2020 Preventive Services Report

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

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

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Commonly Used Abbreviations and Acronyms

Following is a list of abbreviations and acronyms used throughout this report.

- **A**—administrative
- **AUS**—*Alcohol Use Screening*
- **BMI**—body mass index
- **CA**—California
- **CDF**—*Screening for Depression and Follow-Up Plan*
- **CDPH**—California Department of Public Health
- **CHIP**—Children's Health Insurance Program
- **CHL**—*Chlamydia Screening in Women*
- **CMS**—Centers for Medicare & Medicaid Services
- **CDT**—Code on Dental Procedures and Nomenclature
- **CPT**—Current Procedural Terminology
- **COHS**—County Organized Health System
- **COVID-19**—coronavirus disease 2019
- **DEV**—*Developmental Screening in the First Three Years of Life*
- **DFV**—*Dental Fluoride Varnish*
- **DHCS**—California Department of Health Care Services
- **EHR**—electronic health record
- **EQR**—external quality review
- **H**—hybrid
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HIPAA**—Health Insurance Portability and Accountability Act of 1996
- **HMO**—health maintenance organization
- **HSAG**—Health Services Advisory Group, Inc.
- **IDSS**—Interactive Data Submission System
- **MCAS**—Managed Care Accountability Set
- **MCP**—managed care health plan
- **MRR**—medical record review
- **MS**—Microsoft

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

- **N**—number
- **NA**—small denominator or suppressed rate
- **N/A**—not available
- **NCQA**—National Committee for Quality Assurance
- **OB/GYN**—obstetrician/gynecologist
- **PCP**—primary care provider
- **PIP**—performance improvement project
- **PNA**—population needs assessment
- **S**—suppressed rate (i.e., small numerator)
- **TUS**—*Tobacco Use Screening*
- **VBP**—value based payment
- **WCV**—*Child and Adolescent Well-Care Visits*
- **W30**—*Well-Child Visits in the First 30 Months of Life*

1. Executive Summary

Background

At the request of the Joint Legislative Audit Committee, the California State Auditor published an audit report in March 2019 regarding the California Department of Health Care Services' (DHCS') oversight of the delivery of preventive services to children enrolled in California's Medicaid managed care program (Medi-Cal). The audit report recommended that DHCS expand its monitoring beyond the existing set of quality measures as a way to ensure that children in Medi-Cal managed care are receiving all of the appropriate preventive services from DHCS' contracted managed care health plans (MCPs).[2] In response to this recommendation, DHCS worked with Health Services Advisory Group, Inc. (HSAG), which currently serves as the Department's independent external quality review organization (EQRO), to develop an annual Preventive Services Report.

The 2020 Preventive Services Report reflects data collected during calendar year 2019. The report provides in-depth analyses of several existing DHCS measures as well as new administrative measures HSAG developed to capture utilization of services by pediatric Medi-Cal managed care members. DHCS' existing Medi-Cal Managed Care Accountability Set (MCAS) measures reflect clinical quality, timeliness, and access to care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. The 2020 Preventive Services Report presents statewide and regional results for a total of nine indicators that assess the utilization of preventive services by Medi-Cal managed care children and adolescents, and includes regional and demographic trends, findings, and recommendations. Additional indicators will be added in future iterations of this report as more complete data become available.

DHCS continues to collaborate with the California Department of Public Health (CDPH) to link available blood lead screening laboratory data with Medi-Cal data; however, these efforts have been delayed due to the coronavirus disease 2019 (COVID-19) and the impact it has had on CDPH operations. DHCS will release the information for the *Blood Lead Screening* indicators, as well as MCP-specific results for each indicator, as an addendum to this report in February 2021.

Overall, the Preventive Services Report will be an additional tool that DHCS can use to identify and monitor appropriate utilization of preventive services for children in Medi-Cal managed care. DHCS will leverage findings from the Preventive Services Report to work with MCPs and other stakeholders to implement targeted improvement strategies that can drive positive change and ensure Medi-Cal managed care children receive the right care at the right time.

[2] 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: Aug 12, 2020.

Key Findings and Items for Consideration

The 2020 Preventive Services Report includes the results from the analysis of nine indicators that assess the utilization of preventive services by pediatric Medi-Cal managed care members at the statewide and regional levels, as well as by key demographic characteristics (i.e., race/ethnicity, primary language, gender, and age). Table 1.1 displays the nine indicators included in the 2020 Preventive Services Report. The 2019 California State Auditor Report highlighted DHCS' oversight of the provision of well-child visits for several age ranges in the pediatric population. To address these findings, DHCS, with stakeholder input, added newly revised well-child indicators to the measure set which allow DHCS to fully track and monitor the provision of well-child visits from birth through age 21. Additionally, DHCS also included several indicators that align with the American Academy of Pediatrics (AAP) Bright Futures recommendations in the 2020 Preventive Services Report, and DHCS will continue to add indicators to the report that align with national recommendations as more data become available.

During the development of the Preventive Services Report, DHCS and HSAG determined that three MCAS indicators with a hybrid reporting option, originally planned for inclusion and in-depth analysis, did not yield reliable rates due to the analyses' reliance on administrative data only. HSAG excluded the results for these three indicators (i.e., *Childhood Immunization Status—Combination 10*, *Immunizations for Adolescents—Combination 2*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index [BMI] Assessment for Children/Adolescents*) due to the incompleteness of the administrative data available. The rates for these MCAS indicators will be provided in the EQR Technical Report that will be released in spring 2021. Some MCAS indicators will likely be added to the Preventive Services Report in the future once MCPs resume standardized reporting for the MCAS measures.

Table 1.1—2020 Preventive Services Report Indicators

Indicators
MCP-Calculated MCAS Indicators
Chlamydia Screening in Women—16 to 20 Years (CHL–1620)
Developmental Screening in the First Three Years of Life—Total (DEV)
Screening for Depression and Follow-Up Plan (CDF)
HSAG-Calculated Indicators
Child and Adolescent Well-Care Visits (WCV)
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30)*
Alcohol Use Screening (AUS)
Dental Fluoride Varnish (DFV)
Tobacco Use Screening (TUS)

Based on an evaluation of the nine indicators, the following are the key findings and considerations from the 2020 Preventive Services analyses. Detailed results for the indicators can be found in Section 3.

- **Key Finding 1: Performance is regional.**
  - The highest performance is seen in the Central Coast region of California (i.e., Monterey, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura counties) and in the San Francisco Bay Area (i.e., Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, and Sonoma counties). These counties account for approximately 14 percent of the pediatric Medi-Cal managed care population.
    - These 12 counties had at least half of their reportable indicator rates fall into the top two quintiles (i.e., at or above the 60th percentile of statewide performance).
    - Nine of these 12 counties (75.0 percent) in these high-performing geographic regions also had a larger percentage of non-English primary language speakers when compared to statewide non-English primary language speakers.
  - The lowest performance was seen in the more rural counties in Northern California (i.e., Butte, Del Norte, Humboldt, Lassen, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity counties) and in San Joaquin Valley (i.e., Alpine, Amador, Inyo, Mariposa, Mono, and Tuolumne counties).
    - All 18 counties with the lowest performance had at least half of their reportable indicator rates fall into the bottom two quintiles (i.e., below the 40th percentile of statewide performance), and 16 of the 18 counties (88.9 percent) were predominantly rural.
    - Seventeen of the 18 counties (94.4 percent) had a larger proportion of White members, and nine of the 18 counties (50.0 percent) had a larger proportion of American Indian or Alaska Native members.
    - All 18 counties had substantially fewer non-English speakers when compared to statewide non-English speakers.
- **Conclusions and Considerations for Key Finding 1:**
  - To increase awareness and availability for preventive services, DHCS and all its contracted MCPs initiated a Preventive Services Outreach campaign during 2020. The campaign provided educational materials and calls to the parents/guardians of children to help them understand the services available to them through Medi-Cal.
    - As a result of this new effort, DHCS anticipates that more members and their families will be better informed regarding the timing and availability of necessary preventive services. Improvement in the utilization of preventive services is expected in measurement year 2021 results.[3]
  - Given the low performance of predominantly rural Northern California and the San Joaquin Valley counties, MCPs operating in those counties may consider coordinated provider and targeted member education efforts to improve performance.

[3] Improvement in the utilization of preventive services is not expected until measurement year 2021 results given the anticipated impact of COVID-19 on measurement year 2020 results.

- MCPs operating in lower-performing rural counties should consider expanding the use of telehealth visits, where appropriate, and assess ways to expand the managed care provider networks to improve performance.
- MCPs can leverage quality improvement efforts from successful rural counties and expand similar activities as best practices in lower-performing rural counties to drive improvement.

- **Key Finding 2: Statewide performance varies based on race/ethnicity and primary language.**
  - Three of nine indicator rates (33.3 percent) for the Asian and Other racial/ethnic groups were higher than the statewide aggregate by more than a 10 percent relative difference.
  - The majority of indicator rates for the American Indian and Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White racial/ethnic groups were lower than the statewide aggregate by more than a 10 percent relative difference.
  - Although the rates for the Hispanic or Latino racial/ethnic group were generally above the statewide aggregate, this racial/ethnic group also represents approximately 56 percent of the pediatric Medi-Cal managed care population, making it unlikely that rates for the group would be above the statewide aggregate by more than a 10 percent relative difference.
  - The rates for the Arabic, Chinese, Hmong, Spanish, and Vietnamese primary language groups were consistently higher than the statewide aggregate, while the rates for the Armenian and Russian primary language groups were lower than the statewide aggregate.
  - Although the rates for the English primary language group were generally lower than the statewide aggregate, this primary language group also represents approximately 63 percent of the pediatric Medi-Cal managed care population, making it unlikely that rates for the group would be below the statewide aggregate by more than a 10 percent relative difference.

- **Conclusions and Considerations for Key Finding 2**:
  - MCPs operating in counties or regions with lower rates for certain racial/ethnic or primary language groups have opportunities to use this information to address lower rates in their population needs assessment (PNA) process.
    - DHCS requires MCPs to conduct a PNA to improve health outcomes for members and ensure that MCPs are meeting the needs of their members. The PNA must address the special needs of the Seniors and Persons with Disabilities population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and racial/ethnic backgrounds.
  - DHCS requires MCPs to conduct a performance improvement project (PIP) for an area in need of improvement related to child and adolescent health; information from the Preventive Services Report can assist MCPs in their PIP processes.

- DHCS also requires MCPs to conduct a PIP focusing on an identified health disparity; information from the Preventive Services Report can assist MCPs in their PIP processes for addressing health disparities.

- **Key Finding 3: Overall performance across California's six largest counties is high for a majority of indicators, but improvement is needed for well-child visits.**
  - Six counties in California (Los Angeles, San Bernardino, Riverside, San Diego, Orange, and Sacramento counties) account for approximately 60 percent of the pediatric Medi-Cal managed care population.
  - Overall, each of these six counties besides Riverside County demonstrated high performance across the indicators analyzed in this report (i.e., at least half of their reportable indicator rates are in the top two quintiles).
  - Opportunities exist to improve performance on the *Well-Child Visits in the First 30 Months of Life* indicators given that none of the six counties had rates in the top quintile (i.e., above the 80th percentile of statewide performance) for either the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* or the *Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits* indicators.
    - San Bernardino, Riverside, and Orange counties had indicator rates that fell into the bottom two quintiles (i.e., below the 40th percentile of statewide performance) for both *Well-Child Visits in the First 30 Months of Life* indicators.

