Medi-Cal Managed Care Advisory Group Meeting

March 11, 2021 – (Webex Only)
Webex Meeting number (access code): 145 710 0607
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Agenda

- Welcome and Introductions
- DHCS COVID-19 Updates
  - Encounter Data Trends
  - Vaccine Distribution
- Rate Setting
- Population Health Management
- Children's Preventive Services Report
- Health Disparities Report
- Asian Disparities Report
- Updates
  - Managed Care Project Updates
  - Ombudsman Report
  - Network Monitoring 2021
  - CalAIM
- APLs and DPLs Update
- Open Discussion
- Next Meeting – June 3, 2021

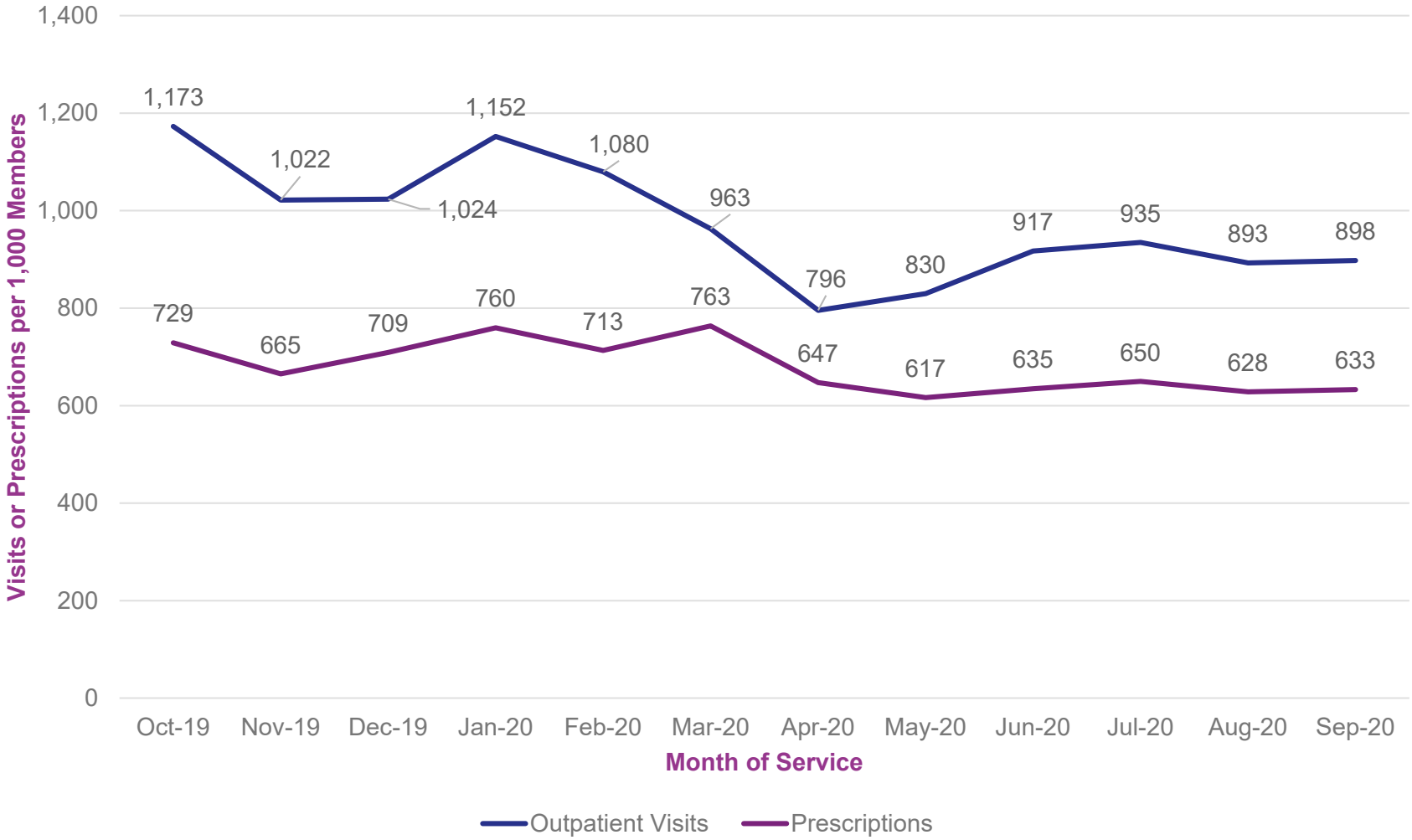
Welcome and Introductions

DHCS COVID-19 Updates

Encounter Data and Grievance Trends

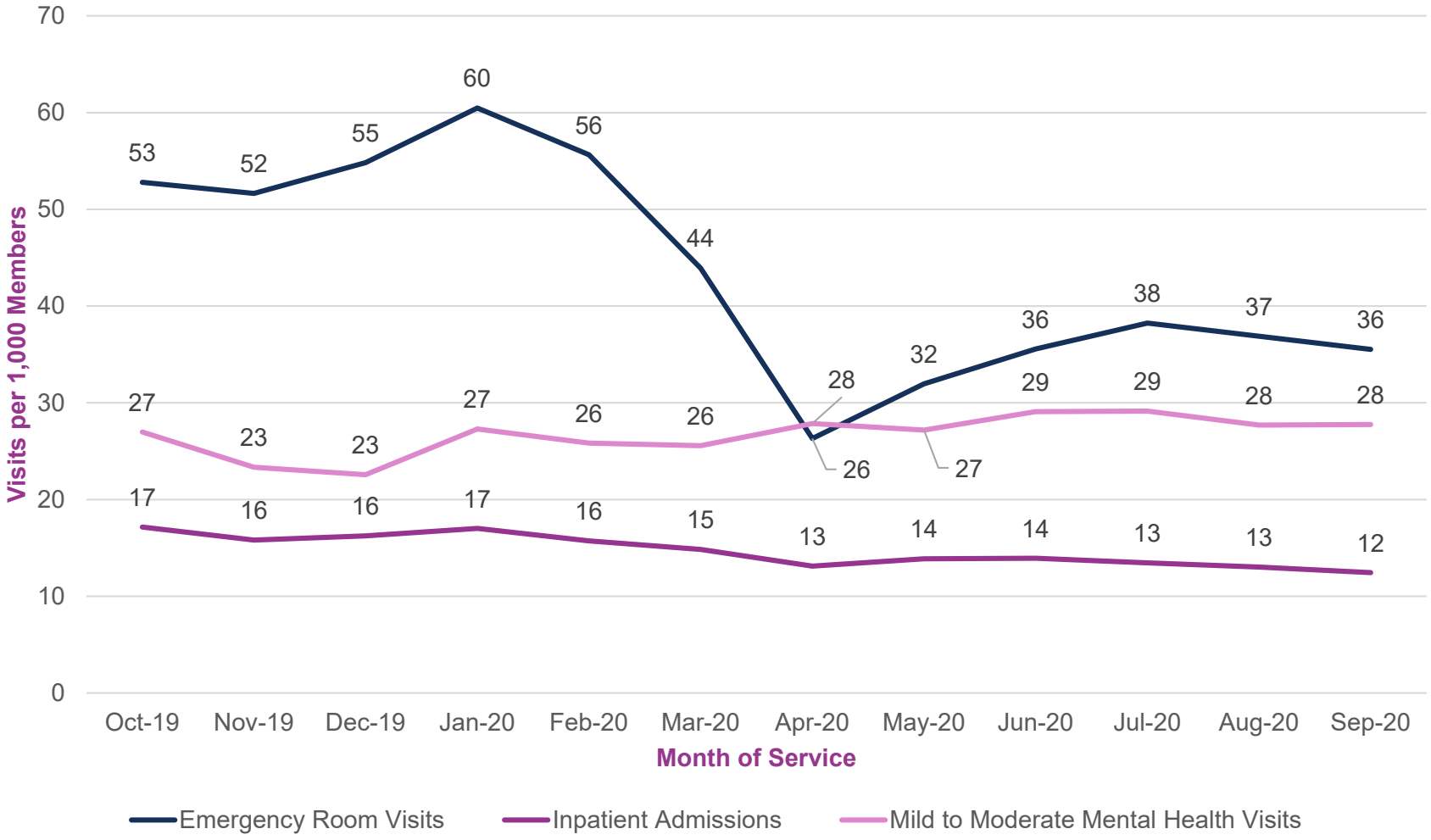
Andrew Wong
Program Data Section, Chief
Data Analytics Branch

Outpatient and Prescription Utilization Trends



Data Source: MIS/DSS | Data Represents: October 2019 – September 2020 | Date Downloaded: 02/19/2021

ER, Inpatient, and Mild to Moderate Mental Health Utilization Trends



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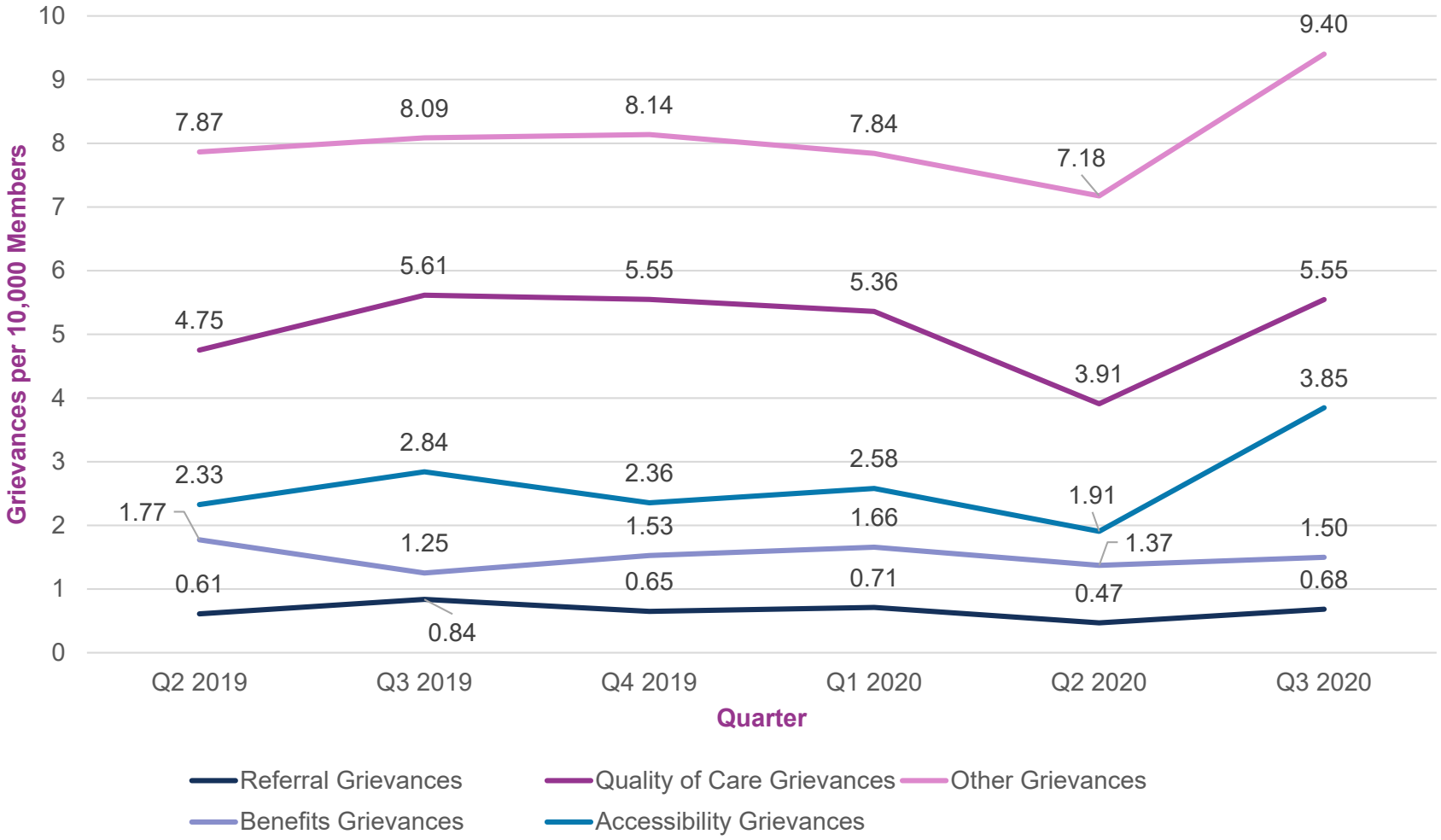
Grievances Trends



Data Source: Enterprise Performance Monitoring | Data Represents: April 2019– September 2020 | Date Downloaded: 02/19/2021

DHCS

Questions?

Vaccine Distribution

Karen Mark
Medical Director
Office of the Medical Director

Rate Setting

Jesse Delis
Staff Services Manager III
Capitation Rates Development Division

Rate-Setting Overview (Rate-Setting 101)

Medi-Cal Managed Care

- Medi-Cal Managed Care (MC) health plans serve approximately 80% of the Medi-Cal population.
  - DHCS contracts with MC plans to provide health care services to Medi-Cal MC beneficiaries across every California county.
- When DHCS contracts with more than one plan in a given county, the Medi-Cal MC beneficiary has the option to select which plan in their county they choose to enroll in based on the list of DHCS contracted plans within that county.
  - If the beneficiary does not select a plan, they will be assigned one (auto-assignment).
- Plans provide health care services to their assigned/enrolled beneficiaries through established networks of organized systems of care, which emphasizes primary and preventive care.
- Plans typically do not provide direct care to the beneficiaries; instead, they utilize their network to provide the appropriate medical care for covered services/benefits.

Medi-Cal Managed Care

- MC plans are paid a set monthly premium referred to as a capitation payment.
  - The capitation payment is paid per-member-per-month (PMPM).

- Rates are developed in four primary managed care models:
  - Two Plan
  - Geographic Managed Care (GMC)
  - County Organized Health System (COHS)
  - Regional Model (includes San Benito and Imperial)

- Rates within each model are developed at a county or regional level by category of aid (COA).

Category of Aid

Rates are plan-specific and developed by county/region

COA groups as of CY 2021 (January 1, 2021 through December 31, 2021) are as follows:

- **Adult**
- **Child**
- Seniors and Persons with Disabilities **SPD [Non-Full Dual]**[1]
- **SPD Full-Dual**[2,3]
- Optional Expansion (**OE**)
- **OBRA** (only in COHS – Napa/Solano/Yolo counties)
- Long Term Care (**LTC**) [**Non-Full Dual**][1] (COHS/CCI counties only)
- **LTC Full-Dual**[2] (COHS/CCI counties only)
- Whole Child Model (**WCM**) in all COHS counties (except Ventura)

[1]Non-Full Dual COAs – Medi-Cal only beneficiaries, or Medi-Cal beneficiaries with either Medicare Part A only (IP Medicare Coverage) or Medicare Part B only (OP Medicare Coverage) but not both.
[2]Full-Dual COAs – Medi-Cal beneficiaries with Medicare A *and* B.
[3]Breast and Cervical Cancer Treatment and Prevention (**BCCTP**) was a COA, but is consolidated with SPD as of CY 2021.

