GLOSSARY

Metrics

Certified Eligible: A certified eligible is a beneficiary deemed qualified for Medi-Cal services by a valid eligibility determination, and who have enrolled into the program. This classification excludes beneficiaries who have a monthly share-of-cost obligation that has not been met. Enrollment counts exclude information related to applications received or any other eligible members that may be in the process of becoming certified eligible.

Member Month: A member month represent one certified eligible for one month of enrollment. Counts of Member months represent the number of certified eligible individuals enrolled in a health plan or Fee-For-Service each month.

Per 1,000 Members: Rates per 1,000 members were calculated by dividing overall utilization of a given service (e.g., Emergency Room Visits) by the total number of members for the same time period and multiplying the result by 1,000.

Abbreviated Numbers: Numbers in millions (M) that are less than 50,000 are displayed as 0.0M. Numbers in thousands (K) that are less than 50 are displayed as 0.0K.

Percentages: Percentage metrics are displayed as whole numbers. Charts may add up to 99%, 100%, or 101%.

MO-: Indicates Medi-Cal Only. See Non-Dual definition for more information.

Population Aid Code Groups

Affordable Care Act (ACA): This population consists of the following Adult Expansion aid codes: M1, M2, L1, and 7U.

Optional Targeted Low Income Children (OTLIC): This population consists of the following OTLIC aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, and T9.

Seniors and Persons with Disabilities (SPD): This population consists of the following SPD aid codes: 10, 13, 14, 16, 17, 1E, 1H, 20, 23, 24, 26, 27, 2E, 2H, 36, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8, D2, D3, D4, D5, D6, and D7.

Other Populations (OTHER): This population consists of all aid codes not categorized under ACA, OTLIC, or SPD.

Medicare Status

Source: Enterprise Performance Monitoring System
Note: Data in this dashboard is preliminary and subject to change

Dual: This population consists of any Medi-Cal eligible member who has active Medicare coverage. Active Medicare coverage means one or more of the following Medicare portions are active: Part A, B, or D. Dual members are not identified by an aid code.

Non-Dual: This population consists of any Medi-Cal eligible member who is Medi-Cal Only (MO) and has no active Medicare coverage.

New Enrollments

This population consists of members who were newly eligible for Medi-Cal Managed Care enrollment. The enrollment types are defined below:

Auto Assigned: Members who made no choice that were assigned by default algorithm.

Passive/Prior: Members who were passively enrolled and members defaulted because they were previously a member or because other family members were already assigned to the plan.

Regular: Members who made a choice or selected a health plan by submitting an enrollment form.

Utilization Measures for Certified Eligible Managed Care Members

Utilization is tracked by aid code population and Medicare status.

Emergency Room (ER) Visits: This measure captures the number of ER visits per month. The results from this measure are used to calculate ER visits with an inpatient admission. A visit consists of a unique combination between provider, member, and date of service. This measure is displayed per 1,000 members.

Emergency Room (ER) Visits with an Inpatient (IP) Admission: This measure captures the number of ER visits that resulted in an inpatient admission per month. The results of this measure are a subset of ER visits and IP admissions. The service date and member identification are linked to create this measure. An admission consists of a unique combination between member and date of admission to a facility. This measure is displayed per 1,000 members.

Inpatient (IP) Admissions: This measure captures the number of inpatient admissions per month. The results from this measure are used to calculate ER visits with an inpatient admission. An admission consists of a unique combination between member and date of admission to a facility. This measure is displayed per 1,000 members.

Source: Enterprise Performance Monitoring System
Note: Data in this dashboard is preliminary and subject to change

Outpatient (OP) Visits: This measure captures the number of outpatient visits per month. A visit consists of a unique combination between provider, member, and date of service. This measure is displayed per 1,000 members.

Prescriptions: This measure captures the number of prescriptions per month. A prescription consists of a unique combination between National Drug Code, member, and date of service. This measure is displayed per 1,000 members.

Mild to Moderate Mental Health Visits: This measure captures the number of visits per month related to selected Psychotherapy Services and Diagnostic Evaluations. The selected procedure codes aim to capture mild to moderate mental health visits. A visit consists of a unique combination between provider, member, and date of service. This measure is displayed per 1,000 members.