- **Conclusions and Considerations for Key Finding 3:**
  - Implementing efforts to improve well-child visits within the six largest counties may contribute to substantial improvement for California overall.
  - DHCS' Preventive Services Outreach campaign is expected to have a positive impact across all counties.

- **Key Finding 4: A majority of younger children receive well-care visits, but improvement is needed for developmental screenings and the provision of dental fluoride varnish.**
  - A 2019 audit conducted by the California State Auditor found that lower utilization of well-care visits was identified for some age groups within the pediatric population. HSAG's analysis identified positive findings in that the majority of Medi-Cal managed care children received a well-care visit.
    - Approximately 70 percent of Medi-Cal managed care children 15 months old and younger had at least four of the six recommended comprehensive well-care visits during calendar year 2019.
    - Approximately 85 percent of Medi-Cal managed care children ages 15 to 30 months had at least one comprehensive well-care visit during calendar year 2019.
    - Approximately 68 percent of Medi-Cal managed care children 3 to 6 years of age had at least one comprehensive well-care visit during calendar year 2019.
    - Approximately 50 percent of Medi-Cal managed care children 7 to 11 years of age had at least one comprehensive well-care visit during calendar year 2019.
  - The rates of well-care visits declined for children in older age groups. While 68 percent of children 3 to 6 years of age had at least one comprehensive well-care visit during

calendar year 2019, only 26 percent of adolescents 18 to 21 years of age had at least one comprehensive well-care visit during calendar year 2019.

- Approximately 25 percent of children received a developmental screening in the first three years of life, which is substantially lower than the national benchmark of approximately 33 percent.
- The provision of dental fluoride varnish by non-dental providers is fairly low statewide, with only 9 percent of children 6 months to 5 years of age receiving dental fluoride varnish from a non-dental provider.

- **Conclusions and Considerations for Key Finding 4:**
  - The benefits of receiving well-child visits include the prevention of illness through immunizations; tracking growth and development; allowing parents to raise concerns regarding their child with the child's physician; and building strong relationships among the pediatrician, parents, and child.[4]
  - Based on the results presented in this report, MCPs have an opportunity to increase the number of well-care visits that children receive prior to 30 months of age.
  - MCPs should leverage the anticipated increase in member utilization of preventive services (due to increased member education) by educating providers on the importance of administering comprehensive preventive care during these visits, including the provision of developmental screening and application of dental fluoride in a clinical setting by a primary care provider (PCP).
  - DHCS requires MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health; information from the Preventive Services Report can assist MCPs in their PIP processes.
  - DHCS initiated a Value Based Payment (VBP) program to incentivize the provision of certain preventive services, including well-child visits and dental fluoride varnish, to increase provider participation and delivery of these key pediatric services.
    - This effort is expected to result in improvement in the provision of these key services in the reporting year in which incentive payments are first applied.

- **Key Finding 5: Adolescent rates for well-care visits are lower than rates for younger children**
  - Approximately 51 percent of adolescents ages 12 to 17 years had at least one comprehensive well-child visit during calendar year 2019.
  - Approximately 26 percent of adolescents ages 18 to 21 years had at least one comprehensive well-child visit during calendar year 2019.

- **Conclusions and Considerations for Key Finding 5:**
  - Given that adolescents ages 12 to 21 years account for 45 percent of the pediatric Medi-Cal managed care population, there are opportunities for MCPs to work with

[4] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Nov 5, 2020.

providers to ensure that as children get older, they still continue to receive comprehensive well-care visits and receive the recommended screenings.

- According to the AAP and U.S. Preventive Services Task Force, alcohol and tobacco use and depression can lead to life-long detrimental health complications, and early screening is necessary to prevent chronic health and social issues.[5,6,7]
- Opportunities exist to improve the provision of critical adolescent screenings (i.e., screenings for depression and alcohol and tobacco use) in ages 18 to 21 years. These screenings may be accomplished during comprehensive well-care visits with PCPs and obstetricians/gynecologists (OB/GYNs).
- DHCS' VBP program includes measures related to tobacco use, alcohol use, and depression screenings, and DHCS expects to see a positive impact on screenings due to this incentive program.
- MCPs should work with providers to improve billing practices to capture alcohol and tobacco screenings.
- DHCS requires MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health; information from the Preventive Services Report can assist MCPs in their PIP processes.

5 Knight J, Roberts T, Gabrielli J, et al. Adolescent Alcohol and Substance Use and Abuse, Performing Preventive Services: A Bright Futures Handbook, American Academy of Pediatrics. Available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/Screening.pdf#search=alcohol%20screening. Accessed on: Nov 5, 2020.

6 American Academy of Pediatrics. Teens and Tobacco Use. Available at: https://www.healthychildren.org/English/ages-stages/teen/substance-abuse/Pages/Teens-and-Tobacco-Use.aspx. Accessed on: Nov 5, 2020.

7 Siu A (on behalf of the US Preventive Services Task Force). Screening for Depression in Children and Adolescents: US Preventive Services Task Force Recommendation Statement, *Pediatrics*. Available at: https://pediatrics.aappublications.org/content/early/2016/02/04/peds.2015-4467. Accessed on: Nov 5, 2020.

2. Reader's Guide

Introduction

The "Reader's Guide" is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Preventive Services Population Characteristics

Table 2.1 and Table 2.2 display the statewide counts and percentages for the demographic and regional stratifications of the pediatric Medi-Cal managed care population. Appendix A provides the county and MCP reporting unit counts and percentages for the pediatric Medi-Cal managed care population.

Table 2.1—Statewide Population Characteristics

*The percentage for the total pediatric population (i.e., 21 years of age and younger as of December 31, 2019) is based on all Medi-Cal managed care members enrolled during calendar year 2019.

†Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of June 2017. All non-threshold languages were included in the "Other" primary language group.

Stratification	Count	Percentage
Total Pediatric Population*		
Total	6,733,328	40.21%
Race/Ethnicity		
American Indian or Alaska Native	21,751	0.32%
Asian	418,056	6.21%
Black or African American	449,274	6.67%
Hispanic or Latino	3,793,454	56.34%
Native Hawaiian or Other Pacific Islander	16,294	0.24%
White	919,116	13.65%
Other	408,327	6.06%
Unknown/Missing	707,056	10.50%

Stratification	Count	Percentage
Primary Language†		
Arabic	22,019	0.33%
Armenian	16,342	0.24%
Cambodian	3,662	0.05%
Chinese	64,499	0.96%
English	4,266,469	63.36%
Farsi	9,787	0.15%
Hmong	10,614	0.16%
Korean	12,724	0.19%
Russian	15,699	0.23%
Spanish	2,174,729	32.30%
Tagalog	9,469	0.14%
Vietnamese	60,465	0.90%
Other	34,424	0.51%
Unknown/Missing	32,426	0.48%
Age		
Less than 1 Year	250,643	3.72%
1 to 2 Years	596,849	8.86%
3 to 6 Years	1,253,683	18.62%
7 to 11 Years	1,579,735	23.46%
12 to 17 Years	1,888,632	28.05%
18 to 21 Years	1,163,786	17.28%
Gender		
Female	3,313,359	49.21%
Male	3,419,969	50.79%

Table 2.2—Statewide Population Regional Characteristics

*The percentage for the total pediatric population (i.e., 21 years of age and younger as of December 31, 2019) is based on all Medi-Cal managed care members enrolled during calendar year 2019.

Stratification	Count	Percentage
Total Pediatric Population*		
Total	6,733,328	40.21%
Delivery Type Model		
County Organized Health Systems	1,293,076	19.20%
Geographic Managed Care	738,439	10.97%
Two-Plan (Local Initiative or Commercial Plan)	4,429,890	65.79%
Regional	194,679	2.89%
San Benito	10,836	0.16%
Imperial	50,585	0.75%
Population Density		
Rural	417,243	6.20%
Urban	6,278,828	93.25%

Medi-Cal Managed Care Health Plans

Table 2.3 displays the 58 California counties and the corresponding full-scope Medi-Cal MCPs operating within each county for ease of interpreting the results of this analysis. Figure 2.1 displays a map of California with all counties labeled.

Table 2.3—Counties and Applicable MCPs

County	MCP Names
Alameda	Alameda Alliance for Health, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
Alpine	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Amador	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health

County	MCP Names
	& Wellness Plan, Kaiser NorCal (KP Cal, LLC)
Butte	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Calaveras	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Colusa	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Contra Costa	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, Contra Costa Health Plan
Del Norte	Partnership HealthPlan of California
El Dorado	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan, Kaiser NorCal (KP Cal, LLC)
Fresno	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, CalViva Health
Glenn	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Humboldt	Partnership HealthPlan of California
Imperial	California Health & Wellness Plan, Molina Healthcare of California
Inyo	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Kern	Health Net Community Solutions, Inc., Kern Health Systems, DBA Kern Family Health Care
Kings	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, CalViva Health
Lake	Partnership HealthPlan of California

County	MCP Names
Lassen	Partnership HealthPlan of California
Los Angeles	Health Net Community Solutions, Inc., L.A. Care Health Plan
Madera	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, CalViva Health
Marin	Partnership HealthPlan of California
Mariposa	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Mendocino	Partnership HealthPlan of California
Merced	Central California Alliance for Health
Modoc	Partnership HealthPlan of California
Mono	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Monterey	Central California Alliance for Health
Napa	Partnership HealthPlan of California
Nevada	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Orange	CalOptima
Placer	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan, Kaiser NorCal (KP Cal, LLC)
Plumas	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Riverside	Inland Empire Health Plan, Molina Healthcare of California
Sacramento	Aetna Better Health of California, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, Health Net Community Solutions, Inc.,

County	MCP Names
	Kaiser NorCal (KP Call, LLC), Molina Healthcare of California
San Benito	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
San Bernardino	Inland Empire Health Plan, Molina Healthcare of California
San Diego	Aetna Better Health of California, Blue Shield of California Promise Health Plan (prior to January1, 2019, known as Care1st Health Plan), Community Health Group Partnership Plan, Health Net Community Solutions, Inc., Kaiser SoCal (KP Cal, LLC), Molina Healthcare of California, UnitedHealthcare Community Plan
San Francisco	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, San Francisco Health Plan
San Joaquin	Health Net Community Solutions, Inc., Health Plan of San Joaquin
San Luis Obispo	CenCal Health
San Mateo	Health Plan of San Mateo
Santa Barbara	CenCal Health
Santa Clara	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, Santa Clara Family Health Plan
Santa Cruz	Central California Alliance for Health
Shasta	Partnership HealthPlan of California
Sierra	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Siskiyou	Partnership HealthPlan of California
Solano	Partnership HealthPlan of California
Sonoma	Partnership HealthPlan of California
Stanislaus	Health Net Community Solutions, Inc., Health Plan of San Joaquin

County	MCP Names
Sutter	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Tehama	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Trinity	Partnership HealthPlan of California
Tulare	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, Health Net Community Solutions, Inc.
Tuolumne	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan
Ventura	Gold Coast Health Plan
Yolo	Partnership HealthPlan of California
Yuba	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, California Health & Wellness Plan

Figure 2.1—California Map by County

Summary of Performance Indicators

DHCS selected three existing MCAS indicators reported by the 25 full-scope Medi-Cal MCPs and six HSAG-calculated indicators for inclusion in the 2020 Preventive Services Report. Table 2.4 displays the indicators included in the analysis, age groups for each indicator, and the benchmark source used for comparisons for each applicable indicator.

