Volume 1 of 4

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2020–June 30, 2021

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
- **ABD**—aged, blind, and disabled
- **ADHD**—Attention-Deficit/Hyperactivity Disorder
- **AHRQ**—Agency for Healthcare Research and Quality
- **AIDS**—acquired immunodeficiency syndrome
- **APL**—All Plan Letter
- **BMI**—body mass index
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems[1]
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CAP**—corrective action plan
- **CATI**—Computer Assisted Telephone Interviewing
- **CA WIC**—California Welfare and Institutions Code
- **CCC**—Children with Chronic Conditions
- **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
- **DBA**—doing business as
- **DHCS**—California Department of Health Care Services
- **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
- **HSAG**—Health Services Advisory Group, Inc.
- **ISCAT**—Information Systems Capabilities Assessment Tool

[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).

- **LARC**—Long-Acting Reversible Contraception
- **LTC**—long-term care
- **LTCH**—long-term care hospital
- **LTSS**—long-term services and supports
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCO**—managed care organization
- **MCP**—managed care health plan
- **MLTSS**—Managed Long-Term Services and Supports
- **MLTSSP**—Managed Long-Term Services and Supports Plan
- **MMP**—Medicare-Medicaid Plan
- **MRR**—medical record review
- **MRRV**—medical record review verification
- **MS**—Microsoft
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **NPI**—National Provider Identifier
- **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
- **QIHDS**—Quality Improvement Health Disparities
- **QIP**—quality improvement project
- **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- **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
- **SWOT**—Strengths, Weaknesses, Opportunities, Threats
- **TPM**—Two-Plan Model

1. Executive Summary

As required by the Code of Federal Regulations (CFR) at Title 42, Section (§) 438.364, the California Department of Health Care Services (DHCS) contracts with an external quality review organization (EQRO) to prepare an annual, independent, technical report. Health Services Advisory Group, Inc. (HSAG), is the EQRO for DHCS' Medi-Cal managed care program (MCMC). As described in the CFR, the independent report must summarize findings on access to 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).

Section 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. DHCS designates three of its MCOs as population-specific health plans (PSPs). DHCS contracts with one PIHP with a specialized population, which DHCS designates as a specialty health plan (SHP).

The review period for this *2020–21 Medi-Cal Managed Care External Quality Review Technical Report* is July 1, 2020, through June 30, 2021. The report provides a summary of MCP, PSP, and SHP EQR activities. Except when citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable), 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." Note that DHCS does not exempt any MCMC plans from EQR.

HSAG will report on activities that take place beyond this report's review period in the *2021–22 Medi-Cal Managed Care External Quality Review Technical Report*.

Unless noted otherwise in this report, DHCS provided HSAG with sufficient information to perform the EQR for the July 1, 2020, through June 30, 2021, review period. Additionally:

- The information HSAG used to carry out the EQR was obtained from all mandatory and select optional EQR-related activities described in §438.358.
- As applicable, DHCS followed methods consistent with the protocols established by the Department of Health and Human Services (HHS) Secretary in accordance with §438.352 to provide information relevant to the EQR.
- For each EQR-related activity, information DHCS gathered for use in the EQR included the elements described in §438.364(a)(2)(i) through (iv).
- Consistent with §438.350(f), DHCS made the EQR results available as specified in §438.364.

Overview

MCMC provides managed health care services to more than 11.5 million beneficiaries (as of June 2021)[3] in the State of California through a combination of contracted MCMC plans. During the review period, DHCS contracted with 25 MCPs,[4] three PSPs, and one SHP to provide health care services in all 58 counties throughout California.

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

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

[4] 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).

COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

This Executive Summary section provides a high-level overview of the activities completed during the July 1, 2020, through June 30, 2021, review period as well as activities for which a final report was produced and available while HSAG was producing this EQR technical report.

DHCS Comprehensive Quality Strategy

The *DHCS Comprehensive Quality Strategy 2022*[5] outlines DHCS' process for developing and maintaining a broader quality strategy to assess the quality of care that all Medi-Cal beneficiaries receive, regardless of delivery system. The strategy also defines measurable goals and tracks improvement while adhering to the regulatory federal managed care requirements. In the Quality and Health Equity Improvement Strategy section of the comprehensive quality strategy, DHCS includes details about its California Advancing and Innovating Medi-Cal (CalAIM) initiative, a five-year policy framework that encompasses a broader delivery system, program, and payment reforms across the Medi-Cal program.

Compliance Reviews

In accordance with California Welfare and Institutions Code (CA WIC) §19130(b)(3), DHCS directly conducts compliance reviews of MCMC plans, 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 the 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.
- Based on feedback received from CMS after the audit period had concluded for the year, DHCS is strengthening its Medical Audit processes to include all required federal standards

[5] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on Mar 11, 2022.

as well as compliance scoring. DHCS has kept HSAG updated on its progress with the audit process improvements.

Performance Measures

Performance Measure Validation

DHCS' Managed Care Accountability Set (MCAS) is comprehensive and includes measures that assess the quality, accessibility, and timeliness of care MCMC plans provide to their members, including screening, prevention, health care, and utilization services. HSAG auditors determined that all MCMC plans followed the appropriate performance measure specifications to produce valid rates.

Managed Care Health Plans

Performance measure results were mixed for measurement year 2020, with MCPs' performance improving significantly for some measures and declining significantly for others. MCMC weighted average comparisons between measurement years 2020 and 2019 show opportunities for improvement in the Children's Health, Women's Health, and Acute and Chronic Disease Management domains. No MCMC weighted averages declined significantly from measurement year 2019 to measurement year 2020 for measures in the Behavioral Health domain, and aggregate MCP performance improved significantly for 86 percent of the measures in this domain for which HSAG compared measurement year 2020 MCMC weighted averages to measurement year 2019 weighted averages. It is likely that a combination of factors, including COVID-19, affected MCPs' performance in measurement year 2020.

Population-Specific Health Plans and Specialty Health Plan

Due to each PSP and SHP serving a specialized population, HSAG produces no aggregate information related to the PSP and SHP performance measures. Also, due to PSPs and the SHP serving separate, specialized populations, performance measure comparison across these plans is not appropriate.

PSP- and SHP-specific results and findings can be found in the following appendices located in *Volume 2 of 4* of this EQR technical report:

- AIDS Healthcare Foundation—Appendix B
- Family Mosaic Project—Appendix M
- Rady Children's Hospital—San Diego—Appendix Y
- SCAN Health Plan—Appendix BB

Performance Improvement Projects

Through HSAG's performance improvement project (PIP) training, validation, and technical assistance, MCMC plans successfully initiated the 2020–22 PIPs on a variety of health equity and child and adolescent health topics. All MCMC plans successfully met the validation criteria for Module 1, demonstrating that all MCMC plans successfully built a strong foundational framework for their PIPs. Five MCMC plans also met validation criteria for modules 2 and 3, which indicates that they used quality improvement tools to define quality improvement activities that have the potential to impact the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim; established an intervention plan for each intervention to be tested for the PIPs; and began testing the interventions through a series of Plan-Do-Study-Act (PDSA) cycles. Although some MCMC plans faced unforeseen challenges due to COVID-19, HSAG provided plan-specific technical assistance to support those MCMC plans in moving forward with the PIP process.

Validation of Network Adequacy

To assist with assessing and ensuring network adequacy across contracted MCMC plans, 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

Alternative Access Standards Reporting

As part of DHCS' ongoing monitoring and oversight of MCMC plans, DHCS ensures that these plans' provider networks are adequate to deliver services to members. If providers are unavailable or unwilling to service Medi-Cal beneficiaries such that an MCMC plan is unable to meet time and distance standards, MCMC plans 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) 20-003[6] includes DHCS' clarifying guidance for MCMC plans regarding network certification requirements applicable during the time frame of the data analyzed in this 2020–21 EQR technical report, including requests for alternative access standards.

[6] All Plan Letter 20-003. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-003.pdf. Accessed on: Nov 3, 2021.

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 29,029 alternative access standard requests, and 16,171 distinct combinations of request characteristics appeared in the data supplied by DHCS. Of these combinations, 12,098 (74.8 percent) were approved by 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 the nearest network provider and furthest beneficiary
- Time frame for approval or denial of requests
- Consumer complaints
- Process of ensuring out-of-network access
- Contracting efforts
- Providers under contract

Summaries of the analyses are located in Section 11 of this report ("Validation of Network Adequacy"). The complete results of the analysis are located in *Volume 4 of 4* of this EQR technical report (Appendix DD).

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

DHCS requires that MCPs provide coordination of care for their members requiring long-term care (LTC) services, including services received 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, to calculate nursing facility population stratifications and long-stay quality measures for SNFs and to calculate the driving distance between

[7] CA WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05. Accessed on: Nov 3, 2021.

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

members in SNFs/ICFs and their places of residence during calendar year 2020 (i.e., January 1, 2020, through December 31, 2020).

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

Skilled Nursing Facility/Intermediate Care Facility Feasibility Pilot Study Results

Prior to HSAG conducting the SNF Experience and SNF/ICF Distance analyses for the 2020–21 EQR technical report, DHCS contracted with HSAG to conduct a pilot study to determine if SNF and ICF stays could be identified using administrative claims/encounter data in order to capture the experiences of and distance traveled by ICF residents given that Minimum Data Set (MDS) data (i.e., the data used to capture SNF Experience and Distance information in the 2019–20 EQR technical report) only capture SNF stays. HSAG investigated DHCS' administrative claims/encounter data to determine whether it was feasible to identify the date of admission and length of stay for residents living in a SNF/ICF, and, if appropriate, to calculate statewide aggregate observed and risk-adjusted rates for two CMS Medicaid Managed Long-Term Services and Supports (MLTSS) measures (i.e., *Long-Term Services and Supports [LTSS] Successful Transition After Long-Term Institutional Stay* and *LTSS Minimizing Institutional Length of Stay*) for the SNFs/ICFs using data from calendar year 2019.

HSAG identified the following conclusions and items for consideration based on its review of the pilot study findings:

- DHCS should continue to use MDS data to evaluate SNF residents' experience and distance traveled as part of the SNF/ICF Experience and Distance analysis included in the annual EQR technical report, rather than use administrative claims/encounter data.
- DHCS should continue to only assess SNF residents' experiences in the annual EQR technical report until the CMS LTSS measures can more appropriately identify ICF stays.
- DHCS should use administrative claims/encounter data to determine ICF residents' distance traveled as part of the SNF/ICF Experience and Distance analysis included in the annual EQR technical report.

Based on these recommendations, DHCS agreed to continue to analyze the distance SNF residents traveled from their residences to facilities using MDS data and to use the claims/encounter data to analyze the distance ICF residents traveled. DHCS also agreed to continue to analyze only SNF residents' experience using the MDS 3.0 long-stay quality measures, given the administrative data limitations and the CMS MLTSS measure specifications.

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 11 of this report ("Validation of Network Adequacy").

- HSAG identified the following notable observations based on its review of the statewide nursing facility population characteristics:
  - Approximately 68.6 percent of SNF residents were 65 years of age or older during calendar year 2020, which is higher than the calendar year 2019 rate for this age group (68.2 percent). This change for calendar year 2020 is largely due to the percentage increase of SNF residents 65 to 74 years of age.
  - Approximately 46.7 percent of SNF residents were male in calendar year 2020, which is consistent with the calendar year 2019 results and is higher than the most recently published national percentage of SNF residents who were male (31.1 percent).[9]
  - Approximately 58.7 percent of SNF residents had a psychiatric diagnosis during calendar year 2020, which is higher than the rate for calendar year 2019 (55.5 percent). This increase for calendar year 2020 may be attributable to the impact on residents' mental health from the infection control efforts put in place (e.g., social isolation, lack of family contact) to help prevent the spread of COVID-19 in nursing homes.[10]
  - Approximately 85.0 percent of SNF residents entered their facilities from an acute hospital during calendar year 2020, which is higher than the rate for calendar year 2019 (83.9 percent).
- HSAG identified the following notable findings from its assessment of the quarterly and annual statewide rates for each long-stay quality measure:
  - While 12 of the 16 calendar year 2020 long-stay quality measure rates (75.0 percent) improved from calendar year 2019, rates for 11 of the 16 calendar year 2020 long-stay quality measures (68.75 percent) were within 1 percentage point of the calendar year 2019 rates, indicating that the experience of MCMC members residing in California SNFs was consistent for these measures across calendar years 2019 and 2020.
    - Of note, the percentage of residents who experienced depressive symptoms was more than three times higher in calendar year 2020 than in calendar year 2019. Nationally, researchers have found that COVID-19-related social isolation has resulted in increased depressive symptoms among LTC facility residents. The impacts of COVID-19 on the *Percent of Residents Who Have Depressive Symptoms*

[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: Nov 23, 2021.

[10] McArthur C, et al. Evaluating the Effect of COVID-19 Pandemic Lockdown on Long-Term Care Residents' Mental Health: A Data-Driven Approach in New Brunswick*. J Am Med Dir Assoc.* 2021; 22(1). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7587131/. Accessed on: Nov 23, 2021.

are also seen with the nearly 50 percent increase from Quarter 1 2020 to Quarter 2 2020, which aligns with the timing of efforts put in place to mitigate the spread of COVID-19 (e.g., social isolation, lack of family contact). Further, the percentage of residents who experienced depressive symptoms continued to slightly increase from Quarter 2 2020 through the end of calendar year 2020, which might explain the large rate change.

- MCMC members residing in California SNFs experienced better outcomes than SNF residents nationally for eight of the 11 long-stay quality measures that could be compared to national averages (72.72 percent). These same eight long-stay quality measures also had better rates than the national averages for calendar year 2019. For calendar year 2020:
  - The adverse events domain represents an opportunity to improve the experience of MCMC members residing in California SNFs, as only two of the four adverse event measures that could be compared to national benchmarks (50.00 percent) had a rate that was better than the national average.
  - MCMC members residing in California SNFs experienced better outcomes than SNF residents nationally for the two behavioral health measures that were comparable to national averages.
  - MCMC members residing in California SNFs experienced better outcomes than SNF residents nationally for all four physical health measures compared to the national averages.
  - The rates for the *Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder* measure were worse than the national average. However, the rates for the *Percent of Residents with a Urinary Tract Infection* measure continued to be better than the national average.

- HSAG identified the following notable observations from its assessment of whether hospital admissions from SNFs are occurring:
  - More than 85 percent of residents entered their SNF from either an acute hospital or long-term care hospital (LTCH) during calendar year 2020. Of these residents, approximately 21.8 percent and 18.8 percent, respectively, experienced a subsequent admission to a hospital. These percentages declined from calendar year 2019, which is expected given the overall decline in discharges from SNFs during calendar year 2020 due to infection control efforts put in place to mitigate the spread of COVID-19.
- HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Adverse Events* composite measure:
  - For calendar year 2020, there was an increase in the percentage of residents experiencing no adverse events and a decrease in the percentage of residents experiencing at least one adverse event compared to calendar year 2019.
  - The most common adverse event that residents experienced was *Hospital Admissions from SNFs*, with 19.54 percent and 21.55 percent of all residents experiencing at least one hospital admission during calendar year 2020 and calendar year 2019, respectively.

- Within the *Adverse Events* composite measure, 9.13 percent of residents had a pressure ulcer for calendar year 2020, which is an improvement from calendar year 2019.
- Of the residents who experienced more than one adverse event during calendar year 2020, 85.48 percent experienced an admission to a hospital.
  - 45.52 percent experienced both an admission to a hospital and a pressure ulcer.
  - 14.25 percent experienced an admission to a hospital and were dementia residents who received antipsychotics.
  - 11.49 percent experienced an admission to a hospital and inappropriately received an antipsychotic medication.[11]

- HSAG identified the following notable findings from its assessment of the statewide cross-measure results for the *Behavioral Health* composite measure:
  - For calendar year 2020, there was a decrease in the percentage of residents experiencing no behavioral health events and an increase in the percentage of residents experiencing at least one behavioral health event compared to calendar year 2019.
  - The most common behavioral health events that residents experienced during calendar year 2020 were *Percent of Residents Who Used Antianxiety or Hypnotic Medication* and *Prevalence of Behavior Symptoms Affecting Others*. Approximately 29.18 percent of residents experienced at least one of these events during calendar year 2020.
  - Fewer residents experienced more than one behavioral health event compared to adverse events and physical health events. Of the residents who experienced more than one adverse event during calendar year 2020, 64.13 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:
  - For calendar year 2020, the percentages of residents experiencing no events, at least one event, and more than one event stayed relatively the same compared to calendar year 2019.
  - The most common physical health event that residents experienced was *Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder*, with 25.26 percent and 29.37 percent of all residents having lost control of their bowel or bladder during calendar year 2020 and calendar year 2019, respectively.
  - Of the residents who experienced more than one adverse event during calendar year 2020, 46.50 percent experienced both a decrease in their ability to move independently and an increase in their need for help performing activities of daily living. Further, approximately 43.5 percent of residents who experienced more than one adverse event experienced a loss of bladder or bowel control along with a decrease in their ability to

[11] Note that the *Percent of Residents Who Received an Antipsychotic Medication* measure excludes residents from the denominator who have a diagnosis for which the administration of an antipsychotic medication is appropriate.

move independently and/or an increase in their need for help performing activities of daily living.

Skilled Nursing Facility/Intermediate Care Facility Distance Observations and Findings

- HSAG identified the following notable findings from its assessment of the county-level short-stay resident distance results:
  - Overall, there were approximately 20,000 fewer short-stay residents in calendar year 2020 than were identified for calendar year 2019. Additionally, this drop in the count of short-stay SNF residents was noted as being most severe during April, May, and June of 2020. This is likely evident of members being less inclined to enter a SNF or that SNFs were less inclined to accept new residents amidst the COVID-19 pandemic, particularly for members that anticipated having a short stay at the facility.[12]
  - The statewide average driving distance for short-stay residents increased by 1.10 miles from calendar year 2019 to calendar year 2020.
  - For calendar year 2020, while the statewide average driving distance for short-stay residents was 13.64 miles from their place of residence to the facility, at least half of all short-stay residents traveled 7.10 or fewer miles. Because at least 25 percent of long-stay residents traveled 14.60 miles or more from their place of residence to the facility (with a maximum driving distance of 601.80 miles), 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 29 of the 51 counties with sufficient data (56.9 percent), at least half of all short-stay residents traveled fewer than 10.00 miles from their place of residence during calendar year 2020.
- HSAG identified the following notable findings from its assessment of the county-level long-stay resident distance results:
  - The statewide average driving distance for long-stay residents increased by 0.42 miles from calendar year 2019 to calendar year 2020.
  - For calendar year 2020, while the statewide average driving distance for long-stay residents was 17.22 miles from their place of residence to the facility, at least half of all long-stay residents traveled 8.00 or fewer miles. Because at least 25 percent of long-stay residents traveled 17.50 miles or more from their place of residence to the facility (with a maximum driving distance of 653.20 miles), 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 21 of the 45 counties with sufficient data (46.7 percent), at least half of long-stay residents traveled fewer than 10.00 miles from their place of residence during calendar year 2020.

[12] Werner R, Hoffman A, and Coe N. Long-Term Care Policy after Covid-19—Solving the Nursing Home Crisis. *The New England Journal of Medicine.* Sep 3, 2020. Available at: https://www.nejm.org/doi/full/10.1056/nejmp2014811. Accessed on: Nov 23, 2021.

- HSAG identified the following notable findings from its assessment of the statewide short- and long-stay distance results:
  - Long-stay SNF residents had a longer average driving distance from their place of residence to a facility than short-stay residents for calendar year 2020. Additionally, this difference in average driving distances has decreased from calendar year 2019.
  - Both long- and short-stay SNF residents with the following characteristics had longer than average driving distances from their place of residence to a facility for calendar year 2020:
    - SNF residents who had a psychiatric diagnosis other than Alzheimer's disease
    - SNF residents who entered from the community
    - SNF residents who entered from a psychiatric hospital
    - SNF residents whose place of residence was located in rural areas
  - Short- and long-stay SNF residents who resided in rural areas had a longer average driving distance (24.71 and 34.56 miles, respectively) from their place of residence to a facility than SNF residents who resided in urban areas (11.16 and 13.97 miles, respectively). This represents a difference of 13.55 miles on average for short-stay residents and 20.59 miles on average for long-stay residents. However, the difference in average driving distance has decreased from calendar year 2019 for both long- and short-stay residents.
- HSAG identified the following notable findings from its assessment of the county-level ICF short-stay resident distance results:
  - For calendar year 2020, while the statewide average driving distance for short-stay ICF residents was 15.40 miles from their place of residence to the facility, at least half of all short-stay residents traveled 8.70 or fewer miles. Because at least 25 percent of short-stay residents traveled 20.20 miles or more from their place of residence to the facility (with a maximum driving distance of 291.90 miles), the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.
  - Overall, only 16 of the 58 California counties (27.6 percent) had at least one ICF short-stay resident, with only four of these counties (Los Angeles, Orange, Riverside, and San Bernardino counties) having enough residents (i.e., at least 11 residents) to display travel distances.
    - In two of the four counties with reportable data (Orange and San Bernardino counties), at least half of the ICF short-stay residents traveled fewer than 10.00 miles from their place of residence during calendar year 2020.
  - Overall, 48 short-stay ICF residents were excluded from the distance calculation due to having the same place of residence as the ICF address on the date of admission and for months prior to admission. This represents approximately 10 percent of all short-stay ICF residents identified by the analysis and is representative of incomplete data for these ICF stays. Of note, approximately 73.8 percent of these stays may have been excluded if data were complete, as the member's place of residence matched the ICF address prior to March 1, 2018.

  - Approximately 35.4 percent of the ICF short-stay residents with the same place of residence as the ICF address resided in Ventura County—nearly twice as many residents as the next highest county.

- HSAG identified the following notable findings from its assessment of the county-level long-stay ICF resident distance results:
  - For calendar year 2020, while the statewide average driving distance for long-stay ICF residents was 21.06 miles from their place of residence to the facility, at least half of all long-stay residents traveled 10.30 or fewer miles. Because at least 25 percent of long-stay ICF residents traveled 20.40 miles or more from their place of residence to the facility (with a maximum driving distance of 478.80 miles), the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.
  - Overall, 34 of the 58 California counties (58.6 percent) had at least one ICF long-stay resident, with only 14 of these counties having enough residents (i.e., at least 11 residents) to display travel distances.
    - In five of the 14 counties with reportable data (35.7 percent), at least half of the ICF long-stay residents in those counties traveled fewer than 10.00 miles from their place of residence during calendar year 2020.
  - Overall, 383 long-stay ICF residents were excluded from the distance calculation due to having the same place of residence as the ICF address on the date of admission and for months prior to admission. This represents approximately 31.4 percent of all long-stay ICF residents identified by the analysis and is representative of incomplete data for these ICF stays. Of note, approximately 74.2 percent of these stays may have been excluded if data were complete, as the member's place of residence matched the ICF address prior to March 1, 2018.
    - Approximately 33.7 percent of the long-stay ICF residents with the same place of residence as the ICF address resided in Ventura County—more than twice as many residents as the next highest county.
- HSAG identified the following notable findings from its assessment of the statewide short- and long-stay ICF distance results:
  - Long-stay ICF residents had a longer average driving distance from their place of residence to a facility than short-stay residents for calendar year 2020.
  - Short- and long-stay ICF residents who resided in rural areas had a longer average driving distance (30.02 and 24.26 miles, respectively) from their place of residence to a facility than ICF residents who resided in urban areas (13.50 and 20.34 miles, respectively). This represents a difference of 16.52 miles on average for short-stay residents and 3.92 miles on average for long-stay residents.
    - Further, short-stay ICF residents who resided in rural areas traveled over twice as far as short-stay ICF residents who resided in urban areas. Also, short-stay ICF residents who resided in rural areas traveled further than long-stay ICF residents who resided in rural areas.

Health Disparities Study

For the 2021 Health Disparities Study, HSAG evaluated indicator data collected for measurement year 2020 at the statewide level. HSAG aggregated the results from the 25 MCPs and then stratified these statewide rates for all indicators by demographic stratifications (i.e., race/ethnicity, primary language, age, gender, and Seniors and Persons with Disabilities [SPD]/non-SPD), where applicable. HSAG evaluated 35 indicators from the MCAS for racial/ethnic health disparities. Although HSAG stratified all indicators by race/ethnicity, primary language, age, gender, and SPD/non-SPD, where applicable, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification.

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

- The Hispanic or Latino group, the largest racial/ethnic group among Medi-Cal managed care members, exhibited the lowest rate of disparities identified out of all racial/ethnic groups, with disparities identified for only 10 of the 35 indicator rates (28.6 percent).
- Health disparities for the White and Black or African American groups represent areas for overall improvement. The White and Black or African American groups were the only racial/ethnic groups with disparities identified for a majority of indicators. Rates for the White and Black or African American groups were lower than the respective reference rates for 25 of the 35 indicators (71.4 percent) and 22 of the 35 indicator rates (62.8 percent), respectively.
  - Both the White and Black or African American groups had disparities identified for all six indicators within the Children's Health domain.
- The Native Hawaiian or Other Pacific Islander group exhibited the lowest number of disparities identified (eight out of 24 indicators) among all of the racial/ethnic groups. However, this is primarily due to 11 of the 35 possible indicators (31.4 percent) for the Native Hawaiian or Other Pacific Islander group not being evaluated for health disparities due to small numerators or denominators.
  - Additionally, both the Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native groups had smaller denominators than the other racial/ethnic groups for all indicators, resulting in wider confidence intervals for these two groups. As a result, nine indicator rates for the Native Hawaiian or Other Pacific Islander group and seven indicator rates for the American Indian or Alaska Native group were not classified as disparities despite the rates being below the reference rates.
- The overall counts of disparities for each racial/ethnic group are heavily influenced by each racial/ethnic group's performance for the *Contraceptive Care* indicators given these indicators account for 12 of the 35 indicators (34.3 percent) included in the study. Of note, 49 of the 106 disparities identified (46.2 percent) were for the *Contraceptive Care* indicators. Given that the choice to use contraceptive medications is heavily impacted by member preference, low performance for these indicators may not be indicative of MCP performance.
- The Children's Health domain represents an area of overall opportunity for improvement, with rates for at least two racial/ethnic groups falling below the reference rates for each

indicator within the domain. Additionally, all seven racial/ethnic groups and five of the seven racial/ethnic groups (71.4 percent) had disparities identified for the *Developmental Screening in the First Three Years of Life—Total* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* indicators, respectively.

- The Women's Health domain represents an area of overall opportunity for improvement, with the majority of rates for every racial/ethnic group, except the Hispanic or Latino group, within the domain being identified as a disparity. Of note, for the *Breast Cancer Screening* and *Cervical Cancer Screening* indicators, five of the seven racial/ethnic groups (71.4 percent) had disparities identified.
- The Behavioral Health domain represents an area of overall strength. Within this domain, no racial/ethnic group had more than two disparities identified (out of eight indicators). However, within this domain the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator represents an area of opportunity for improvement. All racial/ethnic group rates were below the minimum performance level and six of seven racial/ethnic groups had a disparity identified for this indicator.
- The *Antidepressant Medication Management–Effective Acute Phase Treatment*, *Concurrent Use of Opioids and Benzodiazepines*, and *Use of Opioids at High Dosage in Persons Without Cancer* indicators were identified as areas of overall high performance. For all three of these indicators, no racial/ethnic groups had rates that were identified as disparities.

Preventive Services Study

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 MCMC. The audit report recommended that DHCS expand the performance measures it collects and reports on to ensure all age groups receive preventive services from MCPs.[13] In response to this recommendation, DHCS requested that HSAG produce an annual Preventive Services Report beginning in 2020. This report is published on the DHCS website annually.

2020 Preventive Services Study Addendum

HSAG included a summary of the 2020 Preventive Services Study results in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report* released in April 2021. In addition to the results presented in the 2019–20 EQR technical report, DHCS contracted with HSAG to develop an addendum to the *2020 Preventive Services Report*. The addendum

[13] 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: Dec 13, 2021.

presents the DHCS-calculated *Blood Lead Screening* rates, which were calculated in accordance with California Title 17 requirements[14] as well as following the national Medicaid Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications.

The addendum also presents the MCP reporting unit-level results for the six HSAG-calculated indicators included in the *2020 Preventive Services Report*:

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits*
- *Child and Adolescent Well-Care Visits—Total*
- *Alcohol Use Screening*
- *Dental Fluoride Varnish*
- *Tobacco Use Screening*

The *2020 Preventive Services Report Addendum* includes the detailed results and analyses for the blood lead screening and six HSAG-calculated indicators.[15] The following are high-level descriptions of the findings. More detailed descriptions for the findings are located under the "Findings and Conclusions—2020 Preventive Services Study Addendum Blood Lead Screening" heading in Section 13 of this report ("Preventive Services Study").

- The majority of children in Medi-Cal managed care (60.8 percent) get blood lead screenings by their second birthday.
- Statewide performance varies based on race/ethnicity and primary language.
- No performance differences were noted between males and females.
- Statewide performance for rural versus urban regions varied by indicator.
- Blood lead screening performance is regional.

2021 Preventive Services Study

At the time this EQR technical report is being produced, HSAG is conducting the analyses for the 2021 Preventive Services Study. Based on data availability, DHCS determined to publish the *2021 Preventive Services Report* in April/May 2022. The *2021 Preventive Services Report* will be posted on DHCS' website at the following link: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

[14] Title 17, California Code of Regulations Section 37100 (b)(2)

[15] *2020 Preventive Services Report Addendum.* Available at: https://www.dhcs.ca.gov/Documents/MCQMD/2020-Preventive-Services-Report-Addendum.pdf. Accessed on: Dec 13, 2021.

Consumer Surveys

During the review period, HSAG administered the standardized survey instrument Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1 Child Medicaid Health Plan Survey with the HEDIS and Children with Chronic Conditions (CCC) measurement sets to a statewide sample of CHIP members enrolled in MCPs and the standardized survey instruments CAHPS 5.1 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set (i.e., CAHPS 5.1H Adult and Child Medicaid Health Plan Surveys) to adult members and parents or caretakers of child members enrolled in an MCP or PSP.[16]

Children's Health Insurance Program Survey

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

- The general child population scored higher than the 2020 National Committee for Quality Assurance (NCQA) child Medicaid national 50th percentile but below the 2020 NCQA child Medicaid 90th percentile for the following reportable measures:
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
- The 2021 score for the *Rating of All Health Care* global rating was statistically significantly higher than the 2020 score for the general child population.
- The CCC population scored higher than the 2020 NCQA CCC Medicaid national 50th percentile but below the NCQA CCC Medicaid national 90th percentile for one reportable measure, *Access to Prescription Medicines*.
- The CCC population scored higher than the 2020 NCQA CCC Medicaid national 90th percentile for one measure, *Rating of Specialist Seen Most Often*.

The following findings indicate opportunities for improvement in member experience for several areas of care:

- The general child population scored below the 2020 NCQA Medicaid national 50th percentiles for the following five reportable measures:
  - *Rating of Health Plan*
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
  - *Customer Service*

[16] HSAG used the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set.

- The CCC population scored below the 2020 NCQA CCC Medicaid national 50th percentiles for the following eight reportable measures:
  - *Rating of Health Plan*
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
  - *Family-Centered Care (FCC): Personal Doctor Who Knows Child*
  - *FCC: Getting Needed Information*

Medicaid Managed Care Survey

At the time this EQR technical report was produced, the *2021 CAHPS Medicaid Managed Care Survey Summary Report* was not yet final. HSAG will include the CAHPS Medicaid Managed Care results in the 2021–22 EQR technical report.

Focus Studies

During the review period, HSAG concluded three focus studies. The following are summaries of HSAG's notable conclusions from these focus studies.

CAHPS Focused Study[17]

During contract year 2019–20, DHCS contracted with HSAG to conduct a survey of MCPs to gather promising initiatives and strategies to improve MCPs' CAHPS survey results.

For this focused study, HSAG and DHCS developed a focused study survey that asked MCPs about interventions (e.g., policies, initiatives, and strategies) they implemented between June 2013 and June 2018 to improve their 2016 and 2019 adult and child Medicaid CAHPS survey results. The focused study survey also asked about regulations (e.g., federal mandates, California State laws, and DHCS policies) that were enacted between June 2013 and June 2018 which MCPs believed may have impacted their 2016 and 2019 adult and child Medicaid CAHPS survey results.

[17] In its previous protocol version (*EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012), CMS referred to this study type as a "focused" study. In its most recent protocol version (*Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, October 2019), CMS began referring to these studies as "focus" studies, which accounts for the reference to both "focused" and "focus" studies in this report.

The results of the focused study revealed that MCPs implemented several interventions between 2013 and 2018; however, HSAG could not identify one specific intervention which improved the member experience, impacting CAHPS scores. Instead, a combination of interventions or another cause not measured by this focused study is most likely what contributed to improved CAHPS scores. HSAG encourages MCPs to consider implementing interventions that have not been implemented or setting goals for interventions already in place to improve member experience.

Homelessness Focused Study

During contract year 2019–20, DHCS contracted with HSAG to design an approach for identifying homeless members eligible for MCMC during calendar year 2018 based on administrative data sources only. HSAG assessed approaches for identifying homeless members based on self-reported address data and with codes to indicate homelessness within administrative claim/encounter data.

To complete the Homelessness Focused Study analysis, HSAG used administrative data provided by DHCS; publicly available information with addresses for social services, homeless shelters, and health care providers (e.g., outpatient clinics, hospitals) in California; and patient-level detail files provided by MCPs that contain measure indicator information for each member.

HSAG assessed the following approaches for identifying homeless members: using address key words, matching social services/homeless shelter addresses, matching hospital/outpatient clinic addresses, and using claims/encounter homelessness codes. If a member was identified as homeless at any point during the measurement period using any of the below approaches, then the member was included in subsequent analyses to finalize the approach for identifying homeless members.

Based on key findings from the homeless member identification approaches, HSAG identified potential approaches for DHCS to consider for improving identification of the homeless population. These approaches are detailed under the “Conclusions and Recommendations” heading in Section 16 of this report (“Focus Studies”).

Network Hotspots Focus Study

During contract years 2016–17 and 2018–19, DHCS contracted with HSAG to conduct a Timely Access Focus Study for the MCPs. The two studies identified various issues for the sampled providers in three domains: provider compliance, provider data quality, and provider training. Therefore, during contract year 2019–20, DHCS requested that HSAG conduct a Network Hotspots Focus Study to answer the following study question:

- *Using the data from the Year 1 and Year 2 Timely Access Focus Studies, what are the problematic provider clusters (i.e., hotspots) for each MCP?*

A hotspot in the study question refers to either 1) a provider cluster that accounts for a large proportion of the total identified issues based on the calls to sampled providers from the Timely Access Focus Studies, or 2) a large proportion of provider records that have a problem within the provider cluster. Overall, the deliverables from the study identified the hotspots for each MCP so that MCPs would contact the least number of provider clusters while correcting the most issues.

There were 14 measures for the study. For each measure, HSAG identified hotspots based on the following criteria:

- Criterion 1: Top provider clusters that contributed to at least 50 percent of all problematic provider records.
- Criterion 2: There were at least three problematic provider records in a cluster, and the percentage of problematic records within a cluster was at least 75 percent.

Any provider cluster that was a hotspot for more than half of the measures in a domain was considered a super-hotspot for this study. Across all MCPs, there were 80, 47, and 254 super-hotspots for the compliance, data quality, and provider training domains, respectively.