Medi-Cal Managed Care

- DHCS' goals in the rate development process is to ensure rates are reasonable, appropriate and attainable, encourage quality and efficiency in our Medi-Cal MC plans, and match payment to risk.
- In general, DHCS uses actual MC plan experience for the specified population in setting rates for the managed care populations and uses a combination of plan-specific and risk-adjusted county average experience for each plan's rates.
  - Other data sources may be utilized as appropriate for rate development, especially when populations/services are new to MC and/or new to Medi-Cal.

State and Federal Rate Setting Requirements

State and Federal Requirements

- Rate setting must follow CA Welfare and Institutions Code Section 14301.1.
- Per federal regulations, managed care capitation rates are "actuarially sound" if:
  - they have been developed in accordance with standards specified in Title 42, Code of Federal Regulations (CFR) § 438.5, and generally accepted actuarial principles and practices.
  - are appropriate for the populations to be covered and the services to be furnished under the contract.
  - are certified by an actuary as meeting applicable federal requirements specified in Title 42 CFR § 438.4.

CMS Review and Approval

- Centers for Medicare & Medicaid Services (CMS) reviews Medicaid capitation rates for compliance with actuarial standards and federal requirements.
- Capitation rates are developed and must be submitted to CMS for a defined period of time, known as a “rating period”.
- For each rating period, CMS reviews the following components:
  - Actuarial rate methodology and rates
  - Actuarial certification
  - Projection of expenditures for the rating period
  - Base data (utilization and cost), base data adjustments, programmatic changes, trend, etc.

Data Used for Rate Development

Base Data Used for Rate Development

Data specific to the Medicaid population must be used to develop rates. If data is not available, other types of data may be used and then adjusted to fit the Medicaid population.

Data elements used in rate setting include:

- Plan-specific utilization and cost data
- Plan-specific encounter and claims data
- Fee-for-Service (FFS) data and other ad hoc data as needed

Financial statements specific to Medi-Cal operations are also reviewed.

Category of Service

Each COA is subdivided into 19 categories of service (COS):

- Inpatient Hospital Services
- Outpatient Facility Services
- Emergency Room Facility Services
- LTC Facility Services
- Physician Primary Care Services
- Physician Specialty Services
- Federally Qualified Health Centers
- Other Medical Professional Services
- Mental Health – Outpatient
- BHT Services
- Pharmacy[1]
- Laboratory and Radiology
- Transportation
- Community Based Adult Services
- Hospice
- Multipurpose Senior Services Program (CCI counties only)
- In-Home Supportive Services (CCI counties only)
- Home and Community Based Services (HCBS) Other
- All Other

[1]Pharmacy is an add-on effective January 1, 2021. This specific COS is an add-on for the CY 2021 rating period (i.e. not part of the base rate).

Base Data Adjustments

- Actuaries analyze base data at the COA, county/region MC plan, and COS levels, and apply appropriate adjustments to develop a reasonable “base” for rate development.
- Further adjustments are made for changes in utilization, medical cost inflation (trend), program changes or other items that are expected to change in the rating period.
  - ***Trend*** – An estimate of the change in the overall cost of medical services over a finite period of time.
  - ***Program changes*** – Adjustments that recognize the impact of benefit, eligibility, or other programmatic changes that took place during or after the base data period.

Efficiency Adjustments

- As of CY 2021, DHCS incorporates 5 efficiency adjustments into managed care rate-setting:
  - Potentially Preventable Hospital Admissions (PPA)
    - Account for levels of inefficiency and/or potentially avoidable expenses present in the health plan encounter data
  - Maximum Allowable Cost (MAC) Pricing
    - Identify potentially avoidable pharmacy costs due to reimbursement inefficiencies utilizing prior-period pharmacy data and review of reimbursement for generic products
  - Medicare Part B/D
    - Identify pharmacy claims paid for recipients who had Medicare Part B or Part D coverage
  - Low Acuity Non-Emergent (LANE) Services
    - Identify emergency room visits considered to be preventable
  - Healthcare Common Procedure Coding System (HCPCS)
    - Identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications

Risk Adjustment and County Averaging

Risk Adjustment

- As of CY 2021, risk adjustment occurs for all counties/regions with at least 2 health plans.
  - COHS counties do not experience risk adjustment.
  - Risk adjustment will be applied more broadly (including COHS counties) following the full implementation of Regional Rates.

- Risk adjustment helps to:
  - Capture adverse or positive selection by distributing capitation payments across plans based on the health risk of members enrolled in each plan.
  - Address real and imagined perceptions of fairness by reducing the incentive to “cherry pick” low risk individuals and increasing the incentive to attract higher risk individuals.
  - Better match payment to risk.

Risk Adjustment & County Averaging

- County/regional-average rates are currently risk adjusted using the Medicaid Rx Model developed by University of California, San Diego.
  - The Medicaid Rx Model uses National Drug Codes to classify individuals into various disease categories.
- Following risk adjustments, for CY 2021, final rates are blended at the following 75/25 ratio:
  - 75% of the rate is developed using the risk-adjusted county/regional rate.
  - 25% of the rate is developed using the plan-specific rate.
- DHCS is considering a change to the CDPS+RX model which directly incorporates diagnostic data
- Other potential future considerations are:
  - Social indicators
  - Quality component

Other Rate Considerations

Administrative Load & Underwriting Gain

- An administrative load is added to all rates to account for a health plan's operational costs.

- Underwriting Gain:
  - The low end of the rate range utilizes a 1.5 percent assumed load. The high end of the rate range utilizes a 3.5 percent assumed load.
  - Assumptions surrounding the Underwriting Gain load, along with Investment Income generated, are sufficient to cover at least minimum cost of capital needs for a typical health plan.

Rate Add-On's & Supplemental Payments

A **rate add-on** is developed for certain distinct programs or financial policies – e.g., MCO Tax, pass-through and directed payments.

A **supplemental payment** may be developed for certain benefits and/or services with uncertain utilization and/or cost patterns. Currently DHCS utilizes the following supplemental payments:

- Behavioral Health Treatment
- Hepatitis C
- Maternity
- HCBS High (CCI counties only)
- Health Homes Program

Managed Care Carve-Outs to FFS

A subset of MC beneficiaries' services are provided through the FFS delivery system. As of CY 2021, these include but are not limited to:

- Blood Factors and AIDS Drugs
- California Children's Services (CCS) – covered in COHS counties except Ventura County
- Major Organ Transplants (except Kidney) – covered in COHS counties[1]
- Extended LTC – covered in COHS and CCI counties[1]
- In-Home Supportive Services (IHSS)
- Psychotropic Drugs
- Routine Dental Services – covered by separate Dental MC Plans in Los Angeles and Sacramento counties

[1]Major Organ Transplants and LTC are proposed to be carved in to managed care statewide as of CY 2022 and CY 2023, respectively

Questions?

Population Health Management

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Health Program Specialist I

Dana Durham
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Managed Care Quality & Monitoring Division

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Health Program Specialist II
Health Care Delivery Systems

Population Health Management (PHM)

Overview

PHM requires managed care plans (MCPs) to develop and maintain a person-centered population health management (PHM) program for addressing member health and health-related social needs across the continuum of care. MCP PHM programs must meet the National Committee for Quality Assurance (NCQA) standards for population health management as well as additional DHCS requirements.

Core PHM Program Objectives

1. Identify and assess member risks and needs on an ongoing basis;
2. Identify and mitigate social determinants of health, and reduce health disparities;
3. Keep all members healthy by focusing on preventive and wellness services; and
4. Manage member safety and outcomes during transitions across delivery systems or settings through effective care coordination.

DHCS PHM Requirements

Two categories of DHCS PHM requirements:

Operational Requirements

Obligates plans to change their internal processes and procedures, and transform their service delivery systems into a PHM-oriented model that ensures the equitable provision of health care services to all members.

Program Requirements

Increases the standard of care plans must provide their members by using whole person care approaches to enhance program criteria at every level in the continuum of care.

DHCS PHM Requirements

Operational Requirements:

- **Data Integration** – requires greater integration and interoperability and the development of predictive analytics
- **Population Needs Assessment** – informs the development of programs and services to address the identified needs of groups
- **Risk Stratification and Segmentation** – stratifies members into groups to connect them to appropriate programs and services
- **DHCS Risk Tiering** – assigns members risk tiers based on DHCS criteria to allow for state-level evaluation
- **Individual Risk Assessment** – validates initial risk tier assignment and gathers information for members without sufficient data

DHCS PHM Requirements

Program Requirements:

- **Population Health Management Strategy** – details how managed care plans will meet the needs of all members annually
- **Care Management** – supports the needs of all members through enhanced service requirements
- **Case Management & Coordination** – provides additional accountability and strengthens case management services and the coordination of services across delivery systems
- **Transitional Services** – improves the safety of members and the efficiency of coordinating smoother transitions
- **Quality Assurance Reviews** – ensures internal monitoring by managed care plans for core PHM program requirements

Complementary CalAIM Initiatives

- The **Enhanced Care Management** benefit provides a critical set of new services that are a required part of a managed care plan's PHM program. Implementation: Begins January 2022.
- The adoption of **In Lieu of Services** provides flexible wrap-around services designed to fill gaps in medical care as well as those caused by social determinants of health. Implementation: January 2022.
- **Shared Risk/Savings and Incentive Payments** for managed care plans and providers maximizes the effectiveness of PHM programs and new service options. Implementation: January 2022.
- **NCQA Accreditation** provides a foundation of quality best practices and oversight for PHM and other managed care plan activities. Implementation: January 2026.

PHM Implementation Timeline

When	What
Summer 2021	Voluntary Social Determinants of Health (SDOH) Coding Guidance released to managed care plans
Fall 2021	Population Health Management Policy Documents released for stakeholder review and comment
Spring 2022	Finalized Population Health Management Policy Documents released to managed care plans
	Population Health Management Readiness Deliverables released to managed care plans
Fall 2022	Population Health Management Readiness Deliverables due from managed care plans to DHCS
January 2023	Managed Care Plan Population Health Management Implementation

Questions?

For other comments, questions, or concerns, please contact CalAIM@dhcs.ca.gov

Also, for more PHM initiative details see the CalAIM Proposal available online at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

Thank you.

2020 Preventive Services Report (PSR)

Oksana Meyer, Chief
External Quality Organization & Utilization Section
Policy, Utilization & External Relations

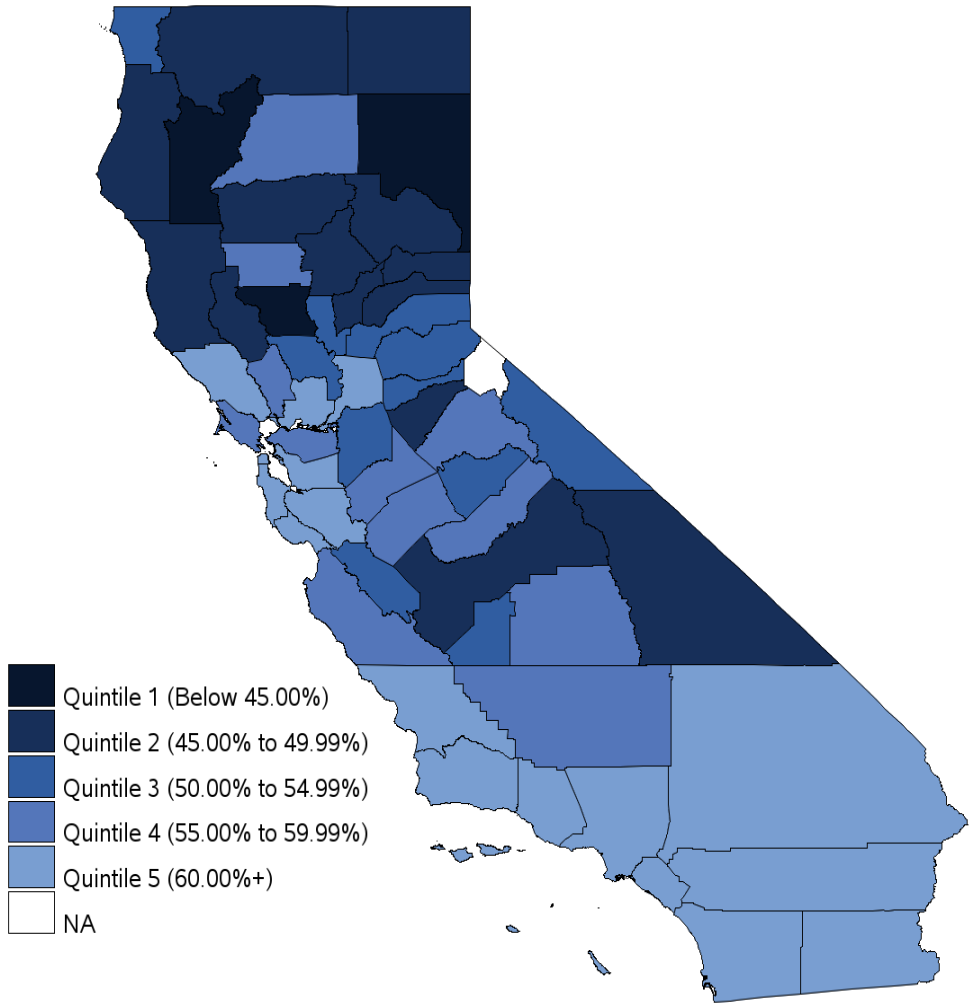
Background

- **2019:** California State Auditor (CSA) recommended DHCS expand its monitoring and oversight of preventive services for children enrolled in Medi-Cal managed care.
- **2020:** DHCS and its External Quality Review Organization (EQRO) developed an annual Preventive Services Report (PSR) that expands analysis & adds metrics to capture preventive services rendered to children in Medi-Cal.
- By assessing provision of children's preventive services across MCPs, measures, and regions DHCS will be able to identify underutilization patterns and implement targeted improvement strategies.

2020 PSR Overview

Report uses admin. data and includes rates that are stratified by:

- Demographic characteristics
  - By racial/ethnic groups, primary language groups, gender (as applicable), and age (as applicable)
- Regionally by county or grouped into larger regions



Indicators for 2020 PSR

Final Measures for PSR 2020	
(1) Alcohol Use Screening	(6) Developmental Screening in the First 3 Years of Life **(MCAS)**
(2) Blood Lead Screening: -HEDIS -Title 17	~~Immunizations for Adolescents-Combo 2*~~ **(MCAS)**
(3) Child and Adolescent Well Care Visits *(MCAS 2021)*	(7) Screening for Depression and Follow up Plan **(MCAS)**
~~Childhood Immunization Status-Combo 10*~~ **(MCAS)**	(8)Tobacco Use Screening
(4) Chlamydia Screening in Women **(MCAS)**	~~Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescent*~~ **(MCAS)**
(5) Dental Fluoride Varnish	(9) Well Child Visits in the First 30 Months of Life *(MCAS 2021)*

COVID Impact - Reporting

Data in future reports could be adversely impacted by COVID:

Report Year (CY)	Data Year (CY)	Expected Data Impact from COVID
2020	2019	Yes
2021	2020	Yes
2022	2021	Yes – (at least first part of year)
2023	2022	Likely Not

Key Assumptions

- Quality improvement takes time & resources
- Leverage ‘umbrella’ measures such as newly expanded **Well-Child & Well-Care Visits**
  - Focus on improvement in these measures can lead to improvement in other non-MCAS measures
  - VBP
  - Increasing the MCAS MPL to 50th percentile
  - Beneficiary Outreach Campaign
- **Blood Lead Screening** indicators, DHCS will work with stakeholders to develop benchmarks
  - Align with new BLS reporting requirements from AB 2276 (APL 20-016)

Statewide & Regional Findings

- Regional analysis showed that overall the **highest** performance is seen in the Central Coast Region and San Francisco Bay Area
- The **lowest** performance overall was seen in the more rural counties in Northern California and the San Joaquin Valley
- Improving performance in just **6 counties**, would boost CA's overall performance.
  - Los Angeles, San Bernardino, Riverside, San Diego, Orange, and Sacramento Counties
- Statewide performance **varied based on race/ ethnicity and primary language**.

