicine and rehabilitation, neither Anthem Blue Cross nor CHW contract with any of the available providers within the counties.

HSAG found similar results when examining the percentage of providers who have demonstrated a willingness to provide services to Medi-Cal beneficiaries who have contracted with each MCP.

HSAG also examined the demonstrated willingness of providers to provide services to Medi-Cal beneficiaries. The majority of providers in all but two specialties (mental health [non-psychiatry] outpatient services and hospitals) provided services to Medi-Cal beneficiaries through an MCP or FFS, suggesting the Medi-Cal network is fairly robust relative to the overall provider network and providing services to Medi-Cal beneficiaries is not entirely unattractive to health care providers. At the county level, HSAG found that at least half of all available providers have demonstrated a willingness to provide services to Medi-Cal beneficiaries.

MCP-Specific Results

When evaluating the impact of hypothetically expanding the provider networks to include all willing Medi-Cal providers, HSAG found that the Anthem Blue Cross network would generally be improved the most, both in terms of the average reduction in maximum travel time across all specialty/county combinations assessed as well as the number of specialty/county combinations for which maximum travel time would be reduced. This was also true when evaluating the impact of hypothetically expanding the provider networks to include all MCMC providers.

Conclusions—Regional Model Access Focused Study

Overall, the results of the HSAG analyses suggest that the driving factor underlying the reported inability of the MCPs operating under the Regional Model to meet access standards is a lack of providers in rural areas. This situation is not unique to California, as a shortage of providers in rural counties is a recognized issue nationwide.

Items for Consideration—Regional Model Access Focused Study

Based on the results of the analyses, HSAG identified the following items for DHCS to consider in addressing the access issues in the Regional Model counties. Note that prior to the *2019–20 Regional Model Access Focused Study Report* being finalized, DHCS indicated that it is already engaged in these actions and efforts.

- Conduct additional analyses to estimate the impact of contracting with all providers in addition to providers willing to provide services to Medi-Cal beneficiaries.
- Encourage Anthem Blue Cross and CHW to use the publicly available list of Medi-Cal FFS providers to identify additional potential providers likely interested in providing care to Medi-Cal beneficiaries in provider shortage areas.
- Evaluate the taxonomy codes used to define provider specialties to ensure all relevant taxonomy codes are included so that all relevant providers are identified within a specialty network.
- Encourage MCPs to ensure that taxonomy codes related to all specialty services for which a provider is contracted with the MCP are captured and reported.
- Encourage the expanded use of telehealth services. Additionally, begin to develop methodologies and approaches to identify and measure the impact of telehealth services on beneficiary access to care.

Based on DHCS reporting that it has already taken action on HSAG's identified items for consideration from the Regional Model Access Focused Study, as part of the EQR technical report process, HSAG has no recommendations for DHCS related to the Regional Model Access Focused Study results and findings.

18. Technical Assistance

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

Background

In addition to the technical assistance provided to MCMC plans as part of the PIP process, DHCS contracted with HSAG to provide supplemental technical assistance to help improve overall statewide performance. DHCS selected three technical assistance activity sets for HSAG to conduct during the July 1, 2019, through June 30, 2020, review period.

Technical Assistance Activity for Performance Measures

Objective

Under the Technical Assistance Activity for Performance Measures, HSAG provides technical assistance to DHCS, as requested, to:

- Help build the DHCS quality improvement team's capacity to work directly with MCPs, PSPs, and the SHP to improve performance on MCAS measures.
- Assist DHCS in identifying priority performance measures. Specifically, assist DHCS in developing and monitoring a strategy to raise performance on each of the priority focus areas identified in DHCS' *Comprehensive Quality Strategy Report*.
- Provide input and feedback to DHCS regarding its development and monitoring of CAPs and IPs for MCPs, PSPs, or the SHP with persistent substandard performance on one or more measures.
- Provide guidance to DHCS on improving monitoring activities and make recommendations, as appropriate, for improving DHCS' processes for holding MCPs, PSPs, and the SHP accountable for meeting contractual requirements.
- Review and provide feedback to DHCS on an array of documents related to quality improvement activities.
- Respond to requests from DHCS for input on a variety of quality improvement-related issues and topics via telephone and email.