For each MCP-calculated MCAS indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the Healthcare Effectiveness Data and Information Set (HEDIS) specification for the Medicaid population or by the Centers for

Medicare & Medicaid Services (CMS) Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program (CHIP) (Child Core Set). For the HSAG-calculated indicators, HSAG developed specifications for three of the indicators and followed the applicable technical specifications for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* indicators.

Table 2.4—Indicators, Age Groups, and Benchmarks

"NCQA Quality Compass" refers to NCQA's Quality Compass national Medicaid Health Maintenance Organization (HMO) 50th percentiles[8] for each of the corresponding indicators.

"CMS Child Core Set" refers to CMS' Child Core Set National Median. This is the calculated 50th percentile of the total statewide rates reported by 28 states.

* NCQA Quality Compass benchmarks are only available for the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* stratification of the *Well-Child Visits in the First 30 Months of Life* indicator.

** NCQA Quality Compass benchmarks are only available for the 3 to 6 Years and 12 to 21 Years stratifications of the *Child and Adolescent Well-Care Visits* indicator.

N/A indicates that national benchmarks are unavailable for the corresponding indicator.

Indicators	Age Groups	Benchmarking Source
MCP-Calculated MCAS Indicators		
Chlamydia Screening in Women—16 to 20 Years (CHL–1620)	16 to 20 Years	NCQA Quality Compass
Developmental Screening in the First Three Years of Life—Total (DEV)	1 Year 2 Years 3 Years	CMS Child Core Set
Screening for Depression and Follow-Up Plan (CDF)	12 to 17 Years 18 to 21 Years	N/A
HSAG-Calculated Indicators		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30)*	15 Months 30 Months	NCQA Quality Compass*

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

Indicators	Age Groups	Benchmarking Source
Child and Adolescent Well-Care Visits (WCV)	3 to 6 Years 7 to 11 Years 3 to 11 Years 12 to 17 Years 18 to 21 Years 12 to 21 Years	NCQA Quality Compass**
Alcohol Use Screening (AUS)	18 to 21 Years	N/A
Dental Fluoride Varnish (DFV)	6 Months to 5 Years	N/A
Tobacco Use Screening (TUS)	12 to 17 Years 18 to 21 Years	N/A

Methodology Overview

The information presented below provides a high-level overview of the preventive services analyses. For the detailed methodology, please see Appendix B. Methodology.

Data Sources

For the MCP-calculated MCAS indicators listed in Table 2.4, HSAG received the CA-required patient-level detail file from each Medi-Cal MCP for each HEDIS reporting unit. The reporting year 2020 (measurement year 2019) patient-level detail files followed HSAG's patient-level detail file instructions and included the Medi-Cal client identification number, date of birth, and member months for members included in the audited MCP-calculated MCAS indicator rates. Additionally, the patient-level detail files indicated whether a member was included in the numerator and/or denominator for each applicable MCP-calculated MCAS indicator. HSAG validated the patient-level detail files to ensure the numerator and denominator counts matched what was reported by MCPs in the audited HEDIS Interactive Data Submission System (IDSS) files and non-HEDIS Microsoft (MS) Excel reporting files. Please note, it is possible that some or all MCPs included non-certified eligible members in the reporting year 2020 rates. HSAG used these patient-level detail files, along with supplemental files (e.g., demographic data provided by DHCS), to perform the measure analysis.

For the HSAG-calculated indicators listed in Table 2.4, HSAG received claims/encounter data; member enrollment, eligibility, and demographic data; and provider files from DHCS. Upon receipt of the data from DHCS, HSAG evaluated the data files and performed preliminary file validation. HSAG verified that the data were complete and accurate by ensuring correct formatting, confirming reasonable value ranges for critical data fields, assessing monthly enrollment and claim counts, and identifying fields with a high volume of missing values.

Statistical Analysis

Using the MCP-calculated and HSAG-calculated data sources, HSAG performed statewide-level and regional-level analyses for the applicable indicators.

Statewide-Level Analysis

HSAG calculated statewide rates for the three MCP-calculated MCAS indicators and the six HSAG-calculated indicators listed in Table 2.4. When available, HSAG also compared the statewide indicator rates to national benchmarks as displayed in Table 2.4 to contextualize statewide rates. HSAG also stratified the statewide indicator rates by the demographic stratifications outlined in Table 2.5.

Table 2.5—Statewide Stratifications

*Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of June 2017. All non-threshold languages were included in the "Other" primary language group.

Stratification	Groups
Demographic	
Race/ethnicity	Hispanic or Latino, White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other, and Unknown/Missing (see Table 2.6 for more detail)
Primary language*	English, Spanish, Arabic, Armenian, Cambodian, Chinese (Mandarin or Cantonese), Farsi, Hmong, Korean, Russian, Tagalog, Vietnamese, Other, and Unknown/Missing
Age	Vary depending on indicator specifications (see Table 2.4 for more detail)
Gender	Male and Female

Table 2.6 displays the individual racial/ethnic groups that comprise the Asian and Native Hawaiian or Other Pacific Islander racial/ethnic demographic stratifications. Racial/ethnic stratifications were based on data collection guidance from the federal Office of Management and Budget as well as the U.S. Department of Health and Human Services.

Table 2.6—Asian and Native Hawaiian or Other Pacific Islander Racial/Ethnic Stratification Groups

*Some "Other Pacific Islanders" who would not be considered part of the Asian racial/ethnic group were included in the Asian racial/ethnic group due to limitations of existing data fields (i.e., the data do not allow HSAG to parse out racial/ethnic groups that may not be considered Asian).

Stratification	Groups
Asian	Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Laotian, Vietnamese, and Other Asian or Pacific Islander*
Native Hawaiian or Other Pacific Islander	Hawaiian, Guamanian, and Samoan

Regional-Level Analysis

HSAG also calculated regional-level rates for the three MCP-calculated MCAS indicators and the six HSAG-calculated indicators listed in Table 2.4. The regional stratifications are listed in Table 2.7.

Table 2.7—Regional Stratification Groups

*The Imperial and San Benito delivery models are not included in the delivery type model analysis since the rates for those models are represented in the county stratifications.

Stratification	Groups
County	Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma,

Stratification	Groups
	Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba
Delivery Type Model*	County Organized Health Systems, Geographic Managed Care, Two-Plan (i.e., Local Initiative or Commercial Plan), Regional
Population Density	Urban, Rural

Caveats and Limitations

Administrative Data Incompleteness

For the *Alcohol Use Screening* and *Tobacco Use Screening* indicators, the administrative rates may be artificially low due to a lack of reporting of applicable Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes in administrative data sources (i.e., medical record review [MRR] or electronic health record [EHR] data could be necessary to capture this information). Caution should be exercised when evaluating these indicator rates, as they may be more indicative of data completeness rather than performance.

Data Run Out

HSAG calculated all administrative measure rates using claims data provided by DHCS. DHCS provided a data refresh in September 2020; however, the eight-month run-out time period may not be sufficient for the data to be complete enough for measure calculation.

Demographic Characteristic Assignment

Members' demographic characteristics may change as their records are updated over time. For instance, a member may relocate and change ZIP Codes during the reporting year. HSAG assigned demographic characteristics using the most recent non-missing record for each member. Therefore, members' assigned demographic characteristics may not always reflect their demographic characteristics at the time of the indicator events.

Discrepancies with the EQR Technical Report

While the 3 to 6 Years and 12 to 21 Years age groups for *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicators follow the HEDIS measure specifications for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Adolescent Well-Care Visits*, and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* indicators, respectively, the HSAG-calculated indicator rates will not match rates reported in the EQR technical report, since the EQR technical report presents weighted statewide rates derived from MCPs' reported MCAS rates. HSAG calculated administrative rates for the 3 to 6

Years and 12 to 21 Years age groups for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicators for use in this report, while the rates for their corresponding HEDIS 2020 indicators in the EQR technical report were based on the hybrid rates reported by most MCPs.

Indicator Specification Development

HSAG developed specifications for *Alcohol Use Screening*, *Dental Fluoride Varnish*, and *Tobacco Use Screening* in alignment with DHCS' value-based purchasing model without testing the frequency of the codes billed to indicate numerator compliance. As a result, the rates for these indicators may be incomplete due to provider billing practices.

Comparisons to Benchmarks

CMS' Child Core Set benchmarks for the *Developmental Screening in the First Three Years of Life* indicator include data from non-managed care populations and are calculated at the statewide level. Caution should be exercised when comparing rates displayed in the report for this indicator to national benchmarks.

HSAG calculated the new HEDIS Measurement Year 2020 *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* indicators using administrative data only, and HEDIS Measurement Year 2020 Quality Compass benchmarks are not yet available for these indicators. As a result, HSAG only made comparisons to HEDIS 2020 Quality Compass benchmarks for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* measures since the 3 to 6 Years and 12 to 21 Years age groups of the new *Child and Adolescent Well-Care Visits* measure align with the HEDIS 2020 measures. Similarly, HSAG compared the new HEDIS Measurement Year 2020 *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator to the existing HEDIS 2020 Quality Compass benchmarks for the *Well-Child Visits in the First 15 Months of Life* measure since both measures include the same population (i.e., children who turned 15 months old during the measurement year) and number of visits. Additionally, because the HEDIS 2020 measures used MRR data, caution should be exercised when comparing the administrative only rates presented in this report for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* indicators to national benchmarks that use MRR data.

Well-Child Visit and Well-Care Visit Indicators

Since DHCS will continue to produce the Preventive Services Report annually, this report preemptively replaces the existing *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* measures with the new HEDIS Measurement Year 2020 *Child and Adolescent Well-Care Visits* measure. Similarly, this report also preemptively replaces the existing *Well-Child Visits in the First 15 Months of Life* measure with the new HEDIS Measurement Year 2020 *Well-Child Visits in the First 30 Months of Life* measure. Please note, this report includes additional age stratifications and well-care visits that are not

part of the HEDIS Measurement Year 2020 technical specifications. In 2021, MCPs will be responsible for reporting the new HEDIS Measurement Year 2020 measures to DHCS for inclusion in future reports. DHCS expects the MCP-reported rates for the new HEDIS Measurement Year 2020 measures will be more comparable to national benchmarks.

Non-Reporting of Hybrid Measures Using Administrative Data Only

Due to the incompleteness of the administrative data available for three measures with a hybrid reporting option (i.e., *Childhood Immunization Status—Combination 10*, *Immunizations for Adolescents—Combination 2*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment for Children/Adolescents*), this report excludes the results for these measures. However, DHCS' annual EQR technical report will present MCP-reported rates for these measures. These three measures will be evaluated for inclusion in future iterations of the Preventive Services Report.