Any provider cluster that was a super-hotspot for at least two domains was considered an aggregate super-hotspot for this study. There were 65 aggregate super-hotspots across all MCPs.

To improve members' access to care via appointment availability and provider data quality, HSAG produced the following two documents for each MCP. DHCS may consider requiring MCPs to use these documents to investigate identified issues and to take action to address them, as needed:

- MCP Results Report presenting hotspots for each measure.
- MCP Microsoft (MS) Excel interactive tool that provides a list of problematic providers for each hotspot.

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 for Plans' Quality Improvement

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each request 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 and MCMC plans by email, telephone, and Web conferences.

Due to the technical assistance that HSAG provided to DHCS and MCMC plans during the review period:

- DHCS gained information to assist DHCS with making informed decisions regarding various EQR activities and MCMC plan requirements and how to best provide guidance to MCMC plans related to EQR activities for which HSAG provided feedback and technical assistance.
- MCMC plans have a better understanding of the EQR activities.
- MCMC plans have a better understanding of how to use data and analyses from various HSAG analytic studies in their quality improvement efforts.

Technical Assistance for Priority Quality Improvement Collaboration

During the review period, HSAG coordinated with DHCS to implement, facilitate, support, and manage quarterly collaborative discussions for each DHCS-identified quality improvement priority area. The discussions provided the opportunity for MCMC plans to share with each other about issues, barriers, promising practices, and solutions related to their quality improvement work in priority areas or other quality performance measure areas. The discussions also provided the opportunity for DHCS to share pertinent resources and insights, particularly around potential collaboration with external partners. All presenters shared helpful information that generated valuable conversation among participants.

Quality Improvement Conference Technical Assistance Activity

DHCS contracted with HSAG to jointly host and facilitate the 2021 Quality Conference, *Rising to the Challenge—Resilience in Quality Improvement During COVID-19 and Other Public Health Emergencies*, on October 26, 2021 (Day 1), and October 27, 2021 (Day 2). Due to COVID-19, the conference was held virtually via Webex. The conference provided MCMC plans the opportunity to build skills to design quality improvement interventions in response to or influenced by unexpected public health emergencies.

Based on evaluation results, the 2021 Quality Conference was very well received, with most evaluation respondents agreeing that as a result of the conference presentations, they gained knowledge and skills to apply to their quality improvement work. Many respondents noted that the conference content was timely, relevant, and informative, and reflected the real challenges MCMC plans face and the amount of work they do, and most respondents agreed that the presenters were effective in presenting the content.

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 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).[18,19]

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.

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 and assessment of the reports. DHCS identified themes across MCPs and PSPs as well as considerations for future PNA report submission processes.

Recommendations Across All Assessed Activities

The following are HSAG's recommendations based on its 2020–21 EQR.

Compliance Reviews

DHCS should ensure that A&I conducts a review of Family Mosaic Project every three years which includes assessment of the SHP's compliance with all required federal standards.

[18] The California Code of Regulations is searchable and may be found at https://govt.westlaw.com/calregs/Search/Index. Accessed on: Dec 1, 2021.

[19] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. Title 42 CFR Parts 431,433, 438, et al. CHIP Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Dec 1, 2021.

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

- The SNF Experience results showed that 19.54 percent of long-stay SNF residents had a hospital admission from their SNF during calendar year 2020. Given that many hospitalizations from SNFs are preventable/avoidable,[20] further analysis is needed to understand why these hospitalizations are occurring. DHCS should consider analyzing these hospitalizations using MDS discharge assessments, primary diagnoses codes on the claim/encounter for the hospital admission from the SNF, and the services received in the hospital. By leveraging additional data, DHCS can begin to understand the reasons why Medi-Cal members are admitted to hospitals from their SNFs and determine if the reason the member was admitted to the hospital could have been managed within the SNF.
- Approximately 25 percent of ICF stays were excluded from the ICF distance analysis due to the resident having the same place of residence as the ICF address on the date of admission and for months prior to admission. Consequently, DHCS should work with MCPs to investigate potential data completeness issues, particularly in Ventura County, where residents with the same place of residence as the ICF address were most frequently identified.

[20] Medicare Payment Advisory Commission. Chapter 9: Hospital and SNF use by Medicare beneficiaries who reside in nursing facilities, June 2017. Available at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch9.pdf. Accessed on: Nov 24, 2021.

2. Introduction

External Quality Review

Title 42 CFR §438.320 defines "EQR" as an EQRO's analysis and evaluation of aggregated information on the quality and timeliness of, and access to health care services that an MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) or their contractors furnish to Medicaid beneficiaries. Each state must comply with §457.1250,[21] and as required by §438.350, each state that contracts with MCOs, PIHPs, PAHPs, or PCCM entities must ensure that:

- Except as provided in §438.362, a qualified EQRO performs an annual EQR for each such contracting MCO, PIHP, PAHP, or PCCM entity.
- The EQRO has sufficient information to perform the review.
- The information used to carry out the review must be obtained from the EQR-related activities described in §438.358 or, if applicable, from a Medicare or private accreditation review as described in §438.360.
- For each EQR-related activity, the information gathered for use in the EQR must include the elements described in §438.364(a)(2)(i) through (iv).
- The information provided to the EQRO in accordance with §438.350(b) is obtained through methods consistent with the protocols established by the HHS Secretary in accordance with §438.352.
- The results of the reviews are made available as specified in §438.364.

DHCS contracts with HSAG as the EQRO for MCMC. HSAG meets the qualifications of an EQRO as outlined in §438.354 and performs annual EQRs of DHCS' contracted MCOs, PIHPs, PAHPs, and PCCM entities to evaluate their quality and timeliness of, and access to health care services to MCMC beneficiaries.

The following activities related to EQR are described in §438.358:

- Mandatory activities:
  - Validation of PIPs required in accordance with §438.330(b)(1) that were underway during the preceding 12 months.
  - Validation of MCO, PIHP, or PAHP performance measures required in accordance with §438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months.
  - A review, conducted within the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Part 438 Subpart D, the

[21] Title 42 CFR §457.1250 may be found at: https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L/subject-group-ECFR9effb7c504b1d10/section-457.1250. Accessed on: Nov 22, 2021.

disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

- Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, §438.14(b)(1).

- Optional activities performed by using information derived during the preceding 12 months:
  - Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity.
  - Administration or validation of consumer or provider surveys of quality of care.
  - Calculation of performance measures in addition to those reported by an MCO, PIHP, PAHP, or PCCM entity and validated by an EQRO in accordance with §438.358(b)(1)(ii).
  - Conducting PIPs in addition to those conducted by an MCO, PIHP, PAHP, or PCCM entity and validated by an EQRO in accordance with §438.358 (b)(1)(i).
  - Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
  - Assisting with the quality rating of MCOs, PIHPs, and PAHPs consistent with §438.334.
- Technical assistance to groups of MCOs, PIHPs, PAHPs, or PCCM entities to assist them in conducting activities related to the mandatory and optional activities described in §438.358 that provide information for the EQR and the resulting EQR technical report.

Unless noted otherwise in this report, DHCS provided HSAG with sufficient information to perform the EQR for the July 1, 2020, through June 30, 2021, review period. Additionally:

- The information HSAG used to carry out the EQR was obtained from all mandatory and select optional EQR-related activities described in §438.358.
- As applicable, DHCS followed methods consistent with the protocols established by the HHS Secretary in accordance with §438.352 to provide information relevant to the EQR.
- For each EQR-related activity, information DHCS gathered for use in the EQR included the elements described in §438.364(a)(2)(i) through (iv).
- Consistent with §438.350(f), DHCS made the EQR results available as specified in §438.364.

Purpose of Report

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

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 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.

Section 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. DHCS designates three of its MCOs as PSPs. MCMC has one PIHP with a specialized population, which DHCS designates as an SHP.

This report provides a summary of MCP, PSP, and SHP EQR activities. Except when citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable), 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." Note that DHCS does not exempt any MCMC plans from 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. Section 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, accessibility, 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 four 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, 2020, through June 30, 2021, 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 §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
  - Focus studies
- Technical assistance

Volume 2—Plan-Specific Evaluation Reports

- MCMC plan-specific evaluation reports (appendices A through CC). 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 the quality of health care services for its members.

Volume 3—Measurement Year 2020 Managed Care Health Plan Performance Measure Comparison

- A table presenting MCP comparative performance measure validation (PMV) information for all DHCS-required performance measures.

Volume 4—Alternative Access Standards Tables

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

The EQR technical report and MCMC plan-specific evaluation reports all align to the same review period—July 1, 2020, through June 30, 2021.

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

Medi-Cal Managed Care Overview

In the State of California, DHCS administers the Medicaid program (Medi-Cal) through its fee-for-service (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 11.5 million beneficiaries (as of June 2021)[22] 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,[23] three PSPs, and one SHP to provide health care services in all 58 counties throughout California. DHCS operates MCMC through a health care delivery system that encompasses six models of managed care for its full-scope services as well as a model for PSPs and a model for SHPs. DHCS monitors MCMC plan performance across model types. The MCMC county map, which depicts the location of each model type, may be found at https://www.dhcs.ca.gov/services/Documents/MMCD-Cnty-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 2021. HSAG obtained the enrollment information from the *Medi-Cal Managed Care Enrollment Report*.[22]

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 2021, the COHS model was serving more than 2.3 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 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 2021, the TPM was serving more than 7.5 million beneficiaries through 12 health plans in 14 counties. Note that Blue Cross of

[22] 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 29, 2021.

[23] 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).

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 2021, the GMC model had five health plans serving more than 486,000 beneficiaries in Sacramento County and seven health plans serving more than 805,000 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 2021, the Regional model was serving more than 333,000 beneficiaries in 18 counties.

Imperial model. This model operates in Imperial County with two commercial health plans. As of June 2021, this model was serving more than 83,000 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 2021, the San Benito model was serving more than 9,000 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. DHCS designates the following three MCOs 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 2021, AIDS Healthcare Foundation was serving 714 members.
- Rady Children's Hospital—San Diego provides pediatric care services in San Diego County. As of June 2021, Rady Children's Hospital—San Diego was serving 384 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 2021, SCAN Health Plan was serving 12,110 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 2021, Family Mosaic Project was serving 13 members.

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, 2021

* 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.

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
		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

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
		Santa Clara	Santa Clara
	TPM—Local Initiative	Tulare	Tulare
Blue Shield of California Promise Health Plan	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	TPM—Local Initiative	Fresno	Fresno
		Kings	Kings
		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

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
		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
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

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
		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
United Healthcare Community Plan	GMC	San Diego	San Diego
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

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.

2019 Comprehensive Quality Strategy Draft for Public Comment

In November 2019, DHCS posted the *State of California Department of Health Care Services Comprehensive Quality Strategy Draft Report*[24] for public comment. The draft comprehensive quality strategy report includes the following MCMC objectives:

- Improve health outcomes.
- Improve health equity.
- Address social determinants of health.
- Improve data quality and reporting.

DHCS requires MCMC plans to report rates for a set of performance measures to evaluate the quality of health care delivered by the plans to their members, and for select measures, establishes minimum performance levels that the plans must meet. See Sections 5, 6, 7, 8, and 9 of this report ("Performance Measure Validation," "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) for more information about performance measure requirements. In alignment with federal requirements, DHCS also requires each MCMC plan to implement two PIPs annually, with one PIP being focused on reducing an identified health disparity and the other on an area in need of improvement related to child and adolescent health. See Section 10 of this report ("Performance Improvement Projects") for more information about these requirements. Finally, DHCS conducts various analytic studies, some in collaboration with HSAG, to assess the MCMC plans' performance and their delivery of services to MCMC beneficiaries.

DHCS monitors MCMC plan performance and reports on its assessment of this performance, including the MCMC objectives, in the quality strategy report. DHCS' MCMC quality strategy objectives, MCMC plan requirements, analytic studies, and MCMC monitoring efforts reflect a

[24] *State of California Department of Health Care Services Comprehensive Quality Strategy Draft Report for Public Comment, November 2019*. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/PRIME/DRAFT-DHCS-Comprehensive-Quality-Strategy.pdf. Accessed on: Nov 19, 2021.

continuous quality improvement approach that supports the delivery of quality, timely, and accessible health care services by MCMC plans.

2022 Final Comprehensive Quality Strategy

To allow DHCS time to incorporate stakeholder feedback and include additional details related to COVID-19 and the CalAIM initiative, CMS allowed DHCS to submit the final comprehensive quality strategy document to CMS in February 2022. Based on the quality strategy report being finalized outside the review dates for this EQR technical report, HSAG will provide its recommendations to DHCS regarding the quality strategy in the 2021–22 EQR technical report. Following is a high-level summary of the *DHCS Comprehensive Quality Strategy 2022*.[25]

The *DHCS Comprehensive Quality Strategy 2022* outlines DHCS' process for developing and maintaining a broader quality strategy to assess the quality of care that all Medi-Cal beneficiaries receive, regardless of delivery system. The strategy also defines measurable goals and tracks improvement while adhering to the regulatory federal managed care requirements. The comprehensive quality strategy:

- Provides an overview of all DHCS health care programs, including managed care, fee-for-service, and others.
- Includes overarching quality and health equity goals, with program-specific objectives.
- Reinforces DHCS' commitment to health equity in all program activities.
- Provides a review and evaluation of the effectiveness of the *2018 Medi-Cal Managed Care Quality Strategy Report*, which provided the foundation for many of the changes and the revised approach described in the 2022 comprehensive quality strategy.

In the Quality and Health Equity Improvement Strategy section of the comprehensive quality strategy, DHCS includes details about its CalAIM initiative, a five-year policy framework that encompasses a broader delivery system, program, and payment reforms across the Medi-Cal program.

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.

[25] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on Mar 11, 2022.

Recommendations—DHCS Comprehensive Quality Strategy

Based on DHCS finalizing and submitting its comprehensive quality strategy to CMS in February 2022, which is outside the review dates for this EQR technical report, HSAG has no recommendations for DHCS regarding the quality strategy and how DHCS can target quality strategy goals and objectives to better support improvement to the quality, timeliness, and accessibility of care. If applicable, HSAG will include recommendations regarding the comprehensive quality strategy in the 2021–22 EQR technical report.

4. 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 MCMC plans 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 MCMC plans, rather than contracting with the EQRO to conduct reviews on its behalf.

DHCS' compliance review process includes, but is not limited to, a review of MCMC 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 ensure full remediation of identified deficiencies.

Under DHCS' monitoring protocols, DHCS oversees the CAP process to ensure that MCMC plans address all deficiencies identified in the compliance reviews conducted (i.e., Medical Audits and State Supported Services Audits for MCPs and PSPs and triennial oversight reviews for the SHP) 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 MCMC 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—Managed Care Health Plans and Population-Specific Health Plans

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

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 and PSP, 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 and PSP'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.

Compliance Reviews—Specialty Health Plan

DHCS A&I conducts triennial oversight reviews of specialty mental health services provided by each county mental health plan (MHP) to determine compliance with federal and State regulations as well as the terms of the MHP contract. Family Mosaic Project, an SHP, is part of the Children, Youth, & Families System of Care operated by the San Francisco Department of Public Health Community Behavioral Health Services; therefore, DHCS includes Family Mosaic Project in its triennial oversight reviews of the San Francisco County MHP. DHCS works closely with each MHP to ensure compliance and to identify opportunities for improvement. Using a collaborative and educational approach, DHCS provides guidance and technical assistance when it determines that the MHP is out of compliance. After the review, DHCS provides feedback related to areas of non-compliance. DHCS provides the MHP with a written report of findings which includes a description of each finding and of any corrective actions needed. Within 60 days of receiving the final report of findings, MHPs are required to

submit to DHCS a CAP for all items that DHCS determined to be out of compliance. If an urgent issue is identified, the issue is addressed immediately.

Objectives

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

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

External Quality Review Methodology

Evidence of Technical Methods of Data Collection and Analysis

DHCS applies the Generally Accepted Government Auditing Standards, also known as the Yellow Book. To show evidence of DHCS' assessment of the standards included in 42 CFR, DHCS provided HSAG with a crosswalk of the categories A&I reviews during the Medical Audits and the federal standards covered within each of the categories. Table 4.1 displays the A&I Medical Audit categories and the corresponding 42 CFR Subpart D and Quality Assessment and Performance Improvement standards assessed during A&I's reviews.

Table 4.1—Subpart D and Quality Assessment and Performance Improvement Standards Reviewed within A&I Medical Audit Categories

A&I Medical Audit Categories	Subpart D and Quality Assessment and Performance Improvement Standard
Utilization Management	§438.114 Emergency and Poststabilization Services §438.210 Coverage and Authorization of Services §438.230 Subcontractual Relationships and Delegation §438.236 Practice Guidelines
Case Management and Coordination of Care	§438.114 Emergency and Poststabilization Services §438.208 Coordination and Continuity of Care §438.210 Coverage and Authorization of Services
Access and Availability	§438.206 Availability of Services §438.207 Assurance of Adequate Capacity and Services §438.210 Coverage and Authorization of Services

A&I Medical Audit Categories	Subpart D and Quality Assessment and Performance Improvement Standard
Member Rights	§438.100 Enrollee Rights §438.206 Availability of Services §438.208 Coordination and Continuity of Care §438.224 Confidentiality §438.228 Grievance and Appeal Systems
Quality Management	§438.214 Provider Selection §438.230 Subcontractual Relationships and Delegation §438.330 QAPI Program

While DHCS does not assess MCP and PSP compliance with 42 CFR §438.242: Health Information Systems as part of the Medical Audit process, DHCS includes references to these standards in its boilerplate managed care contracts and applicable APLs. Additionally, DHCS monitors MCP and PSP encounter data submissions.

Timeliness of Compliance Reviews

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 MCMC plans 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, 2017, (i.e., three years prior to the start of the review period) and later than June 30, 2021, (i.e., the end of the review period).

HSAG reviewed all compliance-related information to assess the degree to which MCMC plans 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.

Scoring Methodology

Note that the compliance review results included in this EQR technical report do not reflect compliance scoring since the reviews were completed before DHCS received CMS' feedback regarding the requirement that DHCS develop a scoring methodology to use when conducting the reviews. DHCS is currently developing a compliance scoring methodology in alignment with CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care*

Regulations: A Mandatory EQR-Related Activity, October 2019.[26] Once developed, this methodology will be communicated to MCMC plans. DHCS will then determine the implementation date for the methodology based on the compliance review schedule already in place.

Results—Compliance Reviews

DHCS A&I continued its suspension of the in-person Medical and State Supported Services Audits of MCMC plans. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCMC plans to comply with all CAP requirements imposed prior to the public health emergency.

To ensure DHCS' compliance with §438.358, HSAG reviewed the dates on which DHCS conducted its most recent compliance reviews of MCMC 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, 2020) and no later than the end of the review period for this report (June 30, 2021) for all MCPs and PSPs. DHCS conducted no compliance review of Family Mosaic Project within the three-year time frame, with the last review of the SHP being in April 2017.

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 2020–21 MCP- and PSP-specific evaluation reports and this EQR technical report. The summary includes new information not reported on in previous review periods.

- DHCS provided evidence to HSAG of DHCS' ongoing follow-up with MCPs and 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 audit results for six MCPs and three PSPs. A&I conducted no new audits for many MCPs during the review period due to their ongoing COVID-19 response efforts. A&I is scheduled to conduct audits of these MCPs in the next review period, and HSAG will include summaries of these audits in the 2021–22 EQR technical report and the respective MCP-specific evaluation reports.
- HSAG identified no common areas for improvement since audit findings were MCP- and PSP-specific.

[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: Nov 22, 2021.

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.

Based on feedback received from CMS, DHCS is strengthening its Medical Audit processes to include all required federal standards as well as compliance scoring. DHCS has kept HSAG updated on its progress with the audit process improvements.

Recommendations—Compliance Reviews

Based on HSAG's assessment of the compliance reviews conducted by DHCS, HSAG recommends that DHCS ensure that A&I conducts a review of Family Mosaic Project every three years which includes assessment of the SHP's compliance with all required federal standards.

MCMC plan-specific compliance review results, findings, and HSAG's recommendations are included in appendices A through CC located in *Volume 2 of 4* of this EQR technical report.

5. 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™,[27] standards, policies, and procedures to assess the validity of the DHCS-selected performance measures calculated and submitted by MCMC plans. Additionally, DHCS contracted with HSAG to conduct an independent audit of the DHCS-selected performance measures calculated and submitted by MCPs that participate in California's Coordinated Care Initiative as Managed Long-Term Services and Supports Plans (MLTSSPs). During each audit, HSAG assesses the validity of each plan's data using CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[28] Following the audits, 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 PMV is to ensure that each MCMC plan 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.
- Determine the extent to which each MCMC plan followed the established specifications for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

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

[28] 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: Nov 22, 2021.

Note: MCMC plans 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 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 MCMC plans, as applicable, within each of the audit phases. Throughout all audit phases, HSAG actively engages with MCMC plans 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 2020 through May 2021)

- Forwarded HEDIS measurement year 2020 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Conducted the annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled virtual audit review 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 MCMC plans were aware of important deadlines.
- Reviewed completed HEDIS Roadmaps and the Information Systems Capabilities Assessment Tool (ISCAT) to assess compliance with the audit standards and provided the information system standard tracking report which 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 MCMC plan used a vendor with HEDIS Certified Measures[SM].[29]
- Reviewed source code used for calculating the non-HEDIS performance measure rates to ensure compliance with the specifications required by the State.

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

- 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 (MRRV) to ensure the integrity of medical record review (MRR) processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Phase (January 2021 through April 2021)

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

Follow-Up and Reporting Phase (May 2021 through July 2021)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final Information Systems 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 measurement year 2019 Audit Means and Percentiles. 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.

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 MCMC plan 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 MCMC plan 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 for all MCMC plans, identified strengths, opportunities for improvement, and recommendations based on its assessment of MCMC plan performance.

Aggregate MCP, PSP, SHP, and MLTSSP performance measure results, findings, and recommendations are included in Section 6, Section 7, Section 8, and Section 9 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 measurement 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 PMVs resulted in 60 separate data submissions for performance measure rates at the reporting unit level. HSAG also conducted PMV 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 audit review, Roadmap review, data systems review, supplemental data validation if applicable, source code review, a virtual audit review, MRRV 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,30] status for the reported HEDIS measures. HSAG reviewed and approved the source code that Family Mosaic Project developed internally for calculation of the required

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

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 did not have any eligible members for its MLTSS population in Sacramento County or San Diego County; therefore, HSAG includes no MLTSSP PMV results for these reporting units.
- 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:

- All MCMC plans were able to fully engage in the audit process and produce valid performance measure rates for all required MCAS measures.
- DHCS permitting MCMC plans to choose the data collection methodology to use for measures with both hybrid and administrative options allowed MCMC plans to decide which data collection method worked best, which may have saved some MCMC plans the costs associated with using the hybrid methodology in instances wherein hybrid reporting did not improve their rates. Additionally, in instances wherein the MCMC plans were not able to report a measure rate using the hybrid methodology, DHCS' decision provided them the opportunity to report the rate administratively, which resulted in a *Reportable* rate instead of a *Biased Rate* (BR).
- Auditors noted that in general, with few exceptions, MCMC plans 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.
- MCMC plans used enrollment data as the primary data source for determining the eligible population for most measures. The routine data transfer and longstanding relationship between MCMC plans and DHCS continued to support implementation of best practices and stable processes for acquiring membership data. In addition to smooth and accurate processing by MCMC plans, the data included fewer issues compared to previous years and fewer retrospective enrollment concerns.
- In measurement 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 should ensure that they have comprehensive, ongoing oversight processes in place.

Although HSAG auditors observed that MCPs and PSPs overall had sufficient quality control processes in place to ensure supplemental data are properly compiled and available for reporting, MCPs and PSPs have opportunities to investigate methods to incorporate supplemental data sources earlier in the audit process to eliminate the review of data sources that are not applicable to the MCAS measures.

The HSAG auditors did not identify issues with encounter data completeness for the majority of MCPs and PSPs; however, in one instance, some gaps in encounter data were identified due to failed file loads from the MCP's contracted independent practice associations. Although these encounter data gaps did not impact administrative measure reporting, an impact to reporting hybrid measures that require claims/encounter data for the eligible population criteria occurred due to the timing of when the gaps were identified. MCPs should ensure that encounter data loads are monitored at each point of data transfer to ensure no data are missed.

Although all MCPs and PSPs were able to report valid rates for all MCAS measures, HSAG noted that for some of the behavioral health measures, in some instances MCPs did not use all available data from DHCS that were needed to report an eligible population. MCPs should be sure to use all data made available to them by DHCS for behavioral health performance measure reporting.

HSAG auditors identified MCMC plan-specific challenges and opportunities for improvement and provided feedback to each plan, as applicable, regarding the challenges and opportunities for improvement. While HSAG identified instances of some MCPs being partially compliant with an information systems standard, HSAG auditors determined that the identified issues for all but one MCP had a minimal impact on performance measure reporting. For the one MCP, although HSAG auditors determined that the identified issues for one information systems standard had a significant impact on reporting, the MCP was able to report valid rates for all required measures. HSAG auditors determined that all PSPs were fully compliant with all information systems standards.

Recommendations—Performance Measure Validation

Based on measurement year 2020 PMVs, HSAG has no recommendations for DHCS.

Note that for the identified opportunities for improvement listed in this Performance Measure Validation Section, HSAG made MCP- and PSP-specific recommendations within the applicable MCP- and PSP-specific evaluation reports.

MCMC plan-specific PMV results and recommendations are included in appendices A through CC located in *Volume 2 of 4* of this EQR technical report.

6. 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. DHCS refers to this DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). MCAS includes select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also HEDIS measures. DHCS consults with HSAG and reviews feedback from MCPs 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' measurement year 2020[31] 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 50. 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 6.1 lists the measurement 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 domain allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS. Additionally, Table 6.1 includes descriptions and indicates the data capture method(s) for each measurement year 2020 MCAS measure. Beginning with measurement year 2020, DHCS allowed MCPs to choose the methodology (i.e., Administrative or Hybrid) for reporting MCAS performance measure rates for HEDIS measures for which the specifications allow for both reporting methods. Note that when reporting performance measure rates using the hybrid methodology, MCPs are required to procure medical record data.

Table 6.1—Measurement Year 2020 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.

[31] The measurement year is the calendar year for which MCPs report the rates. Measurement year 2020 represents data from January 1, 2020, through December 31, 2020.

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.

* DHCS allows MCPs to choose the methodology for reporting the rate for this measure and expects that MCPs will report using the methodology that results in the higher rate.

Measure	Method of Data Capture
Children's Health Domain	
Child and Adolescent Well-Care Visits—Total The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.	Admin
Childhood Immunization Status—Combination 10 The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenza type B; three hepatitis B, one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday.	Admin or Hybrid*
Developmental Screening in the First Three Years of Life—Total The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Admin
Immunizations for Adolescents—Combination 2 The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine, and have completed the human papillomavirus vaccine series by their 13th birthday.	Admin or Hybrid*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.	Admin or Hybrid*

Measure	Method of Data Capture
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.	Admin or Hybrid*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.	Admin or Hybrid*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits The percentage of members who turned 15 months old during the measurement year who had six or more well-child visits with a PCP during the last 15 months.	Admin
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits The percentage of members who turned 30 months old during the measurement year who had two or more well-child visits with a PCP during the last 15 months.	Admin
Women's Health Domain	
Breast Cancer Screening—Total The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.	Admin
Cervical Cancer Screening The percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: ♦ Women 21 to 64 years of age who had cervical cytology performed within the last 3 years. ♦ Women 30 to 64 years of age who had cervical high-risk human papillomavirus testing performed within the last 5 years. ♦ Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus cotesting within the last 5 years.	Admin or Hybrid*

Measure	Method of Data Capture
Chlamydia Screening in Women—Ages 16–20 Years The percentage of women 16 to 20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin
Chlamydia Screening in Women—Ages 21–24 Years The percentage of women 21 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin
Chlamydia Screening in Women—Total The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years Among women ages 15 to 20 at risk of unintended pregnancy, the percentage who were provided a LARC.	Admin
Contraceptive Care—All Women—LARC—Ages 21–44 Years Among women ages 21 to 44 at risk of unintended pregnancy, the percentage who were provided a LARC.	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years Among women ages 15 to 20 at risk of unintended pregnancy, the percentage who were provided a most effective or moderately effective method of contraception.	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years Among women ages 21 to 44 at risk of unintended pregnancy, the percentage who were provided a most effective or moderately effective method of contraception.	Admin
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a LARC within 3 days of delivery.	Admin

Measure	Method of Data Capture
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a LARC within 3 days of delivery.	Admin
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a LARC within 60 days of delivery.	Admin
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a LARC within 60 days of delivery.	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 3 days of delivery.	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 3 days of delivery.	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 60 days of delivery.	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 60 days of delivery.	Admin
Prenatal and Postpartum Care—Postpartum Care The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	Admin or Hybrid*

Measure	Method of Data Capture
Prenatal and Postpartum Care—Timeliness of Prenatal Care The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	Admin or Hybrid*
Behavioral Health Domain	
Antidepressant Medication Management—Effective Acute Phase Treatment—Total The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).	Admin
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days (6 months).	Admin
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Admin
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	Admin
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the 30-day initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	Admin

Measure	Method of Data Capture
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total The percentage of children and adolescents 1 to 17 years of age on two or more antipsychotic prescriptions who received blood glucose testing.	Admin
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total The percentage of children and adolescents 1 to 17 years of age on two or more antipsychotic prescriptions who received cholesterol testing.	Admin
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total The percentage of children and adolescents 1 to 17 years of age on two or more antipsychotic prescriptions who received blood glucose and cholesterol testing.	Admin
Screening for Depression and Follow-Up Plan—Ages 12–17 Years The percentage of members ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Admin
Screening for Depression and Follow-Up Plan—Ages 18–64 Years The percentage of members ages 18 to 64 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Admin
Screening for Depression and Follow-Up Plan—Ages 65+ Years The percentage of members ages 65 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Admin
Acute and Chronic Disease Management Domain	
Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total This measure summarizes utilization of ambulatory care in the category of emergency department visits.	Admin

Measure	Method of Data Capture
Asthma Medication Ratio—Total The percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Admin
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0 percent).	Admin or Hybrid*
Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years The percentage of members ages 18 to 64 with concurrent use of prescription opioids and benzodiazepines. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years The percentage of members ages 65 and older with concurrent use of prescription opioids and benzodiazepines. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin
Controlling High Blood Pressure—Total The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Admin or Hybrid*
Plan All-Cause Readmissions—Observed Readmissions—Total For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of observed 30-day readmissions.	Admin
Plan All-Cause Readmissions—Expected Readmissions—Total For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of expected 30-day readmissions.	Admin

Measure	Method of Data Capture
Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of observed 30-day readmissions divided by the count of expected 30-day readmissions.	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years The percentage of members ages 18 to 64 who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years The percentage of members ages 65 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin

Seniors and Persons with Disabilities Performance Measure Stratification

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

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

DHCS-Established Performance Levels

Each year, to create a uniform standard for assessing MCPs on performance measures, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. 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 measurement year 2020 MCAS HEDIS measures, DHCS used NCQA's Quality Compass®,[32] HEDIS 2020 Medicaid health maintenance organization (HMO) benchmarks. The Quality Compass HEDIS 2020 Medicaid HMO benchmarks reflect the previous year's benchmark percentiles (measurement year 2019). DHCS based the high performance levels for measurement year 2020 on NCQA's Quality Compass HEDIS 2020 Medicaid HMO 90th percentiles and the minimum performance levels for measurement year 2020 on the national Medicaid 50th percentiles.

According to DHCS' license agreement with NCQA, HSAG includes in Table 6.2 the benchmarks that DHCS used to establish the high performance levels and minimum performance levels for the measurement year 2020 HEDIS measures for which DHCS determined to hold MCPs accountable to meet the minimum performance levels.[33]

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

[33] The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the data") is Quality Compass® 2020 and is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on the data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

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Table 6.2—High Performance Level and Minimum Performance Level Benchmark Values for Measurement Year 2020

Measurement year 2020 high performance level and minimum performance level benchmark values represent NCQA's Quality Compass HEDIS 2020 Medicaid HMO 90th and 50th percentiles, respectively, reflecting the measurement year from January 1, 2019, through December 31, 2019.

* A lower rate indicates better performance for this measure.

Measure	Measurement Year 2020 High Performance Level	Measurement Year 2020 Minimum Performance Level
Children's Health		
Childhood Immunization Status—Combination 10	52.07%	37.47%
Immunizations for Adolescents—Combination 2	50.85%	36.86%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total	90.77%	80.50%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	85.16%	71.55%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	81.02%	66.79%
Women's Health		
Breast Cancer Screening—Total	69.22%	58.82%
Cervical Cancer Screening	72.68%	61.31%
Chlamydia Screening in Women—Total	71.42%	58.44%
Prenatal and Postpartum Care—Postpartum Care	84.18%	76.40%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	95.86%	89.05%

Measure	Measurement Year 2020 High Performance Level	Measurement Year 2020 Minimum Performance Level
Behavioral Health Conditions		
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	64.29%	53.57%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	49.37%	38.18%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.91%	82.09%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	56.34%	35.43%
Acute and Chronic Disease Management		
Asthma Medication Ratio—Total	73.38%	62.43%
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total**	27.98%	37.47%

Measurement Year 2020 Quality Monitoring and Corrective Action Plan Process

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

Instead, for measurement year 2020, DHCS will require that all MCPs, regardless of performance, submit a COVID-19 Quality Improvement Plan (QIP), similar to what DHCS required for measurement year 2019. The COVID-19 QIP will consist of two submissions: an initial submission, and a follow-up submission six months later. The initial submission will include a description of the MCP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and chronic disease care for members amidst COVID-19. The second submission will include a six-month progress update on the interventions and/or strategies. Additionally, DHCS will require that MCPs conduct quality improvement projects for measures with rates below the minimum performance levels in measurement year 2020. DHCS will limit the number of quality improvement projects to a maximum of three per MCP, excluding the ongoing PIPs.

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 (DHCS' performance-based Auto Assignment Incentive Program). The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified.

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.

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

MCMC Weighted Average Calculation Methodologies

Measurement Year 2019

For all but two measures, HSAG calculated the measurement year 2019 MCMC weighted averages according to CMS' methodology.[34] To allow MCPs and their providers to focus on COVID-19 efforts, DHCS offered MCPs alternatives for reporting hybrid measure rates for measurement year 2019. Some MCPs used their MCP-level measurement year 2018 rates for all or some of their reporting unit rates; therefore, HSAG modified the measurement year 2019 MCMC weighted average calculations for the following measures:

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

[34] 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: Nov 22, 2021.

The following is a summary of how HSAG modified the methodology for calculating the measurement year 2019 MCMC weighted averages for these two measures:

Childhood Immunization Status—Combination 10

For the reporting units for which Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan and Molina Healthcare of California used their respective measurement year 2018 *Childhood Immunization Status—Combination 3* measure MCP-level rates, HSAG used the eligible populations from the measurement year 2018 reporting unit rates for the *Childhood Immunization Status—Combination 3* measure when calculating the measurement year 2020 MCMC weighted average. Note that 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 measurement year 2018 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

Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan used the measurement year 2018 MCP-level rate for all 12 reporting units for this measure; therefore, HSAG only used Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan's MCP-level rate once to represent all 12 Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan reporting units when calculating the measurement year 2019 MCMC weighted average for this measure.