Under the Technical Assistance Activity for Performance Measures, HSAG also provides technical assistance to MCPs, PSPs, and the SHP requiring additional guidance with IPs and CAPs, as identified by DHCS.

Methodology

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

Results—Technical Assistance Activity for Performance Measures

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

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

DHCS required MCPs to conduct PDSA cycles and submit PDSA Cycle Worksheets for performance measures with rates that did not meet the minimum performance levels for the previous year. Additionally, as part of the CAP process, DHCS required MCPs under CAPs to conduct PDSA cycles and submit PDSA Cycle Worksheets for performance measures with rates below the minimum performance levels for multiple years. During the review period, DHCS made no requests for HSAG to conduct secondary reviews of the PDSA Cycle Worksheets.

At DHCS' request, HSAG reviewed DHCS' Quality Monitoring & Corrective Action Plan Process Document and provided feedback to DHCS on the methodology and process. Additionally, HSAG validated PIPs submitted by MCPs under CAPs and, when needed, conducted individual technical assistance calls with these MCPs to assist them with conducting PIPs using HSAG's rapid-cycle PIP approach.

Performance Measures and Audits

HSAG provided technical assistance to DHCS via emails and conference calls to discuss the reporting year 2020 MCAS measures and DHCS' questions related to the validation process, specifications to use for performance measure reporting, and the type of guidance to provide to MCPs, PSPs, and the SHP regarding performance measure reporting and the audit process. Notably, HSAG provided the following technical assistance:

- HSAG provided extensive technical assistance to MCPs and PSPs via email and conference calls to discuss reporting requirements related to the reporting year 2020 MCAS measures.
- Based on questions received from MCPs and PSPs, HSAG held a webinar meeting with DHCS to discuss potential updates to the reporting year 2020 MCAS list structure. As a result of the discussion, HSAG updated the reporting year 2020 MCAS list to include more details and guidance for MCPs and PSPs and submitted the document to DHCS for review.

- At DHCS' request, HSAG provided a list of PIP interventions implemented by health plans in various states with which HSAG works that are related to the new measures DHCS added to the reporting year 2020 MCAS measure list.
- HSAG reuploaded to its secure file transfer protocol site NCQA's Medicaid HMO 50th percentile information for all HEDIS measures that DHCS required MCPs and PSPs to report in 2020. Some MCPs and PSPs had requested that the information be reposted for retrieval.
- HSAG provided recommendations to DHCS based on NCQA's February 2020 HEDIS 2020 Measure Trending Determinations memorandum.
- HSAG responded to DHCS' questions about how MCPs reported the *Plan All-Cause Readmissions* measure for reporting year 2019 related to the risk adjustment portion of the specification. HSAG recommended that DHCS not compare reporting year 2020 results to reporting year 2019 results for the *Plan All-Cause Readmissions* measure based on the changes NCQA made to the specification for the measure for reporting year 2020.
- HSAG provided extensive information to DHCS regarding the different types of supplemental data and the audit-related processes pertaining to use of supplemental data.
- HSAG provided guidance to DHCS to assist with its response to an MCP's inquiry about whether the MCP can use the administrative methodology to report the rate for a measure for which DHCS requires using the hybrid methodology.