Evaluating Results

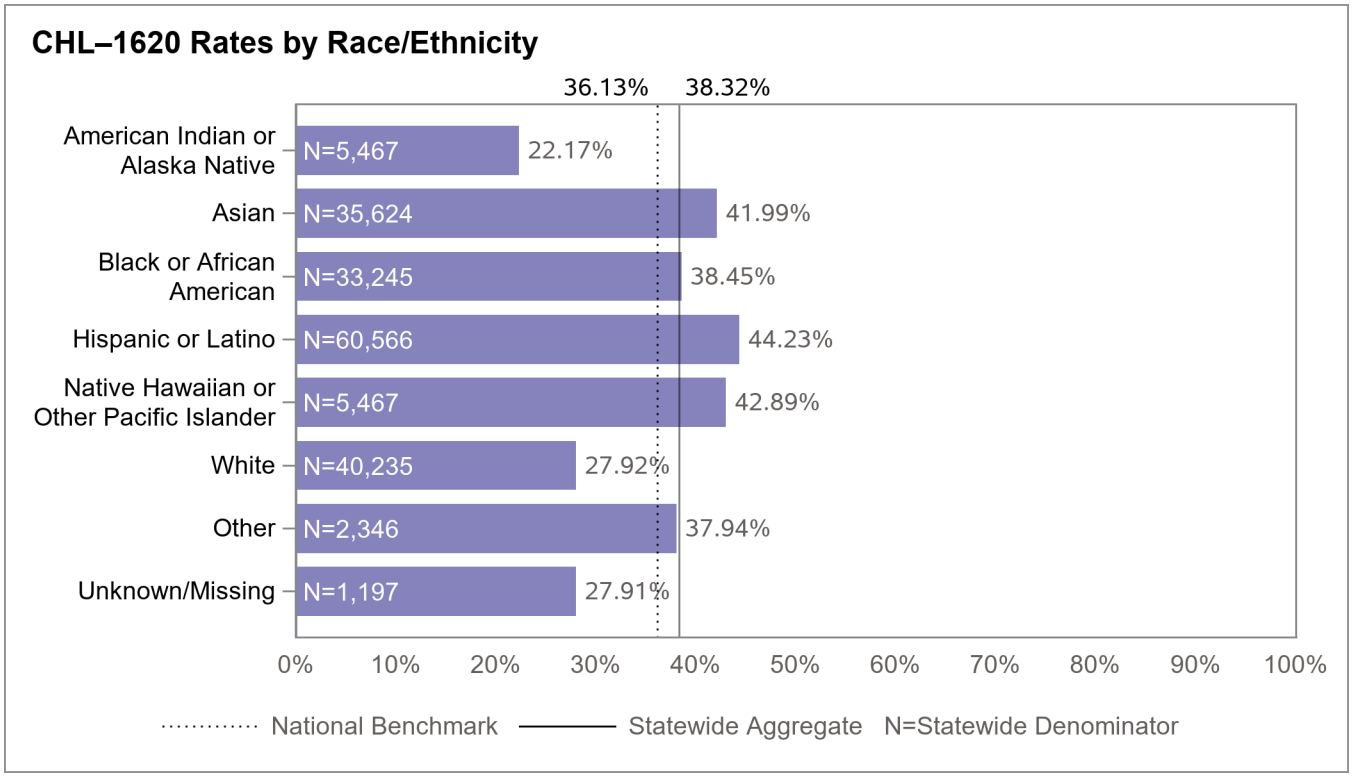
Section 3 of this report presents the statewide demographic and regional results for each indicator.

Figure Interpretation

For each indicator presented within Section 3 of this report, horizontal bar charts display the rates for the racial/ethnic, primary language, gender, delivery type model, and population density stratifications for reporting year 2020. The figures display a single dotted reference line that represents the national benchmark for reporting year 2020, where applicable, and a single solid reference line that represents the statewide aggregate rate for reporting year 2020. The national benchmark value (i.e., the 50th percentile), where applicable, and statewide aggregate are displayed above the corresponding reference lines. "N" represents the total statewide denominator for an indicator for a particular group. An example of the horizontal bar chart for the racial/ethnic stratification is shown in Figure 2.2. All data in the sample figure are mock data.

Figure 2.2—Sample Indicator-Level Horizontal Bar Chart Figure

FIGURE CONTAINS MOCK DATA



County-Level Map Interpretation

In Section 3, HSAG presents county-level rates using a map of California which includes shading to indicate performance. To highlight regional performance differences, HSAG shaded each county using a color gradient based on how the rate for each county compared to the performance quintiles. For each indicator, HSAG calculated performance quintiles based on county performance (i.e., 20th percentile, 40th percentile, 60th percentile, and 80th percentile). HSAG then determined into which quintile each county fell (e.g., below the 20th percentile, between the 20th and 40th percentiles). HSAG shaded each county based on the corresponding quintiles as displayed in Table 2.8.

Table 2.8—Statewide Performance Quintile Thresholds and Corresponding Colors

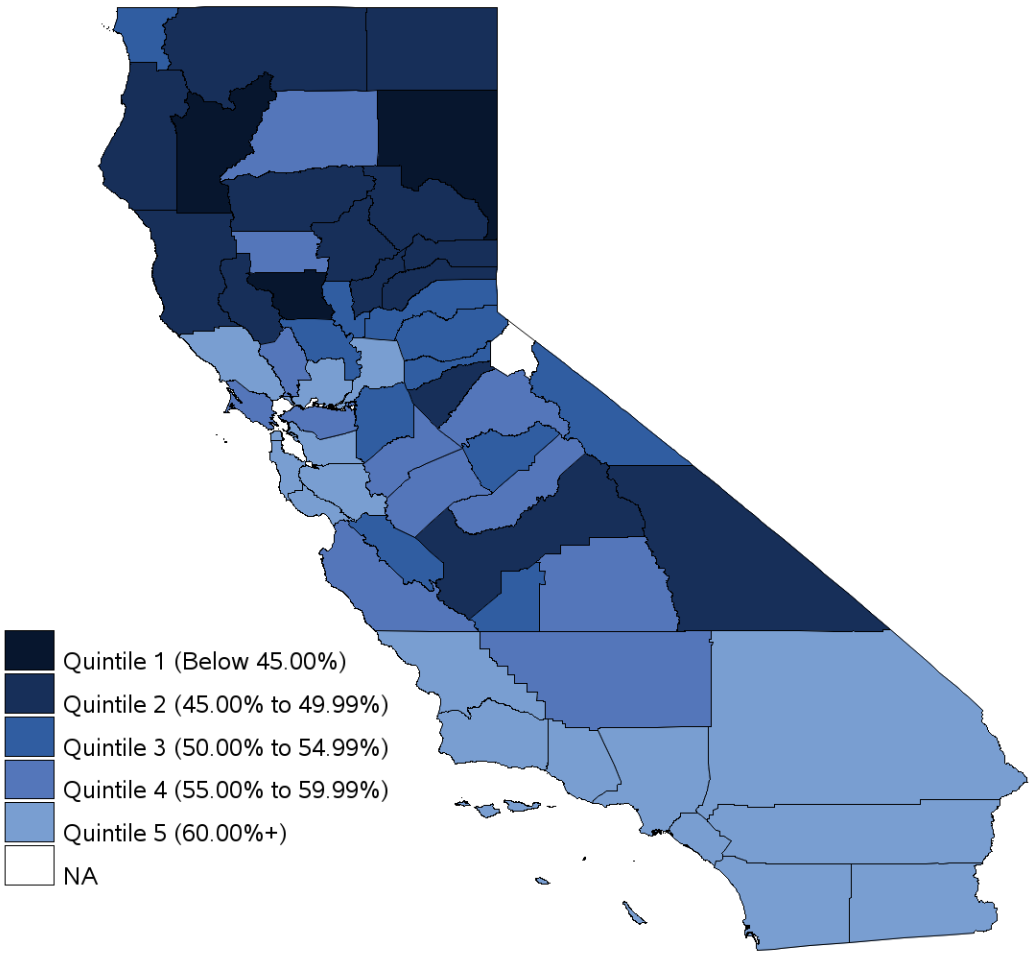
For county rates with a small denominator (i.e., less than 30) or small numerator (i.e., less than 11), HSAG shaded the county white.

Statewide Performance Quintile	Performance Thresholds and Corresponding Colors
NA	Small denominator or suppressed rate
Quintile 1 (least favorable rates)	Below the 20th percentile
Quintile 2	At or above the 20th percentile but below the 40th percentile
Quintile 3	At or above the 40th percentile but below the 60th percentile
Quintile 4	At or above the 60th percentile but below the 80th percentile
Quintile 5 (most favorable rates)	At or above the 80th percentile

An example of a statewide map shaded to indicate county-level performance is shown in Figure 2.3. All data in the sample figure are mock data.

Figure 2.3—Statewide Map—County-Level Results

FIGURE CONTAINS MOCK DATA



3. Statewide Findings

The Statewide Findings section presents the statewide demographic and regional results by indicator for reporting year 2020 (i.e., measurement year 2019 data). For each MCP-calculated and HSAG-calculated indicator presented within the Statewide Findings section, horizontal bar charts display the rates for the racial/ethnic, primary language, age (where applicable), gender, delivery type model, and population density stratifications for reporting year 2020. The figures display a single dotted reference line that represents the national benchmark for reporting year 2020 (i.e., the 50th percentile), where applicable, and a single solid reference line that represents the statewide aggregate rate for reporting year 2020. The national benchmark value, where applicable, and statewide aggregate are displayed above the corresponding reference lines. "N" represents the total statewide denominator for an indicator for a particular group.

HSAG also presents county-level rates using a map of California which includes shading to indicate performance. To highlight regional performance differences, HSAG shaded each county using a color gradient based on how the rate for each county compared to the performance quintiles. HSAG shaded each county based on the corresponding quintiles as displayed in Table 2.8 in the Reader's Guide.

MCP-Calculated MCAS Indicator Results

Figure 3.1 through Figure 3.19 display the statewide and regional results for the three MCAS indicators reported by the 25 full-scope Medi-Cal MCPs.

Chlamydia Screening in Women—16 to 20 Years

The *Chlamydia Screening in Women—16 to 20 Years* (*CHL–1620*) indicator measures 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. Figure 3.1 through Figure 3.5 display the *Chlamydia Screening in Women—16 to 20 Years* (*CHL–1620*) indicator rates at the statewide and regional levels.