Measurement Year 2020

HSAG calculated the measurement year 2020 MCMC weighted averages according to CMS' methodology.[35]

[35] 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: Nov 22, 2021.

Results and Findings—Managed Care Health Plan Performance Measures

HSAG presents the following performance measure results grouped by measure domains in Table 6.3 through Table 6.10:

- The measurement years 2019 and 2020 MCMC weighted averages for each MCAS measure and a comparison of measurement year 2020 MCMC weighted averages both to the measurement year 2019 MCMC weighted averages and, as applicable, to the DHCS-established high performance levels and minimum performance levels.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[36] due to the COVID-19 public health emergency, DHCS decided not to compare measurement year 2019 performance measure results to benchmarks; therefore, HSAG does not display comparison of measurement year 2019 MCMC weighted averages to the high performance levels and minimum performance levels in these tables.
- The measurement year 2020 MCMC weighted average for each MCAS measure that HSAG compared to the corresponding national Medicaid average and whether the weighted average was above or below the national Medicaid average.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[37] due to the COVID-19 public health emergency, DHCS decided not to compare measurement year 2019 performance measure results to benchmarks; therefore, HSAG does not include measurement year 2019 MCMC weighted averages in these tables.

Please refer to Table 6.1 for descriptions of all MCAS measures included in Table 6.3 through Table 6.10. Note the following regarding the benchmarks HSAG used for comparisons included in Table 6.3 through Table 6.10:

- High performance levels and minimum performance levels represent the 2020 NCQA Quality Compass Medicaid HMO 90th and 50th percentiles, respectively.
- National Medicaid averages represent the 2020 NCQA Quality Compass national Medicaid averages.

[36] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Nov 22, 2021.

[37] Ibid.

Children's Health Domain

Table 6.3 presents the MCMC weighted average performance measure results for measurement years 2019 and 2020 within the Children's Health domain.

Note the following regarding Table 6.3:

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

Table 6.3—Children's Health Domain Measurement Years 2019 and 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Rate indicates performance above the high performance level.

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

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

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

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

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

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

^ For measurement year 2019, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan and Molina Healthcare of California elected to use MCP-level rates instead of MCP reporting unit rates for this measure; therefore, caution should be exercised when comparing the measurement year 2020 MCMC weighted average to the measurement year 2019 MCMC weighted average.

^^ For measurement year 2019, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan elected to use an MCP-level rate instead of MCP reporting unit

rates for this measure, and for measurement year 2020, NCQA made specification changes to the measure; therefore, caution should be exercised when comparing the measurement year 2020 MCMC weighted average to the measurement year 2019 MCMC weighted average.

— Indicates that the rate is not available.

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Child and Adolescent Well-Care Visits—Total	—	41.43%	Not Comparable
*Childhood Immunization Status—Combination 10^*	38.32%	37.95%	-0.37
Developmental Screening in the First Three Years of Life—Total	25.42%	23.11%	-2.31
Immunizations for Adolescents—Combination 2	43.57%	43.05%	-0.52
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^^*	86.71%	81.79%	-4.92
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	74.73%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	72.80%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	37.70%	Not Comparable
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	66.40%	Not Comparable

Table 6.4 presents the measurement year 2020 MCMC weighted averages for measures within the Children's Health domain that HSAG compared to the national Medicaid averages.

Table 6.4—Children's Health Domain Measurement Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance above the national Medicaid average.

Bolded Rate = Rate indicates performance below the national Medicaid average.

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

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

Measure	Measurement Year 2020 Rate
Childhood Immunization Status—Combination 10	**37.95%**
Immunizations for Adolescents—Combination 2	43.05%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^	81.79%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	74.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	72.80%

Findings—Children's Health Domain

While MCMC plans' performance declined significantly from measurement year 2019 to measurement year 2020 for all four measures for which HSAG compared the measurement year 2020 MCMC weighted averages to measurement year 2019 MCMC weighted averages, all five measures for which HSAG compared the measurement year 2020 MCMC weighted averages to the minimum performance levels were above the minimum performance levels.

The MCMC weighted averages for four of five measures for which HSAG provides comparative analysis (80 percent) were above the national Medicaid averages in measurement year 2020. The MCMC weighted average for the *Childhood Immunization Status—Combination 10* measure was below the national Medicaid average in measurement year 2020.

Women's Health Domain

Table 6.5 presents the MCMC weighted average performance measure results for measurement years 2019 and 2020 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

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

Table 6.5—Women's Health Domain—Measurement Years 2019 and 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Rate indicates performance above the high performance level.

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

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

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

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

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

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

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Breast Cancer Screening—Total	62.19%	**57.04%**	-5.15
Cervical Cancer Screening^	64.67%	**59.90%**	-4.77
Chlamydia Screening in Women—Ages 16–20 Years	60.49%	57.94%	-2.55
Chlamydia Screening in Women—Ages 21–24 Years	69.52%	65.48%	-4.04
Chlamydia Screening in Women—Total	64.83%	61.63%	-3.20

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.58%	2.24%	-0.34
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.82%	4.35%	-0.47
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.74%	14.70%	-1.04
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.43%	23.58%	-1.85
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	1.66%	2.82%	1.16
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.31%	2.54%	1.23
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	13.36%	14.33%	0.97
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.85%	11.34%	1.49
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.73%	5.01%	2.28
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.24%	10.42%	2.18
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.99%	37.34%	2.35
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	34.68%	36.67%	1.99

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Prenatal and Postpartum Care—Postpartum Care^*	77.55%	78.87%	1.32
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	90.86%	**87.88%**	-2.98

Table 6.6 presents the measurement year 2020 MCMC weighted averages for measures within the Women's Health domain that HSAG compared to the national Medicaid averages.

Table 6.6—Women's Health Domain Measurement Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance above the national Medicaid average.

Bolded Rate = Rate indicates performance below the national Medicaid average.

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

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

Measure	Measurement Year 2020 Rate
Breast Cancer Screening—Total	**57.04%**
*Cervical Cancer Screening^*	**59.90%**
Chlamydia Screening in Women—Ages 16–20 Years	57.94%
Chlamydia Screening in Women—Ages 21–24 Years	65.48%
Chlamydia Screening in Women—Total	61.63%
*Prenatal and Postpartum Care—Postpartum Care^*	78.87%
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	87.88%

Findings—Women's Health Domain

MCMC plans' performance improved significantly from measurement year 2019 to measurement year 2020 for nine of 19 measures for which HSAG compared the measurement year 2020 MCMC weighted averages to measurement year 2019 MCMC weighted averages (47 percent).

MCMC plans' performance declined significantly from measurement year 2019 to measurement year 2020 for 10 of 19 measures for which HSAG compared the measurement year 2020 MCMC weighted averages to measurement year 2019 MCMC weighted averages (53 percent). Additionally, the MCMC weighted averages for the *Breast Cancer Screening—Total*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures were below the minimum performance levels in measurement year 2020.

The MCMC weighted averages for five of seven measures for which HSAG provides comparative analysis (71 percent) were above the national Medicaid averages in measurement year 2020. The MCMC weighted averages for the *Breast Cancer Screening—Total* and *Cervical Cancer Screening* measures were below the national Medicaid averages in measurement year 2020.

Behavioral Health Domain

Table 6.7 presents the MCMC weighted average performance measure results for measurement years 2019 and 2020 within the Behavioral Health domain.

Note the following regarding Table 6.7:

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

Table 6.7—Behavioral Health Domain Measurement Years 2019 and 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Rate indicates performance above the high performance level.

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

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

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

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

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

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

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

— Indicates that the rate is not available.

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.36%	60.05%	2.69
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.12%	43.09%	2.97
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	**75.74%**	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.92%	43.91%	3.99
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	47.21%	49.28%	2.07

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	55.48%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	39.10%	Not Comparable
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	37.60%	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	15.18%	18.25%	3.07
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	9.72%	11.42%	1.70
Screening for Depression and Follow-Up Plan—Ages 65+ Years	11.85%	13.15%	1.30

Table 6.8 presents the measurement year 2020 MCMC weighted averages for measures within the Behavioral Health domain that HSAG compared to the national Medicaid averages.

Table 6.8—Behavioral Health Domain Measurement Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance above the national Medicaid average.

Bolded Rate = Rate indicates performance below the national Medicaid average.

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

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

Measure	Measurement Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	60.05%

Measure	Measurement Year 2020 Rate
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.09%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**75.74%**
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	43.91%
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	**49.28%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	**55.48%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	**39.10%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	**37.60%**

Findings—Behavioral Health Domain

MCMC plans' performance improved significantly from measurement year 2019 to measurement year 2020 for six of seven measures for which HSAG compared the measurement year 2020 MCMC weighted averages to measurement year 2019 MCMC weighted averages (86 percent).

The MCMC weighted average for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was below the minimum performance level in measurement year 2020.

The MCMC weighted averages for three of eight measures for which HSAG provides comparative analysis (38 percent) were above the national Medicaid averages in measurement year 2020. The MCMC weighted averages for five measures (63 percent) were below the national Medicaid averages in measurement year 2020.

Acute and Chronic Disease Management Domain

Table 6.9 presents the measurement years 2019 and 2020 MCMC weighted averages for measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 6.9:

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

Table 6.9—Acute and Chronic Disease Management Domain—Measurement Years 2019 and 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Rate indicates performance above the high performance level.

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

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

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

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

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

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

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

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

— Indicates that the rate is not available.

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

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	44.82	31.96	Not Tested
Asthma Medication Ratio—Total	61.49%	64.26%	2.77
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total***	34.23%	41.50%	7.27
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.60%	12.40%	-1.20
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	11.00%	10.01%	-0.99
Controlling High Blood Pressure—Total	—	58.41%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.91%	9.32%	0.41
Plan All-Cause Readmissions—Expected Readmissions—Total	9.58%	9.74%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.93	0.96	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.25%	4.53%	-0.72
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	2.77%	2.49%	-0.28

Table 6.10 presents the measurement year 2020 MCMC weighted averages for measures within the Acute and Chronic Disease Management domain that HSAG compared to the national Medicaid averages.

Table 6.10—Acute and Chronic Disease Management Domain Measurement Year 2020 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance above the national Medicaid average.

Bolded Rate = Rate indicates performance below the national Medicaid average.

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

* A lower rate indicates better performance for this measure.

Measure	Measurement Year 2020 Rate
Asthma Medication Ratio—Total	64.26%
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total**	**41.50%**

Findings—Acute and Chronic Disease Management Domain

MCMC plans' performance improved significantly from measurement year 2019 to measurement year 2020 for four of seven measures for which HSAG compared the measurement year 2020 MCMC weighted averages to measurement year 2019 MCMC weighted averages (57 percent).

MCMC plans' performance declined significantly from measurement year 2019 to measurement year 2020 for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* and *Plan All-Cause Readmissions—Observed Readmissions—Total* measures.

The MCMC weighted average for the *Asthma Medication Ratio—Total* measure was above the national Medicaid average in measurement year 2020, and the MCMC weighted average for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure was worse than the national Medicaid average in measurement year 2020.

Comparison Across All Managed Care Health Plans—Performance Measures

HSAG calculated the percentage of reported rates that were above the high performance levels for measurement year 2020 across all performance measure domains at the MCP level. Table 6.11 lists each of the MCPs and the percentage of their reported rates that were above the high performance levels in measurement year 2020, from highest to lowest percentage.

Table 6.11—Percentage of Measurement Year 2020 Rates Above the High Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Percentage of Measurement Year 2020 Rates Above the High Performance Levels
Kaiser SoCal	69%
Kaiser NorCal	38%
San Francisco Health Plan	27%
CalOptima	25%
Health Plan of San Mateo	25%
Alameda Alliance for Health	19%
CenCal Health	19%
Santa Clara Family Health Plan	19%
Central California Alliance for Health	17%
Blue Shield of California Promise Health Plan	13%
Community Health Group Partnership Plan	13%
Inland Empire Health Plan	13%
CalViva Health	11%
Partnership HealthPlan of California	8%
Gold Coast Health Plan	7%
Contra Costa Health Plan	6%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	5%
Health Net Community Solutions, Inc.	5%
California Health & Wellness Plan	2%
Aetna Better Health of California	0%

Medi-Cal Managed Care Health Plan	Percentage of Measurement Year 2020 Rates Above the High Performance Levels
Health Plan of San Joaquin	0%
Kern Health Systems, DBA Kern Family Health Care	0%
L.A. Care Health Plan	0%
Molina Healthcare of California	0%
UnitedHealthcare Community Plan	0%

HSAG calculated the percentage of reported rates that were below the minimum performance levels for measurement year 2020 across all performance measure domains at the MCP level. Table 6.12 lists each of the MCPs and the percentage of their reported rates that were below the minimum performance levels in measurement year 2020, from highest to lowest percentage.

Table 6.12—Percentage of Measurement Year 2020 Rates Below the Minimum Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Percentage of Measurement Year 2020 Rates Below the Minimum Performance Levels
Kern Health Systems, DBA Kern Family Health Care	93%
Health Plan of San Joaquin	87%
Aetna Better Health of California	86%
California Health & Wellness Plan	65%
Partnership HealthPlan of California	64%
Health Net Community Solutions, Inc.	60%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	59%
UnitedHealthcare Community Plan	47%
CalViva Health	45%
L.A. Care Health Plan	44%
Alameda Alliance for Health	38%
Blue Shield of California Promise Health Plan	38%
Molina Healthcare of California	38%

Medi-Cal Managed Care Health Plan	Percentage of Measurement Year 2020 Rates Below the Minimum Performance Levels
Gold Coast Health Plan	36%
Inland Empire Health Plan	31%
Health Plan of San Mateo	25%
Central California Alliance for Health	21%
San Francisco Health Plan	20%
Contra Costa Health Plan	19%
Santa Clara Family Health Plan	19%
CenCal Health	16%
CalOptima	13%
Kaiser NorCal	13%
Kaiser SoCal	6%
Community Health Group Partnership Plan	0%

Please refer to *Volume 3 of 4* ("Measurement Year 2020 Managed Care Health Plan Performance Measure Comparison") for comparative information across all MCPs for all DHCS-required performance measures. MCP-specific performance measure results, findings, and recommendations are included in appendices A through CC located in *Volume 2 of 4* of this EQR technical report.

Results and Findings—Seniors and Persons with Disabilities

Table 6.13 presents the SPD and non-SPD MCMC weighted averages, a comparison of these averages, and the total MCMC weighted averages for the two measures MCPs stratified by SPD and non-SPD populations for measurement year 2020.

Table 6.13—Measurement Year 2020 Medi-Cal Managed Care Weighted Averages Comparison and Results for Measures Stratified by the SPD Population

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

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

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

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

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

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

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

Measure	Measurement Year 2020 SPD Rate	Measurement Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2020 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	55.24	30.15	Not Tested	31.96
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.69%	8.51%	3.18	9.32%

Findings—Seniors and Persons with Disabilities

For measurement year 2020, HSAG compared the measurement year 2020 SPD MCMC weighted average to the measurement year non-SPD MCMC weighted average for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure only. The MCMC SPD population had a significantly higher hospital readmissions weighted average than the MCMC non-SPD population in measurement year 2020. Note that the higher rate of hospital

readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Summary of Measurement Year 2019 Quality Monitoring and Corrective Action Plans

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

- California Health & Wellness Plan
- Health Net Community Solutions, Inc.
- Health Plan of San Joaquin
- Partnership HealthPlan of California

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

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

DHCS provided HSAG with a summary of MCPs' and PSPs' PDSA cycles and COVID-19 QIPs for inclusion in the EQR technical report and in MCP- and PSP-specific evaluation reports. Following is an aggregate summary of the MCP PDSA cycles and COVID-19 QIPs. Note that while MCPs submitted their final PDSA cycle information in August 2021, which is outside the review period for this report, HSAG includes the information because it was available at the time this report was produced.

Plan-Do-Study-Act Cycle/Strengths, Weaknesses, Opportunities, Threats Analysis Summary

Across all MCPs, PDSA cycles and SWOT analysis interventions focused on improving performance for the following measures:

- *Asthma Medication Ratio—Total*
- *Breast Cancer Screening—Total*
- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Total*
- *Childhood Immunization Status—Combination 10*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
- *Controlling High Blood Pressure—Total*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

One MCP conducted improvement strategies targeted toward all measures for which the MCP's performance was below the minimum performance levels in measurement year 2019, and another MCP focused its efforts on all measures in the Children's Health domain.

MCPs' interventions included:

- Member outreach, education, and incentives.
- Provider outreach, education, and training.
- Provider and community organization collaboration.
- Use of telehealth visits.
- Use of gap-in-care reports.

Across all MCPs, outcomes were mixed, with some MCPs reporting that they met their intervention goals and other MCPs indicating that the interventions did not result in the desired outcomes. MCPs reported challenges related to COVID-19 as the most frequent reason for the interventions not resulting in the desired outcomes or for delays in MCPs being able to implement the interventions.

COVID-19 Quality Improvement Plan Summary

MCPs described a variety of strategies and interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. Across all MCPs, focus areas were varied. During its review of the COVID-19 summaries, HSAG noted that multiple MCPs focused efforts on:

- Disparate groups and their access to needed health care services.
- Children and adolescents completing preventive care, well-care, and immunization appointments.
- Access to care for members with chronic conditions.
- Member education about behavioral health services and improving access to these services.

Strategies and interventions included:

- Member outreach, education, and incentives.
- Provider outreach, education, and training.
- Provider and community organization collaboration.
- Use of telehealth visits.
- Use of gap-in-care reports.

As with the PDSA cycle and SWOT analyses intervention outcomes, COVID-19 QIP outcomes were mixed, with some MCPs reporting that they met their goals and other MCPs indicating that the strategies and interventions did not result in the desired outcomes. Additionally, as with the PDSA cycle and SWOT analyses, MCPs reported challenges related to COVID-19 as the most frequent reason for the COVID-19 strategies and interventions not resulting in the desired outcomes or for delays in MCPs being able to implement the strategies and interventions.

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 impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results due to the impact of COVID-19 on utilization of medical services throughout much of 2020, DHCS will require all MCPs to engage in quality improvement activities to address the effects of COVID-19. DHCS also will require MCPs to conduct quality improvement activities for measures with rates below the minimum performance levels in measurement year 2020 to ensure MCPs are addressing opportunities for improvement.

Performance measure results were mixed for measurement year 2020, with MCPs' performance improving significantly for some measures and declining significantly for others. MCMC weighted average comparisons between measurement years 2020 and 2019 show opportunities for improvement in the Children's Health, Women's Health, and Acute and Chronic Disease Management domains and opportunities for MCPs to improve the quality, accessibility, and timeliness of services provided to their members. No MCMC weighted averages declined significantly from measurement year 2019 to measurement year 2020 for measures in the Behavioral Health domain, and aggregate MCP performance improved significantly for 86 percent of the measures in this domain for which HSAG compared measurement year 2020 MCMC weighted averages to measurement year 2019 MCMC weighted averages. It is likely that a combination of factors, including COVID-19, affected MCPs' performance in measurement year 2020.

Throughout the review period, DHCS provided extensive support to MCPs for addressing the effects of COVID-19 on their provision of health care services to MCMC members. The technical assistance and resources DHCS provided supported MCPs' efforts to provide quality, accessible, and timely health care to their members, including:

- Allowed MCPs flexibility 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.
- Assisted MCPs with prioritizing areas in need of improvement and identifying performance measures for MCPs to use as focus areas for quality improvement activities.
- Met quarterly via telephone with MCPs previously under CAPs to discuss ongoing quality improvement efforts and support these MCPs in continuing to improve performance.
- Conducted technical assistance calls for MCPs not previously engaged in a CAP, as needed.
- Provided opportunities through quarterly collaborative discussions for DHCS and other State agencies (e.g., the California Department of Public Health [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 postcards highlighting MCP promising practices, educational information, and resources related to:
  - Health equity, with a focus on resources to address and promote health equity among members impacted by COVID-19.
  - Mental health wellness and self-care practices for at-risk populations amidst the COVID-19 public health emergency.
  - Immunizations for children, adults, seniors, pregnant women, and at-risk populations amidst the COVID-19 public health emergency.
  - Telehealth and member engagement, with an emphasis on improving member engagement during virtual preventive health care appointments.
  - Women's preventive health, with an emphasis on ways to encourage women to complete their breast and cervical cancer screenings during the COVID-19 public health emergency.

  - Improving adolescent wellness visits, with an emphasis on strategies and digital engagement support to improve preventive care visit attendance and adolescent mental wellbeing during the COVID-19 public health emergency.
  - Maternal health disparities, with an emphasis on strategies and digital engagement support to improve preventive care visit attendance and maternal mental health and emotional wellbeing during the COVID-19 public health emergency.
  - Addressing COVID-19 vaccine hesitancy, including effective communication techniques for raising awareness and educating the community about the vaccine.
- Provided a list of COVID-19 resources for MCPs to use as part of their quality improvement efforts to improve preventive care access for members during the COVID-19 public health emergency.
- 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.

Recommendations—Managed Care Health Plan Performance Measures

DHCS has well-established, ongoing processes to monitor MCPs' performance and to support low-performing MCPs in identifying the causes for their declining performance or performance below the minimum performance levels. DHCS' MCAS includes measures that collectively assess the extent to which MCPs are delivering quality, accessible, and timely health care, including screening, prevention, health care, and utilization services. Based on its assessment of DHCS' performance measure requirements and processes, HSAG has no recommendations for DHCS in the area of MCP performance measures.

MCP-specific performance measure results, findings, and recommendations are included in appendices A through CC located in *Volume 2 of 4* of this EQR technical report.

7. Population-Specific 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 PSPs delivered to their members. As stated previously, DHCS refers to the DHCS-required performance measure set as the MCAS. The MCAS includes select CMS Adult and Child Core Sets, some of which are also HEDIS measures. AIDS Healthcare Foundation, Rady Children's Hospital—San Diego, and SCAN Health Plan provide services to specialized populations; therefore, DHCS' performance measure requirements for these PSPs are different than its requirements for MCPs or the SHP. DHCS consults with PSPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require PSPs to report. PSPs must report county or regional rates unless otherwise approved by DHCS.

DHCS' measurement year 2020[38] MCAS consisted of a combination of HEDIS and CMS Adult and Child Core Set measures. DHCS requires each PSP to report measures specific to its specialized population; therefore, HSAG does not calculate aggregate results for the PSPs or compare performance measure results across all PSPs.

This section presents DHCS' performance measure requirements for each PSP. Table 7.1 through Table 7.3 provide lists of measurement year 2020 MCAS measures that DHCS required each PSP to report. Please refer to Table 6.1 for descriptions of all MCAS measures included in Table 7.1 through Table 7.3. Individual PSP results, findings, and recommendations can be found in the following appendices located in *Volume 2 of 4* of this EQR technical report:

- AIDS Healthcare Foundation—Appendix B
- Rady Children's Hospital—San Diego—Appendix Y
- SCAN Health Plan—Appendix BB

AIDS Healthcare Foundation

Table 7.1 lists the measurement year 2020 MCAS measures by measure domain and indicates the data capture method(s) for each measure. Beginning with measurement year 2020, DHCS allowed PSPs the option to choose the methodology (i.e., Administrative or Hybrid) for reporting MCAS performance measure rates for HEDIS measures for which the specifications allow for both reporting methods.

[38] The measurement year is the calendar year for which PSPs report the rates. Measurement year 2020 represents data from January 1, 2020, through December 31, 2020.

Table 7.1—AIDS Healthcare Foundation Measurement Year 2020 Managed Care Accountability Set Measures

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

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

* DHCS allows the PSP to choose the methodology for reporting the rate for this measure and expects that the PSP will report using the methodology that results in the higher rate.

Measure	Method of Data Capture
Women's Health Domain	
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 21–44 Years	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—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	
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total	Admin or 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	Admin or Hybrid*
Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years	Admin

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

Rady Children's Hospital—San Diego

Table 7.2 lists the measurement year 2020 MCAS measures by measure domain and indicates the data capture method(s) for each measure. Beginning with measurement year 2020, DHCS allowed PSPs the option to choose the methodology (i.e., Administrative or Hybrid) for reporting MCAS performance measure rates for HEDIS measures for which the specifications allow for both reporting methods.

Table 7.2—Rady Children's Hospital—San Diego Measurement Year 2020 Managed Care Accountability Set Measures

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

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

* DHCS allows the PSP to choose the methodology for reporting the rate for this measure and expects that the PSP will report using the methodology that results in the higher rate.

Measure	Method of Data Capture
Children's Health Domain	
Children and Adolescent Well-Care Visits	Admin
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Body Mass Index (BMI) Percentile Documentation—Total	Admin or Hybrid*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total	Admin or Hybrid*

Measure	Method of Data Capture
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total	Admin or Hybrid*
Well-Child Visits in the First 30 Months of Life	Admin
Women's Health Domain	
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	Admin
Acute and Chronic Disease Management Domain	
Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total	Admin

SCAN Health Plan

Table 7.3 lists the measurement year 2020 MCAS measures by measure domain and indicates the data capture method(s) for each measure. Beginning with measurement year 2020, DHCS allowed PSPs the option to choose the methodology (i.e., Administrative or Hybrid) for reporting MCAS performance measure rates for HEDIS measures for which the specifications allow for both reporting methods

Table 7.3—SCAN Health Plan Measurement Year 2020 Managed Care Accountability Set Measures

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

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

* DHCS allows the PSP to choose the methodology for reporting the rate for this measure and expects that the PSP will report using the methodology that results in the higher rate.

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	
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total	Admin or Hybrid*
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years	Admin
Controlling High Blood Pressure—Total	Admin or Hybrid*
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 6 of this report ("Managed Care Health Plan Performance Measures").

Results and Findings—Population-Specific Health Plan Performance Measures

Due to each PSP serving a specialized population, HSAG produces no aggregate information related to the PSP performance measures. Also, due to the PSPs serving separate, specialized populations, performance measure comparison across PSPs is not appropriate.

PSP-specific results and findings can be found in the following appendices located in *Volume 2 of 4* of this EQR technical report:

- AIDS Healthcare Foundation—Appendix B
- Rady Children's Hospital—San Diego—Appendix Y
- SCAN Health Plan—Appendix BB

Summary of Measurement Year 2019 Quality Monitoring and Corrective Action Plans

As indicated in Section 6 of this report ("Managed Care Health Plan Performance Measures"), following measurement year 2019 performance measure reporting, DHCS required MCPs and PSPs 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, and to develop and submit to DHCS a brief COVID-19 QIP which includes a description of the MCP's/PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. Please see Section 6 for a full description of the requirements.

Each PSP conducted PDSA cycles and implemented strategies to increase the provision of health care services during COVID-19 specific to the PSP's specialized population. The summaries of the PSPs' PDSA cycles and COVID-19 QIP strategies and interventions are located in *Volume 2 of 4* of this EQR technical report.

Conclusions and Recommendations—Population-Specific Health Plan Performance Measures

As with the MCPs, DHCS has well-established, ongoing processes to monitor PSPs' performance and to support low-performing PSPs in identifying the causes for their declining performance or performance below the minimum performance levels. DHCS' MCAS includes measures that collectively assess the extent to which each PSP is delivering quality, accessible, and timely health care, including screening, prevention, health care, and utilization services. Based on its assessment of DHCS' performance measure requirements and processes, HSAG has no recommendations for DHCS in the area of PSP performance measures.

8. 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 measurement 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 following two measures the SHP designed in collaboration with DHCS and HSAG to evaluate performance elements specific to the SHP:

- *Promotion of Positive Pro-Social Activity*
- *School Attendance*

DHCS-Established Performance Levels and Quality Monitoring

No national benchmarks exist for the SHP-developed measures; therefore, DHCS did not establish performance levels for Family Mosaic Project. Additionally, based on Family Mosaic Project's limited number of members and its work with a specialized population, DHCS did not require the SHP to conduct PDSA cycles or submit a COVID-19 QIP.

Results and Findings—Specialty Health Plan Performance Measures

HSAG produces no aggregate information related to the SHP performance measures.

Family Mosaic Project's SHP-specific results and findings are included in Appendix M located in *Volume 2 of 4* of this EQR technical report.

Conclusions and Recommendations—Specialty Health Plan Performance Measures

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

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

As part of the Coordinated Care Initiative, 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.[39] Table 9.1 lists MLTSSPs and the counties in which they operate.

Table 9.1—Managed Long-Term Services and Supports Plan Names and Counties

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	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

[39] 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 9.2 lists the four MCAS performance measures that DHCS required MLTSSPs to report for measurement 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 9.2—Measurement Year 2020 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 (ED) 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—Observed/Expected (O/E) Ratio—Total	Admin

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

Table 9.3 presents the MLTSSP weighted averages for each required performance measure for measurement years 2019 and 2020.

Table 9.3—Measurement Years 2019 and 2020 Statewide Weighted Average Performance Measure Results for Managed Long-Term Services and Supports Plans

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

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

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

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

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

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

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

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

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Years 2019–20 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**	51.52	40.36	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.71%	10.21%	0.50
Plan All-Cause Readmissions—Expected Readmissions—Total	10.32%	10.54%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.94	0.97	Not Tested

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

The MLTSSP weighted average for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure remained consistent, showing no statistically significant change from measurement year 2019 to measurement year 2020.

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

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

MLTSSP-specific performance measure results, findings, and recommendations are included in appendices A through CC located in *Volume 2 of 4* of this EQR technical report.

10. 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 MCMC plans. HSAG uses a two-pronged approach. First, HSAG provides training and technical assistance to MCMC 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 6-2 in September 2020. The following modules guide MCMC plans through the rapid-cycle PIP approach:

- Module 1: PIP Initiation
- Module 2: Intervention Determination

- Module 3: Intervention Testing
- Module 4: PIP Conclusions

HSAG's rapid-cycle PIP process requires extensive, up-front preparation to allow for a structured, scientific approach to quality improvement, and it also provides sufficient 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 MCMC plan conduct a minimum of two DHCS-approved PIPs per each Medi-Cal contract held with DHCS. If an MCMC plan 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).

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

To support DHCS' comprehensive quality strategy goals of improving health equity and addressing social determinants of health, DHCS required that MCMC plans' Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender

identity, occupation, provider, or geographic area.[40] DHCS strongly encouraged MCMC plans to select a health disparity related to an MCAS measure for which they are not performing well, with a particular focus on a disparity that may have been exacerbated by COVID-19. MCMC plans must demonstrate a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate. DHCS allowed MCMC plans that could not identify a health disparity based on population size to conduct their PIP on the entire population instead of a disparate subgroup.

For the Child and Adolescent Health PIPs, DHCS required MCMC plans to identify an area in need of improvement related to child and adolescent health. DHCS required PSPs that do not serve the child and adolescent populations to 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 from a clinical or nonclinical area for which improvement would have a favorable impact on health outcomes or member satisfaction.

The SMART Aim end date for the 2020–22 PIPs is December 31, 2022.

Objectives

The purpose of HSAG's PIP validation is to ensure that MCMC 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 MCMC plans execute quality improvement activities and whether the PIP achieves and sustains the desired aim.

[40] *State of California Department of Health Care Services Comprehensive Quality Strategy Draft Report for Public Comment, November 2019*. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/PRIME/DRAFT-DHCS-Comprehensive-Quality-Strategy.pdf. Accessed on: Nov 19, 2021.

Methodology

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to these plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. HSAG conducts PIP validation in accordance with the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[41] Following are the validation criteria that HSAG uses for each module:

Module 1—PIP Initiation

- The MCMC plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support an opportunity for improvement.
- The narrowed focus baseline specifications and data collection methodology supported the rapid-cycle process and included the following:
  - Complete and accurate specifications.
  - Data source(s).
  - Step-by-step data collection process.
  - Narrowed focus baseline data that considered claims data completeness.
- The SMART Aim was stated accurately and included all required components (i.e., narrowed focus, intervention[s], baseline percentage, goal percentage, and end date).
- The SMART Aim run chart included all required components (i.e., run chart title, Y-axis title, SMART Aim goal percentage line, narrowed focus baseline percentage line, and X-axis months).
- The MCMC plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- The MCMC plan accurately completed all required components of the key driver diagram. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal.

Module 2—Intervention Determination

- The MCMC plan included a process map that clearly illustrated the step-by-step flow of the current processes for the narrowed focus.
- The prioritized steps in the process map identified as gaps or opportunities for improvement were clearly labeled.

[41] 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: Nov 24, 2021.

- 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 modes, failure causes, and failure effects were logically linked to the steps 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 key drivers and interventions in the key driver diagram were updated according to the results of the corresponding process map and FMEA. In the key driver diagram, the MCMC plan included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.

Module 3—Intervention Testing

- The intervention plan included at least one corresponding key driver and one failure mode from Module 2.
- The MCMC plan included all 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) and addressed data completeness.

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 MCMC plan provided evidence to demonstrate at least one of the following:
  - The SMART Aim goal was achieved.
  - Statistically significant improvement over the narrowed focus baseline percentage was achieved (95 percent confidence level, $p < 0.05$).
  - Non-statistically significant improvement in the SMART Aim measure.
  - Significant clinical improvement in processes and outcomes.
  - Significant programmatic improvement in processes and outcomes.
- If improvement was demonstrated, at least one of the tested interventions could reasonably result in the demonstrated improvement.
- The MCMC plan completed the PDSA worksheet(s) with accurately reported data and interpretation of testing results.
- The narrative summary of the project conclusions was complete and accurate.
- If improvement was demonstrated, the MCMC plan documented plans for sustaining improvement beyond 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, they test intervention(s) through the end of the SMART Aim end date. HSAG requests status updates from MCMC plans throughout the PIP intervention testing phase and, when needed, provides technical assistance.

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.
  - The MCMC plan achieved the SMART Aim goal or achieved statistically significant, clinically significant, or programmatically significant improvement.
  - At least one of the tested interventions could reasonably result in the demonstrated improvement.
  - The MCMC plan accurately summarized the key findings and conclusions.
- Moderate confidence
  - The PIP was methodologically sound.
  - At least one of the tested interventions could reasonably result in the demonstrated improvement.
  - One of the following occurred:
    - Non-statistically significant improvement in the SMART Aim measure was achieved, with no evidence of statistically significant, clinically significant, or programmatically significant improvement; and the MCMC plan accurately summarized the key findings and conclusions.
    - The MCMC plan achieved the SMART Aim goal or achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement; however, the MCMC plan did not accurately summarize the key findings and conclusions.
- Low confidence
  - The PIP was methodologically sound.
  - One of the following occurred:
    - No improvement was achieved.
    - The MCMC plan achieved the SMART Aim goal or achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement; however, none of the tested interventions could reasonably result in the demonstrated improvement.
- No confidence
  - The SMART Aim measure and/or approved rapid-cycle PIP methodology was not followed through the SMART Aim end date.

Results—Performance Improvement Projects

Performance Improvement Project Validation Findings

Prior to beginning the 2020–22 PIPs, DHCS required MCMC plans to either submit proposals for new topics or inform DHCS of intentions to continue 2019–21 PIP topics. With HSAG's input, DHCS approved 58 topics for the 2020–22 PIPs.