COVID-19 Impact on External Quality Review Activities

- HSAG provided DHCS with a weekly assessment of the impact of COVID-19 on EQR activities via the weekly deliverables grid to inform DHCS' decision making.
- HSAG reviewed and provided feedback to DHCS on the draft version of DHCS' COVID-19 Supplement to APL 19-017, which outlines DHCS' decisions regarding quality and performance improvement adjustments due to COVID-19.
- HSAG provided its interpretation of CMS' decisions in response to COVID-19, including applicability of the decisions to MCMC.
- HSAG provided DHCS with information from NCQA regarding the impact of COVID-19 on the performance measure audit and reporting processes.
- HSAG responded to DHCS' questions regarding whether the MCMC plans would still be compliant with PIP federal requirements if COVID-19 interferes with their ability to continue PIP activities. HSAG suggested to DHCS that HSAG send an email to MCMC plans, and DHCS approved this suggestion. HSAG then emailed the MCMC plans to send HSAG and DHCS the following information if they determined that enforcement of COVID-19 precautions was interfering with current PIP activities:
    - PIP topic
    - PIP activities impacted
    - Anticipated date for the next PIP module submission
- HSAG provided information to DHCS about using NCQA's mail-only methodology for administering the CHIP CAHPS survey to accommodate changes HSAG's vendor needed

to implement in response to COVID-19. DHCS used the information to inform its decision regarding whether to allow the methodology change.

Other Technical Assistance

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

- CAHPS survey administration and data submission processes.
- Rapid-cycle PIP methodology, validation criteria, and timeline.
- PNA reporting structure and implementation, including data sources MCPs and PSPs can use to complete the PNAs.
- Various EQRO activities for DHCS staff members to gain more comprehensive understanding of the mandatory and optional EQR activities.

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

Conclusions—Technical Assistance Activity for Performance Measures

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

- DHCS has a better understanding of performance measures, which will enable DHCS to make informed decisions regarding future MCAS requirements.
- DHCS has more in-depth understanding of the various EQR activities.
- DHCS gained information to assist in making informed decisions regarding how to best move forward with various EQR activities during the COVID-19 pandemic and to best provide guidance to MCPs, PSPs, and the SHP related to EQR activities impacted by COVID-19.
- MCPs under CAPs became more proficient conducting the rapid-cycle PIP process and strengthened their quality improvement efforts.
- MCPs have a better understanding of the CAHPS survey process.

Recommendations—Technical Assistance Activity for Performance Measures

As part of the technical assistance HSAG provides to DHCS, HSAG makes recommendations to DHCS and DHCS incorporates the recommendations, as applicable; therefore, as part of the EQR technical report process, HSAG identified no recommendations for DHCS related to technical assistance activity for performance measures.

Technical Assistance Activity for Quality Improvement Collaboration

Objective

Under the Technical Assistance Activity for Quality Improvement Collaboration, HSAG facilitates collaborative discussions with MCPs, PSPs, and the SHP for each focus area selected by DHCS. The objectives of the collaborative discussions are:

- To provide MCPs, PSPs, and the SHP the opportunity to share with each other about issues, barriers, promising practices, and solutions related to their quality improvement work in the focus areas.
- For MCPs, PSPs, and the SHP to benefit from HSAG's insight and expertise, particularly related to the PIP process.
- For DHCS to share pertinent resources and insights, particularly around the possibility of collaboration with external partners.

Methodology

Through joint planning meetings, HSAG and DHCS discussed potential topics for the collaborative discussions and the appropriate structure of the meetings based on those topics. DHCS and HSAG collaboratively determined the topic for each collaborative discussion based on:

- Feedback received from MCPs, PSPs, and the SHP about discussion topic preferences.
- MCPs', PSPs', and the SHP's progression of the PIP process.
- Issues identified by HSAG through its PIP validation.
- Issues identified by HSAG during MCP-, PSP-, and SHP-specific technical assistance sessions.
- Issues identified by DHCS and HSAG through review of MCPs' PDSA cycles.
- Issues identified by DHCS as part of its monitoring and oversight processes with MCPs, PSPs, and the SHP.

HSAG conducted the collaborative discussions through webinars and conference calls. Immediately following each collaborative discussion, HSAG invited participants to complete a post-collaborative discussion survey to provide anonymous feedback about the discussion and their input for future discussions. The survey link appeared immediately after participants exited the Webex, and HSAG also emailed the survey link to participants following each discussion. Within 10 business days following each collaborative discussion, HSAG emailed a meeting summary to MCPs, PSPs, and the SHP and reminded collaborative discussion participants to complete the surveys.