Statewide Key Findings

- **Chlamydia Screening in Women age 16-20** rate was 60.5% compared to national rate of 53.7%
- **Developmental Screening in the First 3 Years of Life** was at 25.4% compared to the national rate of 32.7%
  - Highest rate occurring at age 2 (28.99%)
- **Screening for Depression & Follow-up ages 12-21** was 13.85%
  - Highest rates occurring at ages 12-17
- **Dental Varnish** application rate by non-dental providers was at 9%
- **Alcohol & Tobacco Screening** rates were <2%

Well-Child/Care Visit Measures

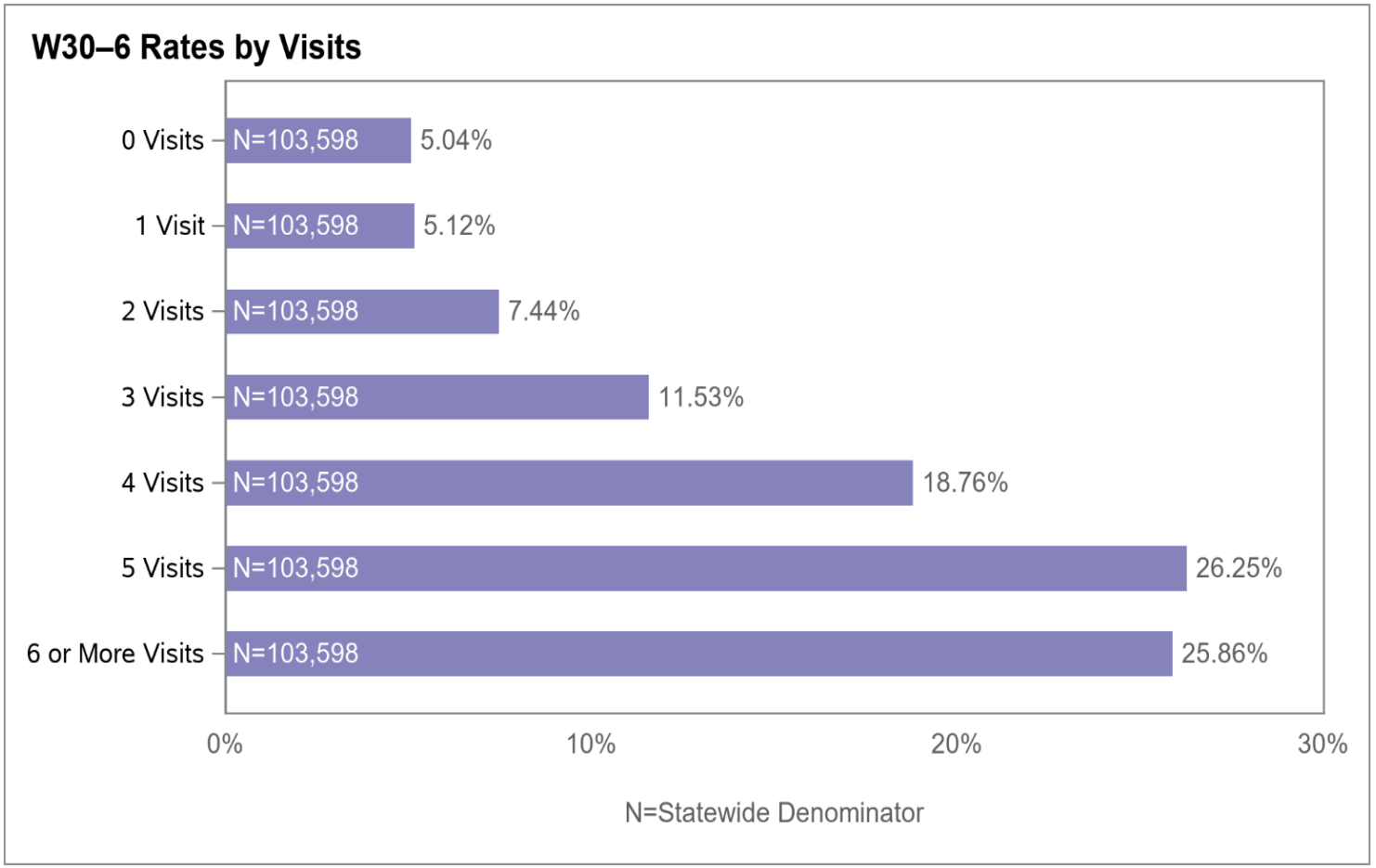
- In 2020 NCQA expanded 'Well-Child Visits in the **First 15 Months** of Life: Six or More Well-Child Visits' (W15) measure with the **new** "Well-Child Visits in the **First 30 Months** of Life" measure

- NCQA amended the 'Well-Child Visits in the **3rd-6th** Years of Life' (W34) measure with a **new** "Child and Adolescent Well-Care Visits" measure that expanded the age range to encompass **ages 3-21** years

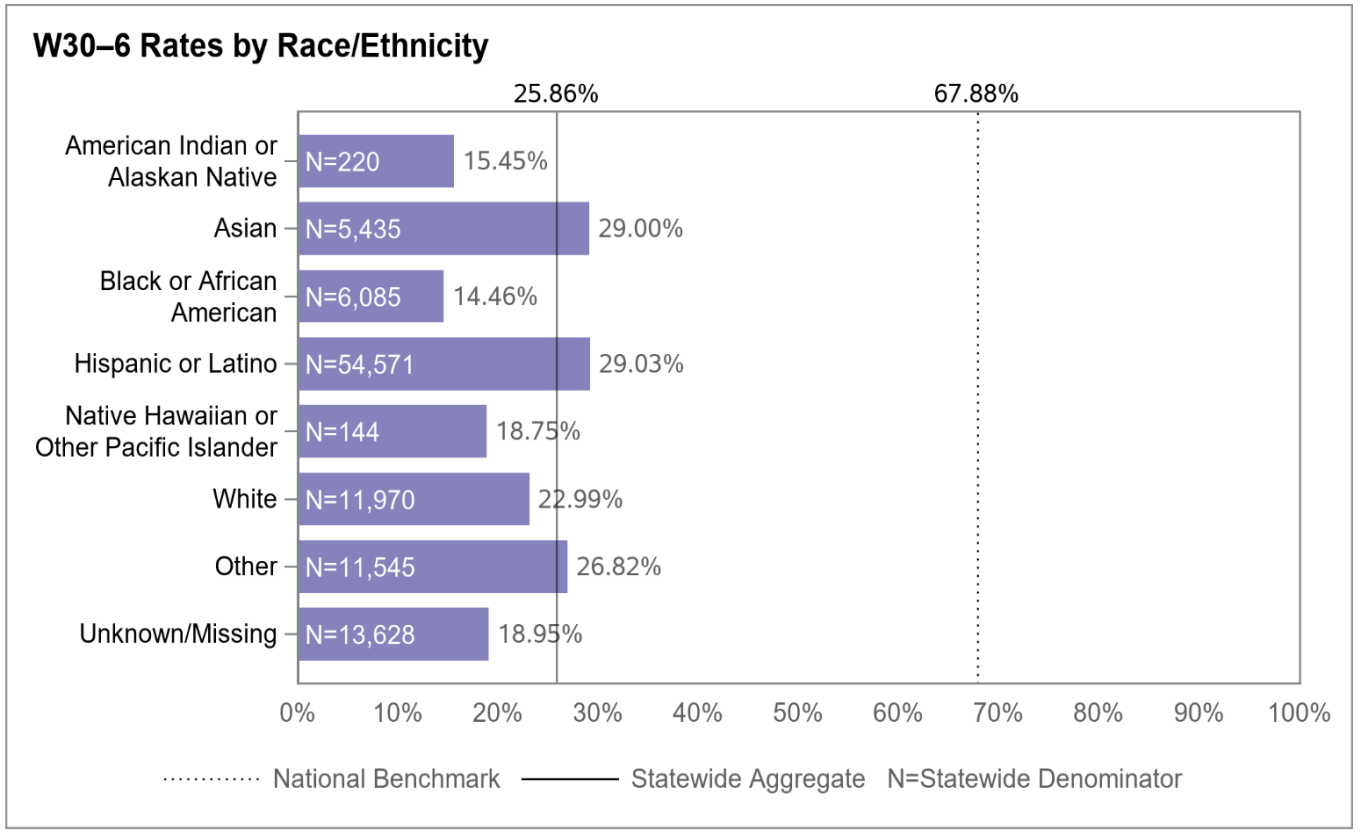
Statewide Key Findings
Well-Child/Care Visits

- Positive findings in that the majority of children received a **Well-Child /Well-Care visit**
  - 70% under 15 months received 4 out of 6 visits
    - Only 26% received 6 out of 6 visits
  - 85% ages 15 to 30 months had at least one visit
  - 68% ages 3-6 had at least one visit
  - 50% ages 7-11 had at least one visit
- Rates declined in older age groups
  - 51% of adolescents ages 12 to 17 had at least one visit
  - Only 26% ages 18-21 had at least one visit

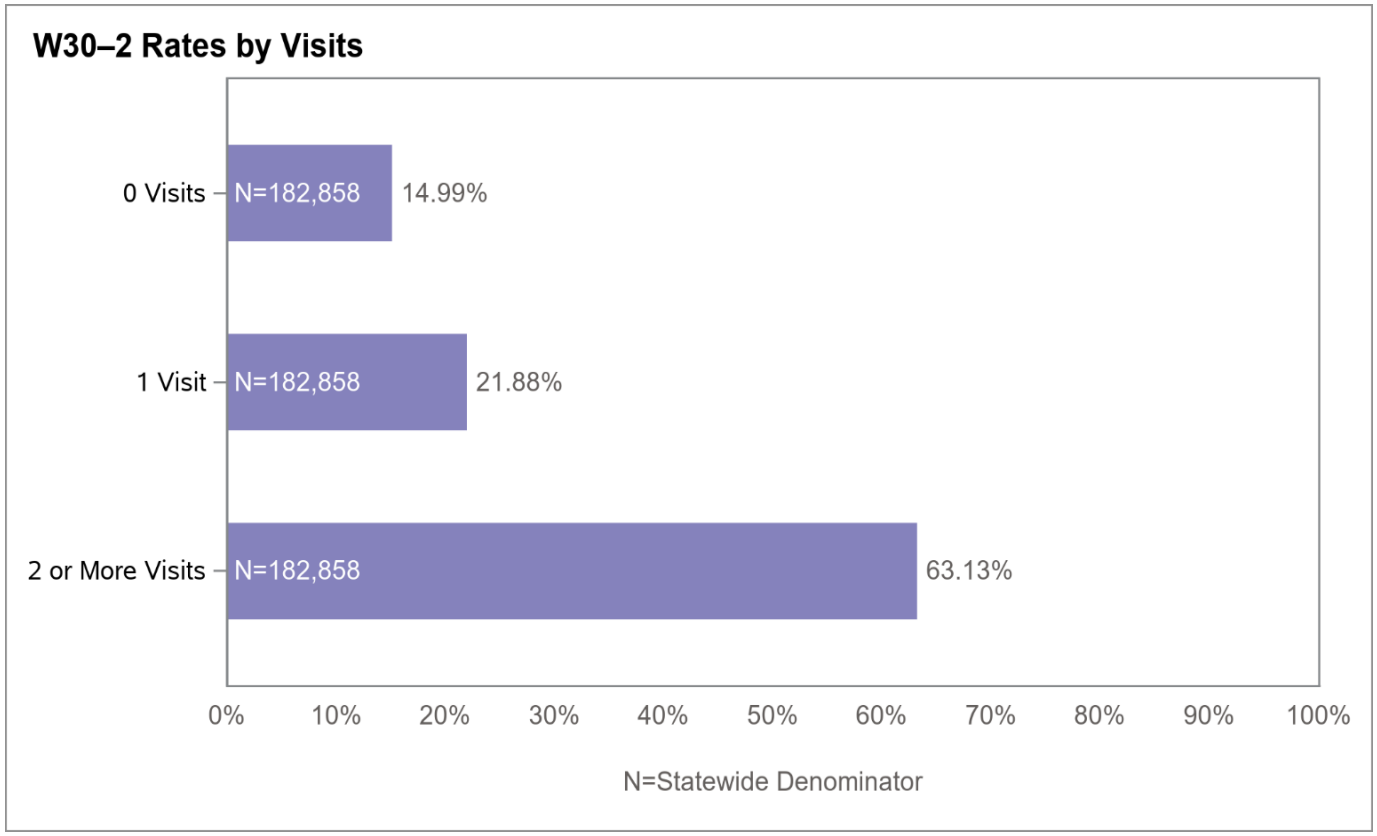
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6)—Statewide Number of Visits Results