Figure 3.1—Chlamydia Screening in Women—16 to 20 Years (CHL–1620)—Statewide Racial/Ethnic Results

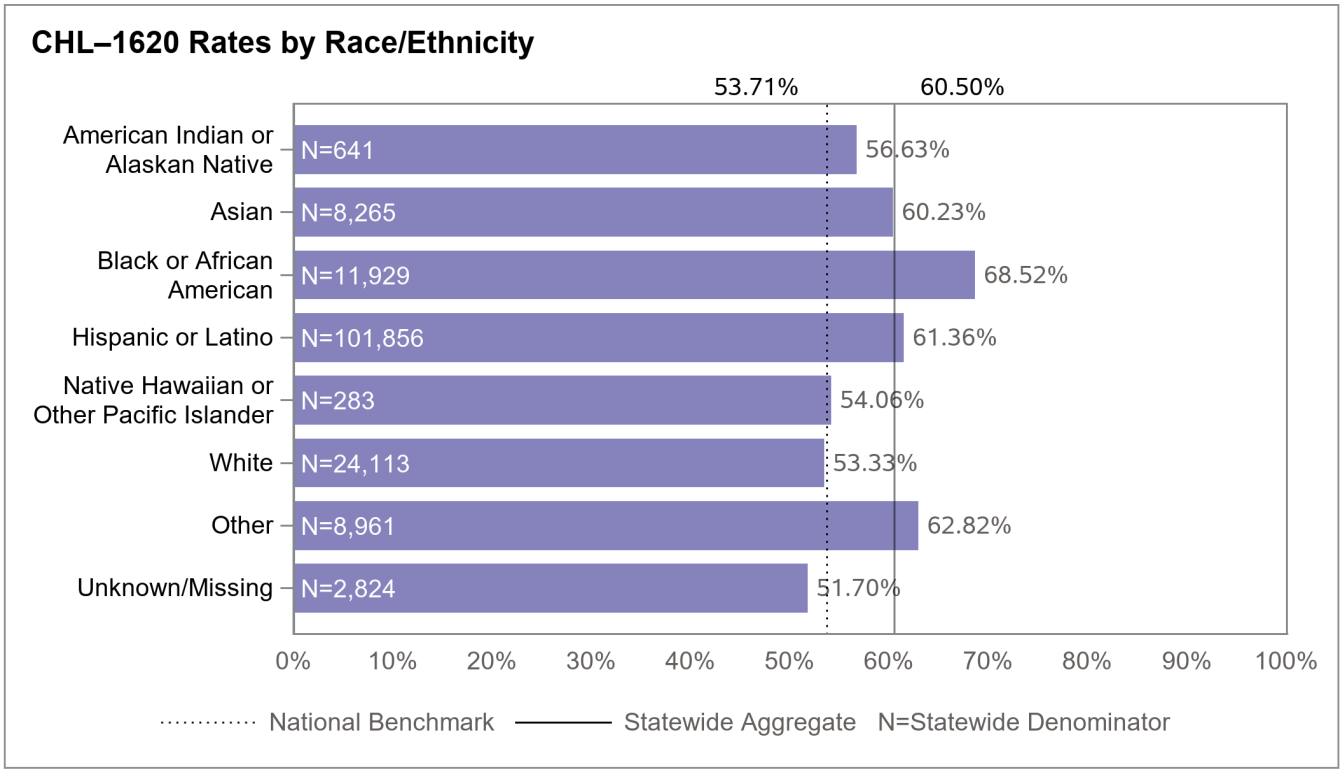
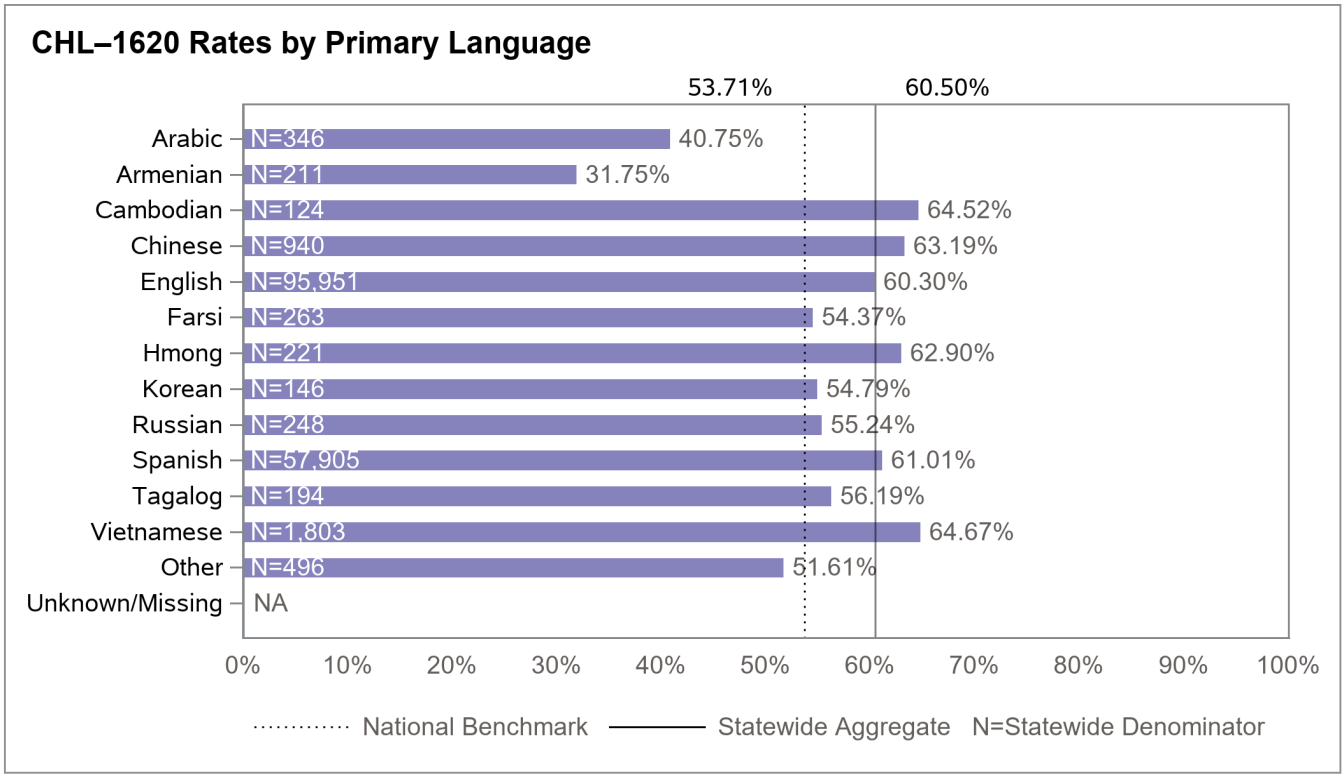


Figure 3.2—Chlamydia Screening in Women—16 to 20 Years (CHL–1620)—Statewide Primary Language Results

NA indicates the rate had a small denominator (i.e., less than 30).



- The statewide aggregate rate for the *Chlamydia Screening in Women—16 to 20 Years* indicator was at or above the national benchmark, indicating that MCPs ensured that an adequate number of female members received appropriate chlamydia screenings.
- For calendar year 2019, rates for two of the eight (25.0 percent) racial/ethnic groups and three of the 13 (23.1 percent) primary language groups fell below the national benchmark.
- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Native Hawaiian or Other Pacific Islander
  - White
  - Unknown/Missing
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Arabic
  - Armenian
  - Farsi
  - Other

Figure 3.3—Chlamydia Screening in Women—16 to 20 Years (CHL–1620)—Regional-Level Delivery Type Model Results

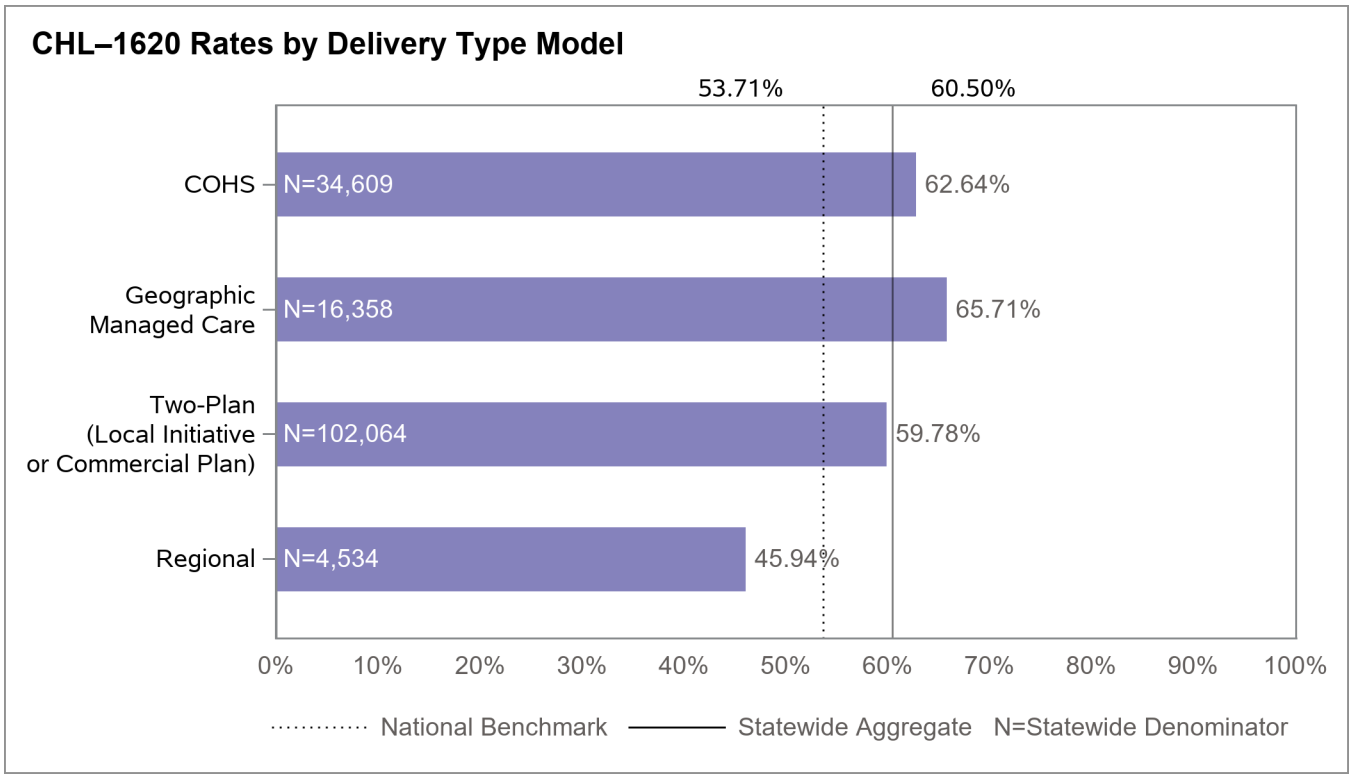
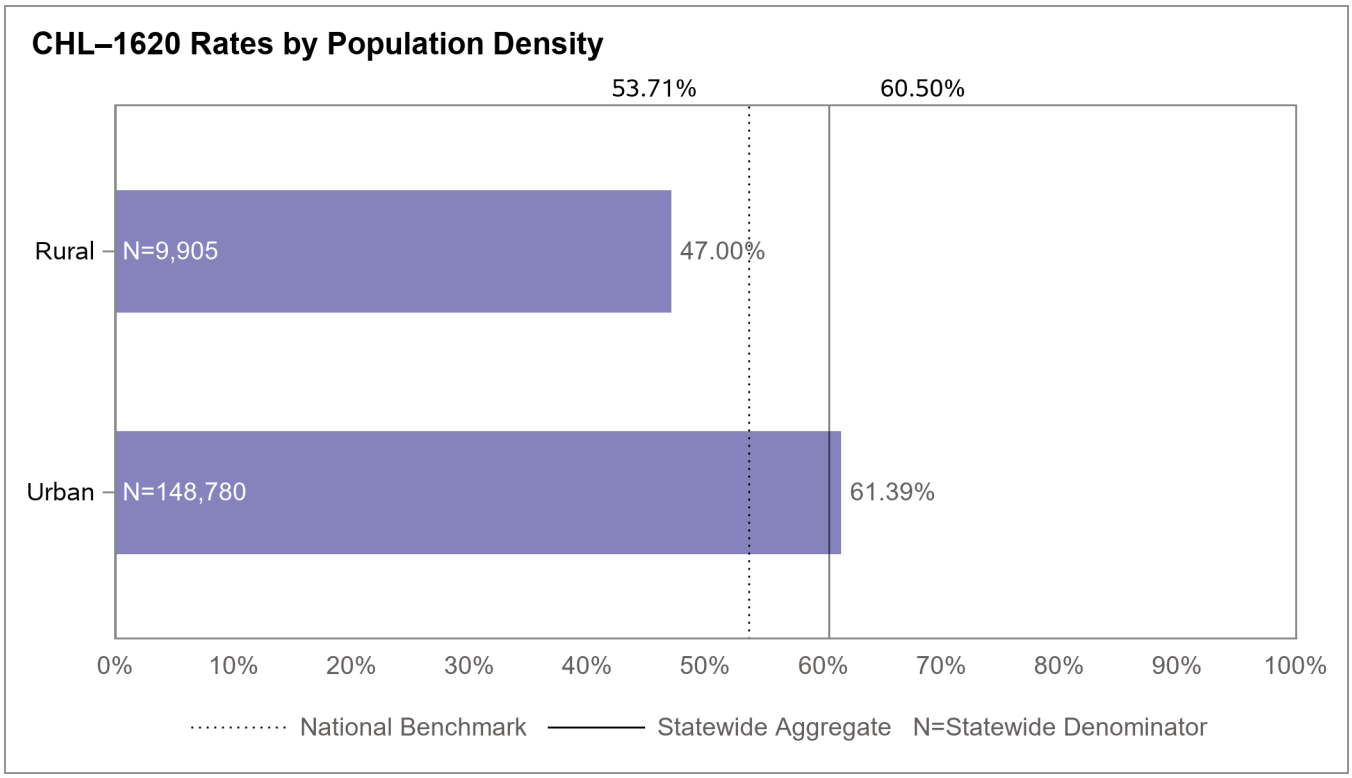