Upon receiving PIP topic approvals, MCMC plans initiated the 2020–22 PIPs. During the review period, HSAG conducted trainings on rapid-cycle PIP Version 6.2 modules 1 through 4 submission forms and requirements. HSAG validated the following modules and notified MCMC plans and DHCS of the validation findings:

- Module 1—58 initial submissions and 56 resubmissions
- Module 2—45 initial submissions and five resubmissions
- Module 3—Eight initial submissions and one resubmission

Performance Improvement Project Topics and Module Progression

As of the end of the review period of this report, all MCMC plans met Module 1 validation criteria for both their PIPs. Table 10.1 lists MCMC plans' PIP topics and shows module progression during the review period.

Table 10.1—Medi-Cal Managed Care Health Plan Performance Improvement Project Topics and Module Progression

*The MCMC plan did not have enough data to demonstrate an identified health disparity; therefore, DHCS waived the requirement for the MCMC plan to conduct a PIP on a health disparity.

^The MCMC plan does not serve the child and adolescent populations; therefore, DHCS waived the requirement for the MCMC plan to conduct a PIP on child and adolescent health.

MCMC Plan Name	PIP Topic	PIP Module Progression
Managed Care Health Plans		
Aetna Better Health of California*	*Diabetes Control*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process

MCMC Plan Name	PIP Topic	PIP Module Progression
Alameda Alliance for Health	*Breast Cancer Screening Among African Americans* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
	Child and Adolescent Well-Care Visits	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	*Cervical Cancer Screening Among Vietnamese Members* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
	Childhood Immunizations	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
Blue Shield of California Promise Health Plan	*Childhood Immunizations Among Non-Hispanic Members* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
California Health & Wellness Plan	*Breast Cancer Screening Among Members Living with Disabilities in Region 1* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Childhood Immunization Status—Combination 10	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
CalOptima	*Breast Cancer Screening Among Chinese and Korean Members* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits in the First 15 Months of Life	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
CalViva Health	*Breast Cancer Screening Among Hmong-Speaking Members* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
	Childhood Immunizations	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process

MCMC Plan Name	PIP Topic	PIP Module Progression
CenCal Health	*Postpartum Care for Members Residing in San Luis Obispo County* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
Central California Alliance for Health	*Child and Adolescent Well-Care Visits Among Members Residing in Merced County* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
	Childhood Immunizations	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: Validation Criteria Met Intervention Testing: In process
Community Health Group Partnership Plan	*Adolescent Well-Care Visits*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Cervical Cancer Screening Among Black/African-American Members (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
Contra Costa Health Plan	*Diabetes Control Among Members Residing in Specific Regions of Contra Costa County* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
Gold Coast Health Plan	*Adolescent Well-Care Visits*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: Validation Criteria Met Intervention Testing: In process
	Cervical Cancer Screening Among Members Residing in Area 5 (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
Health Net Community Solutions, Inc.	*Breast Cancer Screening Among Russian Members in Sacramento County* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Childhood Immunizations	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process

MCMC Plan Name	PIP Topic	PIP Module Progression
Health Plan of San Joaquin	*Adolescent Well-Care Visits*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Cervical Cancer Screening Among White Members Residing in Stanislaus County (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
Health Plan of San Mateo	*Adolescent Well-Care Visits*	Module 1: Validation Criteria Met Module 2: In process
	Breast Cancer Screening Among African-American Members (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
Inland Empire Health Plan	*Adolescent Well-Care Visits*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Controlling High Blood Pressure Among African-American Members (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
Kaiser NorCal	*Childhood Immunizations*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Hypertension Control Among African-American Members Living in South Sacramento (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: Validation Criteria Met Intervention Testing: In process
Kaiser SoCal	*Adolescent Well-Care Visits*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits Among Members 7 to 11 Years of Age (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
Kern Health Systems, DBA Kern Family Health Care	*Asthma Medication Ratio*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits Among Members Living in Central Bakersfield (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process

MCMC Plan Name	PIP Topic	PIP Module Progression
L.A. Care Health Plan	*Childhood Immunizations*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Diabetes Among African-American Members (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
Molina Healthcare of California	*Childhood Immunizations*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Diabetes Control Among African-American Members Residing in Sacramento County (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: In process
Partnership HealthPlan of California	*Breast Cancer Screening Among Members Living in Rural and Small Counties* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: Validation Criteria Met Intervention Testing: In process
San Francisco Health Plan	*Breast Cancer Screening Among African-American Members* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Well-Child Visits in the First 15 Months of Life	Module 1: Validation Criteria Met Module 2: In process
Santa Clara Family Health Plan	*Adolescent Well-Care Visits in Network 20* (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
	Lead Screening in Children	Module 1: Validation Criteria Met Module 2: In process
UnitedHealthcare Community Plan*	*Cervical Cancer Screening*	Module 1: Validation Criteria Met Module 2: In process
	Child and Adolescent Well-Care Visits	Module 1: Validation Criteria Met Module 2: In process

MCMC Plan Name	PIP Topic	PIP Module Progression
Population-Specific Health Plans		
AIDS Healthcare Foundation*,^	*Controlling High Blood Pressure*	Module 1: Validation Criteria Met Module 2: In process
	HIV Viral Load Suppression	Module 1: Validation Criteria Met Module 2: In process
Rady Children's Hospital—San Diego*	*Diabetes Control*	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: Validation Criteria Met Intervention Testing: In process
	Blood Lead Test	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
SCAN Health Plan^	*Breast Cancer Screening*	Module 1: Validation Criteria Met Module 2: In process
	Diabetes Control Among Spanish-Speaking Members (Health Equity PIP)	Module 1: Validation Criteria Met Module 2: Validation Criteria Met Module 3: In process
Specialty Health Plan		
Family Mosaic Project*	*Improving Family Functioning*	Module 1: Validation Criteria Met Module 2: In process
	Reducing Anxiety Symptoms	Module 1: Validation Criteria Met Module 2: In process

Performance Improvement Project Interventions

Five MCMC plans progressed to the intervention testing phase for one of their PIPs. Table 10.2 provides descriptions of interventions these MCMC plans were testing as of the end of the review period of this report.

Table 10.2—Medi-Cal Managed Care Health Plan Performance Improvement Project Interventions

MCMC Plan Name	PIP Topic	Interventions
Central California Alliance for Health	*Childhood Immunizations*	♦ Working with the local immunization registry to correct data exchange issues
Gold Coast Health Plan	*Adolescent Well-Care Visits*	♦ Implementing a comprehensive outreach

MCMC Plan Name	PIP Topic	Interventions
		program that includes calling members to promote the well-care visit member incentive program to engage adolescent members ages 12 to 17 years who are assigned to the PIP clinic partner to schedule their well-care visits
Kaiser NorCal	*Hypertension Control Among African-American Members Living in South Sacramento* (Health Equity PIP)	♦ Conducting training to providers who already have a relationship with the patient population to order blood pressure monitors and provide member education resources ♦ Collecting blood pressure readings taken at home via a Quick Response (QR) code that links to a secure MS form ♦ Automatically ordering blood pressure machines and enrolling eligible members in a health education class
Partnership HealthPlan of California	*Well-Child Visits*	♦ Implementing Saturday clinics specifically for well-child visit appointments for members 0 to 15 months old
Rady Children's Hospital—San Diego	*Diabetes Control*	♦ Scheduling child life appointments based on provider referral

Performance Improvement Project Technical Assistance Findings

HSAG provided technical assistance via email, telephone, and Web conferences, as needed, to help MCMC plans gain the understanding and skills needed to meet all validation criteria. Some MCMC plans were unable to carry out the PIP process as originally planned due to ongoing challenges related to COVID-19. HSAG worked with individual MCMC plans to address their specific challenges so that they could move forward with the PIP process.

Conclusions—Performance Improvement Projects

Through HSAG's PIP training, validation, and technical assistance, MCMC plans successfully initiated the 2020–22 PIPs on a variety of health equity and child and adolescent health topics that aim to improve the quality and timeliness of, and access to care for members. All MCMC plans successfully met the validation criteria for Module 1, demonstrating that all MCMC plans successfully built a strong foundational framework for their PIPs. Five MCMC plans also met validation criteria for modules 2 and 3, which indicates that they used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim, established an intervention plan for each intervention to be tested for the PIPs, and began testing the interventions through a series of PDSA cycles. Although some MCMC plans faced unforeseen challenges due to COVID-19, HSAG provided plan-specific technical assistance to support those MCMC plans in moving forward with the PIP process.

Recommendations—Performance Improvement Projects

Based on the 2020–22 PIP progress, HSAG has no recommendations for MCMC plans and DHCS related to PIPs.

MCMC plan-specific PIP activities are included in appendices A through CC located in *Volume 2 of 4* of this EQR technical report.

11. 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 MCMC plans, 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

Alternative Access Standards Reporting

As part of DHCS' ongoing monitoring and oversight of MCMC plans, DHCS ensures that these plans' provider networks are adequate to deliver services to members. If providers are unavailable or unwilling to service Medi-Cal beneficiaries such that an MCMC plan is unable to meet time and distance standards, MCMC plans may request that DHCS allow an alternative access standard for specified provider scenarios (e.g., provider type, ZIP Code). The DHCS APL20-003[42] includes DHCS' clarifying guidance for MCMC plans regarding network certification requirements applicable during the time frame of the data analyzed in this 2020–21 EQR technical report, 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.[43] 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

[42] All Plan Letter 20-003. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-003.pdf. Accessed on: Nov 3, 2021.

[43] CA WIC §14197(e)(1)(B).

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 MCMC plans 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[44] 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.

[44] CA WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05. Accessed on: Nov 3, 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 DHCS' approval or denial of a request for alternative access standards.
- Consumer complaints, if any.

Methodology

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

- MCPs' alternative access standard request data (i.e., a MS Excel workbook).[45]
- DHCS' alternative access standard administrative data (i.e., a MS Excel workbook).
- DHCS' quarterly grievance reports data from 2020 Quarter 3 through 2021 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).
- DHCS' modified 274 Provider Demographic data for June 2020 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 May 12, 2020, for those standards to be effective on July 1, 2020. Approved alternative access standards are valid for the July 1, 2020, through June 30, 2021, contract year. The analysis is based on alternative access standard requests submitted to DHCS between May 12, 2020, and May 27, 2021.

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. 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 (NPI) or license number to ensure that providers identified in the 274 file were also identified in

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

the CMB data. For these reasons, the available data are limited in their ability to identify the denominator as defined above. The alternative denominator used in Table 6.1 through Table 6.58, included in *Volume 4 of 4* of this EQR technical report (Appendix DD), is the count of providers physically located in the plan service area that are under contract with any MCP. 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 percentages in Table 6.1 through Table 6.58 therefore represent the upper limit of the percentage of providers located within a service area who are contracted with each MCP serving that area as a percentage of all providers.

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.[46] 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 29,029 requests submitted to DHCS, and 16,171 distinct combinations of request characteristics appeared in the data supplied by DHCS. Of these combinations, 12,098 (74.8 percent) were approved by DHCS.

The complete results of the analysis of the total number of requests submitted and the number approved or denied are located in *Volume 4 of 4* of this EQR technical report (Appendix DD).

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 standard request is within five miles of the closest in-network or out-of-network provider indicated on the request, or the request is within five miles of the time and distance standard.
  - The MCP is contracted with the closest provider (in-network or out-of-network), and DHCS did not identify a closer in-network or out of-network provider than the provider indicated on the request.

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

- Although DHCS identified closer out-of-network providers than the in-network provider indicated on the request, the MCP has attempted to contract with those providers and clearly explained why they could not be added to the MCP's network.
- The alternative access standard request is for a PCP or a mental health provider and is in a designated Health Professional Shortage Area.
- Other

♦ Denial Reasons

- DHCS located an in-network provider within the time and distance standards that the MCP did not identify on the alternative access standard request. The MCP is to submit an updated accessibility analysis that shows the MCP is already meeting the time and distance standard.
- DHCS located an out-of-network provider within the time and distance standard that the MCP did not identify on the alternative access standard request. The MCP is to revise the request with updated justification for the inability to contract.
- DHCS located a closer in-network provider than the in-network provider and out-of-network provider that the MCP identified on the alternative access standard request. The MCP is to revise the request for fewer miles/minutes and resubmit.
- DHCS located a closer out-of-network provider than the in-network provider and out-of-network provider that the MCP identified on the alternative access standard request. The MCP is to revise the request for miles/minutes or provide a justification and resubmit.
- The MCP's justification as to why the MCP was unable to contract with the closer out-of-network provider is insufficient. The MCP is to revise the justification and resubmit.
- The MCP's alternative access standard request is incomplete. The MCP is to revise the request that follows Attachment C instructions and resubmit.
- Insufficient mileage was requested compared to DHCS' mapping of the in-network provider. The MCP is to revise the request with additional miles/minutes and resubmit.
- Excessive mileage was requested compared to DHCS' mapping of the in-network provider. The MCP is to revise the request for fewer miles/minutes and resubmit.

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.

Table 11.1 displays the shortest median distances identified by MCP and ZIP Code. The shortest median distance was 10 miles for seven MCPs and 22 ZIP Codes, while the longest median distance was 400 miles for Molina Healthcare of California and ZIP Code 95626. The shortest median drive time was seven minutes for California Health & Wellness Plan and ZIP Code 95372, while the longest median drive time was 578 minutes for Molina Healthcare of California and ZIP Code 95660. The smallest median number of impacted beneficiaries was zero individuals in 25 combinations of MCPs and ZIP Codes, while the largest median number of impacted beneficiaries was 37,617.5 individuals for Alameda Alliance for Health and ZIP Code 94612.

Table 11.1—Shortest Median Distances Identified by MCP and ZIP Code

MCP	Median Distance	ZIP Codes
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	10 miles	93242, 95232, 95614, 95623, 95651, 95675, 95932, 95948
California Health & Wellness Plan	10 miles	95614, 95623, 95651, 95982
CalViva Health	10 miles	93242
Gold Coast Health Plan	10 miles	90265, 93001
Health Net Community Solutions, Inc.	10 miles	93274, 93308, 95320
Health Plan of San Joaquin	10 miles	95206, 95212
Partnership HealthPlan of California	10 miles	95448, 96007

The complete results for the analysis of distances, drive times, and impacted beneficiaries are located in *Volume 4 of 4* of this EQR technical report (Appendix DD).

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 91 days for requests submitted between May 12, 2020, and October 13, 2020, for their initial submission and 90 days for requests submitted between October 13, 2020, and May 27, 2021, 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 4 of 4* of this EQR technical report (Appendix DD).

Consumer Complaints

HSAG reviewed DHCS' quarterly grievance reports from 2020 Quarter 3 through 2021 Quarter 2 for beneficiaries' complaints related to access to providers, and specifically to time and distance standards. 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, there were 537 grievance calls for each MCP and county. The lowest number of grievances was one, and the highest number of grievances was 12,538.

The complete results for the analysis of consumer complaints are located in *Volume 4 of 4* of this EQR technical report (Appendix DD).

Process of Ensuring Out-of-Network Access

DHCS sets the requirements for MCPs to provide out-of-network access. Specifically, MCPs must provide 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.

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:

- The provider was unwilling to accept the MCP contract or Medi-Cal FFS rates.
- The provider refused to contract with the MCP.
- The provider did not meet the MCP's professional standards or credentialing requirements or had a disqualifying quality of care issue.
- The provider was currently in contracting negotiations with the MCP.[47]

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

- The provider could not be found.
- The provider retired.
- The provider was deceased.
- The plan will reach out to an alternate provider for contracting.
- The provider specializes in different services than needed.
- The provider delivers limited services.
- The population is too sparse to find providers.
- A very small number of beneficiaries are impacted (e.g., 1 percent of membership).
- Providers cannot contract due to competing contracts.
- The closest provider is already contracted with the plan.
- Closer providers are too difficult for beneficiaries to travel to than the currently contracted provider.
- The closer provider is not within the 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.[48] Note that because the available data do not provide reliable information on the practice locations of all providers (i.e., under Medi-Cal contract or

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

[48] Within the 274 file received from DHCS, there were 194,290 records for which the DHCS_CLASS field was missing. Because this field was missing in the data, it is unclear if these providers were within the scope of the provider types for this analysis. No records were dropped from the analysis due to missing data on any other required fields in the 274 file.

not), the actual percentage of all providers contracted with each MCP in a service area will be smaller than the percentage 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 56.0 percent. This indicates that MCPs typically contract with at most just over half of the providers who are contracted with any MCP, across counties and provider types. That percentage is the upper limit of the number of providers contracted with each MCP located within a service area and serving that area as a percentage of all providers.
- The MCPs with the highest median percentage of contracted providers across counties and provider types are CenCal Health and Partnership HealthPlan of California (both at 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 Kaiser SoCal (10.1 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 (82.1percent). MCPs typically contract with a higher proportion of providers of this type located within the counties they serve compared to other provider types.
- The provider type with the lowest median percentage of contracted providers across counties and MCPs is Adult Dermatology (6.9 percent). MCPs typically contract with a lower proportion of providers of this type located within the counties they serve compared to other provider types.

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 4 of 4* of this EQR technical report (Appendix DD).

Considerations—Alternative Access Standards Reporting

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

- The DHCS grievance call data indicated that the number of grievances made by members increased from an average of 259.9 calls for each MCP and county in the 2019–20 analysis of alternative access standard requests to an average of 537.0 calls in the 2020–21 analysis, a 107 percent increase in grievance volume. While the lowest volume of calls remained consistent across the two years of analyses, the highest number of calls for a single MCP and county increased from 8,111 in the 2019–20 analysis to 12,538 in the 2020–21 analysis.
  - The time frame for the 2020–21 analysis includes the ongoing COVID-19 public health emergency, which could have contributed to increased grievance calls as a result of

increased stress experienced by beneficiaries. The current data, however, do not provide sufficient detail to determine the degree to which the COVID-19 public health emergency contributed to the increased call volume. DHCS might consider performing outreach to MCPs exhibiting the greatest increases in grievance calls to identify the source of beneficiary complaints and develop appropriate resolutions.

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 received at SNFs/ICFs. The DHCS APL 17-017[49] 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 to calculate nursing facility population stratifications and long-stay quality measures for SNFs and to calculate the driving distance between members in SNFs/ICFs and their places of residence during calendar year 2020 (i.e., January 1, 2020, through December 31, 2020).

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

SNF/ICF Feasibility Pilot Study Results

Prior to HSAG conducting the SNF Experience and SNF/ICF Distance analyses for the 2020–21 EQR technical report, DHCS contracted with HSAG to conduct a pilot study to determine if SNF and ICF stays could be identified using administrative claims/encounter data in order to capture the experiences of and distance traveled by ICF residents given that MDS data (i.e., the data used to capture SNF Experience and Distance information in the 2019–20 EQR technical report) only capture SNF stays. HSAG investigated DHCS' administrative claims/encounter data to determine whether it was feasible to identify the date of admission and length of stay for residents living in a SNF/ICF, and, if appropriate, to calculate statewide aggregate observed and risk-adjusted rates for two CMS Medicaid MLTSS measures (i.e., *Long-Term Services and Supports [LTSS] Successful Transition After Long-Term Institutional*

[49] All Plan Letter 17-017. Available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-017.pdf.

Stay and *LTSS Minimizing Institutional Length of Stay*) for the SNFs/ICFs using data from calendar year 2019.

HSAG identified the following conclusions and items for consideration based on its review of the pilot study findings:

- DHCS should continue to use MDS data to evaluate SNF residents' experience and distance traveled as part of the SNF/ICF Experience and Distance analysis included in the annual EQR technical report, rather than use administrative claims/encounter data.
- DHCS should continue to only assess SNF residents' experiences in the annual EQR technical report until the CMS LTSS measures can more appropriately identify ICF stays.
- DHCS should use administrative claims/encounter data to determine ICF residents' distance traveled as part of the SNF/ICF Experience and Distance analysis included in the annual EQR technical report.

Based on these recommendations, DHCS agreed to continue to analyze the distance SNF residents traveled from their residences to facilities using MDS data and to use the claims/encounter data to analyze the distance ICF residents traveled. DHCS also agreed to continue to analyze only SNF residents' experience using the MDS 3.0 long-stay quality measures, given the administrative data limitations and the CMS MLTSS measure specifications.

Methodology

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

Data Sources

To complete the SNF Experience and SNF/ICF Distance analyses, HSAG used administrative demographic, eligibility, enrollment, and claims/encounter data provided by DHCS; MDS 3.0 resident assessment and facility data provided by the California Department of Public Health (CDPH); and the Licensed and Certified Healthcare Facility Locations Microsoft Excel file downloaded from the California Health and Human Services Agency (CHHS) Open Data Portal (henceforth referred to as the "CHHS facility file"). Upon receipt of the data files, HSAG analyzed the files for data validity and completeness.

Combining Data

For the SNF Experience and Distance analyses, HSAG matched SNF residents in the MDS 3.0 data to the administrative data sources provided by DHCS by combining the administrative demographic file with the MDS 3.0 data file using different combinations of the following fields: Medi-Cal client identification number, member Social Security number, member date of birth, and member name. Once HSAG combined the MDS 3.0 data with the demographic file, HSAG

then linked the SNF residents to the enrollment and eligibility files by Medi-Cal client identification number.

For the ICF Distance analysis, HSAG matched the ICFs in the CHHS facility file to the administrative data sources provided by DHCS using the NPI. The CHHS facility file contained the Facility Type Code data field that HSAG used to identify ICFs. If an ICF had multiple associated NPIs, HSAG kept all NPIs. HSAG removed all ICFs that had missing NPI information. HSAG then matched NPIs in this ICF list to the billing provider NPI in the administrative claims/encounter data to identify Medi-Cal client identification numbers for members in ICFs. HSAG then linked these members to the member demographic, enrollment, and eligibility files using the Medi-Cal client identification number.

Identifying Long- and Short-Stay SNF Residents

Using the MDS 3.0 assessments for residents whom HSAG matched to a Medi-Cal identification number, HSAG limited the MDS 3.0 data to assessments for episodes that began, occurred, or ended during the measurement year (i.e., January 1, 2020, through December 31, 2020). HSAG further limited the MDS 3.0 data to residents who were admitted to the SNF on or after January 1, 2018, 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 Version 14.0[50] Residents are considered long-stay if their episode in the facility is more than 100 days, and residents are considered short-stay if their episode in the facility is 100 days or fewer. For the SNF Experience analysis, the long- and short-stay identification is based on the most recent episode during each quarter while the SNF Distance analysis considers all episodes during the measurement year when determining long and short stays.

Identifying Long- and Short-Stay ICF Residents

HSAG used all claims/encounters with a first date of service from January 1, 2018, through April 30, 2021, for which the billing provider NPI was included in the ICF list derived from the CHHS facility file. HSAG collapsed claims/encounters with the same Medi-Cal client identification number and billing provider NPI (limited to the NPIs included in the ICF list) with overlapping dates of service or dates of service within 31 days of each other. HSAG allowed up to a one-month gap in claims/encounters to account for interim billing and variability in ICFs' billing practices, whereby ICFs may bill monthly, biweekly, or weekly, and the dates of service do not necessarily reflect the length of stay. Similarly, HSAG applied as few restrictions as possible to the claims/encounters used for constructing ICF stays in order to capture the most ICF claims/encounters possible to fill in these gaps in dates of service.

HSAG used the earliest date of service from the collapsed claims/encounters as the administrative stay admission date and the latest date of service as the administrative stay

[50] Centers for Medicare & Medicaid Services. MDS 3.0 Quality Measures User's Manual (v14.0). Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures. Accessed on: Nov 22, 2021.

discharge date. HSAG calculated length of stay as the difference in days between the discharge date and the admission date. HSAG followed the stay type definitions used in the MDS specifications to classify stays as short stay or long stay. Short stays are 100 days or less, and long stays are 101 days or more.

SNF Experience Analysis

HSAG calculated statewide nursing facility population characteristics and 14 quarterly long-stay quality measures for all matched long-stay Medi-Cal residents following the MDS 3.0 Quality Measures User's Manual Version 14.0.[51] Of note, the *Percent of Residents Who Received an Antipsychotic Medication* measure was modified to include additional exclusion criteria. HSAG also calculated two additional MDS 3.0 measures, one developed by Pharmacy Quality Alliance that captures antipsychotic use in residents with dementia and one developed by HSAG that captures hospital admissions. In alignment with CMS' five-star rating algorithm, HSAG aggregated the quarterly quality measure rates to obtain an annual rate for each quality measure, which also allowed HSAG to compare the annual measure rates to national averages.[52]

Table 11.2 displays the statewide nursing facility population characteristics, and Table 11.3 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 11.3. For the cross-measure analysis, HSAG first determined if a resident was numerator positive in any of the four quarters for each measure included in the composite measure. HSAG then determined how many residents had no events, one event, or more than one event for each composite measure during each quarter and during the measurement year.

SNF Distance Analysis

For each SNF stay that overlapped the measurement year for which residents were admitted to the SNF on or after January 1, 2018, and enrolled in Medi-Cal managed care at the time of admission, HSAG determined their places of residence prior to the SNF admission using the monthly demographic data provided by DHCS and determined the SNF's address using the California MDS 3.0 facility files provided by CDPH. HSAG used Quest Analytics Suite software (Quest) to geocode the SNF's address and the SNF resident's place of residence prior to admission, assigning each address an exact geographic location (i.e., latitude and longitude).

[51] Ibid.

[52] Centers for Medicare & Medicaid Services. Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide, January 2021. Available at: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf. Accessed on: Nov 22, 2021.

HSAG then used Quest to calculate the driving distance between the SNF's address and the resident's place of residence prior to SNF admission.

ICF Distance Analysis

For each ICF stay that overlapped the measurement year for which the member was admitted to the ICF on or after March 1, 2018, and enrolled in Medi-Cal managed care at the time of admission, HSAG determined the address of the ICF facility using the CHHS facility file. For ICFs associated with more than one address, HSAG used the provider location number and provider name in the claims/encounter data to identify a facility address for each stay. HSAG then determined the member's place of residence prior to the ICF admission using the monthly demographic data provided by DHCS. Members whose address for their place of residence exactly matched the ICF address were excluded from the analysis, as HSAG was unable to determine a place of residence prior to the ICF admission. HSAG then used Quest to calculate the driving distance between the ICF address and the member's place of residence prior to ICF admission.

SNF Experience and SNF/ICF Distance Analysis

SNF Experience Findings

To better understand the experiences of SNF residents, it is important to understand the population characteristics of these residents. Table 11.2 presents the annual statewide facility population characteristics for long-stay residents, stratified by age, gender, resident characteristic, discharge planning status, location from which the resident entered the facility, and resident entry date.

Table 11.2—Statewide Nursing Facility Population Characteristics

Note: The 2019 and 2020 counts and percentages are derived from aggregated quarterly data; therefore, a resident may be included more than once in the annual counts and percentages.

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.

— indicates data are not applicable to the calendar year.

Stratification	2019 Count	2019 Percent	2020 Count	2020 Percent
Age				
<25 Years	484	0.72%	632	0.71%
25–54 Years	8,285	12.39%	10,458	11.83%
55–64 Years	12,509	18.71%	16,701	18.89%

Stratification	2019 Count	2019 Percent	2020 Count	2020 Percent
65–74 Years	15,200	22.73%	21,231	24.01%
75–84 Years	14,331	21.43%	18,695	21.14%
85+ Years	16,055	24.01%	20,703	23.41%
Gender				
Male	31,283	46.79%	41,262	46.67%
Female	35,581	53.21%	47,158	53.33%
Resident Characteristics				
Residents with a Psychiatric Diagnosis	37,114	55.51%	51,864	58.66%
Residents with Intellectual Disability or Developmental Disability (ID/DD) indicated	24	0.04%	50	0.06%
Hospice Residents	3,795	5.68%	4,479	5.07%
Residents with Life Expectancy of Less Than 6 Months	3,231	4.83%	4,013	4.54%
Discharge Planning for Residents				
Discharge planning is already occurring for the resident to return to the community	15,599	23.33%	16,957	19.18%
Location the Resident Entered Facility From				
Community	2,844	4.25%	3,289	3.72%
Another Nursing Home or Swing Bed	4,107	6.14%	5,189	5.87%
Acute Hospital	56,087	83.88%	75,185	85.03%
Psychiatric Hospital	2,811	4.20%	3,466	3.92%
Inpatient Rehabilitation Facility	175	0.26%	245	0.28%
ID/DD Facility	S	S	S	S
Hospice	287	0.43%	315	0.36%
LTCH	174	0.26%	281	0.32%
Other	S	S	S	S

Stratification	2019 Count	2019 Percent	2020 Count	2020 Percent
Resident Entry Date				
Resident with Entry Date Prior to January 1, 2019	—	—	12,285	13.89%

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

- Approximately 68.6 percent of SNF residents were 65 years of age or older during calendar year 2020, which is higher than the calendar year 2019 rate for this age group (68.2 percent). This change for calendar year 2020 is largely due to the percentage increase of SNF residents 65 to 74 years of age.
- Approximately 46.7 percent of SNF residents were male in calendar year 2020, which is consistent with the calendar year 2019 results and is higher than the most recently published national percentage of SNF residents who were male (31.1 percent).[53]
- Approximately 58.7 percent of SNF residents had a psychiatric diagnosis during calendar year 2020, which is higher than the rate for calendar year 2019 (55.5 percent). This increase for calendar year 2020 may be attributable to the impact on residents' mental health from the infection control efforts put in place (e.g., social isolation, lack of family contact) to help prevent the spread of COVID-19 in nursing homes.[54]
- Approximately 85.0 percent of SNF residents entered their facilities from an acute hospital during calendar year 2020, which is higher than the rate for calendar year 2019 (83.9 percent).

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.[55] To better understand these impacts, HSAG calculated quarterly and annual long-stay quality measures. Table 11.3 presents the quarterly and annual statewide rates for each long-stay quality measure. The annual rates

[53] 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: Nov 23, 2021.

[54] McArthur C, et al. Evaluating the Effect of COVID-19 Pandemic Lockdown on Long-Term Care Residents' Mental Health: A Data-Driven Approach in New Brunswick*. J Am Med Dir Assoc.* 2021; 22(1). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7587131/. Accessed on: Nov 23, 2021.

[55] 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: Nov 23, 2021.

include shading for comparisons to the national averages, where applicable, which were derived from *Nursing Home Compare's Four Quarter Average Score* for calendar years 2020 and 2019.[56]

Table 11.3—Long-Stay Quality Measures

Note: The 2019 and 2020 annual long-stay quality measure rates are derived from aggregated quarterly data; therefore, a resident may be included more than once in the annual long-stay quality measure rates.

2020 Quarter 1 represents the January 1, 2020, through March 31, 2020, measurement period.

2020 Quarter 2 represents the April 1, 2020, through June 30, 2020, measurement period.

2020 Quarter 3 represents the July 1, 2020, through September 30, 2020, measurement period.

2020 Quarter 4 represents the October 1, 2020, through December 31, 2020, measurement period.

The Annual Rates represent January 1 through December 31 of the respective year.

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

indicates the rate was better than the national average for the respective year.

*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.

+The *Percent of Residents Who Received an Antipsychotic Medication* measure was calculated using modified specifications that use additional exclusion criteria.

Long-Stay Quality Measures	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
Adverse Events Composite Measures						
*Antipsychotic Use in Persons with Dementia**,^	8.22%	7.88%	7.70%	7.84%	7.91%	8.94%
*Hospital Admissions from SNFs**,^^	21.61%	19.36%	18.06%	19.23%	19.54%	21.55%

[56] Centers for Medicare & Medicaid Services. MDS Quality Measures. *Data.Medicare.gov*, 2020. Available at: https://data.cms.gov/provider-data/dataset/xcdc-v8bm. Accessed on: Nov 23, 2021.

Long-Stay Quality Measures	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
*Percent of High-Risk Residents With Pressure Ulcers**	8.84%	9.13%	9.02%	9.56%	9.13%	9.66%
*Percent of Residents Experiencing One or More Falls with Major Injury**	1.69%	1.62%	1.63%	1.54%	1.62%	1.82%
Percent of Residents Who Received an Antipsychotic Medication,+*	2.71%	2.61%	2.16%	2.34%	2.46%	3.28%
*Percent of Residents Who Were Physically Restrained**	0.28%	0.27%	0.30%	0.30%	0.29%	0.38%
*Percent of Residents with a Urinary Tract Infection**	1.25%	1.07%	1.04%	1.07%	1.11%	1.43%
*Prevalence of Antianxiety/Hypnotic Medication Use**	4.25%	4.18%	3.86%	4.14%	4.11%	5.07%
Behavioral Health Composite Measures						
*Percent of Residents Who Have Depressive Symptoms**	2.84%	4.32%	4.87%	5.93%	4.50%	1.07%
*Percent of Residents Who Used Antianxiety or Hypnotic Medication**	14.66%	14.54%	14.75%	14.86%	14.70%	15.58%

Long-Stay Quality Measures	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
*Prevalence of Behavior Symptoms Affecting Others**	12.38%	12.90%	12.64%	11.86%	12.45%	12.84%
Physical Health Composite Measures						
*Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder**	26.86%	25.05%	24.44%	24.55%	25.26%	29.37%
*Percent of Residents Who Lose Too Much Weight**	4.71%	6.03%	6.90%	5.71%	5.84%	4.66%
*Percent of Residents Whose Ability to Move Independently Worsened**	10.47%	13.42%	12.92%	13.99%	12.65%	11.96%
*Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased**	8.38%	9.63%	9.06%	9.71%	9.21%	8.82%
Other Long-Stay Quality Measures						
*Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder**	2.08%	1.96%	1.88%	1.88%	1.95%	2.34%

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

- While 12 of the 16 calendar year 2020 long-stay quality measure rates (75.0 percent) improved from calendar year 2019, rates for 11 of the 16 calendar year 2020 long-stay quality measures (68.75 percent) were within 1 percentage point of the calendar year 2019 rates, indicating that the experience of MCMC members residing in California SNFs was consistent for these measures across calendar years 2019 and 2020.
  - Of note, the percentage of residents who experienced depressive symptoms was more than three times higher in calendar year 2020 than in calendar year 2019. Nationally, researchers have found that COVID-19-related social isolation has resulted in increased depressive symptoms among LTC facility residents.[57] The impacts of COVID-19 on the *Percent of Residents Who Have Depressive Symptoms* are also seen with the nearly 50 percent increase from Quarter 1 2020 to Quarter 2 2020, which aligns with the timing of efforts put in place to mitigate the spread of COVID-19 (e.g., social isolation, lack of family contact). Further, the percentage of residents who experienced depressive symptoms continued to slightly increase from Quarter 2 2020 through the end of calendar year 2020, which might explain the large rate change.
- MCMC members residing in California SNFs experienced better outcomes than SNF residents nationally for eight of the 11 long-stay quality measures that could be compared to national averages (72.72 percent). These same eight long-stay quality measures also had better rates than the national averages for calendar year 2019. For calendar year 2020:
  - The adverse events domain represents an opportunity to improve the experience of MCMC members residing in California SNFs, as only two of the four adverse event measures that could be compared to national benchmarks (50.00 percent) had a rate that was better than the national average.
  - MCMC members residing in California SNFs experienced better outcomes than SNF residents nationally for the two behavioral health measures that were comparable to national averages.
  - MCMC members residing in California SNFs experienced better outcomes than SNF residents nationally for all four physical health measures compared to the national averages.
  - The rates for the *Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder* measure were worse than the national average. However, the rates for the *Percent of Residents with a Urinary Tract Infection* measure continued to be better 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

[57] Nierengarten MB. COVID and the Ongoing Mental Health Needs of Long-Term Care Residents. *Psycom Pro*. 2021. Available at: https://pro.psycom.net/special_reports/covid-and-mental-health-long-term-care-residents. Accessed on: Feb 1, 2022.

hospital. Further, national studies indicate that many hospitalizations from SNFs are preventable/avoidable.[58] As a result, it is important to understand whether hospital admissions from SNFs are occurring. Table 11.4 displays the *Hospital Admissions from SNFs* measure rates stratified by each member's admission source.