Results—Technical Assistance Activity for Quality Improvement Collaboration

During the first quarter of the review period, HSAG and DHCS jointly facilitated two collaborative discussions on the following focus areas selected by DHCS:

- Data—A discussion focused on improving access to and collection of accurate laboratory, pharmacy, vendor, and supplemental data to help ensure better health outcomes and improve quality metric performance.
- Immunizations—A discussion focused on the quality improvement work of the numerous MCPs and PSPs working on the *Childhood Immunization Status—Combination 3* and *Immunizations for Adolescents—Combination 2* measures.

In each of the remaining three quarters of the review period, HSAG and DHCS jointly facilitated three collaborative discussions on the following focus areas that align with the MCAS domains:

- Child and Adolescent Health—Focusing on MCPs', PSPs', and the SHP's quality improvement work for the *Child and Adolescent Health* PIPs and PDSA cycles related to child and adolescent health measures, as well as preparation for the new MCAS measures related to child and adolescent health.
- Disease Management and Behavioral Health—Focusing on MCPs' and PSPs' quality improvement work on PIPs and PDSA cycles related to acute and chronic disease management, as well as preparation for the new MCAS measures related to behavioral health.
- Women's Health—Focusing on MCPs' and PSPs' quality improvement work on PIPs and PDSA cycles related to women's health, as well as preparation for the new MCAS measures related to women's health, including maternal health.

While there was no specific collaborative call dedicated to the topic of health equity, DHCS and HSAG worked with MCPs, PSPs, and the SHP to include a health equity focus whenever possible in the collaborative call discussion topics.

During the fourth quarter of the review period, instead of facilitating a collaborative discussion on the topic of women's health, DHCS and HSAG conducted a collaborative discussion to discuss with MCPs, PSPs, and the SHP the impact of COVID-19 on PIPs.

At the beginning of each collaborative discussion, DHCS provided an update on statewide efforts, partnerships, resources, and other pertinent information related to the collaborative discussion topic. Following DHCS' update, representatives from one or more MCPs conducted presentations about their quality improvement efforts related to the collaborative discussion topic. During some presentations, MCP partner organizations also presented information. Following the presentations, HSAG facilitated a question-and-answer session to provide the opportunity for MCPs, PSPs, and the SHP to ask the presenters' questions. HSAG also encouraged the participants to engage in discussion around the presentation topic.

During the review period, HSAG and DHCS worked with the following entities to present about their successful quality improvement efforts related to the collaborative discussion focus areas:

- Data:
  - Health Plan of San Mateo
- Immunizations:
  - Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
  - CenCal Health
- Child and Adolescent Health:
  - Golden Valley Health Centers
  - Health Plan of San Joaquin
  - Partnership HealthPlan of California
  - UnitedHealthcare Community Plan
- Disease Management and Behavioral Health
  - Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
  - Inland Empire Health Plan
  - Kaiser SoCal
  - Kern Health Systems, DBA Kern Family Health Care
- Women's Health:
  - Alameda Alliance for Health
  - CalViva Health

In all four quarters, most post-collaborative discussion survey respondents completed the surveys on the days of the calls. The survey respondents generally gave favorable ratings, and the survey results yielded no notable responses or feedback.

Conclusions—Technical Assistance Activity for Quality Improvement Collaboration

During the review period, DHCS and HSAG facilitated successful collaborative discussions and engaged MCPs, PSPs, and the SHP to actively participate by sharing their own experiences, challenges, and lessons learned from their quality improvement efforts. All presenters shared helpful information that generated valuable conversation among participants. Additionally, holding the COVID-19 Impact on PIPs Collaborative Discussion was helpful in alleviating MCPs', PSPs' and the SHP's anxiety about PIP requirements since DHCS made a decision to end the 2019–21 PIPs.