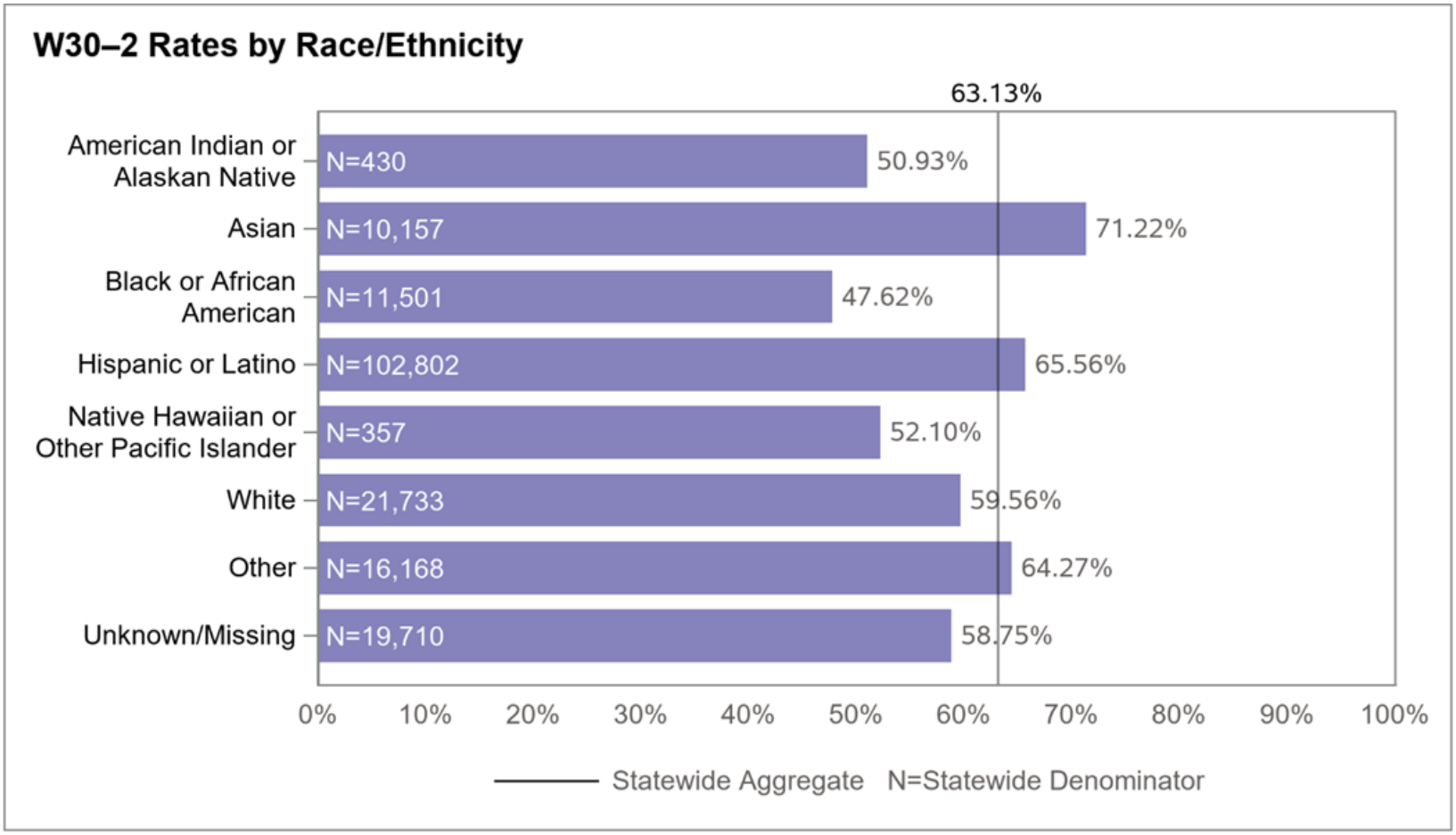
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6)—Statewide Racial/Ethnic Results



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 (W30–2)—Statewide Number of Visits Results

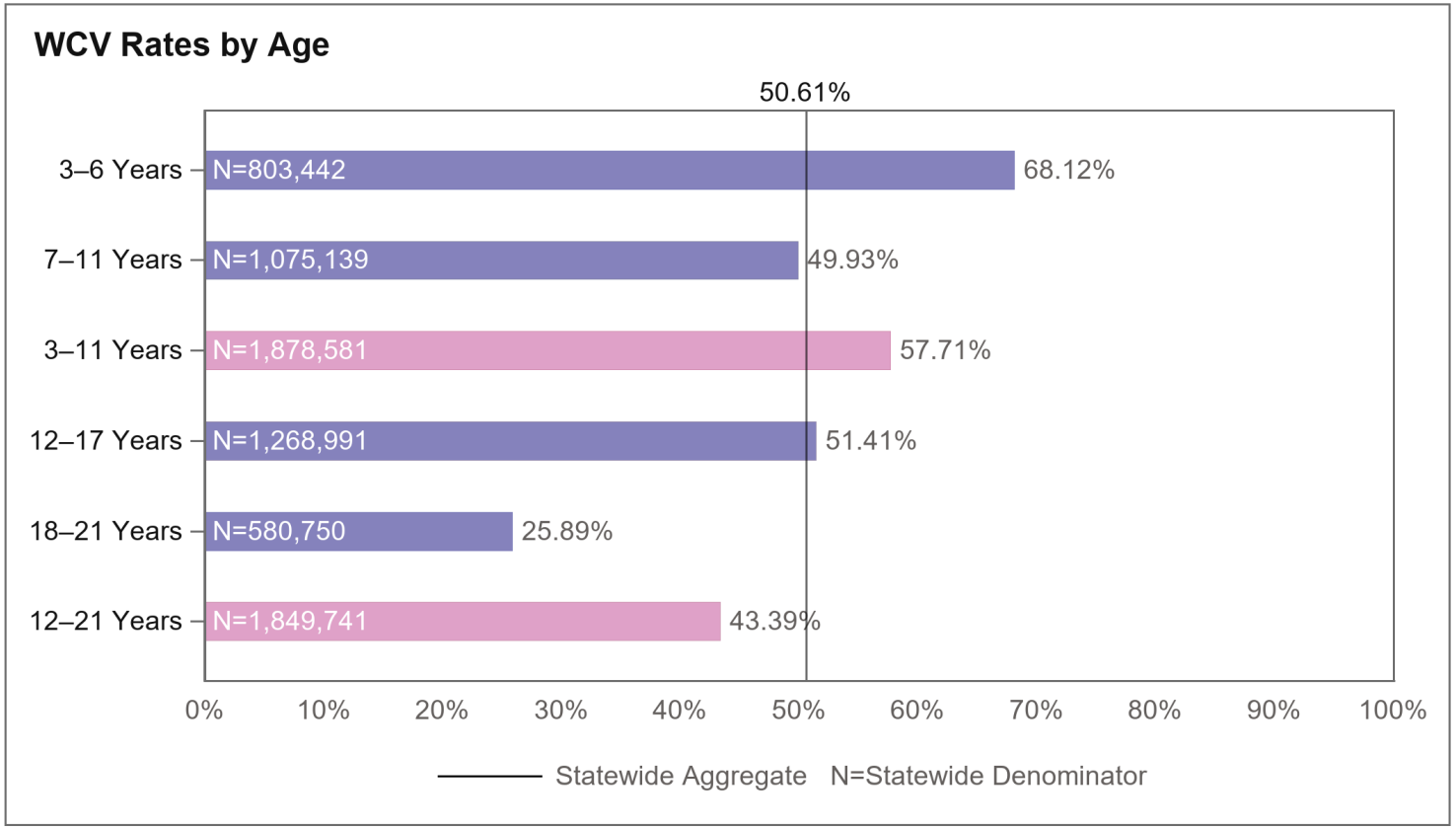


Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits (W30–2)—Statewide Racial/Ethnic Results

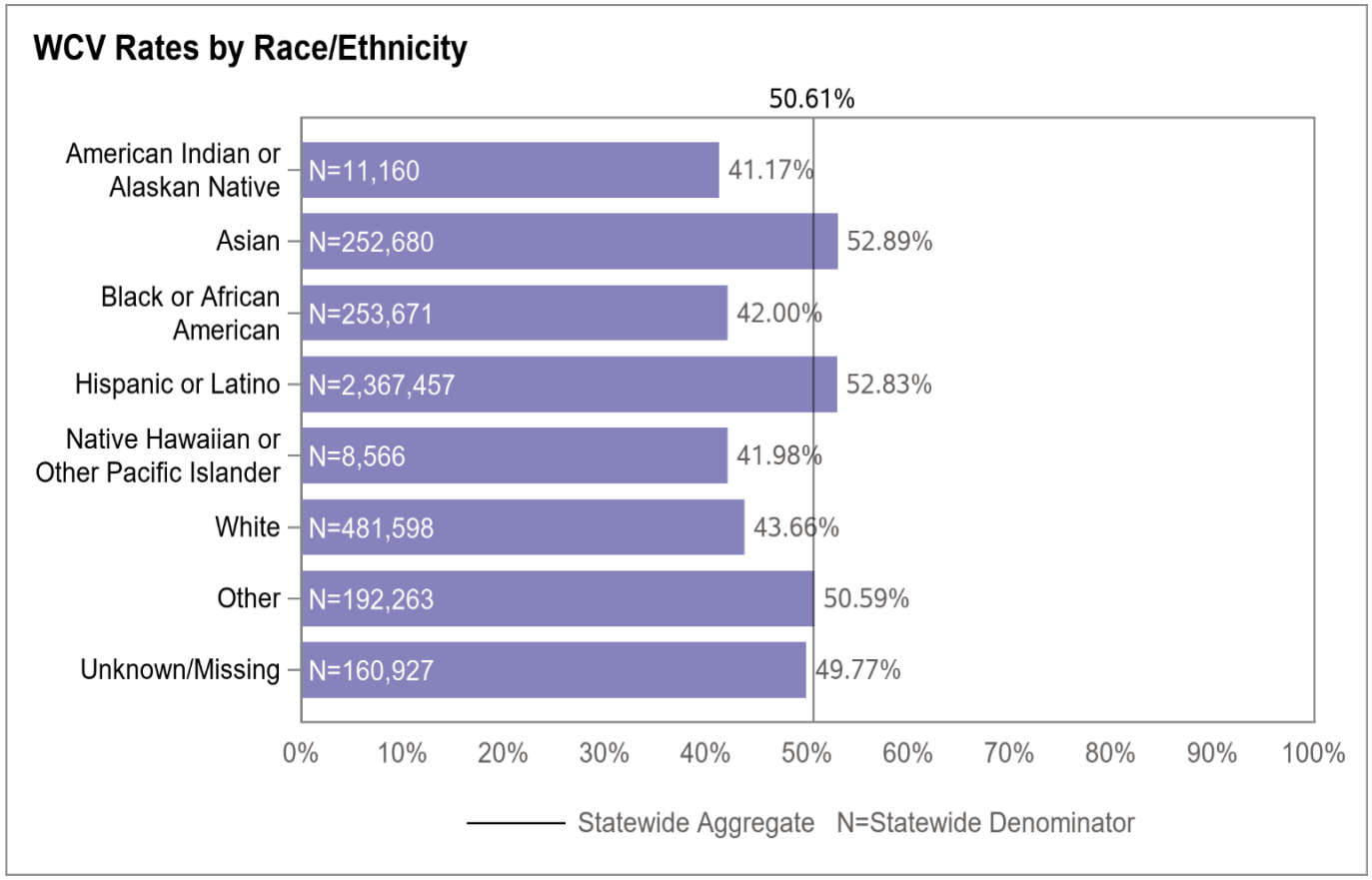


Child and Adolescent Well-Care Visits—Total (WCV)—Statewide Age Results

The national benchmarks for the 3 to 6 Years and 12 to 21 age groups are 74.70 percent and 57.18 percent, respectively.



Child and Adolescent Well-Care Visits—Total (WCV)—Statewide Racial/Ethnic Results



Blood Lead Screening

- DHCS developed metrics to capture Blood Lead (BL) Screening rates in two ways:
  - **HEDIS:** National technical specifications allow California BL Screening performance to be compared to other state Medicaid programs (screens up to age 2).
  - **CA Title 17:** BL Screening rates will be calculated and reported for all relevant age stratifications in accordance with California law (Screens at age 1, 2, and 6).
- HEDIS paves the way for development of the California-based benchmarks as efforts are underway to establish BL Screening performance standards in alignment with Title 17.

Statewide Blood Lead Screening Rates

- HEDIS MPL: 73.1% -- CA is 60.8%
- Title 17:
  - 1 year of age: 53.3%
  - 2 years of age: 43.4%
    - 2 tests by age 2: 30.5%
  - 6 years of age: 37.0%

Statewide Blood Lead Screening Rates

- Statewide performance varies based on race/ethnicity and primary language
  - Asian and Hispanic/Latino racial/ethnic groups had the highest screening rates
  - Black/African Americans, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, and White groups had the lowest rates, with Black/African Americans having the lowest screening rates.

Statewide Blood Lead Screening Rates (continued)

- Blood lead screening performance is regional
  - highest performance was seen in Imperial, Marin, Humboldt, and San Francisco
  - 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)

Recommendations

EQRO recommendations align with existing DHCS interventions:

- Utilize Population Needs Assessment (PNA) and Performance Improvement Plan (PIP) processes to address rates, improve health outcomes, and reduce disparities.
- Leverage provider education efforts to increase member awareness and well-care visit utilization.

Additional EQRO recommendations to improve utilization:

- Coordinate regional provider and member education efforts.
- Expand services (telehealth) and managed care provider networks.
- Use successful county quality improvement efforts as best practices to drive improvement for other counties.
- For well-child visits, target the six largest counties for substantial improvement in California overall.
- For alcohol and tobacco, improve billing practices (coding) and/or consider medical record review to increase accuracy of data reporting.

Current DHCS Interventions

DHCS initiatives are occurring to positively impact outcomes:

- **Provider & Member Education:** *Preventive Services Outreach Campaign* may positively impact utilization due to increased awareness of preventive services.
- **Quality Improvement Processes:** *PNA and PIP* processes can be used to improve the rate of child and adolescent screenings.
- **Incentives:** Value Based Payment (*VBP*) program incentivizes by providing additional payment for alcohol use, tobacco use, blood lead screenings, dental fluoride varnish, and well-child visits.

Oversight and Monitoring

- MCAS measures will remain subject to established monitoring mechanisms and minimum performance levels (MPLs).
- For Non-MCAS measures, DHCS is evaluating alternative performance standard options:
  - Technical assistance approach in existing quality improvement processes (PIP, Population Health Management (PHM), and disparities work).
  - Performance-enhancing quality awards, year-over-year improvement, and a tiered approach.
  - *Blood Lead Screening* benchmarking with input from stakeholders.
  - COVID impact when setting performance standards and timing of holding MCPs accountable.

Next Steps

- Establish benchmarks for Blood Lead Screening.
  - Engage stakeholders in development of performance standards for Blood Lead Screening.
  - Guidance document for stakeholder comment to be released in March/April.
- Evaluate alternative performance standards for remaining non-MCAS indicators.
- Engage stakeholders in the development of the 2021 PSR

Questions?

Health Disparities Report

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Quality & Medical Policy Branch

Background

- The purpose is to assess potential differences in health outcomes between groups within a population
- EQRO uses annual quality measures to conduct a health disparities study of Medi-Cal MCPs
- Stratifications were made based on race/ethnicity, primary language, age, and sex. Statistical analysis was performed using race and ethnicity data
- EQRO aggregated results from the MCP for a statewide interpretation
- There are currently five reports available to view for measurement years 2015-2019

https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfDisp.aspx

Evolution of Reports

- 2015:
  - Compared 12 External Accountability Set (EAS) indicators through a relative difference
  - A disparity was defined as greater than or equal to a 10% difference between racial/ethnic groups as compared to the reference group, which was determined as the most favorable rate per measure
- 2016:
  - Compared 28 EAS indicators through logistical regression
  - A disparity was defined as an absolute difference greater than or equal to 3% between racial/ethnic groups to the reference group (White group)

Evolution of Reports (Cont.)