Table 11.4—Hospital Admissions from SNFs—Stratified Results

Note: The 2019 and 2020 annual long-stay quality measure rates are derived from aggregated quarterly data; therefore, a resident may be included more than once in the annual long-stay quality measure rates.

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	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
Community	4.18%	5.64%	3.77%	6.12%	4.93%	4.60%
Another Nursing Home or Swing Bed	8.44%	9.81%	7.16%	9.81%	8.82%	8.30%
Acute Hospital	24.21%	21.47%	20.21%	21.27%	21.76%	24.40%
Psychiatric Hospital	4.60%	3.83%	3.38%	5.26%	4.28%	4.05%
Inpatient Rehabilitation Facility	S	S	S	S	S	S
ID/DD Facility	S	S	S	S	S	S
Hospice	S	S	S	S	S	S
LTCH	23.81%	19.40%	16.00%	16.67%	18.77%	20.93%
Other	S	S	S	S	5.73%	6.41%

As presented in Table 11.2, more than 85 percent of residents entered their SNF from either an acute hospital or LTCH during calendar year 2020. Of these residents, approximately 21.8 percent and 18.8 percent, respectively, experienced a subsequent admission to a hospital. These percentages declined from calendar year 2019, which is expected given the overall decline in discharges from SNFs during calendar year 2020 due to infection control efforts put in place to mitigate the spread of COVID-19.

[58] Medicare Payment Advisory Commission. Chapter 9: Hospital and SNF use by Medicare beneficiaries who reside in nursing facilities, June 2017. Available at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch9.pdf. Accessed on: Nov 23, 2021.

Cross-Measure Analysis Results

To better understand members' experiences in SNFs, HSAG assessed how many Medi-Cal residents experienced an adverse, behavioral health, or physical health event. Table 11.5 through Table 11.7 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 11.5—Statewide Cross-Measure Results for the Adverse Events Composite Measure

Note: The 2019 and 2020 annual long-stay composite measure rates are derived from aggregated quarterly data; therefore, a resident may be included more than once in the annual long-stay composite measure rates.

2020 Quarter 1 represents the January 1, 2020, through March 31, 2020, measurement period.

2020 Quarter 2 represents the April 1, 2020, through June 30, 2020, measurement period.

2020 Quarter 3 represents the July 1, 2020, through September 30, 2020, measurement period.

2020 Quarter 4 represents the October 1, 2020, through December 31, 2020, measurement period.

The Annual Rates represent January 1 through December 31 of the respective year.

Number of Events	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
Residents Experiencing No Events	69.56%	71.74%	73.10%	71.94%	52.58%	51.87%
Residents Experiencing At Least One Event	30.44%	28.26%	26.90%	28.06%	47.42%	48.13%
Residents Experiencing More Than One Event	5.75%	5.23%	4.97%	5.09%	12.33%	13.78%

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

- For calendar year 2020, there was an increase in the percentage of residents experiencing no adverse events and a decrease in the percentage of residents experiencing at least one adverse event compared to calendar year 2019.

- The most common adverse event that residents experienced was *Hospital Admissions from SNFs*, with 19.54 percent and 21.55 percent of all residents experiencing at least one hospital admission during calendar year 2020 and calendar year 2019, respectively.
- Within the *Adverse Events* composite measure, 9.13 percent of residents had a pressure ulcer for calendar year 2020, which is an improvement from calendar year 2019.
- Of the residents who experienced more than one adverse event during calendar year 2020, 85.48 percent experienced an admission to a hospital.
  - 45.52 percent experienced both an admission to a hospital and a pressure ulcer.
  - 14.25 percent experienced an admission to a hospital and were dementia residents who received antipsychotics.
  - 11.49 percent experienced an admission to a hospital and inappropriately received an antipsychotic medication.[59]

Table 11.6—Statewide Cross-Measure Results for the Behavioral Health Composite Measure

Note: The 2019 and 2020 annual long-stay composite measure rates are derived from aggregated quarterly data; therefore, a resident may be included more than once in the annual long-stay composite measure rates.

2020 Quarter 1 represents the January 1, 2020, through March 31, 2020, measurement period.

2020 Quarter 2 represents the April 1, 2020, through June 30, 2020, measurement period.

2020 Quarter 3 represents the July 1, 2020, through September 30, 2020, measurement period.

2020 Quarter 4 represents the October 1, 2020, through December 31, 2020, measurement period.

The Annual Rates represent January 1 through December 31 of the respective year.

Number of Events	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
Residents Experiencing No Events	76.65%	75.49%	75.10%	74.68%	66.76%	69.89%

[59] Note that the *Percent of Residents Who Received an Antipsychotic Medication* measure excludes residents from the denominator who have a diagnosis for which the administration of an antipsychotic medication is appropriate.

Number of Events	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
Residents Experiencing At Least One Event	23.35%	24.51%	24.90%	25.32%	33.24%	30.11%
Residents Experiencing More Than One Event	3.03%	3.42%	3.52%	3.60%	7.15%	5.50%

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

- For calendar year 2020, there was a decrease in the percentage of residents experiencing no behavioral health events and an increase in the percentage of residents experiencing at least one behavioral health event compared to calendar year 2019.
- The most common behavioral health events that residents experienced during calendar year 2020 were *Percent of Residents Who Used Antianxiety or Hypnotic Medication* and *Prevalence of Behavior Symptoms Affecting Others*. Approximately 29.18 percent of residents experienced at least one of these events during calendar year 2020.
- Fewer residents experienced more than one behavioral health event compared to adverse events and physical health events. Of the residents who experienced more than one adverse event during calendar year 2020, 64.13 percent experienced both the use of antianxiety or hypnotic medications and behavior symptoms that affected others.

Table 11.7—Statewide Cross-Measure Results for the Physical Health Composite Measure

Note: The 2019 and 2020 annual long-stay composite measure rates are derived from aggregated quarterly data; therefore, a resident may be included more than once in the annual long-stay composite measure rates.

2020 Quarter 1 represents the January 1, 2020, through March 31, 2020, measurement period.

2020 Quarter 2 represents the April 1, 2020, through June 30, 2020, measurement period.

2020 Quarter 3 represents the July 1, 2020, through September 30, 2020, measurement period.

2020 Quarter 4 represents the October 1, 2020, through December 31, 2020, measurement period.

The Annual Rates represent January 1 through December 31 of the respective year.

Number of Events	2020 Quarter 1 Rate	2020 Quarter 2 Rate	2020 Quarter 3 Rate	2020 Quarter 4 Rate	2020 Annual Rate	2019 Annual Rate
Residents Experiencing No Events	75.11%	74.37%	74.60%	75.88%	57.67%	57.68%
Residents Experiencing At Least One Event	24.89%	25.63%	25.40%	24.12%	42.33%	42.32%
Residents Experiencing More Than One Event	3.66%	4.41%	4.30%	3.94%	14.59%	14.09%

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

- For calendar year 2020, the percentages of residents experiencing no events, at least one event, and more than one event stayed relatively the same compared to calendar year 2019.
- The most common physical health event that residents experienced was *Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder*, with 25.26 percent and 29.37 percent of all residents having lost control of their bowel or bladder during calendar year 2020 and calendar year 2019, respectively.
- Of the residents who experienced more than one adverse event during calendar year 2020, 46.50 percent experienced both a decrease in their ability to move independently and an increase in their need for help performing activities of daily living. Further, approximately 43.5 percent of residents who experienced more than one adverse event experienced a loss of bladder or bowel control along with a decrease in their ability to move independently and/or an increase in their need for help performing activities of daily living.

SNF/ICF Distance Results and Findings

Table 11.8 and Table 11.9 present the statewide and county-level averages and percentiles (i.e., 25th, 50th, 75th, and 100th [maximum distance]) of the driving distances between members in SNFs and their places of residence prior to their SNF admissions, as well as the number of SNF residents for calendar year 2020, with comparisons to the calendar year 2019 average rate, for short- and long-stay residents, respectively.

Table 11.8—County-Level Short-Stay SNF Resident Distance Results

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

^ 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.

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

S indicates that the county had fewer than 11 SNF residents during the respective year; therefore, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

* indicates a COHS county

+ indicates a Cal MediConnect county

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance	2019 Average Distance
Statewide	58,976	3.30	7.10	14.60	601.80	13.64	12.54
Alameda	1,627	2.40	4.50	9.50	448.10	9.73	8.03
Alpine	0	N/A	N/A	N/A	N/A	N/A	N/A
Amador	23	10.50	19.10	39.20	86.70	25.35	22.65
Butte	230	1.90	3.80	18.20	552.20	16.49	38.93
Calaveras	26	15.20	22.10	40.90	67.40	28.56	S
Colusa	S	S	S	S	S	S	S
Contra Costa	871	4.30	11.50	18.30	377.30	14.11	13.14
Del Norte*	50	1.40	5.80	134.10	281.20	75.09	127.40
El Dorado	59	8.80	19.80	43.40	152.70	29.53	57.54
Fresno	704	4.00	7.70	19.95	321.40	21.80	20.85
Glenn	13	17.70	18.50	31.40	50.60	21.15	31.61
Humboldt*	160	8.80	32.40	162.15	601.80	87.99	75.58
Imperial	222	28.70	86.10	90.80	162.50	70.25	63.10
Inyo	S	S	S	S	S	S	S
Kern	487	3.70	8.50	34.20	228.60	23.33	21.61
Kings	77	2.50	18.80	29.40	213.80	32.78	35.98
Lake*	268	15.10	36.25	52.40	511.50	43.13	41.60
Lassen*	19	0.80	16.50	103.30	227.50	57.84	90.31

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance	2019 Average Distance
Los Angeles+	19,556	3.20	6.80	13.00	392.10	10.49	9.48
Madera	81	2.00	21.90	38.50	228.90	31.14	21.24
Marin*	320	3.00	5.90	12.25	388.30	12.16	12.91
Mariposa	S	S	S	S	S	S	58.48
Mendocino*	215	5.00	36.20	75.70	545.30	51.46	50.22
Merced*	716	3.10	8.20	28.05	359.80	19.07	17.63
Modoc*	18	1.20	21.65	121.00	544.30	100.03	80.43
Mono	S	S	S	S	S	S	S
Monterey*	671	2.20	4.40	16.30	365.60	14.39	13.88
Napa*	213	1.90	3.70	12.90	218.30	10.86	9.49
Nevada	70	2.30	9.75	39.20	101.50	22.33	24.93
Orange*,+	5,717	3.40	6.50	11.20	477.70	9.65	8.22
Placer	121	6.00	16.00	25.80	402.10	27.72	22.76
Plumas	S	S	S	S	S	S	S
Riverside+	4,013	4.10	10.60	21.80	495.40	16.73	14.97
Sacramento	1,420	4.50	7.70	13.50	474.40	14.49	13.24
San Benito	12	11.00	44.35	47.35	57.10	32.63	42.99
San Bernardino+	3,501	4.20	8.80	20.70	394.00	15.19	14.74
San Diego+	6,610	3.60	6.90	12.60	498.60	10.70	10.21
San Francisco	810	1.90	3.40	6.40	465.60	9.22	9.24
San Joaquin	679	2.30	4.70	11.30	399.10	10.11	11.26
San Luis Obispo*	348	3.50	14.25	27.45	276.40	34.00	25.73
San Mateo*,+	837	3.60	8.90	15.80	449.00	12.40	11.19
Santa Barbara*	697	2.10	4.00	10.10	301.10	17.51	22.16
Santa Clara+	2,539	3.50	6.40	10.70	429.60	10.20	9.13

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance	2019 Average Distance
Santa Cruz*	535	2.10	4.40	16.80	324.40	12.26	14.13
Shasta*	511	2.70	7.00	17.40	599.20	33.46	40.51
Sierra	0	N/A	N/A	N/A	N/A	N/A	S
Siskiyou*	78	11.70	31.25	80.80	588.90	71.52	62.66
Solano*	583	2.60	12.70	24.60	473.20	19.71	15.63
Sonoma*	725	3.30	8.50	18.20	517.20	18.46	15.55
Stanislaus	514	3.60	6.50	13.90	370.00	11.83	12.93
Sutter	66	2.00	4.10	34.00	429.60	23.58	29.46
Tehama	63	16.30	29.50	44.40	177.30	40.82	48.08
Trinity*	26	33.10	37.40	48.40	525.40	70.90	74.65
Tulare	380	2.40	8.60	19.55	284.90	20.67	20.16
Tuolumne	42	3.00	27.30	48.70	284.00	36.20	45.84
Ventura*	1,037	2.70	6.70	14.50	479.20	12.01	11.12
Yolo*	295	2.20	9.20	18.00	478.80	15.36	11.24
Yuba	87	4.60	7.80	35.70	83.70	17.93	31.62

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

- Overall, there were approximately 20,000 fewer short-stay residents in calendar year 2020 than were identified for calendar year 2019. Additionally, this drop in the count of short-stay SNF residents was noted as being most severe during April, May, and June of 2020. This is likely evident of members being less inclined to enter a SNF or that SNFs were less inclined to accept new residents amidst the COVID-19 pandemic, particularly for members that anticipated having a short stay at the facility.[60]
- The statewide average driving distance for short-stay residents increased by 1.10 miles from calendar year 2019 to calendar year 2020.
- For calendar year 2020, while the statewide average driving distance for short-stay residents was 13.64 miles from their place of residence to the facility, at least half of all short-stay residents traveled 7.10 or fewer miles. Because at least 25 percent of long-stay

[60] Werner R, Hoffman A, and Coe N. Long-Term Care Policy after Covid-19—Solving the Nursing Home Crisis. *The New England Journal of Medicine.* Sep 3, 2020. Available at: https://www.nejm.org/doi/full/10.1056/nejmp2014811. Accessed on: Nov 23, 2021.

residents traveled 14.60 miles or more from their place of residence to the facility (with a maximum driving distance of 601.80 miles), 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 29 of the 51 counties with sufficient data (56.9 percent), at least half of all short-stay residents traveled fewer than 10.00 miles from their place of residence during calendar year 2020.

Table 11.9—County-Level Long-Stay SNF Resident Distance Results

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

^ 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.

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

S indicates that the county had fewer than 11 SNF residents during the respective year; therefore, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

* indicates a COHS county

+ indicates a Cal MediConnect county

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance	2019 Average Distance
Statewide	32,883	3.30	8.00	17.50	653.20	17.22	16.80
Alameda	588	3.05	5.25	11.95	456.00	12.24	11.89
Alpine	0	N/A	N/A	N/A	N/A	N/A	N/A
Amador	S	S	S	S	S	S	S
Butte	69	2.90	7.50	39.90	428.50	34.21	78.03
Calaveras	S	S	S	S	S	S	S
Colusa	S	S	S	S	S	S	S
Contra Costa	345	3.20	9.80	17.90	341.90	13.42	16.18
Del Norte*	47	1.10	2.60	81.80	653.20	89.10	104.47
El Dorado	31	11.30	44.70	55.90	174.10	48.73	S
Fresno	390	4.30	11.50	40.60	431.80	45.11	35.37
Glenn	S	S	S	S	S	S	S
Humboldt*	156	6.00	15.65	98.25	627.50	76.43	68.89
Imperial	88	21.05	83.65	90.90	182.80	69.70	74.63

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance	2019 Average Distance
Inyo	S	S	S	S	S	S	S
Kern	230	3.10	10.75	44.30	198.60	33.13	31.83
Kings	32	16.90	33.15	85.15	176.00	53.14	42.72
Lake*	141	6.00	22.10	55.00	451.20	42.13	46.08
Lassen*	19	0.50	25.00	85.00	175.30	45.91	45.40
Los Angeles+	14,145	2.90	7.10	14.50	393.10	11.02	10.78
Madera	26	1.70	16.40	28.40	263.30	35.90	48.30
Marin*	241	3.50	10.30	29.20	425.10	26.32	21.31
Mariposa	S	S	S	S	S	S	S
Mendocino*	147	3.30	37.70	85.10	473.40	58.86	63.10
Merced*	274	2.80	12.15	42.00	372.70	33.04	24.32
Modoc*	24	1.10	1.75	14.25	101.70	14.15	10.77
Mono	0	N/A	N/A	N/A	N/A	N/A	N/A
Monterey*	333	2.80	6.90	23.40	343.60	28.87	25.09
Napa*	153	0.30	3.40	21.10	397.20	23.20	27.61
Nevada	17	2.10	4.80	18.80	54.60	11.91	S
Orange*,+	3,018	3.10	6.90	12.90	413.50	11.77	11.83
Placer	41	5.90	14.70	41.50	399.60	62.40	48.30
Plumas	S	S	S	S	S	S	S
Riverside+	1,822	6.50	16.70	30.70	478.90	22.92	23.05
Sacramento	487	5.40	9.50	17.10	473.90	27.15	25.48
San Benito	S	S	S	S	S	S	S
San Bernardino+	1,904	4.30	10.35	24.50	421.50	17.96	19.25
San Diego+	2,456	3.80	8.80	15.70	469.00	13.52	12.83
San Francisco	352	3.05	5.00	11.65	463.70	15.45	14.46
San Joaquin	236	3.30	6.10	20.00	446.10	28.01	29.78

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance	2019 Average Distance
San Luis Obispo*	172	7.15	14.40	35.25	204.20	39.87	32.38
San Mateo*,+	556	4.50	10.30	19.25	425.30	15.59	15.77
Santa Barbara*	361	2.10	4.70	39.90	230.30	31.64	35.73
Santa Clara+	1,364	3.60	7.00	11.20	360.40	14.42	14.65
Santa Cruz*	233	1.70	4.60	18.70	313.10	22.42	22.28
Shasta*	252	3.55	9.50	68.20	546.20	78.70	79.91
Sierra	S	S	S	S	S	S	S
Siskiyou*	31	30.60	68.10	152.40	565.80	124.93	128.21
Solano*	365	3.40	16.10	26.10	218.50	19.46	22.48
Sonoma*	451	2.90	10.90	28.90	428.80	29.08	31.78
Stanislaus	189	4.70	9.30	22.50	382.40	27.73	27.66
Sutter	26	10.60	34.25	45.80	107.30	37.80	31.89
Tehama	18	22.40	29.75	81.40	128.20	49.79	S
Trinity*	S	S	S	S	S	S	S
Tulare	135	2.60	8.70	21.80	196.50	25.92	26.93
Tuolumne	S	S	S	S	S	S	S
Ventura*	674	3.20	10.15	20.50	316.50	18.76	16.48
Yolo*	166	1.40	9.30	20.20	412.60	25.37	22.79
Yuba	19	3.90	24.60	37.30	91.50	23.99	34.50

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

- The statewide average driving distance for long-stay residents increased by 0.42 miles from calendar year 2019 to calendar year 2020.
- For calendar year 2020, while the statewide average driving distance for long-stay residents was 17.22 miles from their place of residence to the facility, at least half of all long-stay residents traveled 8.00 or fewer miles. Because at least 25 percent of long-stay residents traveled 17.50 miles or more from their place of residence to the facility (with a maximum driving distance of 653.20 miles), 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 21 of the 45 counties with sufficient data (46.7 percent), at least half of long-stay residents traveled fewer than 10.00 miles from their place of residence during calendar year 2020.

Table 11.10 displays the statewide average driving distance for short- and long-stay SNF 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 rural/urban,[61] for calendar years 2019 and 2020.

Table 11.10—Statewide Short- and Long-Stay SNF Resident Distance Results

The average distances are presented in miles.

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

Stratification	2019 Short-Stay SNF Resident Average Distance	2019 Long-Stay SNF Resident Average Distance	2019 Aggregate Average Distance	2020 Short-Stay SNF Resident Average Distance	2020 Long-Stay SNF Resident Average Distance	2020 Aggregate Average Distance
Statewide						
Statewide Average Distance	12.54	16.80	13.68	13.64	17.22	14.92
Resident Characteristics						
Residents with Alzheimer's Disease Diagnosis	10.92	13.32	12.35	11.72	13.98	13.25
Residents with Other Psychiatric Diagnosis	13.97	19.02	15.77	14.59	18.89	16.52

[61] Population density (i.e., rural/urban) is assigned by Quest Analytics based on the member's ZIP Code using Population Density Standards. ZIP Codes with more than 3,000 people per square mile are classified as urban; ZIP Codes with between 1,000 and 3,000 people per square mile are classified as suburban; ZIP Codes with between seven and 1,000 people per square mile are classified as rural; and ZIP Codes with less than seven people per square mile are classified as frontier. For this report, both urban and suburban classifications are considered Urban and both rural and frontier classifications are considered Rural.

Stratification	2019 Short-Stay SNF Resident Average Distance	2019 Long-Stay SNF Resident Average Distance	2019 Aggregate Average Distance	2020 Short-Stay SNF Resident Average Distance	2020 Long-Stay SNF Resident Average Distance	2020 Aggregate Average Distance
Residents with ID/DD Indicated	11.35	19.44	14.79	13.11	20.59	17.07
Hospice Residents	13.66	15.12	14.43	14.81	16.11	15.64
Residents with Life Expectancy of Less Than 6 Months	13.99	15.42	14.75	14.86	15.94	15.55
Location the Resident Entered Facility From						
Community	12.86	18.41	15.30	14.92	18.56	16.49
Another Nursing Home or Swing Bed	N/A	N/A	N/A	N/A	N/A	N/A
Acute Hospital	12.38	15.51	13.17	13.50	16.06	14.38
Psychiatric Hospital	27.63	36.56	33.78	30.00	40.61	38.24
Inpatient Rehabilitation Facility	N/A	N/A	N/A	N/A	N/A	N/A
ID/DD Facility	N/A	N/A	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	N/A	N/A	N/A
LTCH	N/A	N/A	N/A	N/A	N/A	N/A
Other	29.14	34.91	32.77	11.93	37.28	28.25
Rural/Urban						
Rural	23.97	34.37	26.52	24.71	34.56	27.91
Urban	10.13	13.60	11.08	11.16	13.97	12.19

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

- Long-stay SNF residents had a longer average driving distance from their place of residence to a facility than short-stay residents for calendar year 2020. Additionally, this difference in average driving distances has decreased from calendar year 2019.
- Both long- and short-stay SNF residents with the following characteristics had longer than average driving distances from their place of residence to a facility for calendar year 2020:
  - SNF residents who had a psychiatric diagnosis other than Alzheimer's disease
  - SNF residents who entered from the community
  - SNF residents who entered from a psychiatric hospital
  - SNF residents whose place of residence was located in rural areas
- Short- and long-stay SNF residents who resided in rural areas had a longer average driving distance (24.71 and 34.56 miles, respectively) from their place of residence to a facility than SNF residents who resided in urban areas (11.16 and 13.97 miles, respectively). This represents a difference of 13.55 miles on average for short-stay residents and 20.59 miles on average for long-stay residents. However, the difference in average driving distance has decreased from calendar year 2019 for both long- and short-stay residents.

Table 11.11 and Table 11.12 present the statewide and county-level averages and percentiles (i.e., 25th, 50th, 75th, and 100th [maximum distance]) of the driving distances between members in ICFs and their places of residence prior to their ICF admissions, as well as the number of short- and long-stay ICF residents for calendar year 2020.

Table 11.11—County-Level Short-Stay ICF Resident Distance Results

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

^ 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.

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

S indicates that the county had fewer than 11 ICF residents during the respective year; therefore, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

* indicates a COHS county

+ indicates a Cal MediConnect county

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance
Statewide	434	4.40	8.70	20.20	291.90	15.40
Alameda	0	N/A	N/A	N/A	N/A	N/A
Alpine	0	N/A	N/A	N/A	N/A	N/A
Amador	0	N/A	N/A	N/A	N/A	N/A
Butte	0	N/A	N/A	N/A	N/A	N/A
Calaveras	0	N/A	N/A	N/A	N/A	N/A
Colusa	0	N/A	N/A	N/A	N/A	N/A
Contra Costa	S	S	S	S	S	S
Del Norte*	0	N/A	N/A	N/A	N/A	N/A
El Dorado	0	N/A	N/A	N/A	N/A	N/A
Fresno	0	N/A	N/A	N/A	N/A	N/A
Glenn	0	N/A	N/A	N/A	N/A	N/A
Humboldt*	0	N/A	N/A	N/A	N/A	N/A
Imperial	0	N/A	N/A	N/A	N/A	N/A
Inyo	0	N/A	N/A	N/A	N/A	N/A
Kern	S	S	S	S	S	S
Kings	0	N/A	N/A	N/A	N/A	N/A
Lake*	0	N/A	N/A	N/A	N/A	N/A
Lassen*	0	N/A	N/A	N/A	N/A	N/A
Los Angeles+	49	12.00	18.80	37.60	69.80	26.04
Madera	0	N/A	N/A	N/A	N/A	N/A
Marin*	0	N/A	N/A	N/A	N/A	N/A
Mariposa	0	N/A	N/A	N/A	N/A	N/A
Mendocino*	0	N/A	N/A	N/A	N/A	N/A
Merced*	0	N/A	N/A	N/A	N/A	N/A
Modoc*	0	N/A	N/A	N/A	N/A	N/A
Mono	0	N/A	N/A	N/A	N/A	N/A
Monterey*	0	N/A	N/A	N/A	N/A	N/A

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance
Napa*	0	N/A	N/A	N/A	N/A	N/A
Nevada	0	N/A	N/A	N/A	N/A	N/A
Orange*,+	127	5.20	8.30	13.40	32.90	9.79
Placer	0	N/A	N/A	N/A	N/A	N/A
Plumas	0	N/A	N/A	N/A	N/A	N/A
Riverside+	49	20.90	28.40	38.00	69.20	31.29
Sacramento	S	S	S	S	S	S
San Benito	0	N/A	N/A	N/A	N/A	N/A
San Bernardino+	178	2.80	4.75	10.10	64.60	9.56
San Diego+	S	S	S	S	S	S
San Francisco	S	S	S	S	S	S
San Joaquin	0	N/A	N/A	N/A	N/A	N/A
San Luis Obispo*	S	S	S	S	S	S
San Mateo*,+	S	S	S	S	S	S
Santa Barbara*	S	S	S	S	S	S
Santa Clara+	S	S	S	S	S	S
Santa Cruz*	0	N/A	N/A	N/A	N/A	N/A
Shasta*	0	N/A	N/A	N/A	N/A	N/A
Sierra	0	N/A	N/A	N/A	N/A	N/A
Siskiyou*	0	N/A	N/A	N/A	N/A	N/A
Solano*	S	S	S	S	S	S
Sonoma*	S	S	S	S	S	S
Stanislaus	0	N/A	N/A	N/A	N/A	N/A
Sutter	0	N/A	N/A	N/A	N/A	N/A
Tehama	0	N/A	N/A	N/A	N/A	N/A

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance
Trinity*	0	N/A	N/A	N/A	N/A	N/A
Tulare	0	N/A	N/A	N/A	N/A	N/A
Tuolumne	0	N/A	N/A	N/A	N/A	N/A
Ventura*	S	S	S	S	S	S
Yolo*	0	N/A	N/A	N/A	N/A	N/A
Yuba	0	N/A	N/A	N/A	N/A	N/A

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

- For calendar year 2020, while the statewide average driving distance for short-stay ICF residents was 15.40 miles from their place of residence to the facility, at least half of all short-stay residents traveled 8.70 or fewer miles. Because at least 25 percent of short-stay residents traveled 20.20 miles or more from their place of residence to the facility (with a maximum driving distance of 291.90 miles), the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.
- Overall, only 16 of the 58 California counties (27.6 percent) had at least one ICF short-stay resident, with only four of these counties (Los Angeles, Orange, Riverside, and San Bernardino counties) having enough residents (i.e., at least 11 residents) to display travel distances.
  - In two of the four counties with reportable data (Orange and San Bernardino counties), at least half of the ICF short-stay residents traveled fewer than 10.00 miles from their place of residence during calendar year 2020.
- Overall, 48 short-stay ICF residents were excluded from the distance calculation due to having the same place of residence as the ICF address on the date of admission and for months prior to admission. This represents approximately 10 percent of all short-stay ICF residents identified by the analysis and is representative of incomplete data for these ICF stays. Of note, approximately 73.8 percent of these stays may have been excluded if data were complete, as the member's place of residence matched the ICF address prior to March 1, 2018.
  - Approximately 35.4 percent of the ICF short-stay residents with the same place of residence as the ICF address resided in Ventura County—nearly twice as many residents as the next highest county.

Table 11.12—County-Level Long-Stay ICF Resident Distance Results

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

^ 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.

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

S indicates that the county had fewer than 11 ICF residents during the respective year; therefore, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

* indicates a COHS county

+ indicates a Cal MediConnect county

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance
Statewide	837	5.00	10.30	20.40	478.80	21.06
Alameda	S	S	S	S	S	S
Alpine	0	N/A	N/A	N/A	N/A	N/A
Amador	0	N/A	N/A	N/A	N/A	N/A
Butte	S	S	S	S	S	S
Calaveras	0	N/A	N/A	N/A	N/A	N/A
Colusa	0	N/A	N/A	N/A	N/A	N/A
Contra Costa	S	S	S	S	S	S
Del Norte*	0	N/A	N/A	N/A	N/A	N/A
El Dorado	0	N/A	N/A	N/A	N/A	N/A
Fresno	S	S	S	S	S	S
Glenn	0	N/A	N/A	N/A	N/A	N/A
Humboldt*	S	S	S	S	S	S
Imperial	0	N/A	N/A	N/A	N/A	N/A
Inyo	0	N/A	N/A	N/A	N/A	N/A
Kern	S	S	S	S	S	S
Kings	S	S	S	S	S	S
Lake*	0	N/A	N/A	N/A	N/A	N/A
Lassen*	0	N/A	N/A	N/A	N/A	N/A

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance
Los Angeles+	168	5.60	10.95	18.45	122.10	15.39
Madera	S	S	S	S	S	S
Marin*	S	S	S	S	S	S
Mariposa	0	N/A	N/A	N/A	N/A	N/A
Mendocino*	0	N/A	N/A	N/A	N/A	N/A
Merced*	13	1.70	5.40	30.90	122.20	22.92
Modoc*	0	N/A	N/A	N/A	N/A	N/A
Mono	0	N/A	N/A	N/A	N/A	N/A
Monterey*	S	S	S	S	S	S
Napa*	S	S	S	S	S	S
Nevada	0	N/A	N/A	N/A	N/A	N/A
Orange*,+	236	5.00	8.85	16.10	87.60	12.23
Placer	S	S	S	S	S	S
Plumas	0	N/A	N/A	N/A	N/A	N/A
Riverside+	38	20.00	24.45	30.70	80.90	28.46
Sacramento	S	S	S	S	S	S
San Benito	0	N/A	N/A	N/A	N/A	N/A
San Bernardino+	81	4.20	10.90	27.10	78.50	17.91
San Diego+	37	5.50	11.90	23.80	91.30	22.29
San Francisco	0	N/A	N/A	N/A	N/A	N/A
San Joaquin	S	S	S	S	S	S
San Luis Obispo*	28	3.45	12.40	15.30	104.90	13.04
San Mateo*,+	23	2.10	13.00	14.90	22.80	9.47
Santa Barbara*	13	9.70	16.00	33.50	104.50	27.16
Santa Clara+	13	8.70	10.30	17.90	68.10	16.70

County	Number of Residents^	2020 25th Percentile	2020 50th Percentile	2020 75th Percentile	2020 Maximum Distance	2020 Average Distance
Santa Cruz*	S	S	S	S	S	S
Shasta*	15	5.50	7.00	10.30	63.70	17.60
Sierra	0	N/A	N/A	N/A	N/A	N/A
Siskiyou*	0	N/A	N/A	N/A	N/A	N/A
Solano*	16	3.35	9.35	19.35	444.00	40.34
Sonoma*	30	8.90	26.60	241.60	478.80	101.54
Stanislaus	S	S	S	S	S	S
Sutter	0	N/A	N/A	N/A	N/A	N/A
Tehama	S	S	S	S	S	S
Trinity*	S	S	S	S	S	S
Tulare	S	S	S	S	S	S
Tuolumne	0	N/A	N/A	N/A	N/A	N/A
Ventura*	55	1.00	5.30	18.70	116.50	11.62
Yolo*	S	S	S	S	S	S
Yuba	0	N/A	N/A	N/A	N/A	N/A

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

- For calendar year 2020, while the statewide average driving distance for long-stay ICF residents was 21.06 miles from their place of residence to the facility, at least half of all long-stay residents traveled 10.30 or fewer miles. Because at least 25 percent of long-stay ICF residents traveled 20.40 miles or more from their place of residence to the facility (with a maximum driving distance of 478.80 miles), the average is a less reliable indicator of the typical distance traveled, and the median (50th percentile) more accurately represents the typical distance traveled.
- Overall, 34 of the 58 California counties (58.6 percent) had at least one ICF long-stay resident, with only 14 of these counties having enough residents (i.e., at least 11 residents) to display travel distances.
  - In five of the 14 counties with reportable data (35.7 percent), at least half of the ICF long-stay residents in those counties traveled fewer than 10.00 miles from their place of residence during calendar year 2020.
- Overall, 383 long-stay ICF residents were excluded from the distance calculation due to having the same place of residence as the ICF address on the date of admission and for

months prior to admission. This represents approximately 31.4 percent of all long-stay ICF residents identified by the analysis and is representative of incomplete data for these ICF stays. Of note, approximately 74.2 percent of these stays may have been excluded if data were complete, as the member's place of residence matched the ICF address prior to March 1, 2018.

- Approximately 33.7 percent of the long-stay ICF residents with the same place of residence as the ICF address resided in Ventura County—more than twice as many residents as the next highest county.

Table 11.13 displays the calendar year 2020 statewide average driving distance for short- and long-stay ICF residents along with the aggregate average driving distance (i.e., short- and long-stay residents combined) stratified by rural/urban. Please note, due to the different data sources used for calculating SNF and ICF distance results (i.e., MDS data for SNF and claims/encounter data for ICF), the ICF distance results are only stratified by rural/urban at this time.

Table 11.13—Statewide Short- and Long-Stay ICF Resident Distance Results

The average distances are presented in miles.

Stratification	2020 Short-Stay ICF Resident Average Distance	2020 Long-Stay ICF Resident Average Distance	2020 Aggregate Average Distance
Statewide			
Statewide Average Distance	15.40	21.06	19.13
Rural/Urban			
Rural	30.02	24.26	25.68
Urban	13.50	20.34	17.88

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

- Long-stay ICF residents had a longer average driving distance from their place of residence to a facility than short-stay residents for calendar year 2020.
- Short- and long-stay ICF residents who resided in rural areas had a longer average driving distance (30.02 and 24.26 miles, respectively) from their place of residence to a facility than ICF residents who resided in urban areas (13.50 and 20.34 miles, respectively). This represents a difference of 16.52 miles on average for short-stay residents and 3.92 miles on average for long-stay residents.
  - Further, short-stay ICF residents who resided in rural areas traveled over twice as far as short-stay ICF residents who resided in urban areas. Also, short-stay ICF residents who resided in rural areas traveled further than long-stay ICF residents who resided in rural areas.