Recommendations—Technical Assistance Activity for Quality Improvement Collaboration

As part of the collaborative discussion planning process and quarterly reports, HSAG makes recommendations to DHCS regarding future collaborative discussions based on the post-collaborative discussion survey results and HSAG's observations during each quarter's discussions. DHCS and HSAG consider all recommendations when planning for the next set of collaborative discussions; therefore, as part of the EQR technical report production process HSAG has no recommendations for DHCS related to technical assistance activity for quality improvement collaboration.

Technical Assistance Activity for Quality Conference

DHCS contracted HSAG to organize and facilitate the quality conference, *Health Equity: Promoting Quality and Access for All; Building Skills to Bridge the Health Divide*, on October 30, 2019, in Sacramento, California. Note that only MCPs and PSPs were represented at the quality conference.

Objective

The conference provided MCPs and PSPs the opportunity to build skills to bridge the health divide. Presentations focused on strategies related to addressing health equity gaps and ensuring access to health care for all Medi-Cal members.

Methodology

Conference Planning

DHCS and HSAG began logistical planning for the conference in August 2018, which continued up to the event in October 2019.

DHCS identified the theme of the conference based on DHCS priorities; feedback received from MCPs, PSPs, and the SHP through the PIP process; and initial conference planning discussions between DHCS and HSAG regarding wanting to ensure that the theme would be meaningful as well as support MCPs, PSPs, and the SHP in their quality improvement efforts. To ensure that the conference content and structure would meet the needs of MCPs, PSPs, and the SHP, DHCS and HSAG collaborated to develop a survey to obtain MCPs', PSPs', and the SHP's input on the content and structure of the day. In November 2018, DHCS sent the online survey link to MCPs, PSPs, and the SHP.

DHCS solicited MCPs, PSPs, and the SHP for individuals who were willing to volunteer to participate on the conference planning committee. Twelve MCP/PSP staff members volunteered, representing 10 MCPs/PSPs. Representatives from DHCS also participated on the committee. HSAG facilitated two calls with the conference planning committee (February

and March 2019) to obtain the committee's input on the conference content, structure, and speakers. HSAG presented a summary of the survey results to aid the committee in its decision making, provided a proposed conference agenda based on the survey results, and offered suggestions for speakers. HSAG communicated with committee members via email to keep them updated on the status of the decisions related to the conference content, structure, and speakers.

Unattended Poster Presentations

Based on positive feedback on the 2017 Quality Conference unattended poster presentations, DHCS and HSAG requested volunteers from MCPs and PSPs to create posters for unattended poster presentations at the 2019 conference. The poster presentations provided the opportunity for MCPs and PSPs to share about their quality improvement interventions, innovations, or initiatives that promote health equity. Thirteen MCPs/PSPs created posters. Throughout the day, conference attendees reviewed the poster information and had the opportunity to vote for the most innovative poster. CalViva Health's poster titled *Health Disparities: Culture is More than Language* received the most votes; and DHCS acknowledged CalViva Health with a certificate during the 2019 Quality Awards presentation.

Conference Program

DHCS and HSAG, with input from the conference planning committee, designed the conference program to include speakers with expertise in strategies to bridge health equity gaps, opportunities for skill-building to address health inequities, and time for discussion related to strategies to address disparities. The following is a high-level summary of the conference agenda:

- DHCS Welcome and Updates
- Participant Introductions
- Keynote Address by Contra Costa Health Services—*From Transactional to Transformational: Our Health Equity Personal and Professional Journey*
- Panel Discussion—Member and Community Partner Engagement to Promote Health Equity
  - Inland Empire Health Plan—*Strategies to Address Disparities and Improve Immunization Compliance*
  - CalViva Health—*Member Centered Model for Preventative Screening for Breast Cancer in Hmong Population*
  - Health Net Community Solutions, Inc.—*Reducing Cultural Barriers to Care: A Provider, Member, and Community Approach to Improving Women's Health Outcomes*
  - Gold Coast Health Plan—*Health Promotion Strategies to Working with Migrant and Seasonal Farmworkers*
- Molina Healthcare of California—*MOM (Mothers of Molina) In-Home Visit Program: Making an Impact in the African-American Community*

- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—*Data-Driven Approaches for Addressing Health Disparities: Case Studies of Moving Data to Action*
- DHCS Closing Remarks

During breaks and lunch, MCPs and PSPs were encouraged to network with each other.