- 2017:
  - Compared 30 indicators
  - No changes to disparity definition from 2016 report
- 2018:
  - Compared 28 indicators
  - Eight indicators were chosen to trend for measurement years 2016, 2017, and 2018. Both race/ethnicity and primary language were examined.
- 2019:
  - Available quality metrics impacted by COVID
  - Compared 10 administrative MCAS indicators
  - Continue disparity definition as previous three reports

COVID-19 Reporting Impact

- For measurement year 2019, the COVID-19 pandemic impacted MCP retrieval of complete medical records and decreased accuracy for hybrid measures. DHCS allowed for three different methods to report hybrid measures, in alignment with NCQA:
  - Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
  - Report the measurement year 2018 audited hybrid rates, if available.
  - Report the hybrid rates using measurement year 2019 administrative data only.
- Given the uncertainty, variation, and limited hybrid measurement data reporting, administration measures could only be assessed for the 2019 Health Disparities Report

2019 Metrics Breakdown

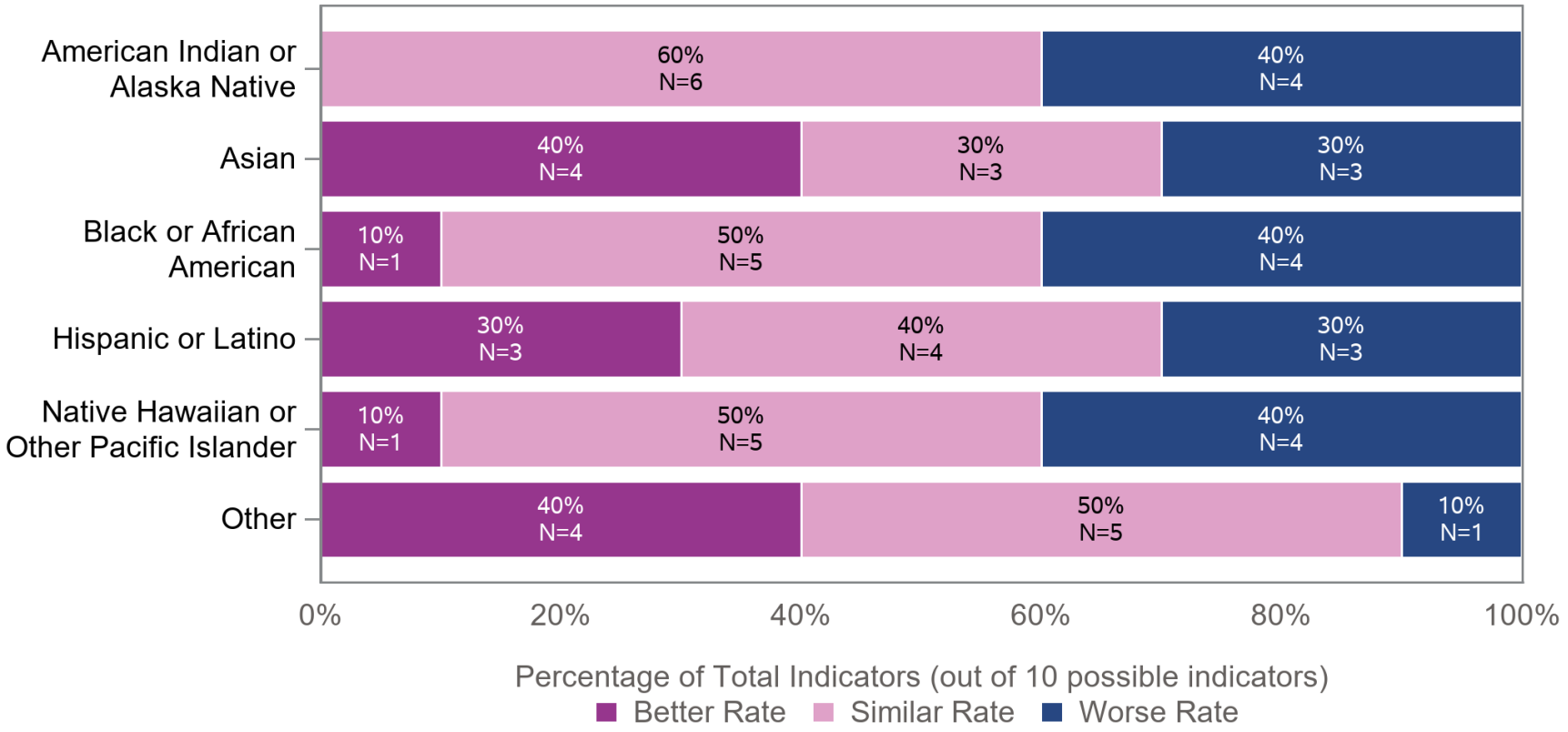
- Indicators based on the 10 administrative MCAS measures
- Measures were stratified into seven racial/ethnic groups (White, American Indian/Alaska Native, Asian, Black/African American, Hispanic/Latino, Native Hawaiian/other Pacific Islander, and other) for statistical analysis
- Measures were stratified by primary language derived from current threshold languages for Medi-Cal Managed Care (MCMC) counties; number of languages assessed varies from measure to measure due to potential small numbers and data suppression

2019 Metrics Breakdown (Cont.)

Indicators
Antidepressant Medication Management – Effective Acute Phase Treatment and Effective Continuation Phase Treatment
Asthma Medication Ratio – Total
Breast Cancer Screening
Chlamydia Screening in Women – Total
Contraceptive Care – All Women – Most or Moderately Effective Contraception – Ages 15-20 Years and Ages 21-44 Years
Contraceptive Care – Postpartum Women – Most or Moderately Effective Contraception – 60 Days – 21-44 Years
Developmental Screening in the First Three Years of Life – Total
Plan All-Cause Readmissions – Observed Readmission Rate – Total

2019 Report Findings

Overall Racial/Ethnic Health Disparities for All MCAS Indicators

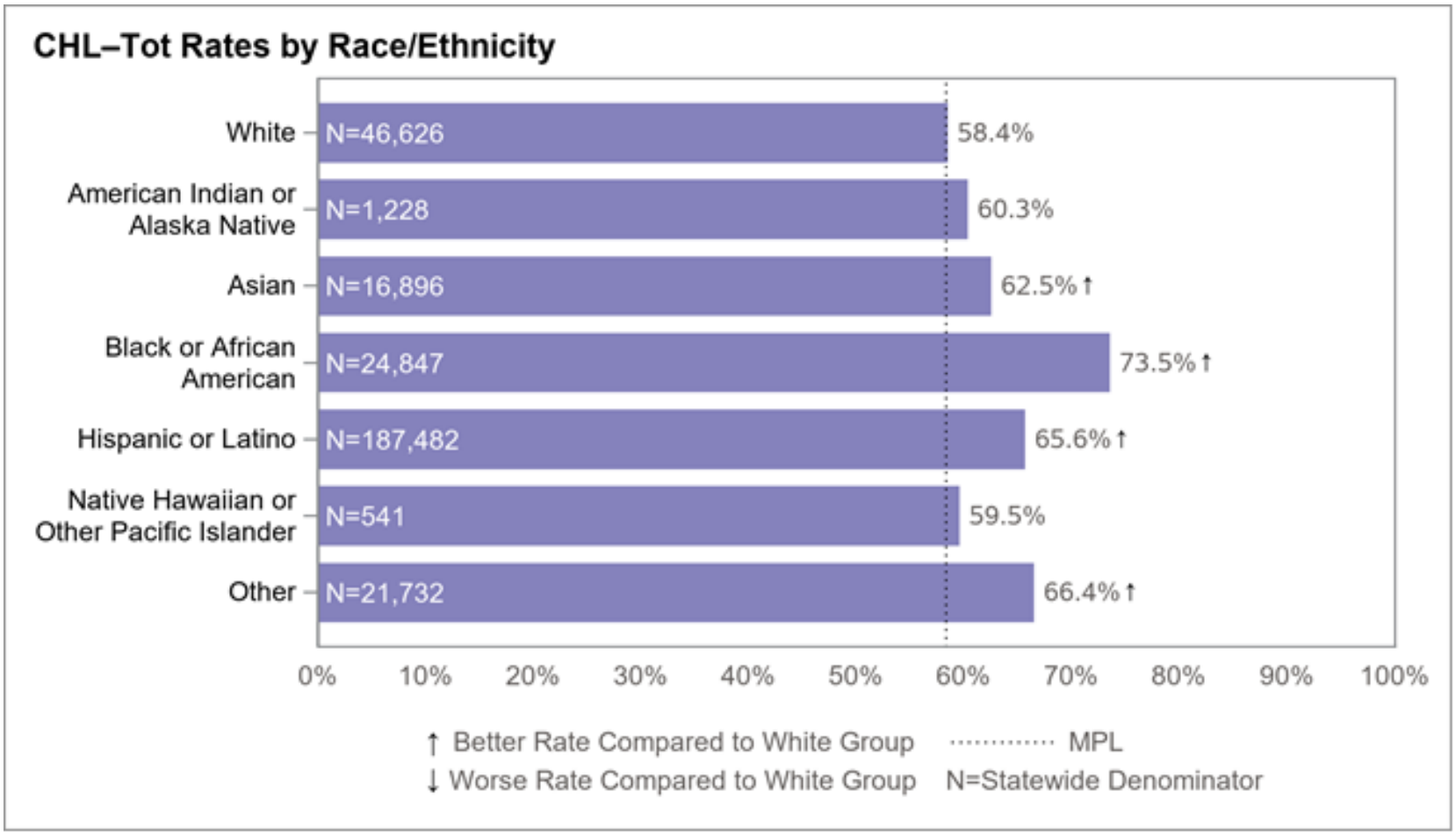


N=Number of Indicators

Compared to White Group

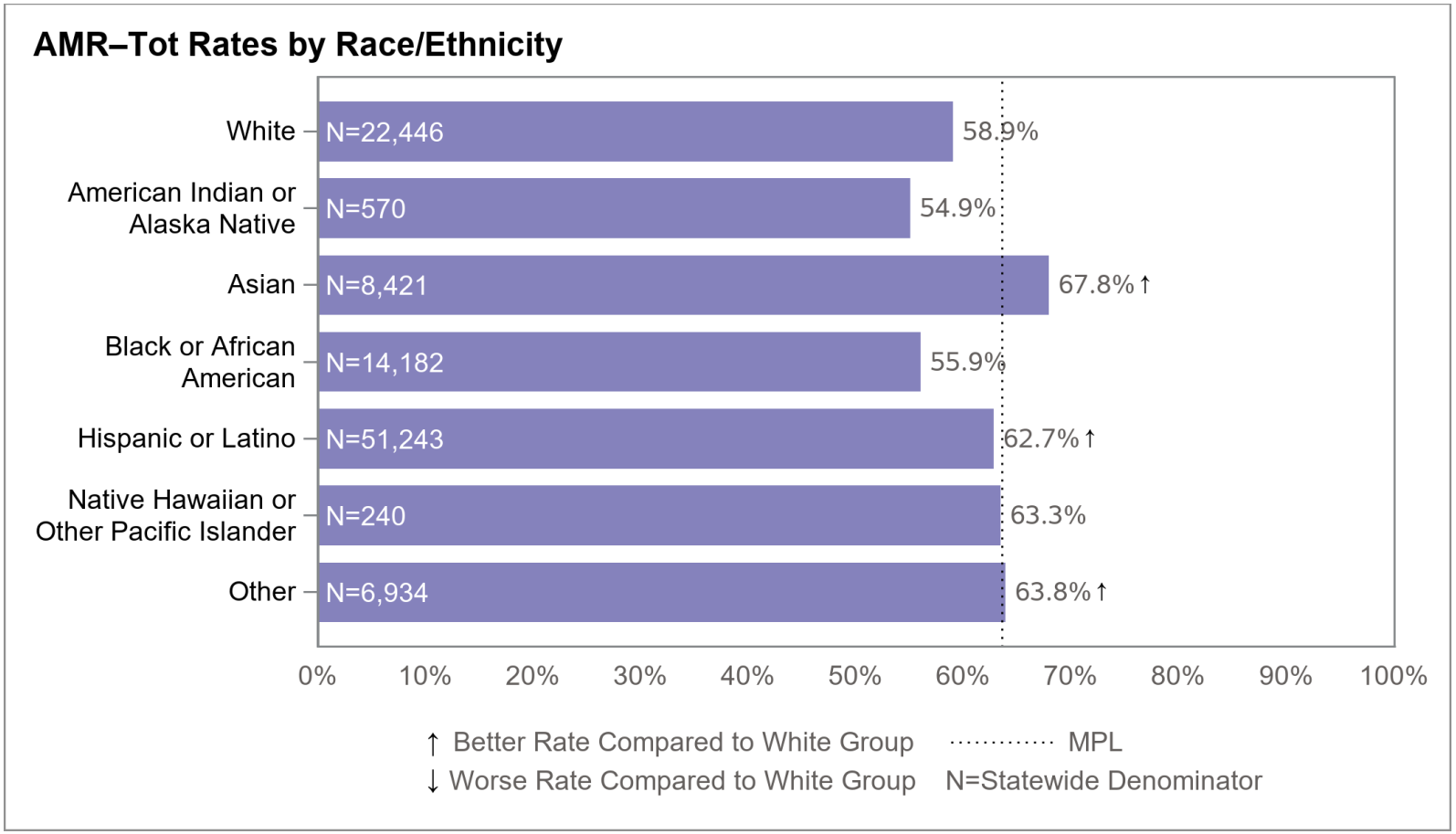
2019 Report Finding Highlights

- Chlamydia Screening in Women-all rates were above the minimum performance level (MPL)