Recommendations and Items for Consideration

Based on the results of the 2020–21 SNF Experience and SNF/ICF Distance analyses, HSAG developed the following recommendations for DHCS:

- The SNF Experience results showed that 19.54 percent of long-stay SNF residents had a hospital admission from their SNF during calendar year 2020. Given that many hospitalizations from SNFs are preventable/avoidable,[62] further analysis is needed to understand why these hospitalizations are occurring. DHCS should consider analyzing these hospitalizations using MDS discharge assessments, primary diagnoses codes on the claim/encounter for the hospital admission from the SNF, and the services received in the hospital. By leveraging additional data, DHCS can begin to understand the reasons why Medi-Cal members are admitted to hospitals from their SNFs and determine if the reason the member was admitted to the hospital could have been managed within the SNF.
- Approximately 25 percent of ICF stays were excluded from the ICF distance analysis due to the resident having the same place of residence as the ICF address on the date of admission and for months prior to admission. Consequently, DHCS should work with MCPs to investigate potential data completeness issues, particularly in Ventura County, where residents with the same place of residence as the ICF address were most frequently identified.

Based on the results of the 2020–21 SNF Experience and SNF/ICF Distance analyses, HSAG offers the following for DHCS' consideration:

- The calendar year 2020 SNF Distance results demonstrate large differences in the median distance traveled for rural and urban counties for both short- and long-stay residents. For example, long-stay residents in Los Angeles County had a median distance traveled of 7.10 miles to their SNF, while long-stay residents in Imperial County had a median distance traveled of 83.65 miles to their SNF. Given that DHCS may set time and distance traveled standards for LTC facilities once all MCPs (not just those in COHS and Cal MediConnect counties) are medically responsible for all care to members in LTC, DHCS should consider performing an analysis to determine appropriate time and distance standards for rural and urban counties. As part of this analysis, DHCS should also consider the populations served by the SNF (e.g., psychiatric, Alzheimer's and dementia care) as the populations served could dictate why a member selects a particular SNF and subsequently why members may travel to a SNF further away from their place of residence.
  - Additionally, DHCS should consider classifying SNFs by the populations they serve (e.g., Alzheimer's/dementia care, psychiatric) and make the information easily accessible to members to use when selecting a SNF.

[62] Medicare Payment Advisory Commission. Chapter 9: Hospital and SNF use by Medicare beneficiaries who reside in nursing facilities, June 2017. Available at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch9.pdf. Accessed on: Nov 24, 2021.

- DHCS should consider avoiding setting time/distance standards for ICFs based on the results of the ICF distance analysis. Only 32 of the 58 counties (55.2 percent) had an eligible ICF in the CHHS facility file, so time/distance standards may not be achievable for all MCPs in all counties.
- To analyze ICF residents' experience, DHCS should consider developing a resident assessment that would be administered to all ICF residents and collect information related to physical and mental health, cognitive status, nutrition, and living environment. DHCS should seek input from clinical experts and stakeholders to develop the assessment and determine how to operationalize it.
- The SNF/ICF distance analysis is limited to those members enrolled in Medi-Cal at the time of admission to the SNF or ICF. When setting time/distance standards, DHCS may want to consider adding margins when interpreting these results to account not only for these members but also for those who are not currently eligible for Medi-Cal but would become eligible after being admitted to an SNF or ICF. This approach would allow for standards that are more generalizable to the target population.

12. Health Disparities Study

Background

Health disparities reflect gaps in the quality of care between populations.[63] To assess and improve health disparities, DHCS contracted with HSAG to conduct a health disparities study using the MCAS measures reported by the 25 MCPs[64] for measurement year 2020 with data derived from calendar year 2020. MCAS measures reflect the clinical quality, timeliness, and accessibility of care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. 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. The analysis did not include data for fee-for-service beneficiaries in Medi-Cal.

To identify and understand health disparities affecting Medi-Cal members, it is important to consider the MCMC population mix. In 2020, the approximate racial/ethnic distribution of the MCMC population consisted of the following racial/ethnic groups: Hispanic or Latino (48.7 percent), White (18.7 percent), Other or Unknown (14.7 percent), Asian (8.8 percent), Black or African American (7.7 percent), and Native Hawaiian or Other Pacific Islander (1.5 percent). In addition, the MCMC's age distribution in 2020 was as follows: 18-year-olds and younger (40.4 percent), 19-to-64-year-olds (50.8 percent), and 65 and older (8.8 percent).[65]

The *2020 Health Disparities Report* includes the detailed study methodology, findings, and items for DHCS' consideration.[66] Following are high-level summaries of the study methodology; DHCS' health disparities vision and guiding principles; COVID-19 cases; and study key findings, conclusions, and considerations.

[63] Kilbourne AM, Switzer G, Hyman K, et al. Advancing health disparities research within the health care system: A conceptual framework. *American Journal of Public Health.* 2006; 96:2113-2121. Available at: https://doi.org/10.2105/AJPH.2005.077628. Accessed on: Oct 18, 2021.

[64] Only the Medi-Cal MCPs that provide the full scope of Medi-Cal benefits were included in this study (i.e., the three PSPs and one SHP were excluded).

[65] Managed Care Performance Monitoring Dashboard Report, July 2021. Available at: https://data.chhs.ca.gov/dataset/managed-care-performance-monitoring-dashboard-report/resource/bf3c1774-6b11-4def-bf7f-76fc6a3e1a63. Accessed on: Oct 18, 2021.

[66] Health Services Advisory Group, Inc. *2020 Health Disparities Report*. Managed Care Quality and Monitoring Division: California Department of Health Care Services; December 2021. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2020-21-Health-Disparities-Report.pdf. Accessed on: Jan 11, 2022.

Methodology

For the 2020–21 contract year, HSAG evaluated indicator data collected for measurement year 2020 at the statewide level. HSAG aggregated the results from the 25 MCPs and then stratified these statewide rates for all indicators by demographic stratifications (i.e., race/ethnicity, primary language, age, gender, and SPD/non-SPD), where applicable. HSAG evaluated 35 indicators from the MCAS for racial/ethnic health disparities.

Although HSAG stratified all indicators by race/ethnicity, primary language, age, gender, and SPD/non-SPD, where applicable, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification.

Data Sources

HSAG received a California-required patient-level detail file from each MCP for each HEDIS reporting unit containing member-level information. HSAG validated the patient-level detail files to ensure the numerator and denominator counts matched what was reported by MCPs in the audited HEDIS Interactive Data Submission System files and non-HEDIS MS Excel reporting files. Additionally, DHCS provided supplemental files with demographic data (e.g., date of birth, gender, ZIP Code, race/ethnicity, primary language) from DHCS' Management Information System/Decision Support System data system. For the SPD/non-SPD stratification for the *Ambulatory Care* and *Plan All-Cause Readmissions* indicators, HSAG used the audited SPD and non-SPD rates all MCPs were required to report for measurement year 2020 using the SPD MS Excel reporting file.

Statistical Analysis

Using the member-level files created from matching the demographic records with the indicator files, HSAG performed a statewide-level health disparity analysis of the racial/ethnic demographic stratification using national benchmarks and calculating a 95 percent confidence interval around each racial/ethnic group's rate. HSAG calculated a statewide aggregate for each MCAS indicator by summing the numerators and denominators reported by each MCP reporting unit.

For this study, a health disparity was defined as a rate for a racial/ethnic group that was worse than the reference rate (i.e., the minimum performance level or median State performance rate) and the upper interval of the 95 percent confidence interval was below the minimum performance level/median State performance rate. If the upper interval of the 95 percent confidence interval was at or above the minimum performance level/median State performance rate, then no disparity was identified.

Medi-Cal Managed Care Program and Health Disparities

DHCS' vision is to preserve and improve the health of all Californians. DHCS focuses on three interconnected guiding principles to advance this vision:[67]

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability, and member involvement

Based on these guiding principles, DHCS established the following goals related to preserving and improving the health of all Californians:

- Engage members as owners of their own care
- Keep families and communities healthy via preventive care
- Provide early interventions for rising risk and patient-centered chronic disease management
- Provide whole person care for high-risk populations, including addressing drivers of health

COVID-19 Summary

Over the course of 2020, the COVID-19 pandemic had a detrimental impact on the entire health care system, including limited access to care, overburdened hospitals, and fatigued essential workers. Additionally, vulnerable populations experienced disproportionate effects, as evidenced by health disparities for COVID-19 cases, hospitalizations, and deaths widening nationally for certain racial/ethnic groups, lower socioeconomic status populations, and disabled individuals.[68] Vulnerable populations within California were also disproportionately impacted by the pandemic with higher population-adjusted rates of cases and deaths for the Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Black or African American groups, and lower income communities.[69] The MCMC population has also experienced disparate hospitalization and case rates among vulnerable groups.

DHCS provided the counts of confirmed COVID-19 cases and hospitalizations for the MCMC population and MCMC aged, blind, and disabled (ABD) population stratified by select

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[67] *State of California Department of Health Care Services. Comprehensive Quality Strategy: Draft Report for Public Comment, November 2019*. Available at: DRAFT-DHCS-Comprehensive-Quality-Strategy.pdf. Accessed on: Nov 23, 2021.

[68] Centers for Disease Control and Prevention. Introduction to COVID-19 racial and ethnic health disparities. Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html. Accessed on: Oct 12, 2021.

[69] California All. California's commitment to health equity. Available at: https://covid19.ca.gov/equity/. Accessed on: Oct 12, 2021.

demographics (i.e., gender, age, and race), which were used to derive the percentages of total confirmed COVID-19 cases and hospitalizations as presented in Figure 12.1 through Figure 12.6. Please note, for COVID-19 cases and hospitalizations stratified by race, DHCS grouped the Asian and Pacific Islander races together; however, for the Health Disparities Study, HSAG presents these groups separately as Asian and Native Hawaiian or Pacific Islander. Therefore, please exercise caution when assessing the confirmed COVID-19 cases and hospitalizations by race.

Figure 12.1—Confirmed COVID-19 Cases by Gender

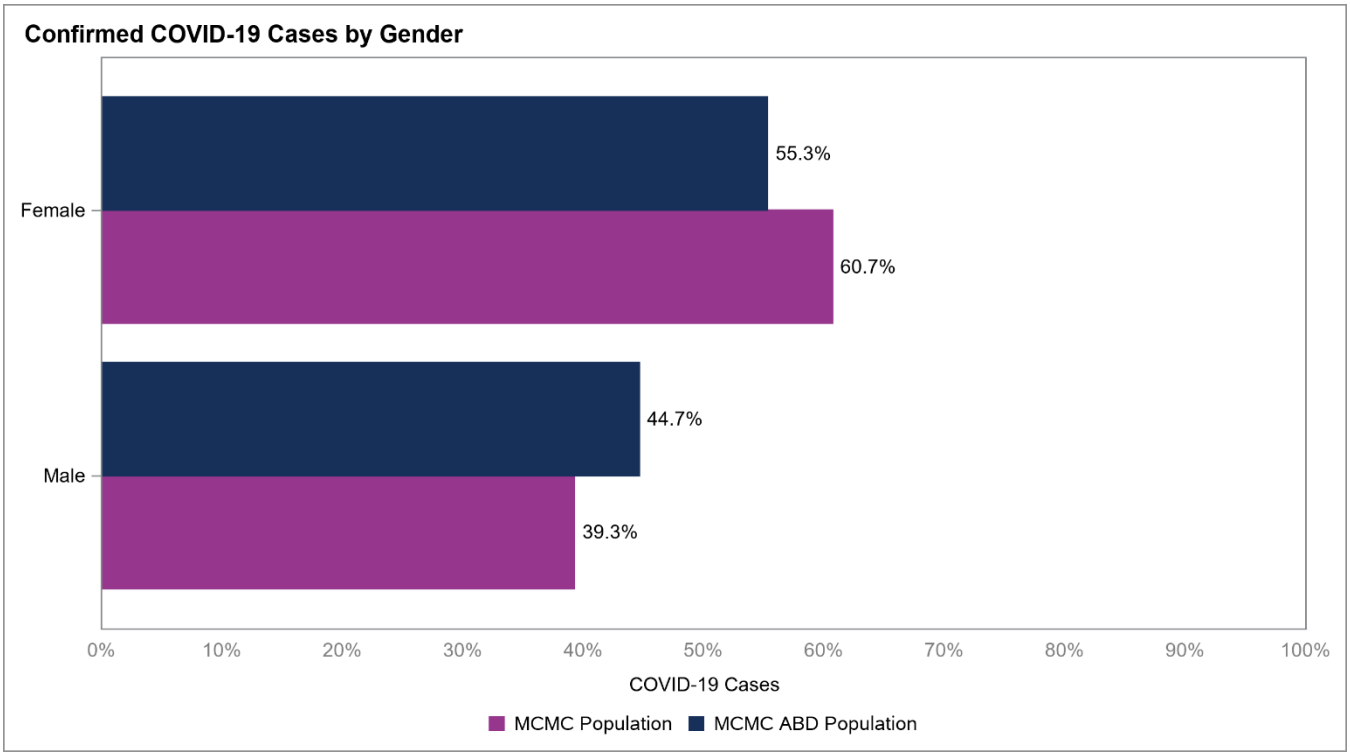


Figure 12.2—Confirmed COVID-19 Cases by Age

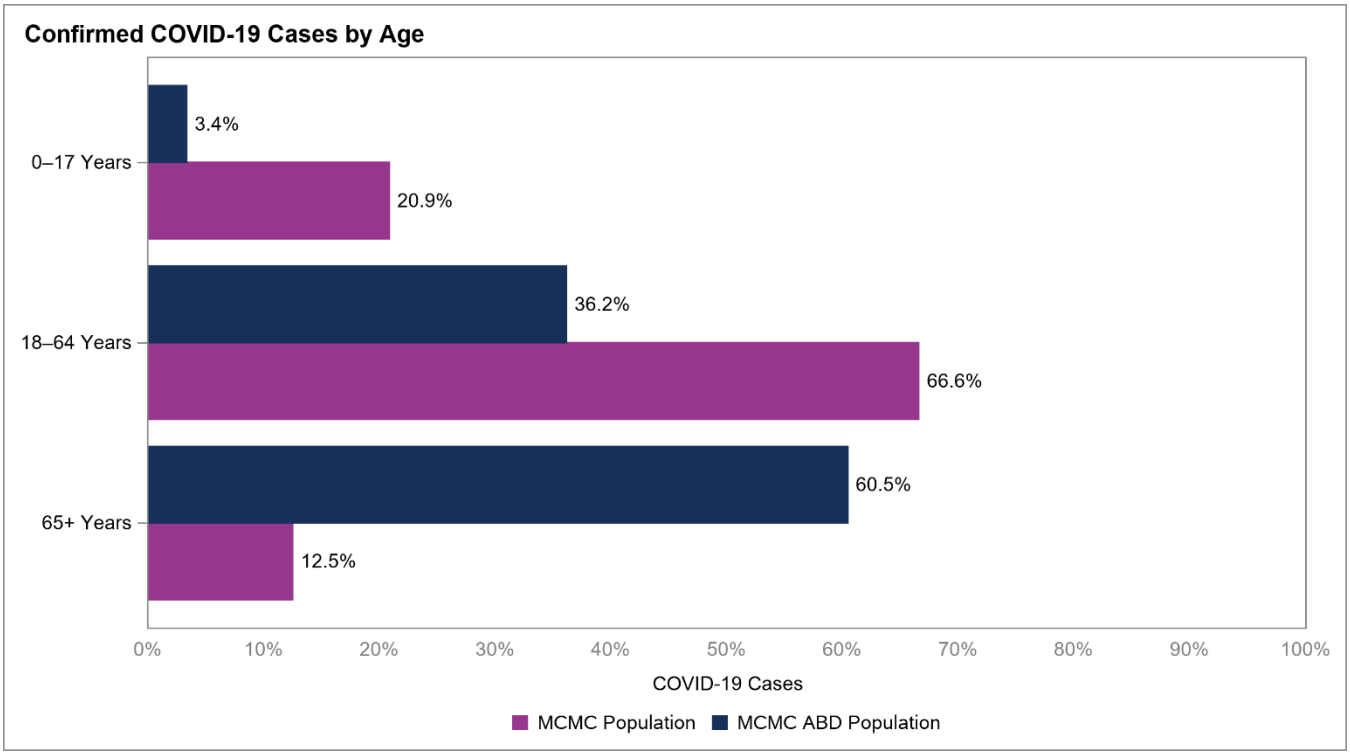


Figure 12.3—Confirmed COVID-19 Cases by Race

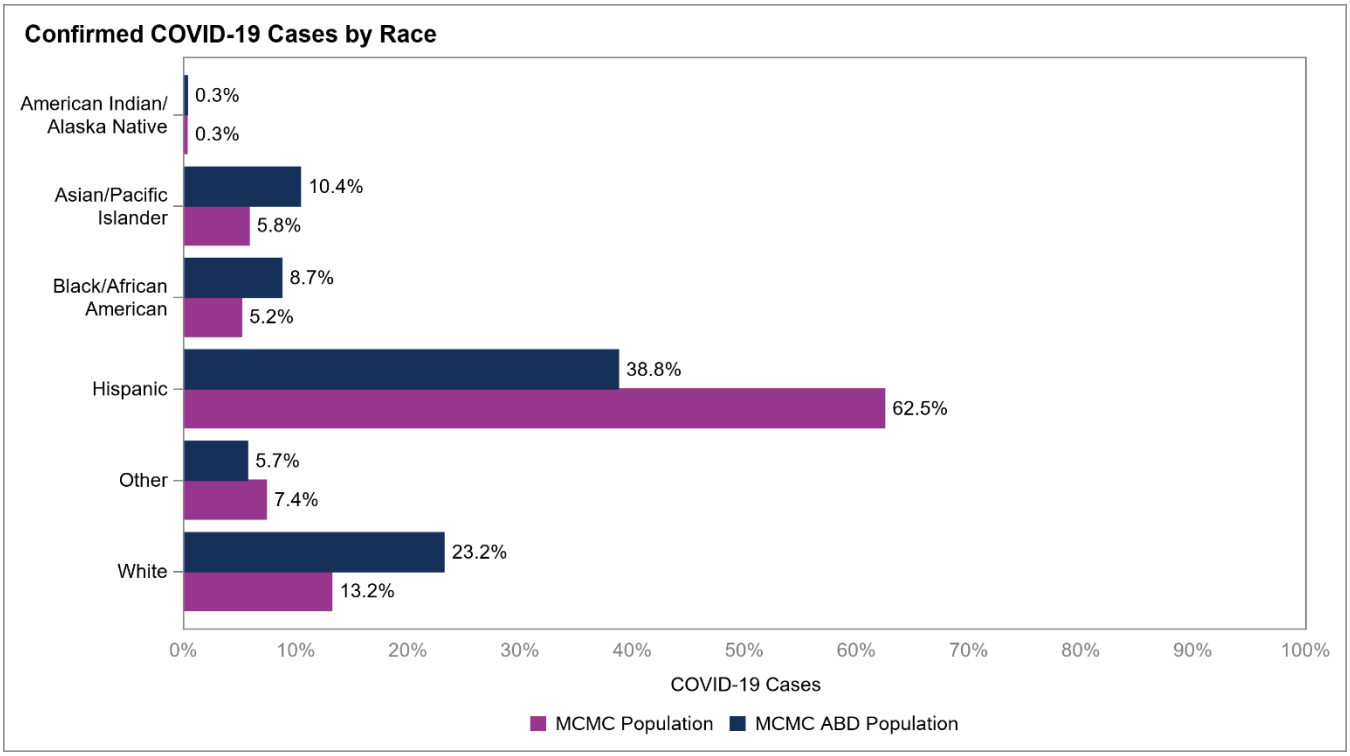


Figure 12.4—Confirmed COVID-19 Hospitalizations by Gender

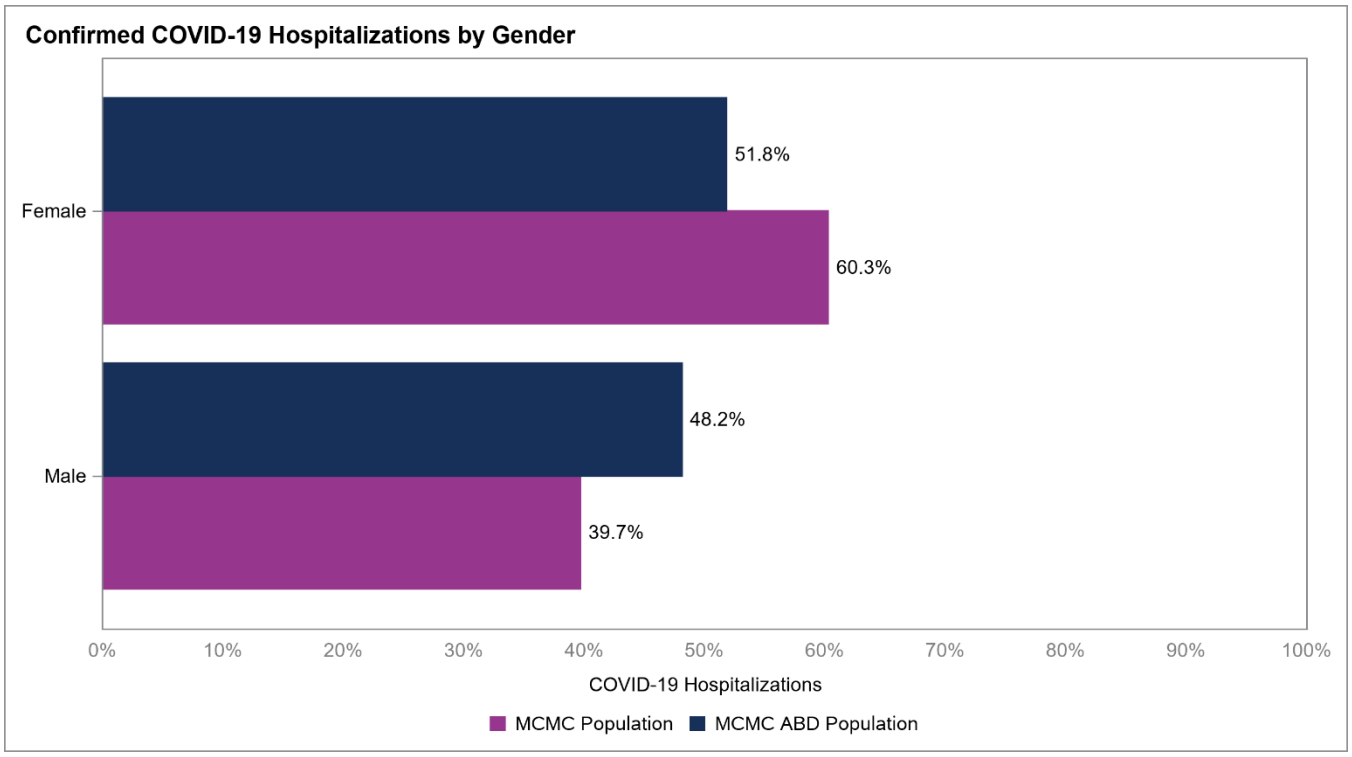


Figure 12.5—Confirmed COVID-19 Hospitalizations by Age

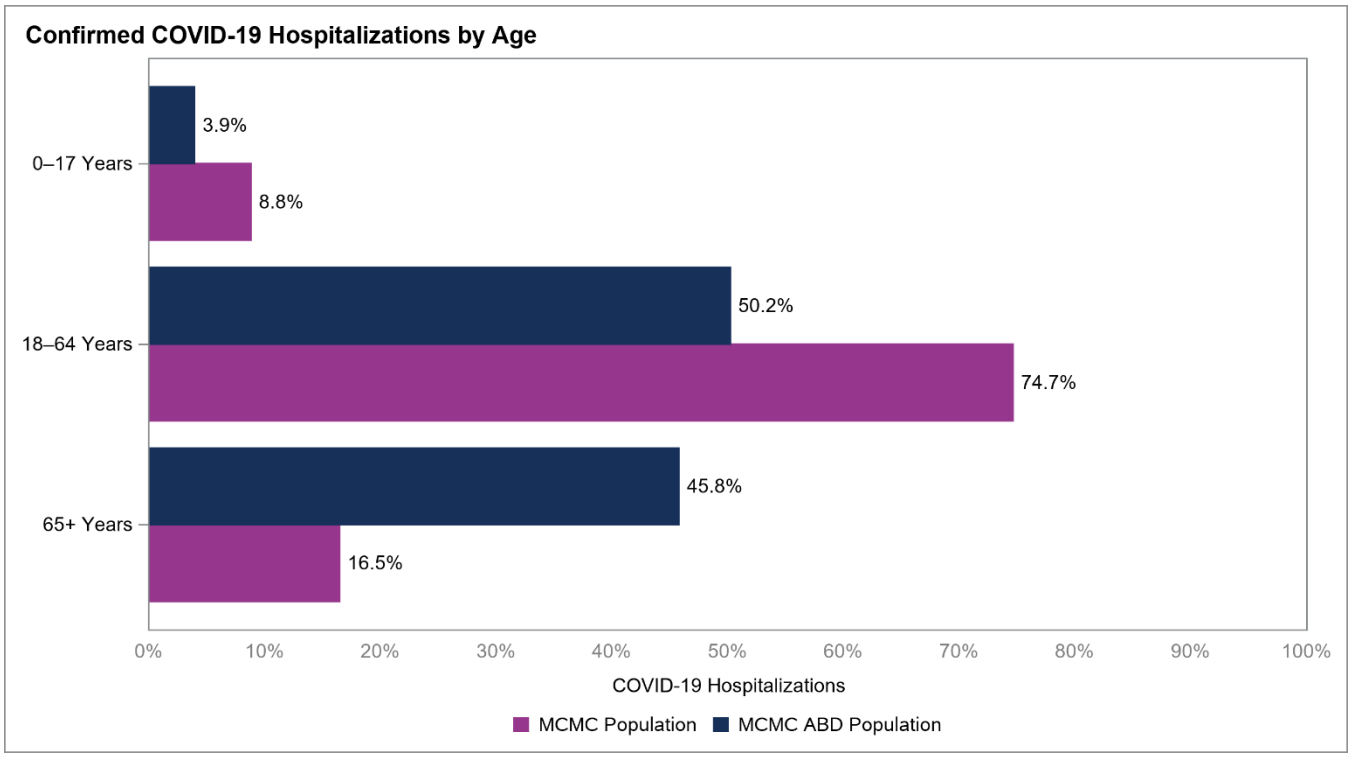
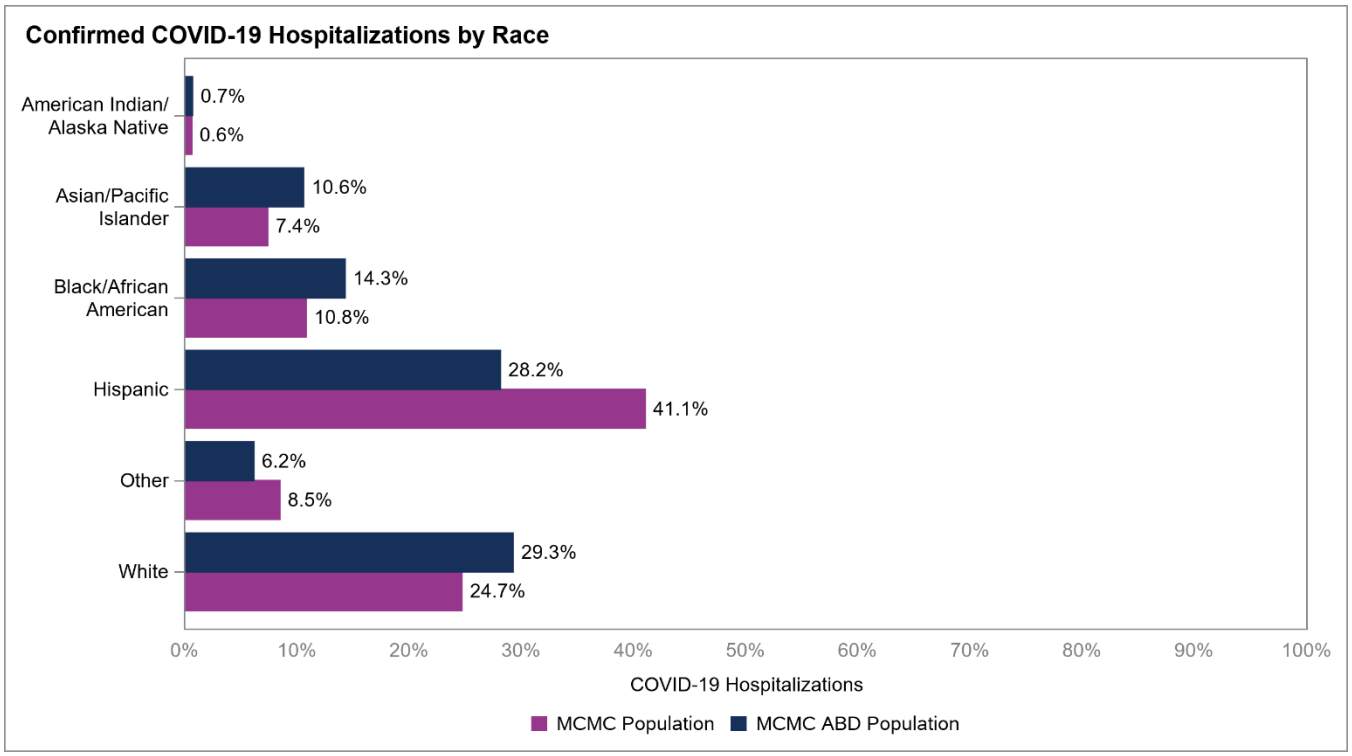


Figure 12.6—Confirmed COVID-19 Hospitalizations by Race

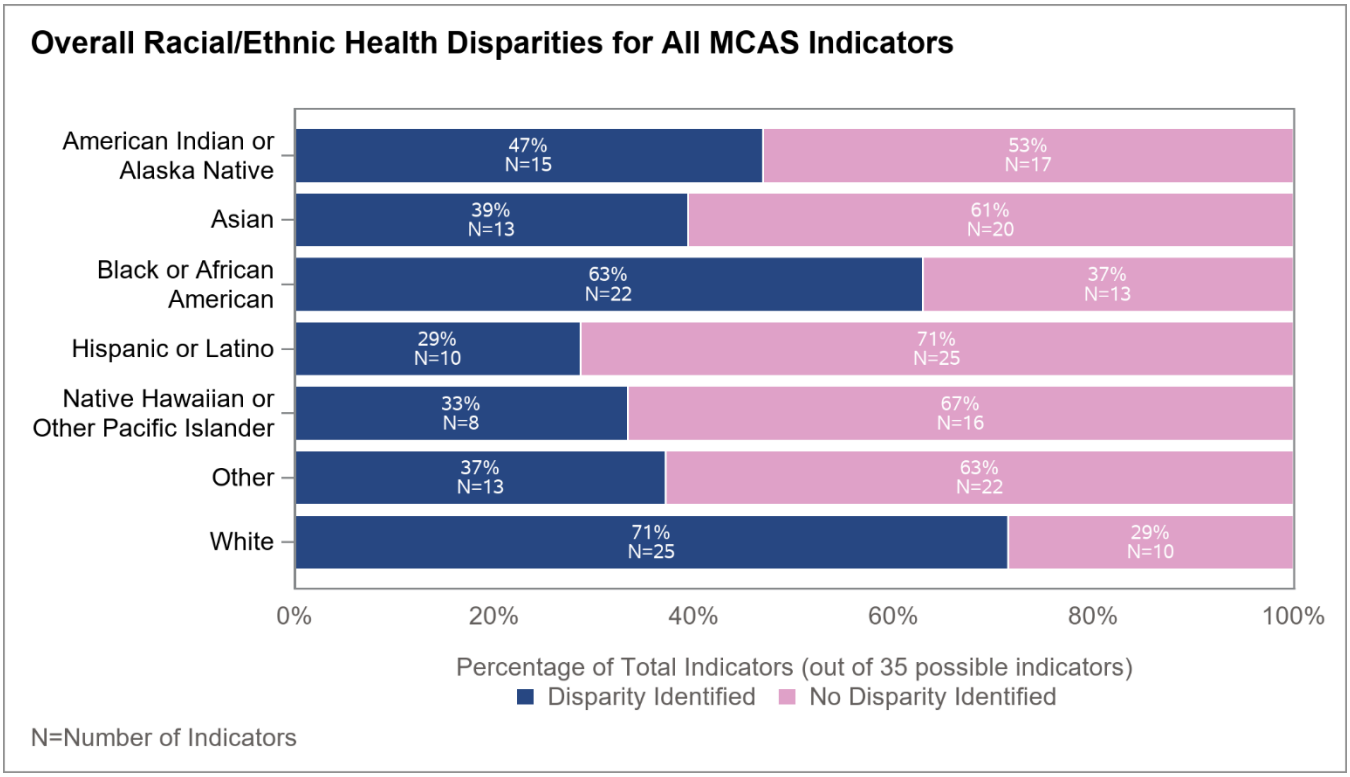


Key Findings—Health Disparities Study

Health disparities were identified when indicator rates for racial/ethnic groups were below the minimum performance level/median state performance rate (i.e., the upper bound of the 95 percent confidence interval for the rate was below the national reference rate). If a racial/ethnic group's indicator rate was equal to or higher than the minimum performance level/median state performance rate, then no health disparity was identified. Figure 12.7 displays the percentage and number of indicators (out of 35 possible indicators) for which a disparity was identified or no disparity was identified.

Figure 12.7—Overall Racial/Ethnic Disparities for All MCAS Indicators

Note: Due to small numerators or denominators, the American Indian or Alaska Native (N=32), Asian (N=33), and Native Hawaiian or Other Pacific Islander (N=24) groups were not evaluated for health disparities for all 35 possible indicators.



American Indian or Alaska Native

- Disparities were identified for 15 of the 32 indicators (46.9 percent) evaluated in measurement year 2020 for the American Indian or Alaska Native group.
- For the following domains, disparities were identified for a majority of the indicator rates for the American Indian or Alaska Native group:
  - Children's Health
  - Women's Health

Asian

- Disparities were identified for 13 of the 33 indicators (39.4 percent) evaluated in measurement year 2020 for the Asian group.
- For the Women's Health domain, disparities were identified for a majority of the indicator rates for the Asian group.

Black or African American

- Disparities were identified for 22 of the 35 indicators (62.9 percent) evaluated in measurement year 2020 for the Black or African American group.
- For the following domains, disparities were identified for a majority of the indicator rates for the Black or African American group:
  - Children's Health
  - Women's Health
  - Acute and Chronic Disease Management

Hispanic or Latino

- Disparities were identified for 10 of the 35 indicators (28.6 percent) evaluated in measurement year 2020 for the Hispanic or Latino group.
- There were no domains where a majority of the indicator rates for the Hispanic or Latino group exhibited a disparity.

Native Hawaiian or Other Pacific Islander

- Disparities were identified for eight of the 24 indicators (33.3 percent) evaluated in measurement year 2020 for the Native Hawaiian or Other Pacific Islander group.
- For the Women's Health domain, disparities were identified for a majority of the indicator rates for the Native Hawaiian or Other Pacific Islander group.

Other

- Disparities were identified for 13 of the 35 indicators (37.1 percent) evaluated in measurement year 2020 for the Other group.
- There were no domains where a majority of the indicator rates for the Other group exhibited a disparity.