2019 Quality Awards Presentation

Prior to making the closing remarks, DHCS presented the following 2019 quality awards:

- Outstanding Performance Award 2019—Small Scale Plan: Kaiser—Northern California
- Outstanding Performance Award 2019—Medium Scale Plan: Central California Alliance for Health
- Outstanding Performance Award 2019—Large Scale Plan: CalOptima
- Greatest Overall Improvement in One Year Award Runner-Up 2019: Community Health Group Partnership Plan—San Diego County
- Greatest Overall Improvement in One Year Award 2019: Gold Coast Health Plan—Ventura County
- Quality Strategy Focus Areas Most Improved Award Runner-Up 2019: Health Net Community Solutions, Inc.—Tulare County
- Quality Strategy Focus Areas Most Improved Award 2019: Gold Coast Health Plan—Ventura County
- Innovation Award Runner-Up 2019: Anthem Blue Cross Partnership Plan—Live video access on personal mobile devices in a home setting to physician, psychiatry, and counseling services
- Innovation Award Winner 2019: CenCal Health—Know More: HPV—Addressing HPV vaccination rate disparity with a digital, in-office patient intervention
- Health Equity Award Runner-Up 2019: Health Net Community Solutions, Inc.—Cervical Cancer Screening Disparity Project among Chinese Women in San Gabriel Valley
- Health Equity Award Winner 2019: CalViva Health—CalViva Postpartum Visit Disparities Project with United Health Centers Mendota Clinic

Program Evaluations

Conference participants were asked to complete an evaluation form at the end of the program. HSAG compiled the data from all completed and partially completed evaluation forms and summarized the results.

Continuing Education Units

HSAG obtained approval for continuing education units for:

- Physicians.

- Registered nurses.
- Certified Professionals in Healthcare Quality.
- Certified Health Education Specialists and Master Certified Health Education Specialists.

Results—Technical Assistance for Quality Conference

The conference drew 201 attendees, of which 162 represented MCPs or PSPs, 35 represented DHCS, and four represented other stakeholders. Of the 224 attendees who pre-registered, 197 attended; and eight individuals registered on-site as walk-in participants.

Of the 201 conference participants, 137 (68 percent) submitted a completed or partially completed conference evaluation form upon exiting the conference. Note that 109 of the 137 participants who completed or partially completed the conference evaluation form (80 percent) were MCP and PSP staff members, and 28 (20 percent) were DHCS staff or stakeholders.

Conclusions—Technical Assistance for Quality Conference

Based on evaluation results, the 2019 Quality Conference was very well received, with most of the conference attendees agreeing that as a result of the conference presentations, they gained knowledge and skills to apply to their quality improvement work to bridge the health care divide. Most conference attendees also agreed that the presenters were effective in presenting the content and that they met their presentation objectives.

Recommendations—Technical Assistance for Quality Conference

Based on feedback from conference attendees and results of the conference facilitation, HSAG provided recommendations for DHCS to consider for future quality conferences. Following receipt of HSAG's recommendations, DHCS confirmed that it will consider HSAG's recommendations when planning the next quality conference; therefore, as part of the EQR technical report production process, HSAG has no additional recommendations for DHCS related to technical assistance for quality conference.

19. Population Needs Assessment

Background

DHCS requires MCPs and PSPs to conduct a PNA to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of members. The PNA identifies member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues. MCP and PSP contractual requirements related to the PNA are based on Title 22 of the California Code of Regulations, sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), and Title 42 CFR §438.206(c)(2), §438.330(b)(4), and 438.242(b)(2).[80,81]

The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and must take action to address the opportunities for improvement.