Grievances and State Fair Hearings

Grievances: Grievance data is collected quarterly and is plan reported. A single member can have multiple grievances, and a single grievance can have multiple reasons. Grievance reasons include Accessibility, Benefits, Quality of Care, and Referral. The count of grievances that do not fall into one of the above mentioned categories will be noted as “Other”.

State Fair Hearings: Hearing data is reported from the Department of Social Services. Hearing outcomes have been grouped into three outcomes types: Denied or Dismissed, Granted, and Withdrawal or Non-Appearance.

Encounter Completeness

Encounter Completeness Monitoring Summary: Mercer Government Human Services Consulting provides DHCS a quarterly report that represents the aggregate encounter monitoring grade for all contracted health plans by category of service. Color grades are determined by the encounter completeness percentage: (encounter utilization/1,000) / (benchmark utilization /1,000) where the benchmark is selected to be the most favorable to the health plan (i.e. the benchmark selected shows encounters as the most complete). DHCS evaluates the aggregate encounter monitoring results for all contracted health plans by category of service no less than every 1st and 3rd quarter. Any score of Red may result in a Corrective Action Plan and/or Financial Sanctions.

Aetna Better Health and United Healthcare have currently not been included in the encounter monitoring summary because of the lack of time spent providing Medi-Cal services. For reference, Aetna Better Health began January 1, 2018 and United HealthCare began October 1, 2017. It is planned to include these health plans in future reporting.

Encounter Completeness Percentage (ECP):
Red (R) indicates major encounter completeness challenges; ECP is less than 70%.
Yellow (Y) indicates moderate encounter completeness or other reporting challenges; ECP is between 70% and less than 90% or above 110%.
Green (G) indicates that there are no clear encounter completeness challenges; ECP is between 90-110%.

Source: Enterprise Performance Monitoring System
Note: Data in this dashboard is preliminary and subject to change

Network Adequacy

Provider Ratios: These metrics are designed to showcase the number of Primary Care Physicians (PCPs) per 2,000 plan enrollees and all Physicians per 1,200 plan enrollees.

Health Effectiveness Data and Information Set (HEDIS®) Aggregated Quality Factor Score (AQFS)

The HEDIS® measures and specifications were developed by and are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). The HEDIS® AQFS is a single score that accounts for plan performance on all DHCS selected HEDIS® indicators. It is a composite rate calculated as percent of the National High Performance Level (HPL). The High Performance Level is 100%. The Minimum Performance Level is 40%. The State Population Weighted Average is calculated annually. A HEDIS® reporting unit is a combination of one health plan in a county or region.

AQFS Calculations: The AQFS listed on the MCQMD Dashboard is calculated by DHCS and is based on the audited HEDIS rates for each reporting year. The HEDIS indicators that DHCS holds MPLs (minimum performance levels) will be included in the calculation.

Step 1: Calculate the Assigned Score - for each HEDIS indicator, assign a score to each plan at the county (or reporting unit) level according to its NCQA Medicaid benchmark (percentile) as shown below:

NCQA Percentile Performance	Assigned Score
Below 10%	1
10%<= and <17.5%	2
17.5% <=and <25%	3
25%<= and <37.5%	4
37.5%<= and <50%	5
50%<= and <62.5%	6
62.5%<= and <75%	7
75% <=and <82.5%	8
82.5%<= and <90%	9
90% and above	10

Source: Enterprise Performance Monitoring System
Note: Data in this dashboard is preliminary and subject to change

Step 2: Total Assigned Score - calculate the Total Assigned Score for each plan at the county (or reporting unit) level by summing up the Assigned Scores of all HEDIS indicators.

Step 3: Identify the Aggregate HPL (High Performance Level, the 90th percentile of national level) Score - assign the maximum possible score (10) to each HEDIS indicator and the total of all indicators is the Aggregate HPL Score.

Step 4: Normalize - normalize (divide) the Total Assigned Score calculated in Step 2 by the Aggregated HPL Score calculated in Step 3. The final score is the AQFS for each plan at the county level.

Step 5: Interpretation - the AQFS is a single score that accounts for plan performance on DHCS-selected HEDIS indicators. It is a composite rate calculated as a percent of the HPL (National High Performance Level - the 90th percentile of NCQA national Medicaid level).

Note: "NR" (not reportable) is treated as <10th percentile; "NA" (not applicable) is excluded and its corresponding score (for the same indicator) is taken away from the Aggregated HPL Score when normalizing.