White

- Disparities were identified for 25 of the 35 indicators (71.4 percent) evaluated in measurement year 2020 for the White group.
- For the following domains, disparities were identified for a majority of the indicator rates for the White group:
  - Children's Health
  - Women's Health
  - Acute and Chronic Disease Management

Conclusions—Health Disparities Study

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

- The Hispanic or Latino group, the largest racial/ethnic group among Medi-Cal managed care members, exhibited the lowest rate of disparities identified out of all racial/ethnic groups, with disparities identified for only 10 of the 35 indicator rates (28.6 percent).
- Health disparities for the White and Black or African American groups represent areas for overall improvement. The White and Black or African American groups were the only racial/ethnic groups with disparities identified for a majority of indicators. Rates for the White and Black or African American groups were lower than the respective reference rates for 25 of the 35 indicators (71.4 percent) and 22 of the 35 indicator rates (62.8 percent), respectively.
  - Both the White and Black or African American groups had disparities identified for all six indicators within the Children's Health domain.
- The Native Hawaiian or Other Pacific Islander group exhibited the lowest number of disparities identified (eight out of 24 indicators) among all of the racial/ethnic groups. However, this is primarily due to 11 of the 35 possible indicators (31.4 percent) for the Native Hawaiian or Other Pacific Islander group not being evaluated for health disparities due to small numerators or denominators.
  - Additionally, both the Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native groups had smaller denominators than the other racial/ethnic groups for all indicators, resulting in wider confidence intervals for these two groups. As a result, nine indicator rates for the Native Hawaiian or Other Pacific Islander group and seven indicator rates for the American Indian or Alaska Native group were not classified as disparities despite the rates being below the reference rates.
- The overall counts of disparities for each racial/ethnic group are heavily influenced by each racial/ethnic group's performance for the *Contraceptive Care* indicators given these indicators account for 12 of the 35 indicators (34.3 percent) included in the study. Of note, 49 of the 106 disparities identified (46.2 percent) were for the *Contraceptive Care* indicators. Given that the choice to use contraceptive medications is heavily impacted by member preference, low performance for these indicators may not be indicative of MCP performance.
- The Children's Health domain represents an area of overall opportunity for improvement, with rates for at least two racial/ethnic groups falling below the reference rates for each indicator within the domain. Additionally, all seven racial/ethnic groups and five of the seven racial/ethnic groups (71.4 percent) had disparities identified for the *Developmental Screening in the First Three Years of Life—Total* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* indicators, respectively.
- The Women's Health domain represents an area of overall opportunity for improvement, with the majority of rates for every racial/ethnic group, except the Hispanic or Latino group, within the domain being identified as a disparity. Of note, for the *Breast Cancer Screening*

and *Cervical Cancer Screening* indicators, five of the seven racial/ethnic groups (71.4 percent) had disparities identified.

- The Behavioral Health domain represents an area of overall strength. Within this domain, no racial/ethnic group had more than two disparities identified (out of eight indicators). However, within this domain the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator represents an area of opportunity for improvement. All racial/ethnic group rates were below the minimum performance level and six of seven racial/ethnic groups had a disparity identified for this indicator.
- The *Antidepressant Medication Management–Effective Acute Phase Treatment*, *Concurrent Use of Opioids and Benzodiazepines*, and *Use of Opioids at High Dosage in Persons Without Cancer* indicators were identified as areas of overall high performance. For all three of these indicators, no racial/ethnic groups had rates that were identified as disparities.

Considerations—Health Disparities Study

Based on the overall conclusions for the Medi-Cal health disparities analysis, DHCS should continue undertaking the following to improve health care quality:

- While disparities were identified for 22 of 42 racial/ethnic rates (52.4 percent) and 65 of 109 racial/ethnic rates (59.6 percent) for the indicators in the Children's Health and Women's Health domains, respectively, DHCS is currently working with MCPs to implement several quality improvement efforts aimed at improving access to preventive care, including the following:
  - DHCS and the MCPs launched the Preventive Services Outreach campaign in 2020. Via outreach calls and educational materials, the campaign aims to educate the parents/guardians of children about the timing and availability of necessary child preventive services.
  - DHCS requires the MCPs to conduct an annual PNA aimed at improving health outcomes for all members, including the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and racial/ethnic backgrounds. MCPs must use plan-level disparities data to help inform the PNA and use PNA findings to identify opportunities for improvement and take action to address them.
  - DHCS requires MCPs to conduct two PIPs—one focusing on improving child and adolescent health and one on an identified health disparity.
  - As part of the CalAIM initiative that DHCS will implement in early 2022, each MCP will be required to create or maintain a population health management program and submit a description of the MCP's population health management plan to DHCS annually.[70]

[70] California Department of Health Care Services. Medi-Cal Healthier California for All Proposal. Available at: PHM-Revised-Proposal-02112020.pdf. Accessed on: Nov 30, 2021.

Each MCP's population health management plan must include how the MCP will accomplish the following:

- Identify and assess member health risks and needs on an ongoing basis
- Keep all members healthy by focusing on preventive and wellness services
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination
- Identify and mitigate social drivers of health
- Reduce health disparities or inequities

- The improvement efforts described above were impacted by the COVID-19 pandemic; therefore, DHCS should continue monitoring and evaluating the outcomes of these improvement efforts over time to determine their impact on the disparities HSAG identified in this *2020 Health Disparities Report*.

Further, DHCS should consider the following to continue to close gaps in disparities:

- For measures with widespread low performance (e.g., *Breast Cancer Screening*, *Cervical Cancer Screening*), DHCS should consider working with MCPs to assess if current MCP initiatives aimed at improving performance need to be revised or if more time is needed for these initiatives to impact outcomes.
- More than 75 percent of indicator rates for the Black or African American, White, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander groups were below the reference rates, regardless if disparities were identified. As a result, DHCS should consider working with MCPs that serve larger proportions of these racial/ethnic groups to identify the causes of the low performance and assess if current MCP quality improvement strategies are designed to address the causes or if the MCPs need to modify their strategies to improve care for these racial/ethnic groups.

13. Preventive Services Study

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 MCMC. The audit report recommended that DHCS expand the performance measures it collects and reports on to ensure all age groups receive preventive services from MCPs.[71] In response to this recommendation, DHCS requested that HSAG produce an annual Preventive Services Report beginning in 2020. This report is published on the DHCS website annually.

2020 Preventive Services Study Addendum

HSAG included a summary of the 2020 Preventive Services Study results in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report* released in April 2021. In addition to the results presented in the 2019–20 EQR technical report, DHCS contracted with HSAG to develop an addendum to the *2020 Preventive Services Report*. The addendum presents the DHCS-calculated *Blood Lead Screening* rates, which were calculated in accordance with California Title 17 requirements[72] as well as following the national Medicaid HEDIS technical specifications.

The addendum also presents the MCP reporting unit-level results for the six HSAG-calculated indicators included in the *2020 Preventive Services Report*:

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits*
- *Child and Adolescent Well-Care Visits—Total*
- *Alcohol Use Screening*
- *Dental Fluoride Varnish*
- *Tobacco Use Screening*

[71] 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: Dec 13, 2021.

[72] Title 17, California Code of Regulations Section 37100 (b)(2)

The *2020 Preventive Services Report Addendum* includes the detailed results and analyses for the blood lead screening and six HSAG-calculated indicators.[73] Following is a summary of the overall findings and conclusions from DHCS' blood lead screening analyses.

Findings and Conclusions—2020 Preventive Services Study Addendum Blood Lead Screening

- The majority of children in Medi-Cal managed care get blood lead screenings by their second birthday.
  - Statewide performance of children in Medi-Cal managed care, based on the HEDIS *Lead Screening in Children* indicator, found that approximately 60.8 percent of children who turned 2 years of age during calendar year 2019 received a blood lead screening before their second birthday.
    - Although the majority of children receive a lead screening, California has an opportunity to improve. The national Medicaid benchmark for the HEDIS *Lead Screening in Children* indicator is 73.1 percent and represents the 50th percentile. California's statewide aggregate rate of 60.8 percent is below the national benchmark, with varying rates of performance across counties and regions throughout the State.
    - Seven counties (Imperial, Monterey, Madera, Marin, Humboldt, Santa Cruz, and San Francisco) performed above the HEDIS benchmark, and all other counties were below the national benchmark.
  - Statewide performance of children in Medi-Cal managed care using Title 17 age-stratified indicators varies and reflects opportunity for improvement:
    - 53.3 percent of children who turned 1 year of age during calendar year 2019 were screened within six months of their first birthday.
    - 43.4 percent of children who turned 2 years of age during calendar year 2019 were screened within six months of their second birthday.
    - 30.5 percent of children who turned 2 years of age during calendar year 2019 had been screened within six months of their first and second birthdays (received two screenings).
    - 37.0 percent of children who turned 6 years of age during calendar year 2019, and had not been screened before 31 months of age, had been screened between 31 months of age and their sixth birthday (catch-up screening).
- Statewide performance varies based on race/ethnicity and primary language.
  - Asian and Hispanic/Latino racial/ethnic groups had the highest screening rates, which were consistently higher than statewide aggregate rates by more than a 10 percent relative difference.

[73] *2020 Preventive Services Report Addendum.* Available at: https://www.dhcs.ca.gov/Documents/MCQMD/2020-Preventive-Services-Report-Addendum.pdf. Accessed on: Dec 13, 2021.

- Screening rates for Black/African Americans, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, and White groups were consistently below statewide aggregate rates by more than a 10 percent relative difference, with Black/African Americans having the lowest screening rates.
- Chinese, Spanish, and Arabic primary language groups had the highest screening rates, which were consistently higher than statewide aggregate rates, by more than a 10 percent relative difference. Hmong, Vietnamese, Farsi, Cambodian, Tagalog, and Other primary language groups' screening rates were generally higher than the statewide aggregate rates.
- Rates for Korean, English, and Russian primary language groups were consistently below statewide aggregate rates by more than a 10 percent relative difference.
  - Armenian, Korean, and English primary language group rates for children who turned 6 years of age during calendar year 2019, and had not been screened before 31 months of age, were below the statewide aggregate rates by more than a 10 percent relative difference.

- No performance differences were noted between males and females.
- Statewide performance for rural versus urban regions varied by indicator.
  - Rates for rural regions were higher than rates for urban regions for the 12 months, 24 months, and two by 24 months indicators (by a 3.0, 5.4, and 8.8 percent relative difference, respectively).
  - Rates for rural regions for children who turned 6 years of age during calendar year 2019, and had not been screened before 31 months of age, were below rates for urban regions by a 23 percent relative difference and were below the statewide aggregate rate by more than a 10 percent relative difference.
- Blood lead screening performance is regional.
  - The highest performance was seen in Imperial, Marin, Humboldt, and San Francisco counties, with the highest rates across all indicators.
  - The lowest performance was seen in the Far North and Sierra Range/Foothills regions, with 11 counties (Nevada, Placer, El Dorado, Mariposa, Alpine, Shasta, Siskiyou, Plumas, Inyo, Sierra, and Mono) in the lowest performance quintile across most/all indicators.
  - Rates for children residing in 26 of 58 counties (45 percent) were above the statewide aggregate rate for the *Lead Screening in Children* indicator, and consistently above the statewide aggregate rate (60.81 percent) by more than a 10 percent relative difference across most/all blood lead screening indicators. These counties were in regions spread across the State: Bay Area, Central Coast, Central Valley, North Coast, Sacramento Valley, and Southern California.
  - Rates for children residing in 15 of 58 (26 percent) Far North and Sierra Range/Foothills counties were consistently below the statewide aggregate rate by more than a 10 percent relative difference across most/all blood lead screening indicators.
  - Screening rates for children who turned 6 years of age during calendar year 2019, and had not been screened before 31 months of age, were below the statewide aggregate

rate by more than a 10 percent relative difference in 40 of the 58 (69 percent) California counties.

2021 Preventive Services Study

For the 2021 Preventive Services Study, HSAG continued to analyze child and adolescent performance measures that were calculated by HSAG and DHCS, and reported by the 25 full-scope MCPs from the MCAS. MCAS measures reflect the clinical quality, timeliness, and accessibility of care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. DHCS can leverage the findings from the Preventive Services Study to identify and monitor appropriate utilization of preventive services for MCMC children.

For the 2021 study, HSAG evaluated measure data collected for HEDIS measurement year 2020, which consists of data collected during calendar year 2020. The indicator set for this analysis included 11 MCP-calculated indicators, three HSAG-calculated indicators (i.e., administrative indicators calculated by HSAG for DHCS), and five DHCS-calculated indicators. For each MCP-calculated 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 Child Core Set. For the HSAG-calculated indicators, HSAG developed specifications for the indicators; for the DHCS-calculated indicators, DHCS developed specifications for four of the indicators and used the HEDIS specifications for the remaining indicator. HSAG also conducted COVID-19 analyses and is working with DHCS to determine how to present the results of these analyses in the report.

At the time this EQR technical report is being produced, HSAG is conducting the analyses for the Preventive Services Study. Based on data availability, DHCS determined to publish the *2021 Preventive Services Report* in April/May 2022. The *2021 Preventive Services Report* will be posted on the DHCS website at the following link: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

14. 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 and Medi-Cal populations. The 2021 CAHPS surveys included beneficiaries assigned to 25 MCPs and two PSPs.

HSAG administered the CAHPS surveys to Medi-Cal populations that fall under two separate titles of the Social Security Act of 1935, Section 1932:

- Title XXI: CHIP population
- Title XIX: Medicaid Managed Care adult and child populations

Objective

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

Children's Health Insurance Program Survey

The *2021 CHIP CAHPS Survey Summary Report* includes the survey's detailed methodology, results, conclusions, and recommendations. Following is a high-level summary of the survey.

Methodology—Children's Health Insurance Program Survey

During the review period, HSAG administered the standardized survey instrument CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS and CCC measurement sets to a statewide sample of CHIP members enrolled in MCPs.

Table 14.1 lists the measures included in the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set.

Table 14.1—CAHPS Measures

Global Ratings	Composite Measures	CCC Composite Measures and Items
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 Children with Chronic Conditions*
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 for at least five of the last six months of 2020 (July through December). The members eligible for sampling included those who were 17 years of age or younger (as of December 31, 2020).

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 that 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).[74] HSAG drew the supplemental sample to ensure an adequate number of responses from children with chronic conditions.

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

Survey Administration

The survey process offered two methods to complete a survey. The first, or mail phase, consisted of an English or Spanish version of the survey being mailed to the sampled members. All non-respondents received a reminder postcard, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of conducting Computer Assisted Telephone Interviewing (CATI) of sampled members who had not mailed in a completed survey. HSAG attempted up to three CATI calls for each non-respondent.[75]

Survey Analysis

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS Measurement Year 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[76]
- Trend Analysis

Results—Children's Health Insurance Program Survey

Response Rates

HSAG mailed 6,680 child surveys to the sample of CHIP members selected for surveying. Of these, 1,413 child surveys were completed for the CHIP sample.

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 14.2 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 21.35 percent was greater than the national child Medicaid response rate reported by NCQA for 2020, which was 12.80 percent. In 2020, the

[75] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS Measurement Year 2020 Survey Measures*. Washington, DC: NCQA Publication, 2020.

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

CHIP response rate was 23.03 percent, which was 1.68 percentage points higher than the 2021 CHIP response rate. HSAG has observed a steady decline in CAHPS survey response rates over the past several years, so this small decline falls in line with national trends.

Table 14.2—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	28	3,037	607	19.99%
CCC Supplemental Sample	3,615	33	3,582	806	22.50%
CHIP	**6,680**	**61**	**6,619**	**1,413**	**21.35%**

General Child Performance Highlights

HSAG observed the following:

- The gaps between the NCQA Medicaid national 50th and 90th percentiles were on average 3.4 percentage points for the general child population, indicating that the distributions of national performance were close together.
- The differences between the CHIP general child population scores and the NCQA Medicaid national 50th percentiles ranged from 3.5 percentage points above the NCQA Medicaid national 50th percentiles to 6.7 percentage points below the NCQA Medicaid national 50th percentiles, with an average of 2.1 percentage points below the NCQA Medicaid 50th percentiles for the general child population.

Top-Box Scores

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

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

The following findings indicate opportunities for improvement in member experience for several areas of care, as the following reportable measures scored below the NCQA Medicaid national 50th percentiles:

- Global Ratings:
  - *Rating of Health Plan*

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

Trend Analysis

The 2021 score was statistically significantly higher than the 2020 score for the *Rating of All Health Care* global rating. The 2021 scores were not statistically significantly lower than the 2020 scores for any measure.

Children with Chronic Conditions Performance Highlights

HSAG observed the following:

- The gaps between the NCQA CCC Medicaid national 50th and 90th percentiles were on average 3.2 percentage points for the CCC population, indicating that the distributions of national performance were close together.
- The differences between the CHIP CCC population scores and the NCQA CCC Medicaid national 50th percentiles ranged from 4.3 percentage points above the NCQA CCC Medicaid national 50th percentiles to 10.2 percentage points below the NCQA CCC Medicaid national 50th percentiles, with an average of 3.1 percentage points below the NCQA CCC Medicaid national 50th percentiles for the CCC population.

Top-Box Scores

The following reportable measure scored above the NCQA CCC Medicaid national 90th percentile:

- Global Ratings:
  - *Rating of Specialist Seen Most Often*

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

- CCC Composite Measures and Items:
  - *Access to Prescription Medicines*

The following findings indicate opportunities for improvement in member experience for several areas of care, as the following reportable measures scored below the NCQA CCC Medicaid national 50th percentiles:

- Global Ratings:
  - *Rating of Health Plan*
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
- Composite Measures:
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
- CCC Composite Measures and Items:
  - *FCC: Personal Doctor Who Knows Child*
  - *FCC: Getting Needed Information*

Trend Analysis

The 2021 scores were not statistically significantly higher or lower than the 2020 scores for any measure.

Conclusions—Children's Health Insurance Program Survey

HSAG observed the following notable results:

- The general child population scored higher than the 2020 NCQA child Medicaid national 50th percentile but below the 2020 NCQA child Medicaid 90th percentile for the following reportable measures:
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
- The 2021 score for the *Rating of All Health Care* global rating was statistically significantly higher than the 2020 score for the general child population.
- The CCC population scored higher than the 2020 NCQA CCC Medicaid national 50th percentile but below the NCQA CCC Medicaid national 90th percentile for one reportable measure, *Access to Prescription Medicines*.
- The CCC population scored higher than the 2020 NCQA CCC Medicaid national 90th percentile for one measure, *Rating of Specialist Seen Most Often*.

The following findings indicate opportunities for improvement in member experience for several areas of care:

- The general child population scored below the 2020 NCQA Medicaid national 50th percentiles for the following five reportable measures:
  - *Rating of Health Plan*
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
  - *Customer Service*
- The CCC population scored below the 2020 NCQA CCC Medicaid national 50th percentiles for the following eight reportable measures:
  - *Rating of Health Plan*
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
  - *FCC: Personal Doctor Who Knows Child*
  - *FCC: Getting Needed Information*

Considerations—Children's Health Insurance Program Survey

HSAG observed that several measures scored below the NCQA Medicaid and CCC Medicaid national 50th percentiles, which may reflect potential issues with the quality and timeliness of, and access to care for CHIP members. HSAG suggests that DHCS consider working with MCPs to identify if potential issues are systemic beyond the impact of the public health emergency and, if so, identify strategies for improving those areas that fell below the NCQA Medicaid and CCC Medicaid national 50th percentiles.

Medicaid Managed Care Survey

During the review period, HSAG administered the standardized survey instruments CAHPS 5.1 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set (i.e., CAHPS 5.1H Adult and Child Medicaid Health Plan Surveys) to adult members and parents or caretakers of child members enrolled in an MCP or PSP.[77] At the time this EQR technical report was produced, the *2021 CAHPS Medicaid Managed Care Survey Summary Report* was not yet final. HSAG will include the CAHPS Medicaid Managed Care results in the 2021–22 EQR technical report.

[77] HSAG used the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set.

15. 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).

Accurate and complete encounter data are critical to assessing health care 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.

To ensure that MCPs, PSPs, and their providers could continue to focus on COVID-19 response efforts and to not put individuals at risk by requiring travel for collection of medical record data, DHCS determined to have HSAG conduct an alternative encounter data validation study that did not include MRR.

During the 2020–21 contract year, HSAG began conducting the encounter data study through an administrative analysis of historical encounter data in contrast to members' medical records received from service providers. The objectives of the Encounter Data Administrative Profile Study are for HSAG to:

1. Evaluate the completeness and accuracy of DHCS' 837 professional, 837 institutional, and National Council for Prescription Drug Programs encounters with dates of service in calendar years 2018 and 2019.
2. Develop a methodology, based on the 2018 and 2019 encounter data, to monitor encounter data volumes at the category of service level for DHCS to use to monitor future encounter data quality.

At the time this EQR technical report was produced, the Encounter Data Administrative Profile Study was still in process. HSAG will provide a summary of this study in the 2021–22 EQR technical report.

16. Focus 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 focus studies to gain better understanding of and identify opportunities for improving care provided to beneficiaries. HSAG conducted activities related to the following focus studies during the review period:

- CAHPS
- Homelessness
- Network Hotspots
- Quality Improvement Health Disparities

HSAG's Approach to Focus Studies

HSAG conducts each focus study in accordance with the CMS *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*. October 2019.[78]

Study Design

HSAG defines the scope of work and expected objectives for the focus 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 focus study may require the adaptation of standard health care quality measures for applicability to special populations; therefore, HSAG's analytic plan details the technical specifications for these measures to ensure methodological soundness and reliable calculability for the populations under study.

[78] 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: Nov 24, 2021.

Data Collection

As much as possible, HSAG uses administrative data to conduct focus studies. While MRR may provide valuable insight into selected focus study topics, HSAG uses this approach sparingly in order to provide focus study results within a single contract year. After finalizing the methodology for each focus 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 focus 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 focus 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.

Focus Study Summaries

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

CAHPS Focused Study[79]

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 measures included in Table 16.1.

Table 16.1—CAHPS Measures

Global Ratings	Composite Measures
Rating of Health Plan	*Getting Needed Care*
Rating of All Health Care	*Getting Care Quickly*
Rating of Personal Doctor	*How Well Doctors Communicate*
Rating of Specialist Seen Most Often	*Customer Service*
	Shared Decision Making

Since 1997, CAHPS surveys have been considered a national standard for measuring and reporting on consumers' experiences with their health plans. AHRQ developed various CAHPS surveys that ask about a variety of patient experiences, such as experiences with a range of health care services at multiple levels of the delivery system, experiences with providers, or care for specific health conditions. Other surveys ask members about their experiences with health plans and related programs, and several surveys ask about experiences with care delivered in facilities, such as hospitals, dialysis centers, or nursing homes. The CAHPS Health Plan Survey is a tool for collecting standardized information on members' experiences with health plans and their services. Survey results can be used to identify strengths and weaknesses of health plans and target areas for improvement.[80]

[79] In its previous protocol version (*EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary* Protocol *for External Quality Review [EQR]*, Version 2.0, September 2012), CMS referred to this study type as a "focused" study. In its most recent protocol version (*Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, October 2019), CMS began referring to these studies as "focus" studies, which accounts for the reference to both "focused" and "focus" studies in this report.

[80] Agency for Healthcare Research and Quality. *Surveys and Guidance: CAHPS Health Plan Survey*. Available at: https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html. Accessed on: Nov 29, 2021.

Table 16.2 provides a list of the 23 MCPs that participated in the focused study survey.[81] HSAG did not survey two MCPs, Aetna Better Health of California and UnitedHealthcare Community Plan, since these MCPs did not have a contract with DHCS in 2013 and 2016 and did not have results for trending for these two years.

Table 16.2—Participating MCPs

MCP Names	
Alameda Alliance for Health	Health Plan of San Joaquin
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Health Plan of San Mateo
Blue Shield of California Promise Health Plan	Inland Empire Health Plan
California Health & Wellness Plan	Kern Health Systems, DBA Kern Family Health Care
CalOptima	Kaiser NorCal
CalViva Health	Kaiser SoCal
CenCal Health	L.A. Care Health Plan
Central California Alliance for Health	Molina Healthcare of California
Community Health Group Partnership Plan	Partnership HealthPlan of California
Contra Costa Health Plan	San Francisco Health Plan
Gold Coast Health Plan	Santa Clara Family Health Plan
Health Net Community Solutions, Inc.	

At the time the 2019–20 EQR Technical Report was published, the CAHPS Focused Study was not completed; therefore, HSAG was unable to include the results in that report. HSAG completed the CAHPS Focused Study in March 2021 and therefore includes in this EQR technical report the following high-level summaries of the study methodology, key findings, and conclusions.

Methodology—CAHPS Focused Study

For this focused study, HSAG and DHCS developed a focused study survey that asked MCPs about interventions (e.g., policies, initiatives, and strategies) they implemented between June 2013 and June 2018 to improve their 2016 and 2019 adult and child Medicaid CAHPS survey results. The focused study survey also asked about regulations (e.g., federal mandates, California State laws, and DHCS policies) which were enacted between June 2013 and June

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

2018 that MCPs believed may have impacted their 2016 and 2019 adult and child Medicaid CAHPS survey results. Prior to conducting the MCP survey, HSAG performed a trend analysis of the adult and child 2013, 2016, and 2019 CAHPS Health Plan Survey global rating and composite measure results.

Focused Study Survey Protocol

DHCS provided HSAG with the point-of-contact name and email address for each of the 23 MCPs. HSAG sent a link to the focused study survey via email to each of these representatives along with the trend analysis results in a MS Excel workbook to use as a reference when completing the focused study survey.

Trend Analysis

HSAG performed a trend analysis for each measure that compared the 2019 scores to the 2013 and 2016 scores, where applicable, and the 2016 scores to the 2013 scores, where applicable, to determine whether there were statistically significant differences.[82,83] HSAG performed a *t* test to determine whether results in one year were statistically significantly different from results in a previous year. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than or equal to 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance.

Key Findings and Conclusions—CAHPS Focused Study

HSAG evaluated the interventions (domains and sub-domains) listed for MCPs that had scores that were statistically significantly higher in 2019 than 2016 for each CAHPS global rating and composite measure and attempted to identify common themes among MCPs regarding what they did to improve the member experience. Among MCPs with statistically significant findings, HSAG found some common interventions that most MCPs indicated they conducted to improve scores across measures, such as member outreach/education, provider outreach education, provider training, expansion of services, and CAHPS performance monitoring. There were other interventions that fewer MCPs indicated they conducted to improve scores across measures, such as provider incentives, care coordination activities, and improvements in cultural and linguistic services. Most MCPs listed the same interventions for the adult and child Medicaid populations; therefore, although the focused study survey was designed to distinguish between adult and child targeted inventions, HSAG could not determine if a specific intervention had an impact on the adult or child Medicaid population specifically.

[82] DHCS was not contracted with California Health & Wellness Plan in 2013; therefore, trend results for 2013 are not available for this MCP.

[83] NCQA made changes to the question language and response options for the *Shared Decision Making* composite measure after 2013; therefore, HSAG could not trend the 2013 results for this measure.

Similar interventions were listed across multiple MCPs; however, these interventions may have impacted member experiences and the MCPs' CAHPS results differently, due to items unmeasured by the scope of the focused study (e.g., implementation variations). MCPs should read through the detailed interventions to better understand the composition of the interventions and consider implementing some of the interventions implemented by other MCPs. If MCPs find a particular intervention of interest, MCPs should reach out to other MCPs to understand more about the implementation and evaluation process.

MCPs were more likely to assume that the regulations enacted between 2013 and 2018, such as federal regulations and various APLs put in place by DHCS, had positive impacts on members' experiences, which in turn may have had a positive impact on CAHPS results. In theory, regulations are designed to improve member experience directly or indirectly, and MCPs indicated that most regulations positively impacted their work. Although MCPs were required to meet the same regulations, these regulations may have impacted MCPs' systems in different ways depending on MCP readiness, as well as the resources MCPs had available to support them in adapting to the new regulations.

The results of the focused study revealed that MCPs implemented several interventions between 2013 and 2018; however, HSAG could not identify one specific intervention that MCPs implemented which improved the member experience, impacting CAHPS scores. Instead, a combination of interventions or another cause not measured by this focused study most likely contributed to improved CAHPS scores. HSAG encourages MCPs to consider implementing interventions that have not been implemented or setting goals for interventions already in place to improve member experience.

Recommendations—CAHPS Focused Study

HSAG made no recommendations to DHCS based on the CAHPS Focused Study results.

Homelessness Focused Study

During contract year 2019–20, DHCS contracted with HSAG to design an approach for identifying homeless members eligible for MCMC during calendar year 2018 based on administrative data sources only. HSAG assessed approaches for identifying homeless members based on self-reported address data and with codes to indicate homelessness within administrative claim/encounter data. Determining what data can be used to identify homeless members will allow DHCS to better identify and meet the needs of these high-risk members, which supports the DHCS comprehensive quality strategy goals of improving health equity and addressing social determinants of health.

At the time the 2019–20 EQR Technical Report was published, the Homelessness Focused Study was not completed; therefore, HSAG was unable to include the results in that report. HSAG completed the focused study in April 2021 and therefore includes in this EQR technical report the following high-level summaries of the study methodology, key findings, conclusions, and recommendations. The *2020 Homelessness Focused Study Report* includes the detailed methodology, study results, key findings, conclusions, and recommendations.

Methodology—Homelessness Focused Study

Data Sources

To complete the Homelessness Focused Study analysis, HSAG used administrative data provided by DHCS; publicly available information with addresses for social services, homeless shelters, and health care providers (e.g., outpatient clinics, hospitals) in California; and patient-level detail files provided by MCPs that contain measure indicator information for each member.

Identifying Homeless Members

HSAG assessed the following approaches for identifying homeless members: using address key words, matching social services/homeless shelter addresses, matching hospital/outpatient clinic addresses, and using claims/encounter homelessness codes. If a member was identified as homeless at any point during the measurement period using any of the below approaches, then the member was included in subsequent analyses to finalize the approach for identifying homeless members.

Key Findings—Homelessness Focused Study

Following are summaries of the key findings from each homelessness identification approach.

Address Key Word Match Approach

- While a small number of members for whom key words indicated homelessness were not identified by the Address Key Word Match approach, 67 percent of the homeless MCMC

population HSAG identified was identified using the word "homeless" as the member's listed address.

- HSAG found over 33,000 members who used "no address" as their address, with over 91 percent of these members living in Riverside County, and over 83 percent enrolled in Inland Empire Health Plan. These results indicate that the "no address" key word is not a reliable indicator of homelessness and rather indicates potential data incompleteness.
- HSAG found that approximately 62,000 members in the total MCMC population used "refer to mailing address" as their address and that approximately 6 percent of members identified by the Claims/Encounter Homelessness Codes approach used "refer to mailing address" as their address. While this may indicate that homeless members are more likely to use "refer to mailing address" as their address, using this key word would likely overcount the number of homeless members in the State.
- While the Address Key Word Match approach identified the majority of members identified as homeless in this study, it relies on member address information to be up to date and accurate. To identify members' length of homelessness more accurately and classify them as either chronically or temporarily homeless, this approach requires that members' address information be frequently updated.

Social Services/Homeless Shelter Address Match Approach

- HSAG found the use of social services addresses as a member's listed address is inconsistent from county to county. It is likely that using these addresses would result in overcounting the number of homeless members, especially in the counties that frequently use social services address as a member's listed address.
- HSAG found that approximately 20 percent of the members who were identified as homeless by the Claims/Encounter Homelessness Codes approach and could not be identified as homeless through an address-based identification approach (i.e., Address Key Word Match, Homeless Shelter Address Match, or Hospital/Outpatient Clinic Address Match) used an address that matched one of the 158 social services addresses. These addresses were ultimately excluded from the final Homeless Shelter Address Match approach due to the high volume of members with social services addresses as their place of residence in select counties. While this indicates that a significant number of homeless members could be identified by including these social services addresses in the Final Homeless Member Identification approach, it is likely that a larger proportion of non-homeless members would be incorrectly identified as homeless.
- It is possible that the list of homeless shelter addresses HSAG collected was incomplete. Since there is no national or statewide database of homeless shelters available, HSAG collected these addresses through county government websites as well as other non-profit organizations' websites. It is possible that a number of homeless shelters were inadvertently omitted from the list of homeless shelters.

Hospital/Outpatient Clinic Address Match Approach

- A large percentage of members who were identified as homeless by the Hospital/Outpatient Clinic Address Match approach used a homeless shelter or social services location that has a hospital/outpatient clinic NPI as their address. As a result, it is likely that members identified by this approach were either homeless or at risk of homelessness, though it is likely that some homeless members were not captured by this approach due to the limited number of hospital and outpatient clinic addresses identified.

Claims/Encounter Homelessness Codes Approach

- Only approximately 21 percent of members identified by the Claims/Encounter Homelessness Codes approach could be identified by another approach, indicating potential issues with the address-based approaches (i.e., incomplete lists of key words, homeless shelters, or hospitals/outpatient clinics were used; or the members' address information was not comprehensive enough to identify all homeless members).
- Approximately 6 percent of members who were identified as homeless by this approach had a claim that indicated homelessness in more than one county. As a result, HSAG does not recommend using this approach to track homeless members who may migrate across the State.
- The 10 most common primary diagnosis codes used in conjunction with the diagnosis code for homelessness show that a large percentage of homeless members identified by the Claims/Encounter Homelessness Codes approach had severe mental and behavioral health conditions (e.g., schizophrenia, depression, drug and alcohol abuse).

Conclusions and Recommendations—Homelessness Focused Study

Based on key findings from the homeless member identification approaches, HSAG identified the following conclusions and recommendations in order for DHCS to improve the identification of homeless members:

- HSAG identified an average of approximately 101,000 homeless members per month. According to the United States Interagency Council on Homelessness, California had approximately 150,000 people experience homelessness on any given day as of January 2019.[84] HSAG's average count of identified homeless members in any given month suggests that not all homeless individuals in California are being identified. While this is partially due to incomplete or inaccurate member address data, it is also indicative of the challenges associated with enrolling homeless individuals in Medi-Cal.
  - DHCS, County Social Services offices, and MCPs should expand current outreach efforts in counties with low rates of Medi-Cal enrollment for the homeless population

[84] United States Interagency Council on Homelessness. California Homelessness Statistics. Available at: https://www.usich.gov/homelessness-statistics/ca. Accessed on: Nov 29, 2021.

(e.g., Los Angeles County, San Francisco County).[85,86] This could include increasing partnerships with providers, non-profit organizations, and community-based organizations that serve the homeless population to assist with enrolling homeless individuals in Medi-Cal by becoming a certified enrollment entity and designating staff as certified enrollment counselors.[87]

- To increase the identification of homeless members in administrative data, DHCS should consider mechanisms for increasing the billing and use of homelessness codes for services provided by mobile clinics, homeless shelters, and social services sites. If these locations are providing services to the homeless population, opportunities exist to ensure that the individual is not only enrolled in Medi-Cal but the health care service is also being billed to Medi-Cal.
  - This could include ensuring these mobile clinics and organizations have the ability (e.g., dedicated staff with devices) to assist an individual with enrolling in Medi-Cal.[88] If the individual cannot be enrolled at the time of receiving a health care service, the mobile clinic or organization should still collect information about the individual (e.g., name, date of birth) that could be shared with DHCS. If the individual has received services from other State or county services, then DHCS could consider auto-enrolling this individual in MCMC.
  - Auto-enrolling individuals who have previously verified their identity and residency may help circumnavigate some of the challenges homeless shelters and non-profit organizations have experienced when attempting to enroll the homeless population in Medi-Cal who do not necessarily have the required documentation to enroll.[89]

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[85] Oreskes B. L.A. County is counting homeless people this week: Here's everything you need to know. Los Angeles Times. Jan 21, 2020. Available at: https://www.latimes.com/california/story/2020-01-21/homeless-count-los-angeles-county-faq. Accessed on: Nov 29, 2021.