Objectives

The goal of the PNA is to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of all their members by:

- Identifying member health needs and health disparities.
- Evaluating health education, cultural and linguistic, and quality improvement activities and available resources to address identified concerns.
- Implementing targeted strategies for health education, cultural and linguistic, and quality improvement programs and services.

[80] The California Code of Regulations is searchable and available at: https://govt.westlaw.com/calregs/Search/Index. Accessed on: Jan 26, 2021.

[81] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Jan 26, 2021.

Methodology

As part of the EQR technical report production, DHCS provided HSAG with a summary of the PNA report submission reviews.

Note that the PNA report submissions by MCPs and PSPs began during the review period for this EQR technical report; however, the submission, review, and approval processes were completed outside the review period for this report. While the processes were completed outside the review period, HSAG includes a summary of the PNA report submissions because the information was available at the time this report was produced.

Results—Population Needs Assessment

During the PNA report submission and review process, five MCPs requested extensions on their initial submissions, and DHCS requested additional information from eight MCPs and one PSP before providing PNA report approval. DHCS permitted three MCPs to submit sections of their NCQA accreditation reports to meet the PNA report requirements, as the accreditation reports contain information similar to what DHCS requires for the PNA report. Upon review of all submissions and resubmissions, DHCS approved all 25 MCPs' and three PSPs' PNA reports.

From the PNA reports, DHCS identified 149 objectives across all MCPs and PSPs. Of the 149 objectives:

- Fifty-one (34 percent) were related to a health disparity.
- Forty-two (28 percent) targeted a specific race/ethnicity, with the top three being:
  - African American/Black—30 percent.
  - Hispanic/Latinx—21 percent.
  - White—21 percent.
- Forty-one (28 percent) targeted all members.
- Thirty (20 percent) targeted a specific age group, with 63 percent of the age-specific objectives focusing on children.
- Ninety-six (64 percent) focused on quality improvement activities (e.g., MCAS, screenings).
- Forty-three (29 percent) focused on health education.
- Thirty (20 percent) focused on cultural and linguistic strategies.

Based on its review of the PNA reports, DHCS will make adjustments to the PNA submission process for the June 2021 submissions. For these submissions, MCPs and PSPs will be required to:

- Complete the DHCS review rubric and include it with their report submissions.
  - DHCS health education consultant reviewers will continue to use the rubric as a tool to ensure reviews are uniform and all report requirements are met.

  - DHCS will update the review rubric to include MCPs' and PSPs' assessments and signatures.
- Label the data source(s) and data year for the table and chart displays in the Key Findings section.
- Specifically label the objective(s) that target(s) health disparities.
  - DHCS will update the review rubric to include this requirement.
- Submit a PNA report that conforms to the PNA structure and requirements as outlined in the DHCS report template.
  - DHCS will no longer accept alternative submissions.
  - DHCS encourages MCPs and PSPs to include in their PNA reports relevant information from other reports that meets the PNA report requirements.
- Copy their DHCS contract managers and nurse consultants when they submit their reports.

Conclusions—Population Needs Assessment

DHCS' PNA report review process included the opportunity for feedback and resubmission by MCPs and PSPs to ensure they met DHCS' expectations and requirements. DHCS provided HSAG with a summary of its assessment of the PNA reports that reflected DHCS' thorough review of the reports. DHCS identified themes across MCPs and PSPs as well as considerations for future PNA report submission processes.

Recommendations—Population Needs Assessment

Based on DHCS already identifying items for consideration for future PNA report submission processes, as part of the EQR technical report process HSAG has no recommendations for DHCS related to the PNA report review process.

20. Follow-Up on Prior Year's Recommendations

Based on HSAG's assessment of DHCS' delivery of quality, accessible, and timely care through activities described in the *2018–19 Medi-Cal Managed Care Technical Report*, HSAG included no recommendations to DHCS related to EQR activities. Therefore, DHCS had no recommendations for which it was required to provide information on the actions that DHCS took to address recommendations that HSAG made in the *2018–19 Medi-Cal Managed Care Technical Report*.