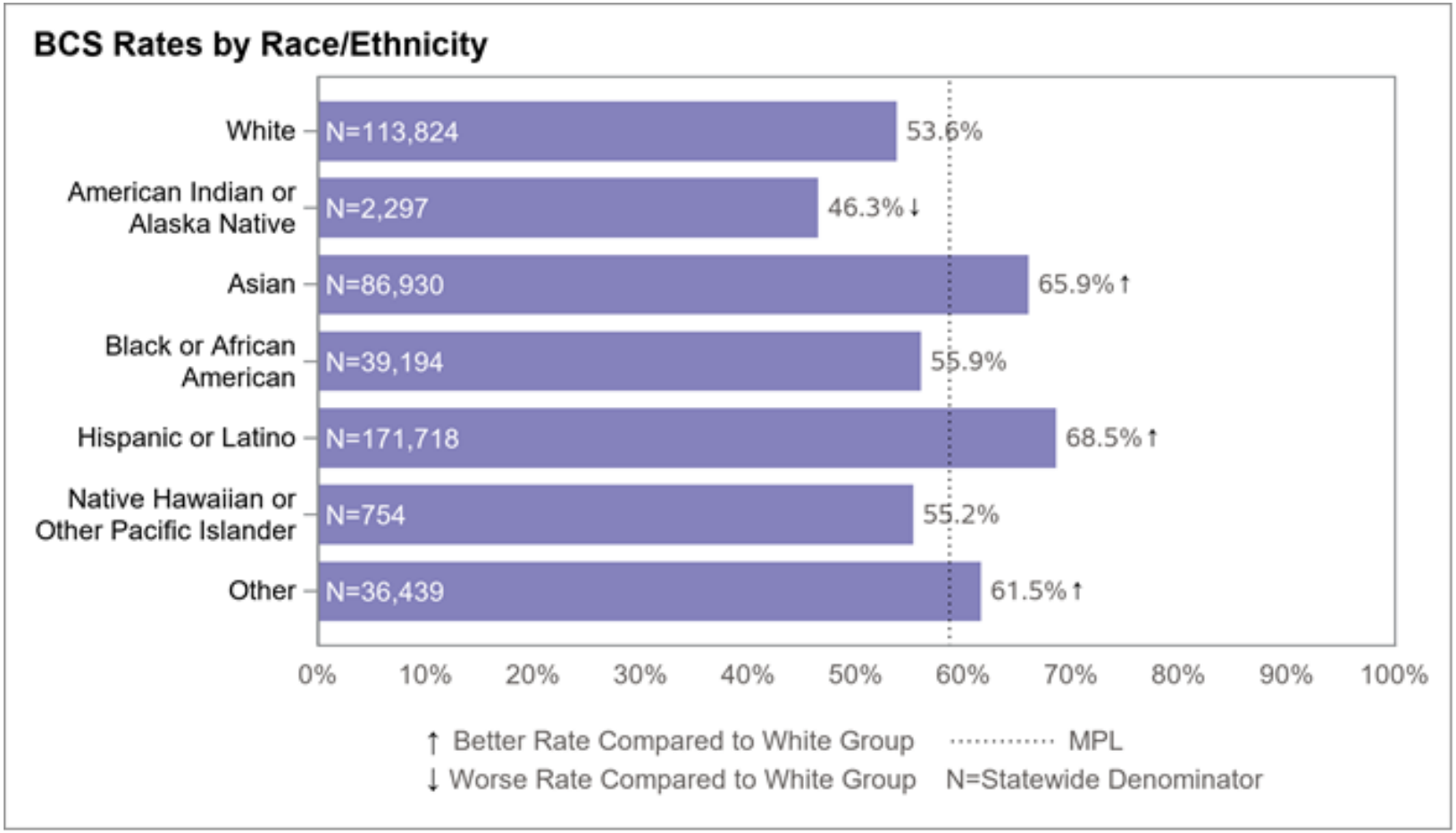
2019 Report Finding Highlights

- The asthma medication ratio-total measure demonstrated rates below the MPL among a majority of racial/ethnic groups



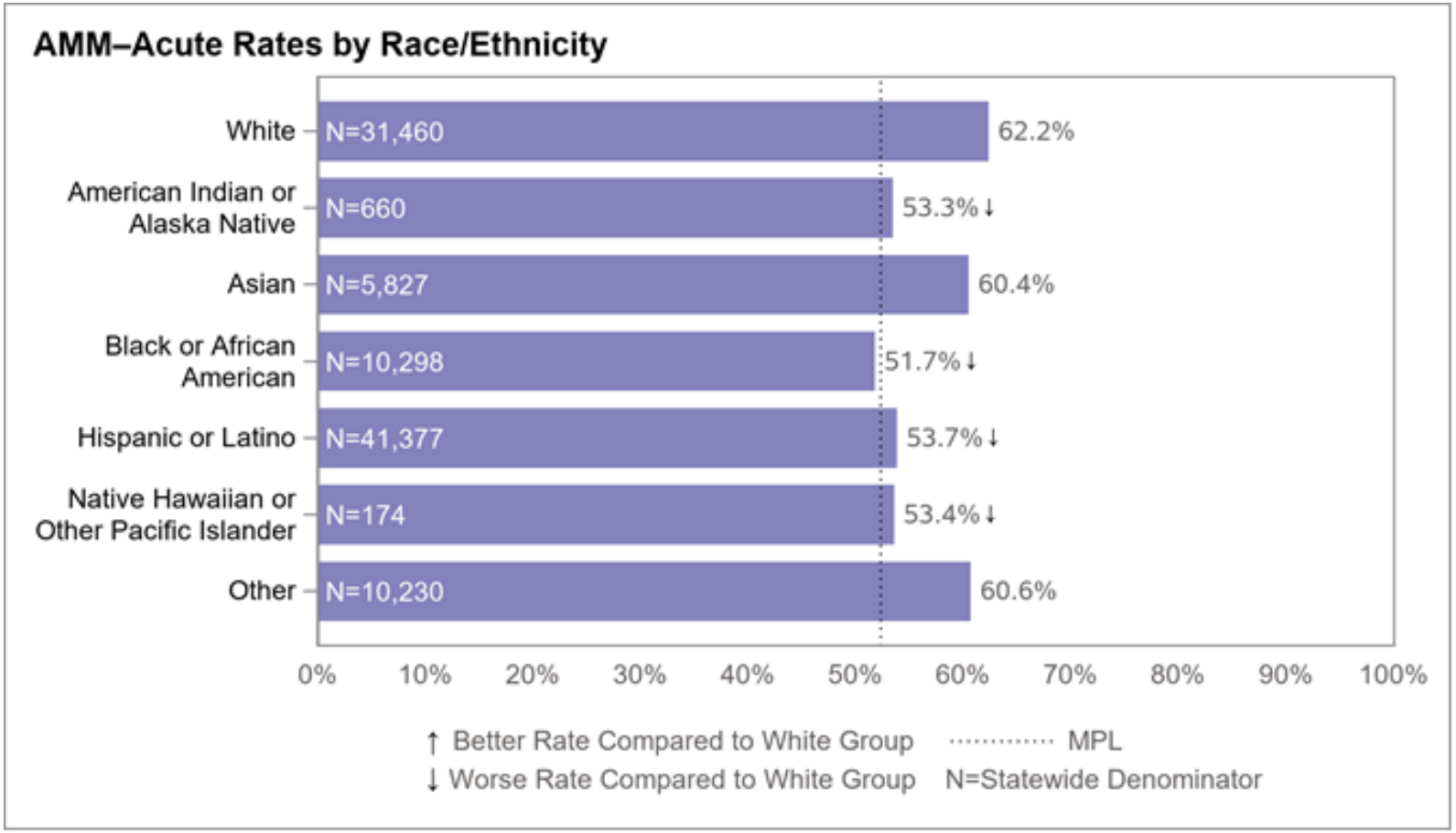
2019 Report Finding Highlights

- Breast cancer screening is another measure with room to improve



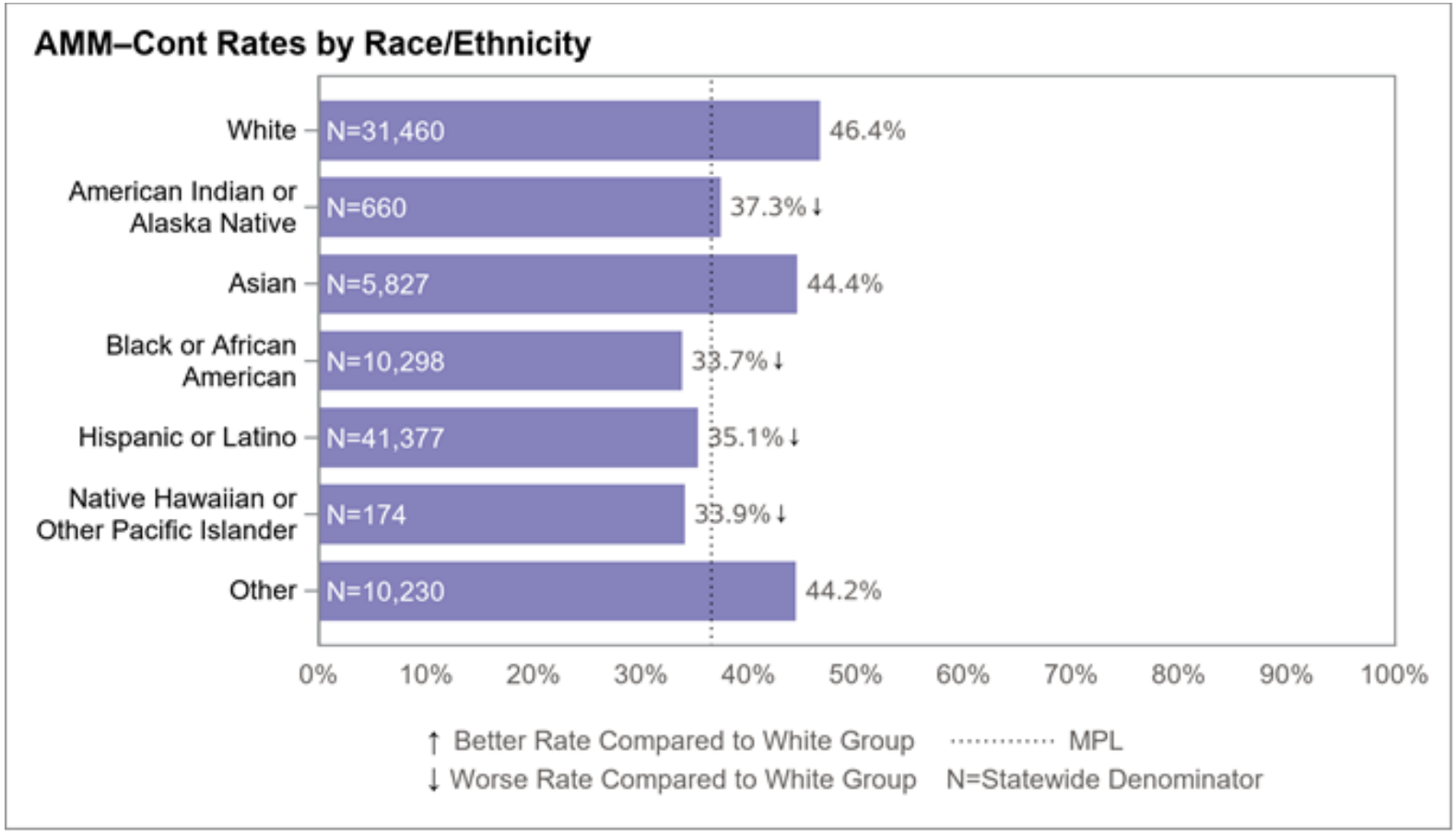
2019 Report Finding Highlights

- Antidepressant Medication Management Effective Acute Phase Treatment demonstrated consistently lower rates than the white group.



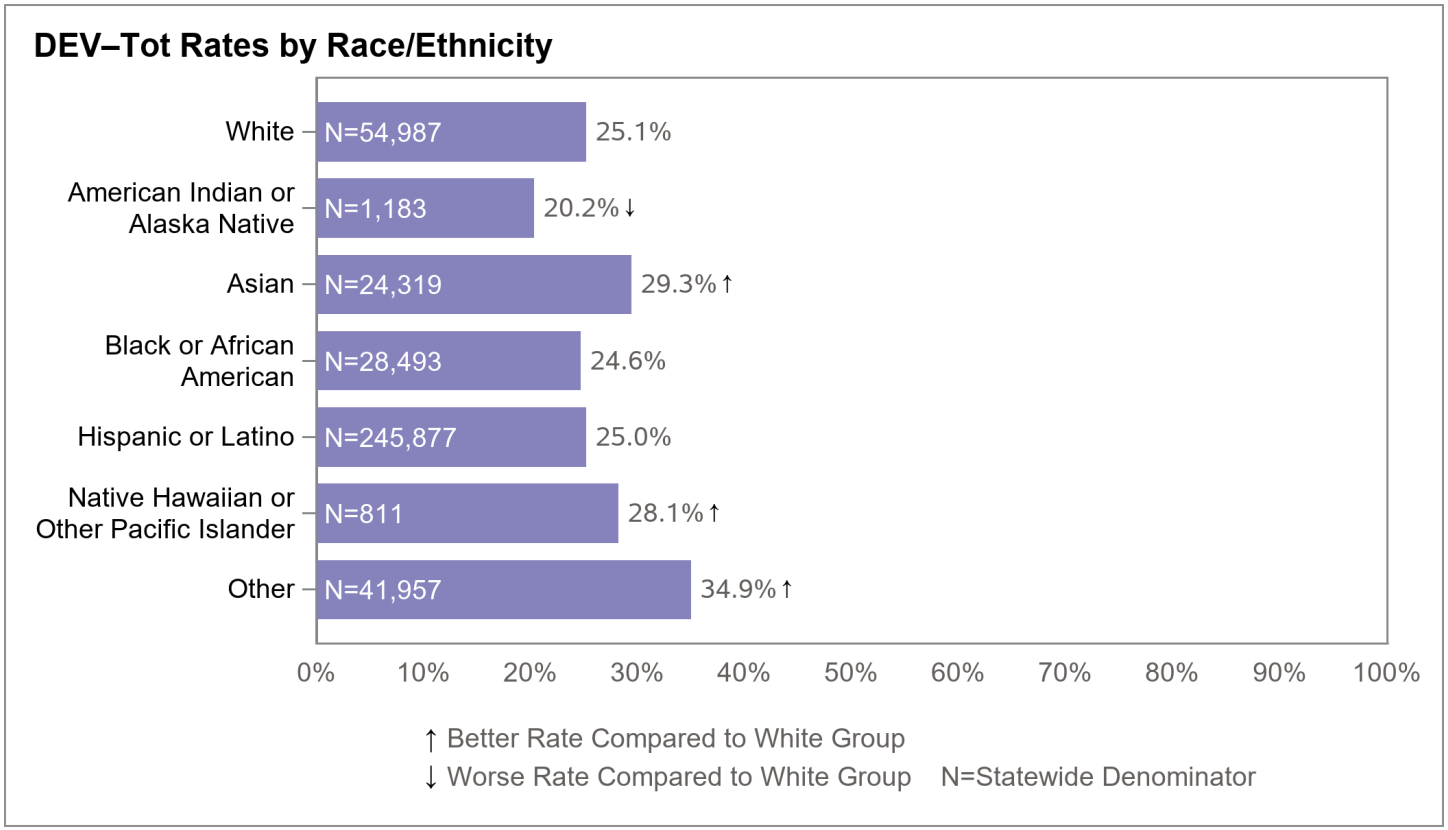
2019 Report Finding Highlights

- Antidepressant Medication Management Effective Continuation Phase Treatment also demonstrated consistently lower rates than the white group.



2019 Report Finding Highlights

- Developmental Screening in the First Three Years of Life—Total indicator does not have an established minimum performance level but it was compared to the white group:



2019 Report Finding Highlights

- For the Contraceptive Care—All Women—Most or Moderately Effective Contraception indicators, five racial/ethnic groups had negative disparities for the Ages 15–20 Years indicator and two negative disparities for the Ages 21–44 Years indicator (Asian and Native Hawaiian or Pacific Islander).
- For the Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years indicator, two racial/ethnic groups (Asian and Black or African American) had negative disparities.