Figure 3.4—Chlamydia Screening in Women—16 to 20 Years (CHL–1620)—Regional-Level Population Density Results

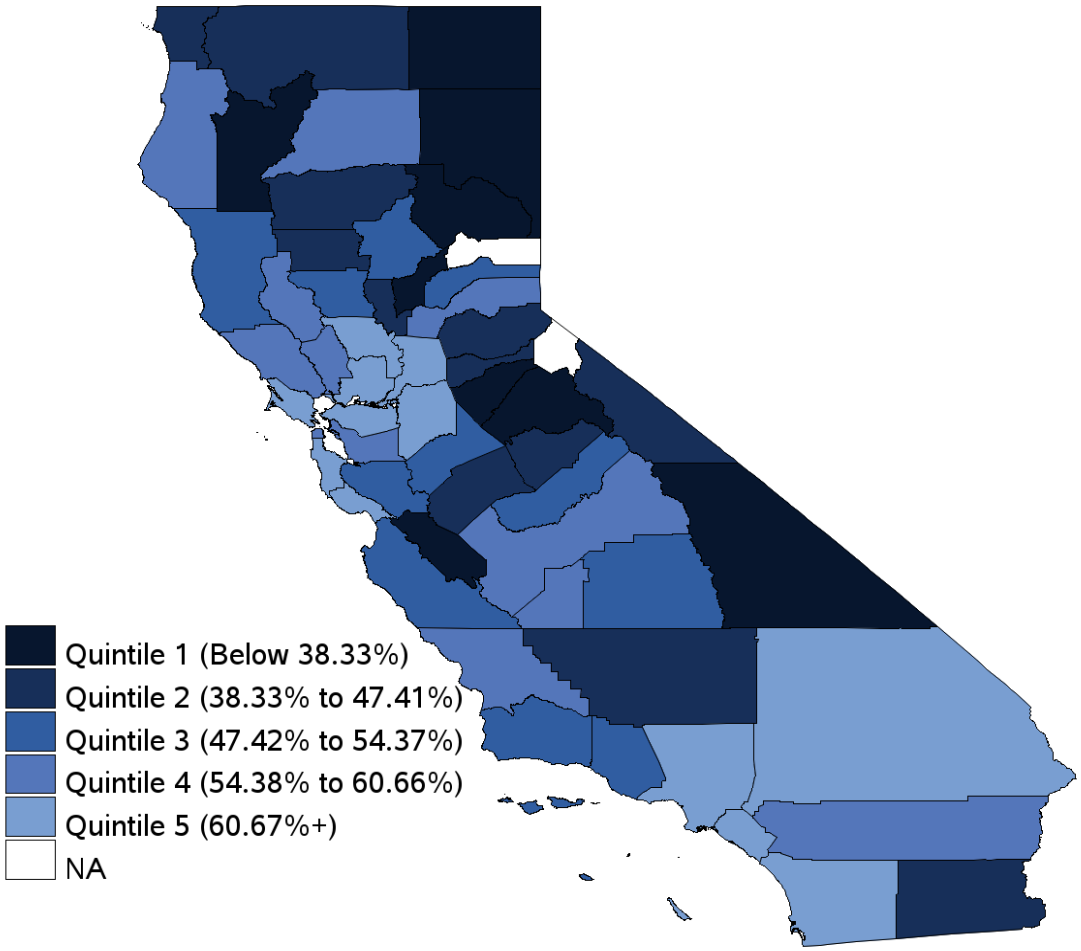


- For calendar year 2019, the *Chlamydia Screening in Women—16 to 20 Years* indicator rate for one of the four (25.0 percent) delivery type models fell below the national benchmark.
- The rate for the rural regions fell below the national benchmark and was below the rate for the urban regions by more than a 20 percent relative difference.

Figure 3.5—Chlamydia Screening in Women—16 to 20 Years (CHL–1620)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



- Eight of the nine counties that had the least favorable *Chlamydia Screening in Women—16 to 20 Years* indicator rates are primarily rural counties. This finding aligns with the results displayed in Figure 3.4, which shows the rate for members living in rural areas was more than 14 percentage points lower than the rate for members living in urban areas.
- All 12 counties that had the most favorable rates were identified as being urban counties. This finding aligns with the results displayed in Figure 3.4, which shows the rate for members living in urban areas was more than 14 percentage points higher than the rate for members living in rural areas.

Developmental Screening in the First Three Years of Life—Total

The *Developmental Screening in the First Three Years of Life—Total* (*DEV*) indicator measures the percentage of children who were screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on the child's first, second, or third birthday. Figure 3.6 through Figure 3.12 display the *Developmental Screening in the First Three Years of Life—Total* (*DEV*) indicator rates at the statewide and regional levels. Due to inconsistent reporting of EHR data by MCPs, differences in rates may be indicative of data completeness rather than performance.

Figure 3.6—Developmental Screening in the First Three Years of Life—Total (DEV)—Statewide Racial/Ethnic Results

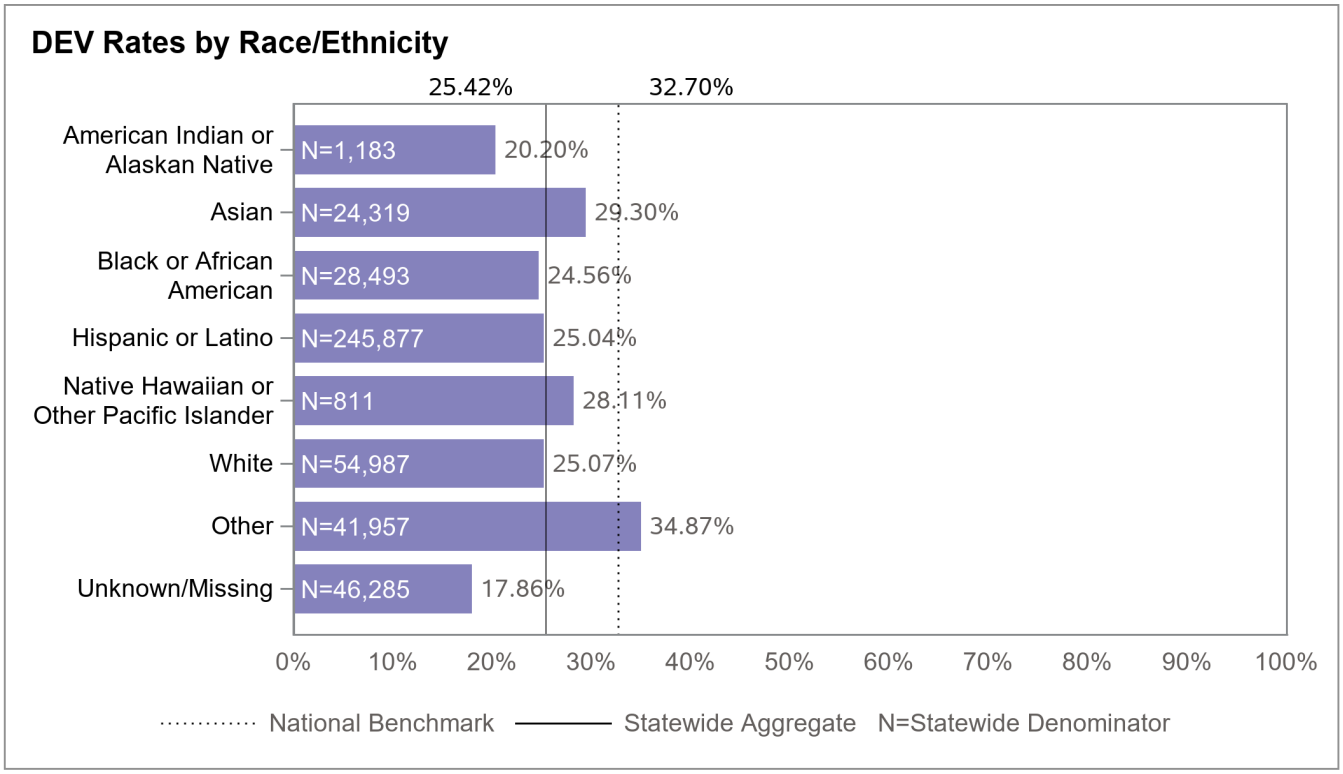


Figure 3.7—Developmental Screening in the First Three Years of Life—Total (DEV)—Statewide Primary Language Results