[86] City and County of San Francisco. City Performance Scorecards: Homeless Population. Available at: https://sfgov.org/scorecards/safety-net/homeless-population. Accessed on: Nov 29, 2021.

[87] Department of Health Care Services. Let's Get Everyone Covered! Medi-Cal Eligibility and Enrollment Tips for Providers of Homeless Assistance and Supportive Housing. Available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/OE/HmlessMCEnrllmntTlkit.pdf. Accessed on: Nov 29, 2021.

[88] U.S Department of Health & Human Services. Office of the Assistant Secretary for Planning and Evaluation. Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field. Available at: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/44466/EmergPrac.pdf. Accessed on: Feb 16, 2021.

[89] Hayden N. The Homeless Often Don't Receive Health Care in California Despite Qualifying for Free Insurance. *Desert Sun.* Available at: https://www.desertsun.com/story/news/health/2019/09/20/how-medi-cal-makes-hard-homeless-access-care/2367926001/. Accessed on: Feb 12, 2021.

- To improve the identification of homeless members enrolled in MCMC, DHCS and MCPs need to improve member address information especially as it relates to the following:
  - Improving the frequency of address updates by members.
    - The frequency of member address updates is essential to determining length of homelessness. DHCS should consider determining the frequency of address updates for members for whom homelessness key words apply (i.e., homeless and transient) to determine if the member's address is only updated upon new enrollment, on annual reenrollment, or at more frequent intervals. HSAG recommends that DHCS assess the frequency of address updates using three years' worth of address data in order to better understand the issues with member address information. Further, MCPs could also use the homelessness key words to identify their homeless members and work with providers, non-profit organizations, homeless shelters, and county social services offices to attempt member outreach.
  - Improving the accuracy for missing address information in Riverside County.
    - Inland Empire Health Plan should work to understand why members residing in Riverside County have a high prevalence of missing address information and work to ensure accurate address information is available for those members.
  - Improving the accuracy of member address information in counties with a high volume of members with social services addresses as their place of residence.
    - DHCS should work with MCPs in San Bernardino, Kern, San Joaquin, Stanislaus, and Alameda counties to address members whose address is a State or county social services location.
- According to the United States Interagency Council on Homelessness, approximately 263,000 school-aged children in California experienced homelessness over the course of the 2017–2018 school year.[90] However, HSAG's Final Homeless Member Identification approach primarily identified homeless MCMC adults—165,000 homeless MCMC adults compared to approximately 28,000 homeless MCMC children. As a result, additional data sources may be necessary in order to identify homeless MCMC children more comprehensively. This may include working with the United States Department of Education's Education of Homeless Children and Youth program to receive the data it collects on children experiencing homelessness from state educational agencies.[91] DHCS and MCPs should investigate the child homeless MCMC population to determine if additional data sources or information could be leveraged to identify children experiencing homelessness.
- Given that approximately 11 percent of members identified as homeless were identified using the Claims/Encounter Homelessness Codes approach, DHCS could consider

[90] United States Interagency Council on Homelessness. California Homelessness Statistics. Available at: https://www.usich.gov/homelessness-statistics/ca. Accessed on: Feb 16, 2021.

[91] National Center for Homeless Education. Guide to Collecting & Reporting Federal Data, Education for Homeless Children & Youth Program, May 2019. Available at: https://nche.ed.gov/wp-content/uploads/2019/05/Data-Collection-Guide-SY-18.19.pdf. Accessed on: Feb 17, 2021.

investigating the use of homelessness International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes in all-payer hospital discharge data to assess the utilization of services by homeless individuals who are not enrolled in Medi-Cal. This would also allow DHCS to understand whether there are certain hospitals or regions wherein homeless individuals who are not enrolled in Medi-Cal have higher utilization rates. This information could then be leveraged to work with MCPs and hospitals in those regions to ensure homeless members enroll with Medi-Cal.

Note that based on DHCS already receiving HSAG's recommendations as part of the Homelessness Focused Study process for discussion and consideration, as part of the EQR technical report process, HSAG has no recommendations for DHCS related to this study.

Network Hotspots Focus Study

During contract years 2016–17 and 2018–19, DHCS contracted with HSAG to conduct a Timely Access Focus Study for the MCPs. The two studies identified various issues for the sampled providers in three domains: provider compliance, provider data quality, and provider training. Therefore, during contract year 2019–20, DHCS requested that HSAG conduct a Network Hotspots Focus Study to answer the following study question:

- *Using the data from the Year 1 and Year 2 Timely Access Focus Studies, what are the problematic provider clusters (i.e., hotspots) for each MCP?*

A hotspot in the study question refers to either 1) a provider cluster that accounts for a large proportion of the total identified issues based on the calls to sampled providers from the Timely Access Focus Studies, or 2) a large proportion of provider records that have a problem within the provider cluster. Overall, the deliverables from the study identified the hotspots for each MCP so that MCPs would contact the least number of provider clusters while correcting the most issues.

The *2019–20 Network Hotspots Focus Study Report* includes the detailed methodology, study results, key findings, conclusions, and recommendations. Additionally, HSAG produced MCP-specific result reports and interactive tools for DHCS to use in its discussions with MCPs regarding appointment availability and provider data quality. Following are high-level summaries of the study methodology, key findings, conclusions, and considerations.

Methodology—Network Hotspots Focus Study

To successfully complete the Network Hotspots Focus Study, HSAG collaborated with DHCS subject matter experts to perform the following key steps:

- Step 1: Determine criteria for problematic providers (i.e., providers with issues identified from the 2016–17 and 2018–19 Timely Access Focus Studies [referred to as Year 1 and Year 2 of the study, respectively]).
- Step 2: Determine criteria for identifying provider clusters (e.g., clinics, federally qualified health centers , and independent physician associations) based on the 274 provider data extracted by DHCS for the study.
- Step 3: Apply the criteria from Steps 1 and 2 to the raw data files from the Year 1 and Year 2 Timely Access Focus Studies and create a MS Excel tool for each MCP and DHCS.
- Step 4: Identify hotspots for each measure.
- Step 5: Submit deliverables to DHCS.

Key Findings and Conclusions—Network Hotspots Focus Study

There were 14 measures for the study. For each measure, HSAG identified hotspots based on the following criteria:

- Criterion 1: Top provider clusters that contributed to at least 50 percent of all problematic provider records.
- Criterion 2: There were at least three problematic provider records in a cluster, and the percentage of problematic records within a cluster was at least 75 percent.

Any provider cluster that was a hotspot for more than half of the measures in a domain was considered a super-hotspot for this study. Across all MCPs, there were 80, 47, and 254 super-hotspots for the compliance, data quality, and provider training domains, respectively.

Any provider cluster that was a super-hotspot for at least two domains was considered an aggregate super-hotspot for this study. There were 65 aggregate super-hotspots across all MCPs.

Considerations—Network Hotspots Focus Study

To improve member's access to care via appointment availability and provider data quality, DHCS should consider requiring MCPs to use the following two documents HSAG produced to investigate and take action to address the identified issues, as needed:

- MCP Results Report presenting hotspots for each measure.
- MCP MS Excel interactive tool that provides a list of problematic providers for each hotspot.

Quality Improvement Health Disparities Focus Study

To help DHCS and MCPs prioritize health disparity areas on which to focus quality improvement efforts, DHCS contracted with HSAG in contract year 2020–21 to conduct the Quality Improvement Health Disparities (QIHDS) Focus Study. The goal of the QIHDS Focus Study is to develop and test four methodologies for identifying three disparities for each MCP reporting unit to choose from for quality improvement efforts each year. HSAG will use 26 of the External Accountability Set HEDIS measures reported by the 25 full-scope Medi-Cal MCPs for measurement years 2017 and 2018 (i.e., reporting years 2018 and 2019). HSAG will develop and test the following methodologies at the following levels to determine if three disparities for each MCP reporting unit can be determined at each level:

- Statewide health disparities
- Regional health disparities
- MCP reporting unit health disparities
- Combination (i.e., statewide, regional, and MCP reporting levels combined) health disparities

At the time this EQR technical report was produced, the QIHDS Focus Study methodology was finalized; however, HSAG had not completed all analyses or produced the final report. HSAG will include a summary of the QIHDS Focus Study in the 2021–22 EQR technical report.

17. 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 categories for HSAG to support during the July 1, 2020, through June 30, 2021, review period.

Technical Assistance for Plans' Quality Improvement

Objective

The objective of Technical Assistance for Plans' Quality Improvement is for HSAG to assist MCMC plans in improving the quality of care they provide to members, which will help to improve their performance measure rates and, ultimately, improve overall statewide performance.

Under this technical assistance category, HSAG supports DHCS by providing technical assistance to each MCMC plan with performance measure rates below the minimum performance levels. Additionally, HSAG provides technical assistance to DHCS in various areas related to quality improvement.

Specifically, HSAG conducts the following activities as requested by DHCS:

- Provide performance measure expertise to DHCS in identifying and researching performance measures regarding updates to measure specifications and to the CMS Core Sets, trends, and best practices.
- Collaborate with DHCS to provide technical assistance to MCMC plans related to DHCS' Quality Monitoring and CAP Process.
- Provide technical assistance to MCMC plans requiring additional guidance with quality improvement activities being conducted as part of DHCS' Quality Monitoring and CAP Process.
- Review and provide feedback to DHCS on an array of documents related to quality improvement activities, including providing subject matter expertise on quality performance measures to be included in or excluded from MCAS.
- Respond to requests from DHCS for input on a variety of quality improvement-related issues and topics.

Methodology

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each request 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 and MCMC plans by email, telephone, and Web conferences.

Results—Technical Assistance for Plans' Quality Improvement

During the review period, HSAG provided technical assistance on various topics to DHCS and MCMC plans. Following is a summary of the notable technical assistance HSAG provided.

Performance Measures and Audits

- Provided technical assistance to DHCS via conference calls regarding DHCS' telehealth guidance and how to best advise plans during the audit process for reporting rates for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures. HSAG also provided information to DHCS regarding NCQA's requirements for documentation of telehealth visits.
- Provided information to DHCS via email to inform its decision making about whether to allow MCMC plans to choose the reporting methodology for measures that allow both hybrid and administrative methodologies.
- Reviewed the measurement year 2021 MCAS measure list and provided feedback to DHCS via email.
- Forwarded emails from NCQA to DHCS to ensure it was informed about all NCQA updates and to assist DHCS with its decision making related to performance measure requirements.
- Met via conference call with DHCS to discuss and provide feedback on its monitoring process for recommendations HSAG includes in the plan-specific evaluation reports related to the HEDIS Compliance Audits. HSAG also sent a summary of the discussion to DHCS, including steps HSAG will take to support DHCS in its MCMC plan monitoring process.
- Conducted research on the Survey of Well-being of Young Children tool to determine if it meets the intent of the CMS Child Core Set specifications for the *Child Developmental Screening in the First Three Years of Life* measure. HSAG sent a summary of its determination to DHCS and provided recommendations regarding next steps.
- Worked with Family Mosaic Project on revising the specification for one of its performance measures to reflect the SHP's processes more accurately.
- Provided to DHCS via email confirmation and additional information regarding how MCMC plans incorporate data from delegated entities, including plan partners, when calculating performance measure rates.
- Provided support to DHCS for answering questions from CMS about DHCS' Medicaid and CHIP Program (MACPro) submission.

- Emailed DHCS a potential explanation for why the *Prenatal and Postpartum Care* benchmarks increased from the prior year, indicating that the increase is likely related to the specification changes NCQA made to these measures in measurement year 2019.
- Reviewed L.A. Care Health Plan's SMART objective and baseline rate information for its *Well-Child Visits in the First 30 Months of Life* measure PDSA cycle and provided feedback to DHCS via email.

Consumer Assessment of Healthcare Providers and Systems

- Emailed several MCMC plans information about the CAHPS surveys, including the survey content and process. HSAG sent the survey materials, deidentified member-level data files, and summary report information to MCMC plans when requested.
- Answered questions from Health Net Community Solutions, Inc,. via email and telephone regarding previous CAHPS surveys HSAG administered and the process for collecting and reporting results.

Other Technical Assistance

- Compiled a summary of the revisions that CMS made to the Medicaid managed care rule under 42 CFR §438 and emailed the summary to aid DHCS in its compliance reviews of plans and also to help DHCS confirm that contracts with plans include all requirements.
- Reviewed and provided feedback on information DHCS planned to submit to CMS regarding the Medicare-Medicaid Plan (MMP) PIPs. HSAG also provided historical information to DHCS regarding the MMP PIP process.
- Provided reports to DHCS in response to a public records request it received related to the Timely Access Focus Study.
- At DHCS' request, participated in a meeting with Sellers Dorsey to provide information on performance measures, PIPs, collaborative discussions, and HSAG's health disparities analyses as they may relate to the DHCS Health Equity Project that Sellers Dorsey is conducting.
- Assisted MCPs via email and telephone with understanding various EQR activities and results.
- Communicated by email and telephone with DHCS staff members to provide clarification about specific EQRO activities and help them gain a more comprehensive understanding of the various activities.

Conclusions—Technical Assistance for Plans' Quality Improvement

Due to the technical assistance that HSAG provided to DHCS and MCMC plans during the review period:

- DHCS gained information to assist in with making informed decisions regarding various EQR activities and MCMC plan requirements and how to best provide guidance to MCMC

plans related to EQR activities for which HSAG provided feedback and technical assistance.

- MCMC plans have a better understanding of the EQR activities.
- MCMC plans have a better understanding of how to use data and analyses from various HSAG analytic studies in their quality improvement efforts.

Recommendations—Technical Assistance for Plans' Quality Improvement

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 the technical assistance for plans' quality improvement activity.

Technical Assistance for Priority Quality Improvement Collaboration

Objective

Under the Technical Assistance for Priority Quality Improvement Collaboration, HSAG implements, facilitates, supports, and manages quarterly collaborative discussions for each DHCS-identified quality improvement priority area. The objectives of the collaborative discussions are:

- To provide MCMC plans the opportunity to share with each other about issues, barriers, promising practices, and solutions related to their quality improvement work in the priority areas or other quality performance measure areas.
- For MCMC plans to benefit from HSAG's insight and expertise.
- For DHCS to share pertinent resources, and its insights, particularly around potential collaboration with external partners.

Methodology

DHCS selected the following collaborative discussion focus areas that align with DHCS' MCAS domains:

- Child and Adolescent Health—Focusing on MCMC plans' quality improvement work for the *Child and Adolescent Health* PIPs and PDSA cycles related to child and adolescent health measures.
- Women's Health—Focusing on MCMC plans' quality improvement work on PIPs and PDSA cycles related to women's health, including maternal health.

- Disease Management and Behavioral Health—Focusing on MCMC plans' quality improvement work on PIPs and PDSA cycles related to acute and chronic disease management, as well as measures related to behavioral health.

Note that while there was no specific collaborative call related to health equity, DHCS and HSAG worked with the MCMC plans to weave a health equity focus into the collaborative call discussions frequently. Additionally, DHCS and HSAG also incorporated into the discussions the effects of COVID-19 on quality improvement efforts and how MCMC plans addressed the COVID-19 challenges.

Through joint planning meetings, HSAG and DHCS discussed potential topics for the collaborative discussions and the appropriate structure for the meetings based on the topics. DHCS and HSAG collaboratively determined the topic for each quarterly collaborative discussion based on:

- Feedback received from MCMC plans about what they would like discussed.
- Issues identified by DHCS and HSAG through EQR work with MCMC plans, including, but not limited to PIPs, MCAS performance measures and associated PDSA cycles, and MCMC plan-specific technical assistance sessions.

Additionally, HSAG:

- Served as the facilitator for each collaborative discussion planning meeting at intervals determined by DHCS.
- Collaborated with DHCS regarding the agenda and prepared agendas.
- Prepared and coordinated webinar presentations with DHCS and any MCMC plan or external partner presenters.
- Led discussions, kept track of participant attendance and roles, and compiled and disseminated notes to DHCS and the plans.

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 five State working days following each collaborative discussion, HSAG emailed the meeting notes to the MCMC plans and reminded collaborative discussion participants to complete the surveys. Once survey results became available, HSAG provided DHCS with a summary of the survey results.

Results—Technical Assistance for Priority Quality Improvement Collaboration

HSAG facilitated collaborative discussions in three quarters of the review period for this report. 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 three presentations, MCP partner organizations joined the MCPs to present about their collaborative efforts. Additionally, during two of the discussions, CDPH presented information to support MCMC plans in their quality improvement activities. Following the presentations, HSAG facilitated a question-and-answer session to provide the opportunity for MCMC plans 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 information related to the collaborative discussion focus areas to support MCMC plans in their quality improvement efforts:

- Child and Adolescent Health
  - CDPH
  - CenCal Health
  - Gold Coast Health Plan
  - Health Plan of San Joaquin and Golden Valley Health Centers
- Disease Management and Behavioral Health
  - CenCal Health
  - Kaiser NorCal
  - Kern Health Systems, DBA Kern Family Health Care
  - Partnership HealthPlan of California and La Clinica de la Raza
- Women's Health
  - Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan and Fresno County Black Infant Health Program
  - CDPH
  - Inland Empire Health Plan
  - Kern Health Systems, DBA Kern Family Health Care and Kern County Public Health Services Department

In all three 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 for Priority Quality Improvement Collaboration

During the review period, DHCS and HSAG facilitated successful collaborative discussions and engaged MCMC plans 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.

Recommendations—Technical Assistance for Priority 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 the next set of collaborative discussions; therefore, as part of the EQR technical report production process, HSAG has no recommendations for DHCS related to the technical assistance for priority quality improvement collaboration activity.

Quality Improvement Conference Technical Assistance Activity

DHCS contracted with HSAG to jointly host and facilitate the 2021 Quality Conference, *Rising to the Challenge—Resilience in Quality Improvement During COVID-19 and Other Public Health Emergencies*, on October 26, 2021 (Day 1) and October 27, 2021 (Day 2). Due to COVID-19, the conference was held virtually via Webex.

The conference provided MCMC plans the opportunity to build skills to design quality improvement interventions in response to or influenced by unexpected public health emergencies. The primary audience for the conference included MCMC plan quality improvement, HEDIS, community and provider outreach, health education, and cultural and linguistic staff members.

Note that the conference planning began during the review period for this EQR technical report; however, the conference took place and HSAG submitted the conference report to DHCS outside the review period for this report. While the conference occurred and HSAG submitted the report outside the review period, HSAG includes a summary of the 2021 Quality Conference because the information was available at the time this EQR technical report was produced.

Objective

The objective of the Quality Improvement Conference Technical Assistance Activity is to provide MCMC plans with the opportunity to learn up-to-date information regarding quality improvement issues, best practices, and lessons learned. Additionally, the quality conference

provides MCMC plans with the opportunity to build skills that they can apply in their quality improvement efforts.

Methodology

Conference Planning

DHCS and HSAG began logistical planning for the conference in November 2020, which continued up to the event in October 2021. DHCS identified the theme of the conference; however, to ensure that the conference content and structure met the needs of the MCMC plans, DHCS and HSAG collaborated to develop a survey to obtain the plans' input on the content and structure of the conference. In December 2021, DHCS sent the online survey link to MCMC plans.

DHCS solicited MCMC plans for individuals who were willing to volunteer to participate on the conference planning committee. Fourteen staff members participated on the committee, representing 11 MCMC plans. Representatives from DHCS also participated on the committee. HSAG facilitated two calls to obtain the committee's input on the conference content, structure, and speakers (February and April 2021). To aid the committee in providing input, HSAG presented the committee with a summary of key feedback from the 2019 Quality Conference, a summary of the 2021 needs assessment survey results, a proposed conference agenda based on the survey results and planning committee feedback, and a list of potential keynote address speakers. Via email, HSAG provided committee members with updates between and after the two meetings to ensure they were kept up to date on the status of the decisions related to the conference content, structure, and speakers.

Conference Content

HSAG created a conference webpage that included the registration link and conference materials.

Conference Agendas

The following is a high-level summary of the agendas for each day of the conference.

Day 1—Resiliency Within the Organization's Quality Improvement Structure

- Keynote Address—*Resilience Under Pressure: When Challenges Create Opportunities*: Dr. Nadine Burke Harris, MD, MPH, FAAP, Surgeon General of the State of California
- Adapting Organizational Structures During COVID-19 or Other Public Health Emergencies Panel
  - *Emergency Preparedness Plan & Geographic Information System Mapping*: Inland Empire Health Plan
  - *COVID-19 Pandemic—Implementing a Response Plan for MCAS Compliance*: Kern Health Systems, DBA Kern Family Health Care

  - *Partnership HealthPlan of California's Medical Equipment Distribution Services Program*: Partnership HealthPlan of California
- Poster Networking Sessions grouped into the following topic areas:
  - Child and Adolescent Care
  - Women's Health
  - Chronic Disease Care/Management
  - COVID-19 and Influenza Vaccinations
  - Provider/Community Partnerships
  - Member Outreach/Engagement

Day 2—Expanding Resiliency in the Community

- DHCS Update—*From Exam Rooms to Community Blocks: Achieving Quality, Health Equity, and Value in Medi-Cal*: Dr. Palav Babaria, MD, MHS, Chief Quality Officer and Deputy Director of Quality and Population Health Management, DHCS
- *Promoting the Emotional Well-Being of Medi-Cal Populations in California During A Public Health Emergency—Approaches and Lessons Learned*: Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- *Children's Health Partnerships During the Pandemic*: Health Plan of San Joaquin
- Quality Improvement Awards, Innovative Poster Award and Closing Remarks: Dr. Palav Babaria, MD, MHS

Virtual Posters

DHCS and HSAG requested volunteers from MCMC plans to create virtual posters for the conference to present or describe a project related to the conference theme that incorporated a focus on promoting health equity and system-level improvements to facilitate even greater sharing of promising practices. Fifteen MCMC plans submitted posters, which were displayed on the conference webpage. DHCS also submitted one poster describing its use of the SWOT process. Prior to and during the conference, conference participants reviewed the posters and had the opportunity to vote for the most innovative poster. Additionally, at the end of Day 1 of the conference, participants had the opportunity to participate in poster networking sessions to learn more from the poster creators about the initiatives described in the posters.

Quality Improvement and Innovative Poster Awards

DHCS announced the following awards during the conference:

- Consumer Satisfaction Award 2021—Adult—Small Scale Plan: Kaiser SoCal
- Consumer Satisfaction Award 2021—Adult—Medium Scale Plan: Partnership HealthPlan of California
- Consumer Satisfaction Award 2021—Adult—Large Scale Plan: CalOptima
- Consumer Satisfaction Award 2021—Child—Small Scale Plan: Kaiser SoCal

- Consumer Satisfaction Award 2021—Child—Medium Scale Plan: Central California Alliance for Health
- Consumer Satisfaction Award 2021—Child—Large Scale Plan: Health Net Community Solutions, Inc.
- Health Equity Award Runner Up 2021: Kern Health Systems, DBA Kern Family Health Care for its Mobile Mammography Event
- Health Equity Award Winner 2021: Blue Shield of California Promise Health Plan for BlueSky, a multi-year initiative to enhance access, awareness, and advocacy to youth mental health supports for California's youth
- Innovation Award Runner-Up 2021: Inland Empire Health Plan for its Medi-Cal primary care provider auto-assignment redesign
- Innovation Award Winner 2021: SCAN Health Plan for leveraging mobile integrated health care and emergency medical technicians to deliver COVID-19 vaccines to homebound members, their caregivers, and family members
- Outstanding Performance on Managed Care Accountability Set Measures for Reporting Year 2021: Community Health Group Partnership Plan
- Most Innovative Quality Conference Poster: SCAN Health Plan for its poster, *Organization-Wide Strategy to Reduce Disparities in COVID-19 Vaccination Rates Among Vulnerable Older Adult Population*

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.

Evaluation Methodology

DHCS and HSAG created separate online evaluation tools for each day of the conference. The evaluation asked participants to rate the overall content and individual presentations and provide open-ended feedback related to the content, presenters, and overall conference, including recommendations for the next conference.

Near the end of each day of the conference, HSAG provided the participants with links to the online evaluation collection tools. To promote evaluation completion, HSAG emailed the links to participants a few hours after the conference concluded each day. Additionally, HSAG required those participants seeking continuing education units to complete the evaluation.

Results—Quality Improvement Conference Technical Assistance Activity

Day 1 of the conference drew 352 participants, of which 316 represented MCMC plans, 35 represented DHCS, and one represented CDPH. Day 2 of the conference drew 328 participants, of which 293 represented MCMC plans, 34 represented DHCS, and one represented CDPH.

Of the 352 Day 1 conference participants, 228 (65 percent) completed a conference evaluation. Of the 228 participants who completed an evaluation, 199 (87 percent) were MCMC plan staff members, and 29 (13 percent) were DHCS staff. Of the 328 Day 2 conference participants, 186 (57 percent) completed a conference evaluation. Of the 186 participants who completed an evaluation, 160 (86 percent) were MCMC plan staff members, and 26 (14 percent) were DHCS staff.

Conclusions—Quality Improvement Conference Technical Assistance Activity

Overall, the 2021 Quality Conference was very well received. Most evaluation respondents agreed that as a result of the conference presentations, they gained knowledge and skills to apply to their quality improvement work. Many respondents noted that the conference content was timely, relevant, and informative, and reflected the real challenges MCMC plans face and amount of work they do. Both MCMC plan and DHCS respondents gave positive feedback about the poster networking sessions and indicated that the awards session was a good way to celebrate MCMC plans' hard work. Most respondents agreed that the presenters were effective in presenting the content. The respondents provided positive feedback about all presenters (including poster presenters), indicating that they were knowledgeable and well-prepared for their presentations.

The respondents indicated that the virtual platform worked well. Most respondents noted the ease of using Webex and value of having a conference webpage to refer to for all conference materials. Only a few respondents encountered minor technology issues. While varying opinions were expressed regarding the format preference for the next conference, more respondents recommended using the virtual platform than convening in person. The respondents also provided recommendations on potential topics for the next conference.

Recommendations—Quality Improvement Conference Technical Assistance Activity

Based on feedback from conference participants and results of the conference facilitation, HSAG provided recommendations for DHCS to consider for future quality conferences. 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 the quality improvement conference technical assistance activity.

18. 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).[92,93]

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.

[92] The California Code of Regulations is searchable and may be found at https://govt.westlaw.com/calregs/Search/Index. Accessed on: Dec 1, 2021.

[93] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. Title 42 CFR Parts 431,433, 438, et al. Medicaid and CHIP Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Dec 1, 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, 25 MCPs and three PSPs submitted reports to DHCS. Five MCPs requested extensions on their final submissions, and DHCS requested additional information from 18 MCPs and the three PSPs before providing PNA report approval. Upon review of all submissions and resubmissions, DHCS approved 24 MCPs' and the three PSPs' PNA reports. DHCS was unable to approve one MCP PNA report.

From the PNA reports, DHCS identified 138 objectives across all MCPs and PSPs. DHCS required MCPs and PSPs to include at least one objective focused on reducing a health disparity. Of the 138 objectives:

- Fifty (36 percent) were related to a health disparity.
- Fifty-seven (41 percent) were new objectives for 2021.
- Fifty (36 percent) were objectives continued from 2020.
- Thirty-one (22 percent) were objectives continued from 2020 but with changes (population, data source, etc.)
- Forty-one (30 percent) targeted a specific race/ethnicity, with the top two being:
  - African American/Black—46 percent.
  - Hispanic/Latinx—17 percent.
- Twenty-seven (20 percent) targeted all members.
- Forty-seven (34 percent) targeted a specific age group, with 23 of these objectives (49 percent) focusing on children.
- Twenty-two (16 percent) specified a language, with 12 of these objectives (55 percent) focusing on non-English-speaking members.
- Some included more than one targeted behavior or disease, with most objectives focusing on preventive services and chronic disease management.

2020 Action Plan Update

DHCS compared MCPs' and PSPs' reported progress toward achieving the 2020 PNA Action Plan objectives and observed the following:

- Sixty objectives were better in 2021.
- Forty-two were worse in 2021 due to pandemic influences between 2020 and 2021.
- Five remained the same.
- Forty-two were unknown due to data source issues.

Highlights—Population Needs Assessments

DHCS noted the following in its review of the PNA reports:

- Of the MCP and PSP staff members who were part of the PNA process:
  - Eighty-six percent and 72 percent of health education and cultural and linguistic staff, respectively, were involved in the PNA objective selection process and strategy implementation.
  - Seventy-six percent of quality improvement staff members participated in strategy implementation, and 52 percent of these staff members helped to select PNA objectives.
- The percentage of PNA objectives aligning with other MCP and PSP priority areas were as follows:
  - Health Equity—83 percent
  - PIPs—55 percent
  - PDSA cycles—48 percent
- The data sources used by MCPs and PSPs were diverse.
- MCP and PSP objectives reflect prioritization of addressing health disparities.
- MCPs and PSPs selected measurable objectives.

Based on its review of the PNA reports, DHCS identified the following lessons learned and considerations for the PNA process:

- MCPs and PSPs that fail to achieve PNA report approval are held accountable to address issues identified in the PNA process via the MCP- and PSP-specific evaluation report process wherein the EQRO makes recommendations to which the MCP or PSP must respond.
- Consider having HSAG include in the MCP- and PSP-specific evaluation reports the number of PNA report submissions each MCP and PSP provides to DHCS before DHCS provides final approval.
- The pending implementation of CalAIM's Population Health Management component and requirement for MCP and PSP NCQA accreditation could impact the PNA as it exists in its current form.

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 and assessment 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.

19. Follow-Up on Prior Year's Recommendations

As part of the process for producing the *2020–21 Medi-Cal Managed Care External Quality Review Technical Report*, DHCS provided the following information on the actions that DHCS took to address recommendations that HSAG made in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report.* Table 19.1 provides EQR recommendations from the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*, along with DHCS' self-reported actions taken through June 30, 2021, that address the EQR recommendations. Please note that HSAG made minimal edits to Table 19.1 to preserve the accuracy of DHCS' self-reported actions.

Table 19.1—DHCS' Self-Reported Follow-Up on External Quality Review Recommendations from the 2019–20 Medi-Cal Managed Care Technical Report

2019–20 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
1. 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.	After internal discussions and input from the EQRO, DHCS determined to allow MCPs and PSPs to choose the methodology for measure reporting for measures with specifications that allow for both the administrative and hybrid methods beginning with measurement year 2020. On May 5, 2021, DHCS informed MCPs and PSPs of its decision, indicating that DHCS expects MCPs and PSPs to choose the method that results in the best performance rate for the MCP/PSP.
2. 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.	DHCS included questions about supplemental data types and collection in its 2019 and 2020 Annual Quality Improvement Surveys; the results of the surveys were then shared with the MCPs and PSPs. DHCS also continues to work with MCPs on improving reporting of new electronic clinical data system measures which rely on EHRs and other electronic data-based systems.
3. When DHCS evaluates the MLTSSP performance measure requirements, HSAG recommends that DHCS obtain input from MLTSSPs and other stakeholders regarding adding MLTSS-	DHCS determined not to consider changes to the MLTSSP performance measure requirements during the period of July 1, 2020, through June 30, 2021, due to various factors, including the ongoing

2019–20 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
specific measures from CMS' MLTSSP measure list to the DHCS MLTSSP required measure set.[94]	COVID-19 public health emergency. DHCS agrees that stakeholder input and consideration of the CMS MLTSSP measure list will be important when MLTSSP performance measure requirements are reevaluated moving forward.
4. While HSAG understands that the difference in the 2020 scores for the *Getting Needed Care* CAHPS 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.	DHCS intends to leverage previous efforts to assess variable CAHPS performance along with ongoing efforts to engage MCPs so that DHCS and MCPs can try to better understand the various contributing factors to CAHPS performance. Increased survey frequency will provide the opportunity for more robust information on a regular basis that can be further utilized to monitor trends and assess strategies as DHCS emphasizes member satisfaction in the Department's quality strategy.
5. When planning for the 2020–21 Medi-Cal Health Disparities Analysis, 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.	DHCS is reexamining certain aspects of the Health Disparities Analysis methodology to include the reference group. Two pilot studies were performed to assess the analysis of the report and various reference groups. DHCS will use these studies along with research to make an evidence-based decision for the reports. Additionally, DHCS is looking into more directed methods to assess/examine disparities as recommended by the EQRO.
To potentially improve access and alternative access reporting:	
6. Identify alternative resources and technologies that could be leveraged by MCPs to provide access to members	DHCS is expanding the network of providers through the use of telehealth to improve access to care. At this time, telehealth cannot be considered for network adequacy

[94] 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: Dec 10, 2021.

2019–20 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
living in remote locations that prevent meeting time and distance standards. a. 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.	standards. A trailer bill is pending in the California Legislature that would allow telehealth providers to assist Medi-Cal MCPs in meeting network adequacy standards.
7. 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.	DHCS agrees with this recommendation and has leveraged the California Health and Human Services Open Data Portal to post a list of all MCPs' contracted providers and their demographic information. DHCS also posts on the Open Data Portal a list of all Medi-Cal enrolled providers and their demographic information.
To further understand the experiences of those placed in SNFs/ICFs and the distance they are placed from their residence, consider the following recommendations for future analyses:	
8. Although some facilities may be licensed as both a SNF and an ICF, Minimum Data Set 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	DHCS agrees with focusing on this area and to this end has conducted a pilot study to further explore this information. Draft results have been shared and are being considered by DHCS.

2019–20 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
both SNF and ICF residents.[95] Further, DHCS could consider calculating MCP-level rates for these measures.	
9. DHCS should 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.	The use of the antipsychotic and hypnotic/antianxiety medications metric looks at SNF residents with stays greater than 100 days, which falls outside the current scope of the managed care plan contracts. DHCS is considering leveraging the findings of this investigation to determine inappropriate overuse of antipsychotic drugs outside of the SNF/ICF Experience Analysis as part of the CalAIM Long-term Care carve-in and/or larger Department-wide effort. For this particular SNF analysis, DHCS will explore other ways to capture member experience either through surveys, other measures in DHCS' administrative data, or the CMS Minimum Data Set.
10. DHCS should 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).	The 2020–21 study will include data and reports related to members who were not placed in the closest SNF to understand limitations including: ♦ Capacity levels of the closest versus the chosen SNF. ♦ Specific health conditions of the member.

[95] 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: Dec 10, 2021.

2019–20 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2020–June 30, 2021, that Address the External Quality Review Recommendations
11. DHCS should consider assessing 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.	DHCS has committed to evaluating distances in this manner in further iterations of this study.

Assessment of DHCS' Self-Reported Actions

HSAG reviewed DHCS' self-reported actions in Table 19.1 and determined that DHCS adequately addressed HSAG's recommendations from the *2019–20 Medi-Cal Managed Care Technical Report*. DHCS provided details regarding the steps it has taken or will take in response to HSAG's recommendations, and the reported actions reflect DHCS' thorough consideration of the recommendations and intent to vet applicable intended actions with stakeholders.