2019 Report Recommendations

- Reference group assessment and reconsideration
- DHCS and MCPs should work closely to determine root causes for disparities
- MCPs should work with providers to help drive improvements in asthma medication prescribing behaviors

Exploring Report Recommendations

- Work closely with EQRO to determine best reference group through testing different methodologies
- Focus study to assess methods in driving closure of health disparity gaps in progress
- Taking a closer look at mild to moderate mental illness diagnoses and services

Oversight, Monitoring & Interventions

- DHCS uses reports to help drive internal projects and develop focus studies for a closer examination of the data
  - Tobacco cessation focus study
  - Long-acting reversible contraceptive focus study
  - Asian subpopulation focus study
  - Methodology for homelessness identification focus study
- DHCS is currently exploring how to best use the reports to drive targeted disparity reductions across the state

Oversight, Monitoring & Interventions

- Reporting of unit level data is shared with MCPs to identify disparities among their members
  - Adjust quality improvement (QI) resources and practices to mitigate disparities
  - MCPs are required to use the health disparity data to help develop the strategic plan for MCPs' annual PNA
  - MCPs can use the data to help determine the metric to target for their health disparity PIP

Oversight, Monitoring & Interventions

- MCPs are required to conduct a health equity performance improvement project (PIP)
- MCPs participate in quarterly PIP collaborative calls and presentations addressing three domains (child/adolescent health, women's health, and disease management/behavioral health), and health equity is addressed through each domain.
- PNAs are required to be conducted by MCPs addressing specific needs, such as members with disabilities, children with special health care needs, as well as members with diverse cultural and ethnic backgrounds.
  - Findings from the assessment are to be used to help drive improvements for achieving health equity

APL 19-017

APL 19-011

Oversight, Monitoring & Interventions

- Produced 10 informative postcards addressing delivery of care during the pandemic that align with health equity efforts
- 2019 Quality Conference, Health Equity: Promoting Quality and Access for All Building Skills to Bridge the Health Divide, hosted by DHCS with diverse panels, presenters, and keynote speaker focusing on identifying and addressing barriers, such as with cultural and language barriers
- Conduct conference calls with EQRO and MCPs
  - Help with performance measure methodology or processes
  - Assist MCPs that may be having difficulties with Plan-Do-Study-Act (PDSA) or PIP process

Action Plan & Next Steps

- Proposition 56 Value Based Payment Program incentives targeting serious mental illness, substance use disorder, and homelessness
- MCPs post notices of non-discrimination and accessibility requirements and provide written translation of these and all other beneficiary informing materials
- DHCS proposes topics for MCPs to work on closing health disparity gaps
  - Data driven
  - Sets long-term goals for closing the gap using short-term incremental goals
- Revamp annual health disparities reports to allow for EQRO recommendations and broader interpretation. More to come in the near future

Questions & Comments

- What changes would you like to see in the reports?
- Are there recommendations for a reference group?
- How would you like to see this report utilized?
- Always appreciate the valuable feedback this group has offered in the past and continues to offer; we appreciate it and encourage to submit additional comments to our Advisory Group email address: advisorygroup@dhcs.ca.gov.

Asian Subpopulations: Focused Study Report on Health Disparities

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Health Education Consultant III
Quality & Medical Policy Branch

Background

- A health disparity is the difference in health outcomes between groups within a population.
- Previous health disparities studies showed that the Asian group had better rates for 65 percent of all indicators compared to the reference group. However, the high performance of the Asian group was primarily driven by the relative high performance of four of the largest Asian subpopulations.
- When the indicators were stratified by primary language, the rates for several of the Asian languages were lower than the rates for English speakers for certain indicators.
- This focused study breaks out the Asian population into 10 Asian subpopulations to assess health disparities.
- The study also assesses health disparities based on language.

Analyses

1. Compared the indicator rates for the individual Asian racial/ethnic subpopulations to the rates for the White group.

2. Compared the rates for the primary language subpopulations to the rates for the English group.

3. Compared the rates within each Asian subpopulation of those whose primary language is not English with those whose primary language is English.
   - E.g., the rates for Korean speakers within the Korean racial/ethnic subpopulation compared to the rates for English speakers within the Korean racial/ethnic subpopulation.

Race by Reporting Year

Racial/Ethnic Group	Reporting Year 2017	Reporting Year 2018	Reporting Year 2019
White Total	2,498,757	2,392,766	2,256,448
Asian Total	1,447,763	1,180,840	1,107,031
Amerasian	0.1%	0.1%	0.1%
Asian Indian	7.5%	9.6%	10.1%
Cambodian	2.6%	3.3%	3.5%
Chinese	18.2%	21.8%	22.5%
Filipino	14.5%	17.3%	17.3%
Japanese	1.1%	1.2%	1.3%
Korean	5.5%	6.4%	6.5%
Laotian	1.8%	2.2%	2.2%
Other Asian or Pacific Islander	30.4%	15.8%	13.3%
Vietnamese	18.4%	22.3%	23.3%

Subpopulations by Primary Language

Primary Language Group	Reporting Year 2017	Reporting Year 2018	Reporting Year 2019
English Total	8,031,771	7,995,272	7,844,687
Asian Primary Language Total	726,667	729,979	704,789
Arabic	6.4%	6.7%	6.7%
Armenian	6.5%	7.3%	7.5%
Cambodian	2.1%	2.1%	2.0%
Cantonese	16.1%	16.0%	16.1%
Farsi	4.2%	4.5%	4.5%
Hmong	3.6%	3.4%	3.2%
Ilocano	0.1%	0.1%	0.0%
Japanese	0.2%	0.2%	0.2%
Korean	5.6%	5.1%	4.8%

Subpopulations by Primary Language (continued)

Primary Language Group	Reporting Year 2017	Reporting Year 2018	Reporting Year 2019
English Total	8,031,771	7,995,272	7,844,687
Asian Primary Language Total	726,667	729,979	704,789
Lao	0.8%	0.7%	0.7%
Mandarin	9.9%	9.7%	9.8%
Mien	0.3%	0.3%	0.3%
Other Chinese	1.3%	1.0%	0.9%
Other Non-English**	8.0%	8.3%	8.4%
Russian	4.7%	4.8%	4.9%
Tagalog	4.7%	4.5%	4.2%
Thai	0.3%	0.3%	0.3%
Vietnamese	25.5%	25.2%	25.5%

Subpopulations by Primary Language

Race/Ethnicity	Dominant Non-English Language
Asian Indian	Other Non-English
Cambodian	Cambodian
Chinese	Cantonese, Mandarin
Filipino	Tagalog
Japanese	Japanese
Korean	Korean
Laotian	Lao, Hmong
Other Asian or Pacific Islander	All Other Languages
Vietnamese	Vietnamese

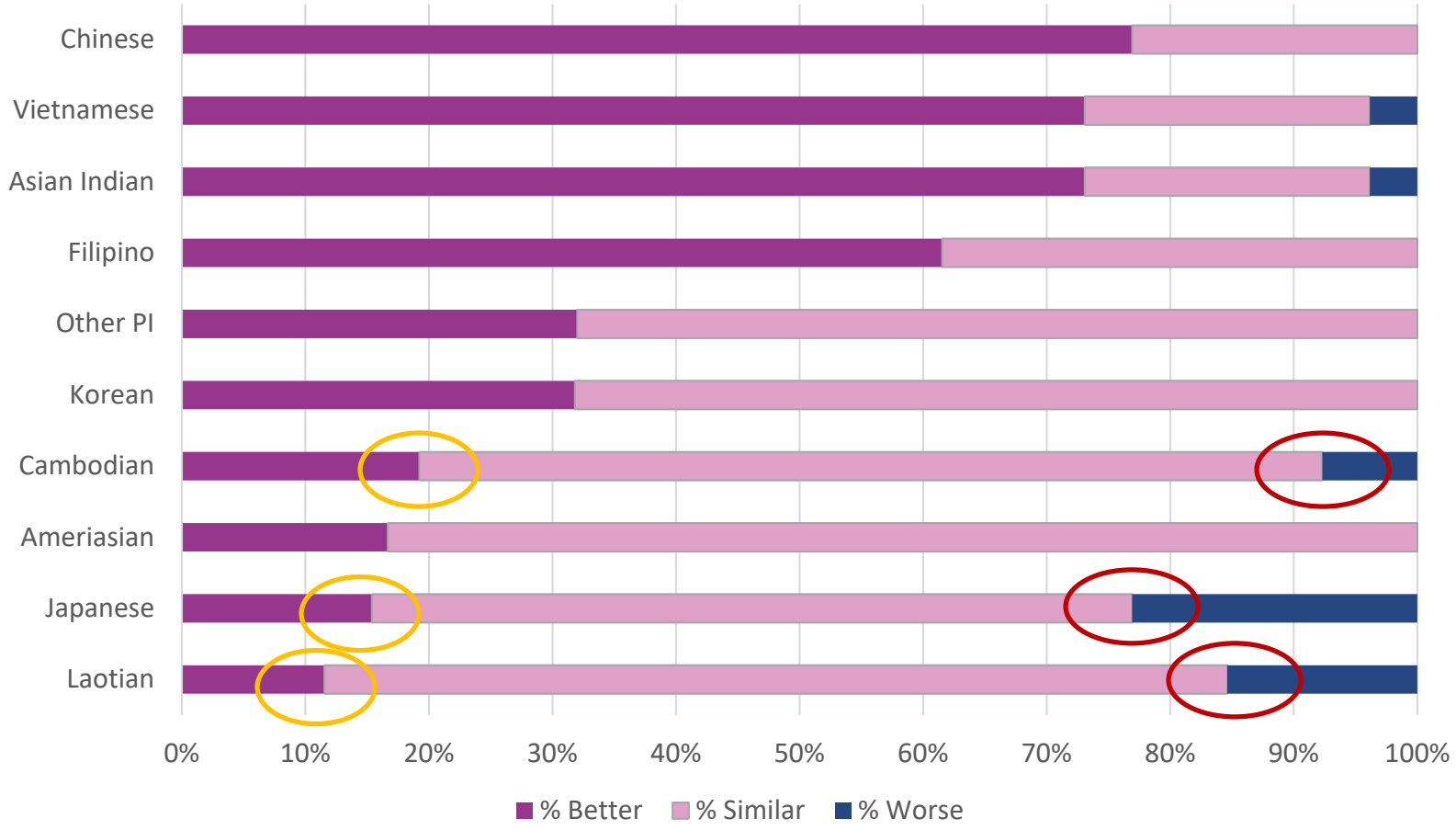
Methodology

1. Evaluated External Accountability Set (EAS) performance indicators for three reporting years (2017–2019).
2. Aggregated results from 25 full-scope MCPs and then stratified these statewide rates by the Asian racial/ethnic subpopulations, primary language subpopulations, and the Asian subpopulation's dominant non-English language.
3. Only identified health disparities based on statistical analysis for the Asian racial/ethnic subpopulations and the primary language subpopulations for reporting years 2017–2019.

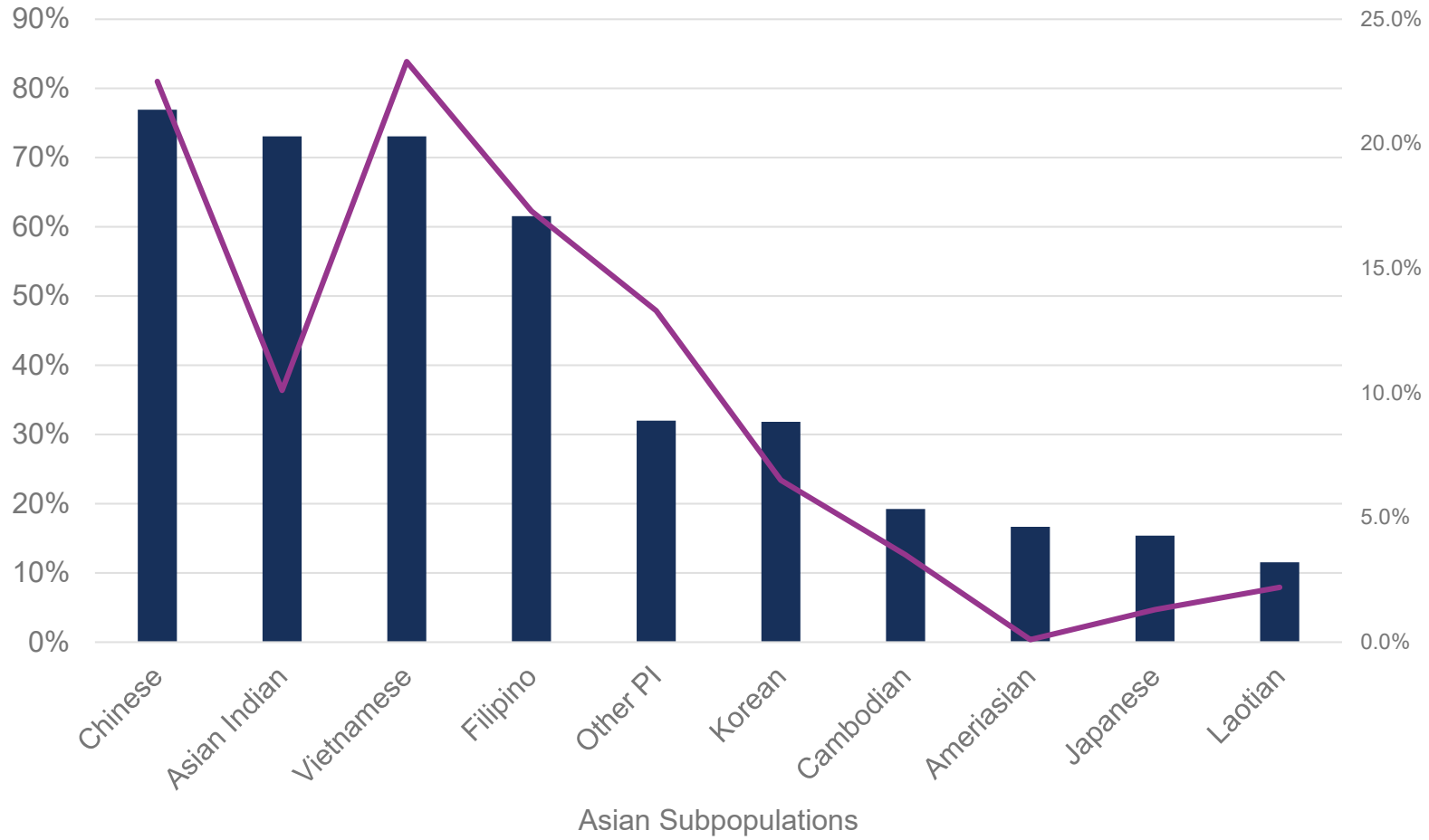
Methodology

4. Disparities were analyzed for three reporting years. Out of the three reporting years, if a subgroup had indicator rates that were better than the reference group two out of the three years, they are considered as having performed “better”. If a subgroup had indicator rates that were worse than the reference group two out of the three years, they are considered as having performed worse than the reference group. If a subgroup had indicator rates that were similar to the reference group two out of the three years, they are considered as having performed “similarly” to the reference group.