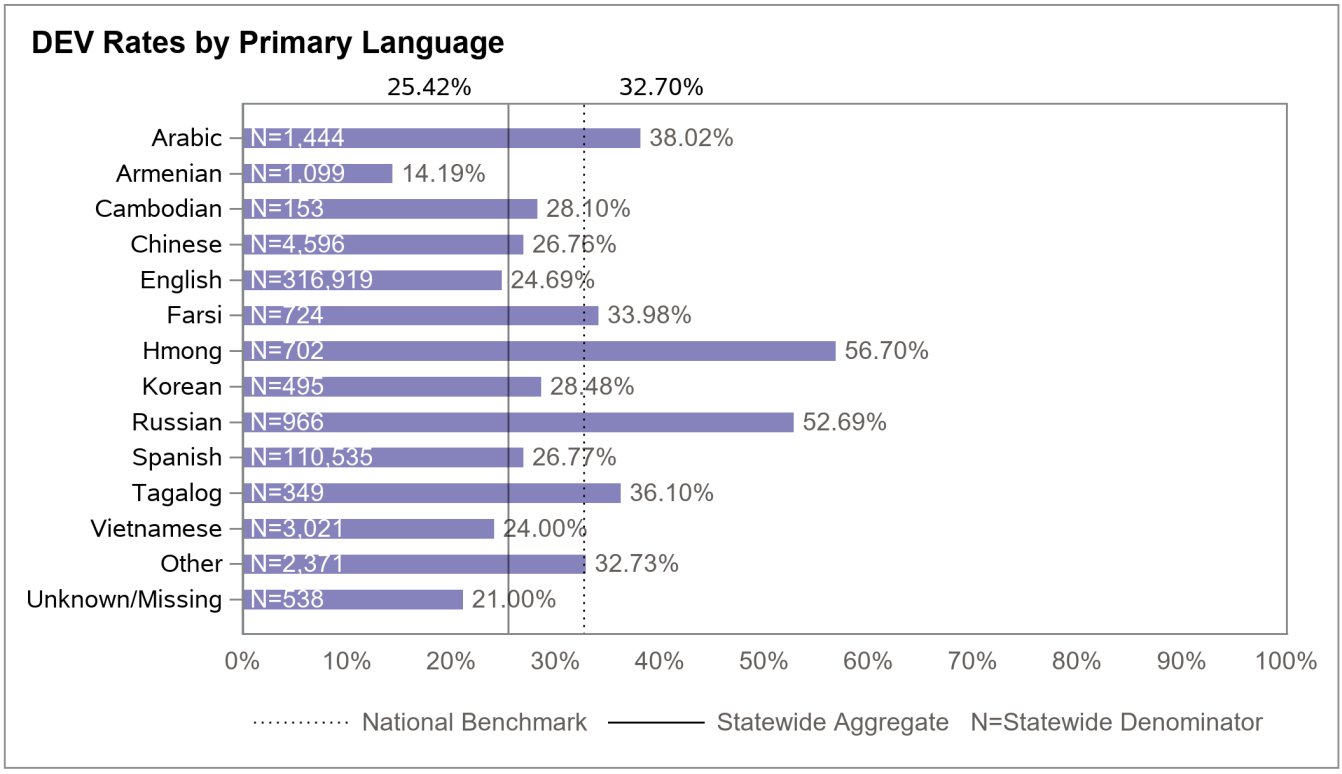


Figure 3.8—Developmental Screening in the First Three Years of Life—Total (DEV)—Statewide Gender Results

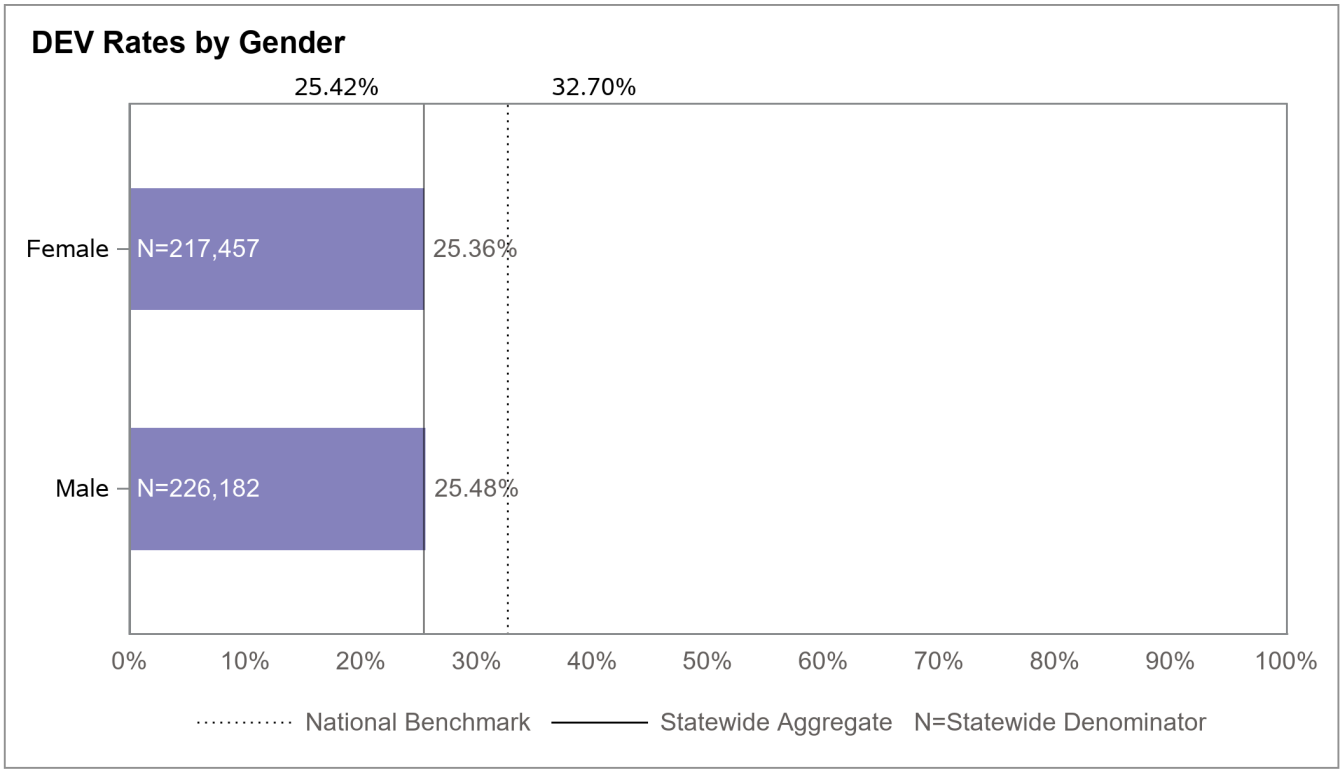
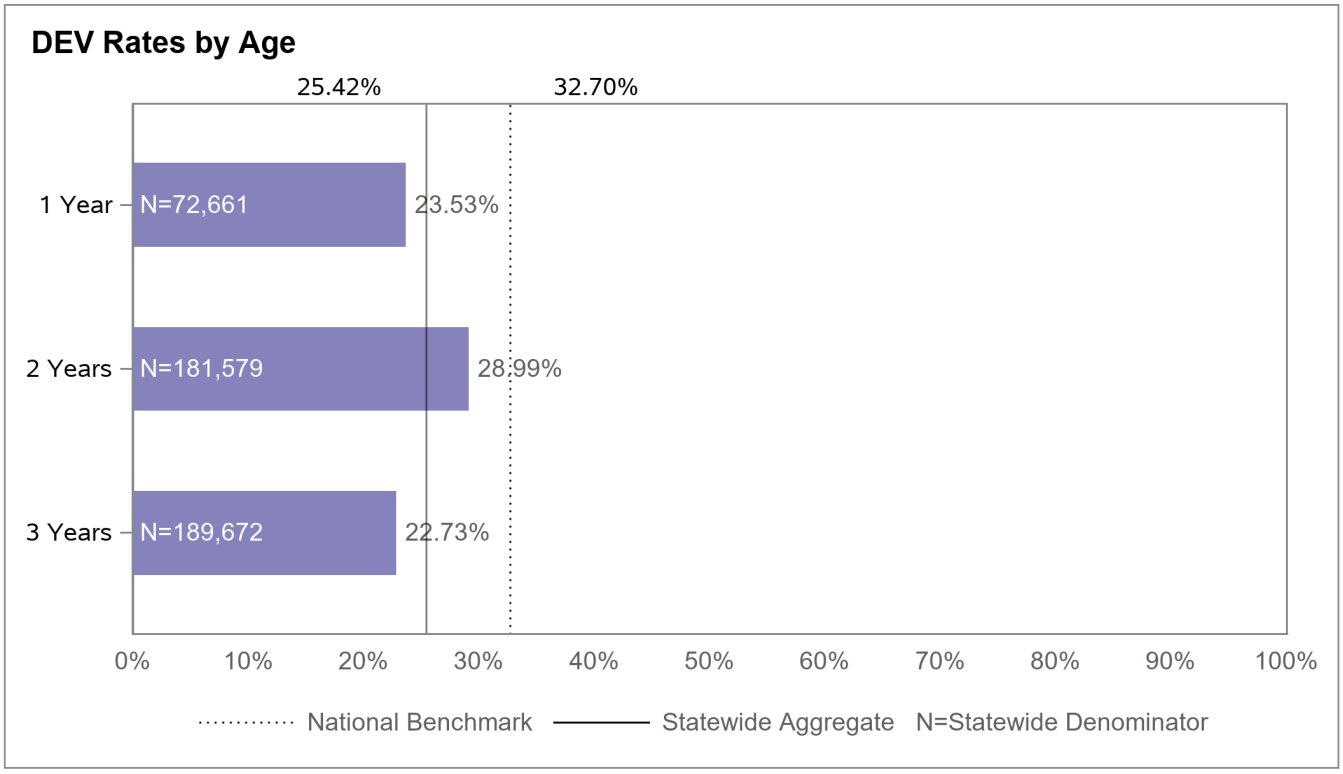


Figure 3.9—Developmental Screening in the First Three Years of Life—Total (DEV)—Statewide Age Results



- The statewide aggregate rate for the *Developmental Screening in the First Three Years of Life—Total* indicator fell below the national benchmark, indicating that MCPs can improve efforts to collect data on and ensure that an adequate number of children receive screenings for risk of developmental, behavioral, and social delays.
- For calendar year 2019, rates for seven of the eight (87.5 percent) racial/ethnic groups and eight of the 14 (57.1 percent) primary language groups fell below the national benchmark. Of note, five of the six (83.3 percent) primary language groups that exceeded the national benchmark are recognized by DHCS as being Asian languages. The rates for both gender groups and for all three age groups fell below the national benchmark.
- The rates for the following racial/ethnic groups were below the statewide aggregate by more than a 10 percent relative difference:
  - American Indian or Alaska Native
  - Unknown/Missing
- The rates for the following primary language groups were below the statewide aggregate by more than a 10 percent relative difference:
  - Armenian
  - Unknown/Missing
- The rate for the 3 Years age group fell below the statewide aggregate by more than a 10 percent relative difference.