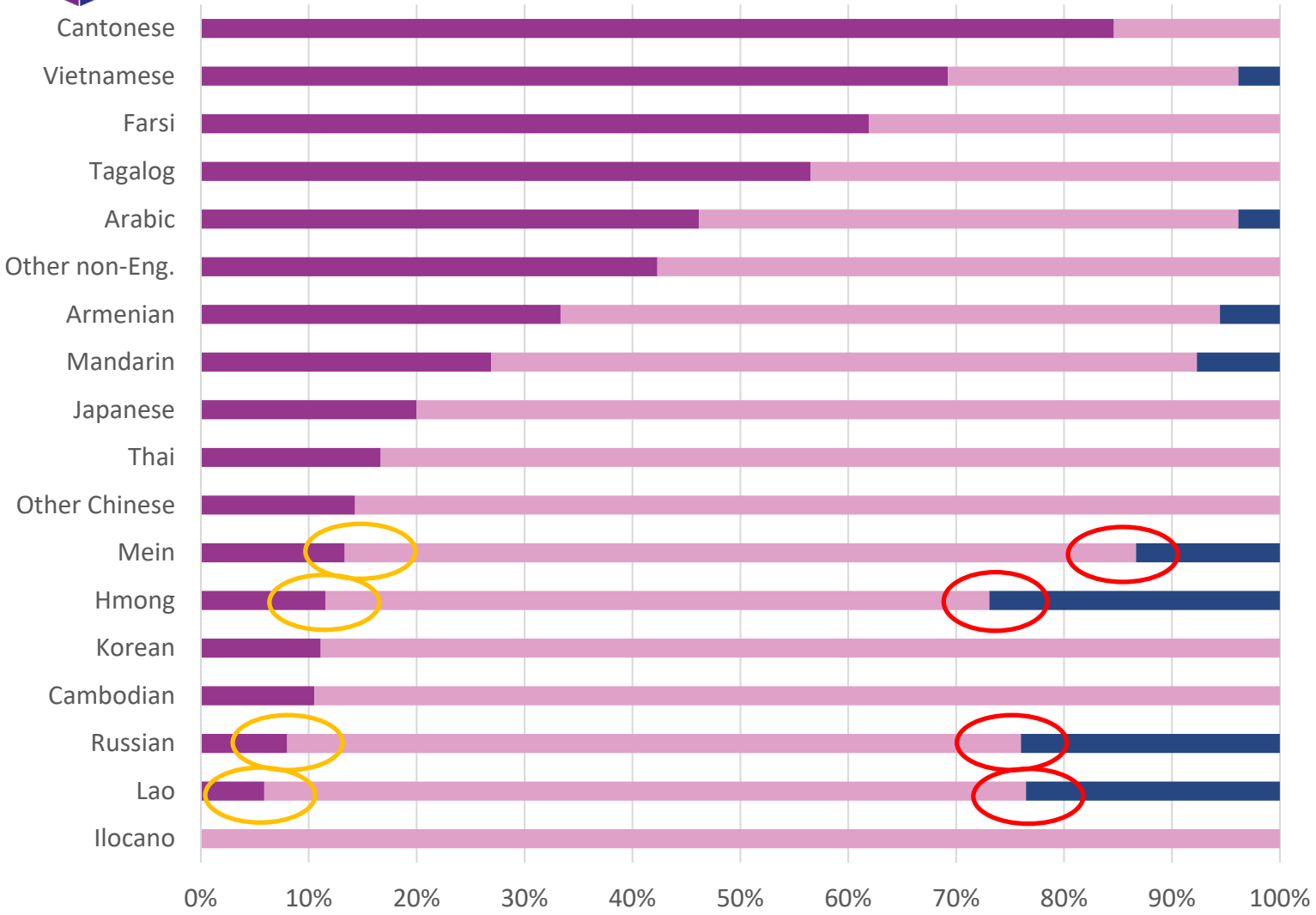
Race/Ethnicity Analysis



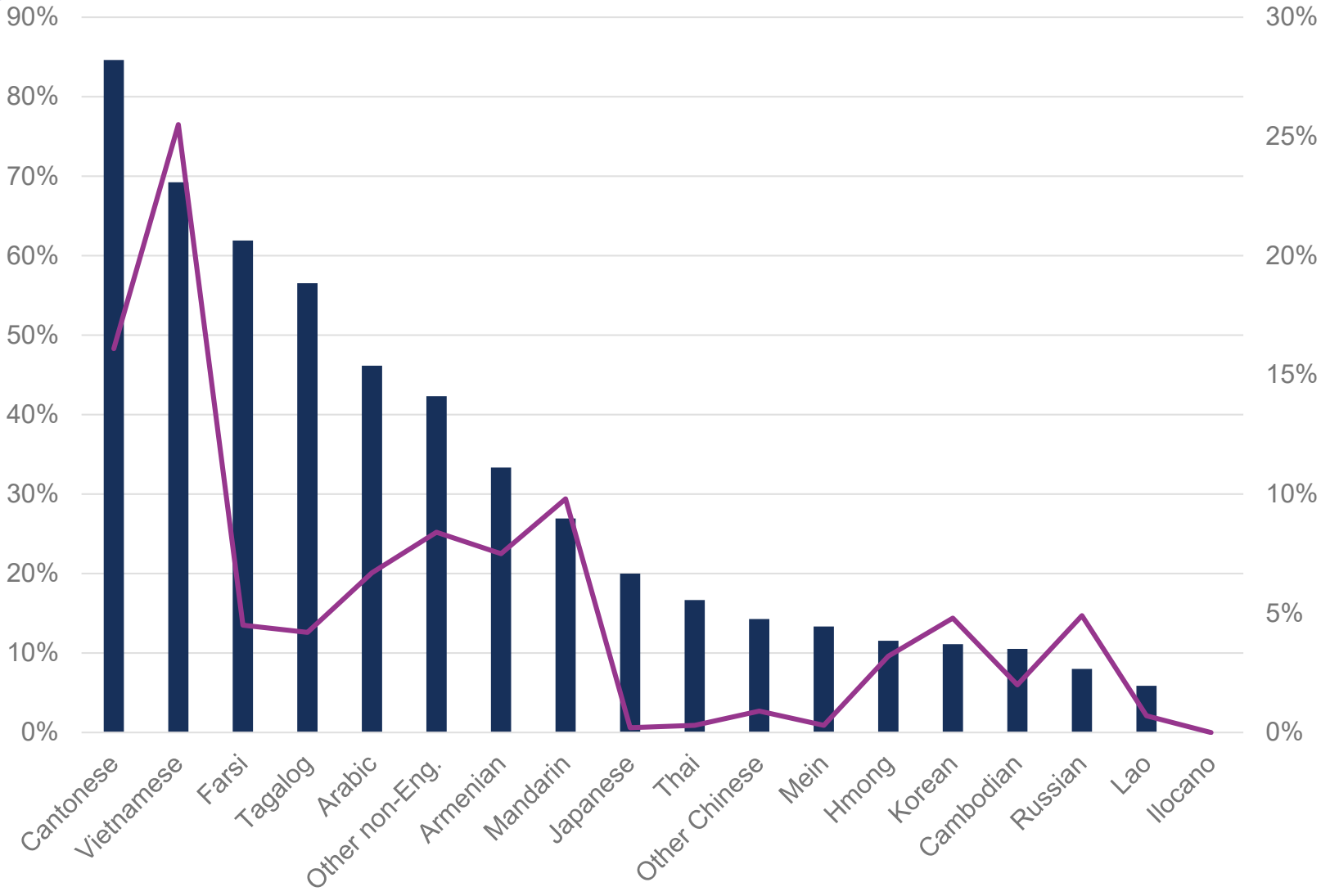
Race/Ethnicity Analysis



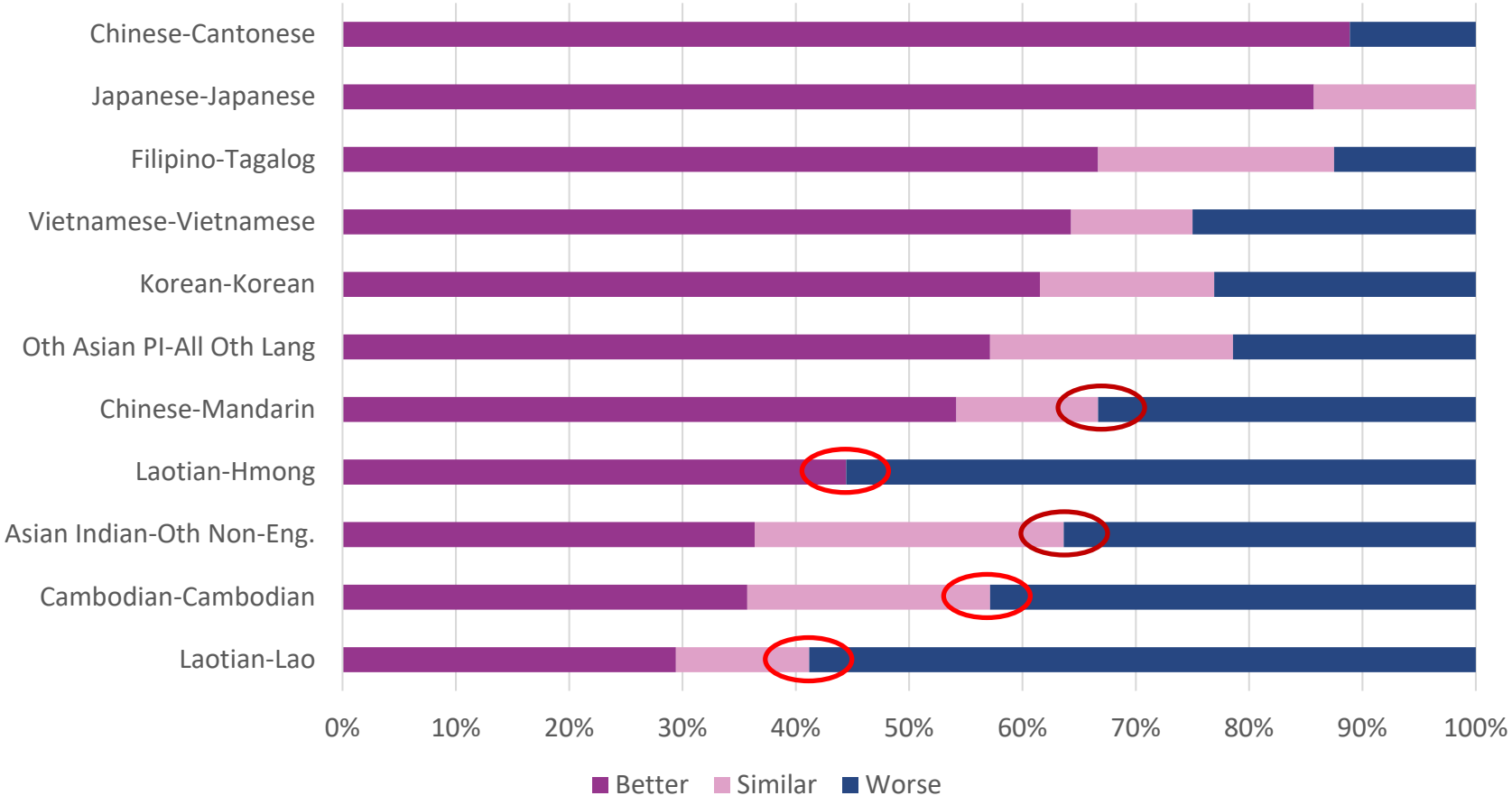
Primary Asian Language Analysis



Primary Asian Language Analysis



English Speaker X Non-English Primary Language of Same Race



Overall Conclusion

- All Asian race subpopulations had a majority of indicators that had rates that were statistically significantly similar or better to the reference group (White).
- While the overall Asian population is performing well, smaller subpopulations did not perform equally well relative to the reference group.
- All Asian non-English language subgroups had a majority of indicators that had rates that were similar or better to the reference group (English). However, smaller language groups did not perform equally well.

Overall Conclusion (Cont.)

- The rates for each individual Asian subpopulation's dominant non-English primary language was largely similar or better compared to the rates for the English primary language for that Asian subpopulation for the majority of indicators, except for Mien and Lao primary languages.

- While it is encouraging that the analysis found there are few indicators where the Asian population overall is experiencing health disparities, certain health disparities were detected in subpopulations.
  - It seems that the same groups are impacted whether it is tied to race or language.

Recommendations

- Continue to monitor health disparities based on race/ethnicity and language, especially those experienced by small subgroups.
- Consider investigating health disparities related to the threshold primary languages in future health disparities reports.
- Consider working with MCPs to identify factors that may be associated with lower indicator rates in the smaller subgroups. (e.g., lack of access to providers, provider behavior, cultural barriers, and possible incomplete data sources)
- Consider using a different reference group for future health disparity studies.

DHCS

Questions?

Updates

Managed Care Project Updates

Michelle Retke
Division Chief
Managed Care Operations

Ombudsman Report

Michelle Retke
Division Chief
Managed Care Operations

Network Monitoring 2021

Cortney Maslyn
Branch Chief
Program Monitoring and Compliance

CalAIM

Nathan Nau
Division Chief
Managed Care Quality & Monitoring

APLs and DPLs Update

Mike Dutra
Branch Chief
Policy, Utilization & External Relations

Acute Hospital Care at Home

- **Date of Issue:** 12/28/2020
- **Revised:**01/19/2021
- **APL 20-021** *(Revised)*

  This APL provides Medi-Cal managed care health plans (MCPs) with policy guidance regarding hospitals participating in the Centers for Medicare & Medicaid Services' (CMS) Acute Hospital Care at Home program. The APL details MCP requirements related to tracking each participating network hospital's waiver authorities and approved waiver status for the duration of the COVID-19 PHE, as well as MCP requirements for authorization, reimbursement, documentation, and reporting.

  The APL was revised to add a link to the Acute Care at Home webpage on the DHCS website, which includes up-to-date information about California hospitals that have been approved to offer acute hospital care at home services.

COVID-19 Vaccine Administration

- **Date of Issue:** 12/28/2020
- **APL 20-022**

  This APL provides MCPs with information and guidance regarding COVID-19 vaccine coverage and administration in the Medi-Cal program. This APL reminds MCPs that, although both the COVID-19 vaccines and associated administration fees are carved out of the managed care delivery system to Medi-Cal Fee-for-Service, MCPs remain contractually responsible for providing case management and care coordination for their members, regardless of whether or not they are financially responsible for the payment of services.

2021-2022 Medi-Cal Managed Care Health Plan MEDs/834 Cutoff and Processing Schedule

- **Date of Issue:** 01/07/2021
- **APL 21-001**

  This APL provides MCPs with the 2021-2022 Medi-Cal Eligibility Data System/834 cutoff and processing schedule for December 2020–January 2022.

Cost Avoidance and Post-Payment Recovery for Other Health Coverage

- **Date of Issue:** 02/25/2021
- **APL 21-002**
- **Supersedes:** Policy Letter 08-011

This APL provides clarification and guidance to MCPs with respect to the requirements for cost avoidance and post-payment recovery when an MCP member has other health coverage (OHC). These requirements also include instructions on the use of the DHCS Medi-Cal eligibility record to process OHC claims and guidelines on reporting to DHCS if the MCP becomes aware of OHC that is not listed on the eligibility record.

Questions?

Open Discussion

Next Meeting: June 3, 2021

For questions, comments or to request future agenda items please email:

advisorygroup@dhcs.ca.gov