Figure 3.10—Developmental Screening in the First Three Years of Life—Total (DEV)—Regional-Level Delivery Type Model Results

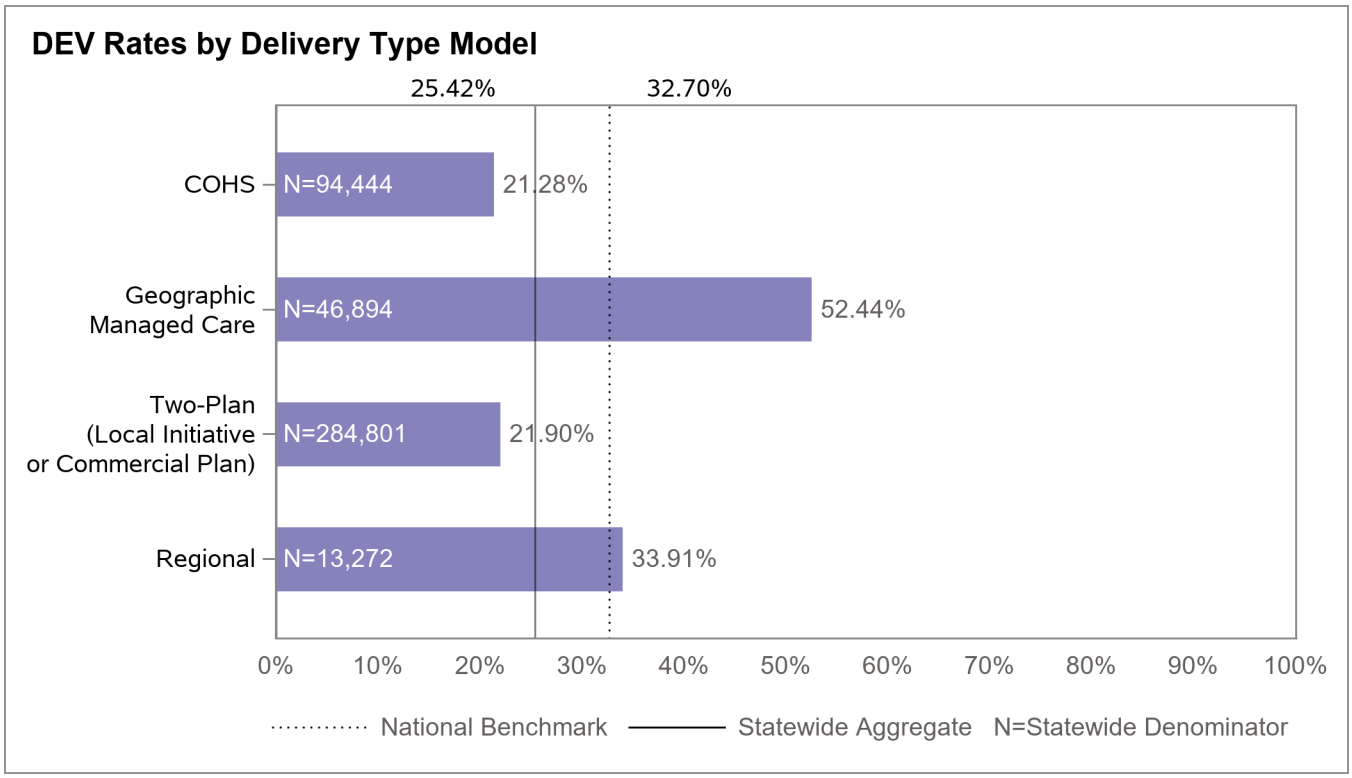
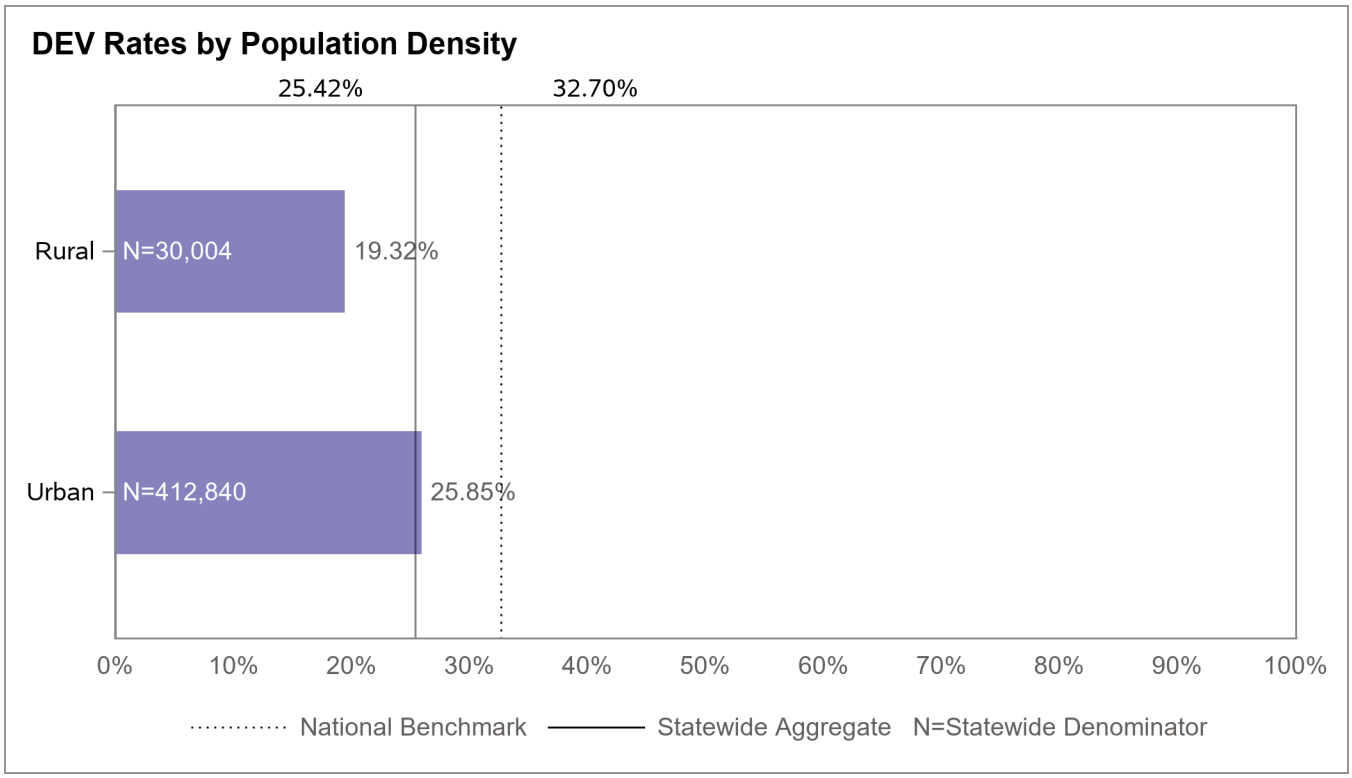


Figure 3.11—Developmental Screening in the First Three Years of Life—Total (DEV)—Regional-Level Population Density Results

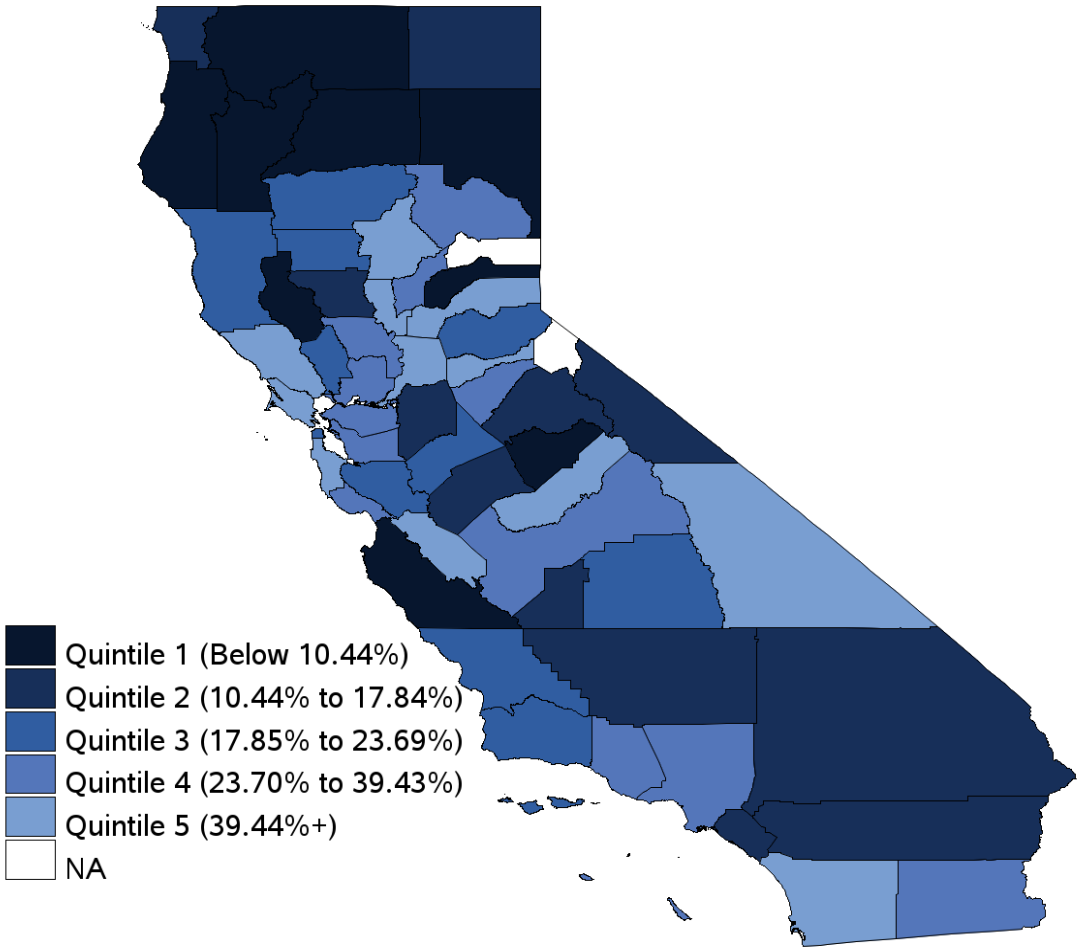


- For calendar 2019, the *Developmental Screening in the First Three Years of Life* indicator rates for two of the four (50.0 percent) delivery type models fell below the national benchmark. Of note, the rate for the Geographic Managed Care delivery type model surpassed the national benchmark by nearly 20 percentage points, as shown in Figure 3.10.
- The rates for the rural and urban regions fell below the national benchmark. The rate for the rural regions was below the rate for the urban regions by more than a 25 percent relative difference.

Figure 3.12—Developmental Screening in the First Three Years of Life—Total (DEV)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



- Trinity, Lassen, Humboldt, Shasta, and Lake counties had the least favorable *Developmental Screening in the First Three Years of Life—Total* indicator rates.
- Marin, Amador, Sacramento, Placer, and Madera counties had the most favorable *Developmental Screening in the First Three Years of Life—Total* indicator rates.

Screening for Depression and Follow-Up Plan

The *Screening for Depression and Follow-Up Plan* (*CDF*) indicator measures the percentage of children ages 12 to 21 years who were screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan was documented on the date of the positive screen. Figure 3.13 through Figure 3.19 display the *Screening for Depression and Follow-Up Plan* (*CDF*) indicator rates at the statewide and regional levels. Due to inconsistent reporting of medical record data by MCPs, differences in rates may be indicative of data completeness rather than performance. Please note, national benchmarks are not available for this indicator.

Figure 3.13—Screening for Depression and Follow-Up Plan (CDF)—Statewide Racial/Ethnic Results

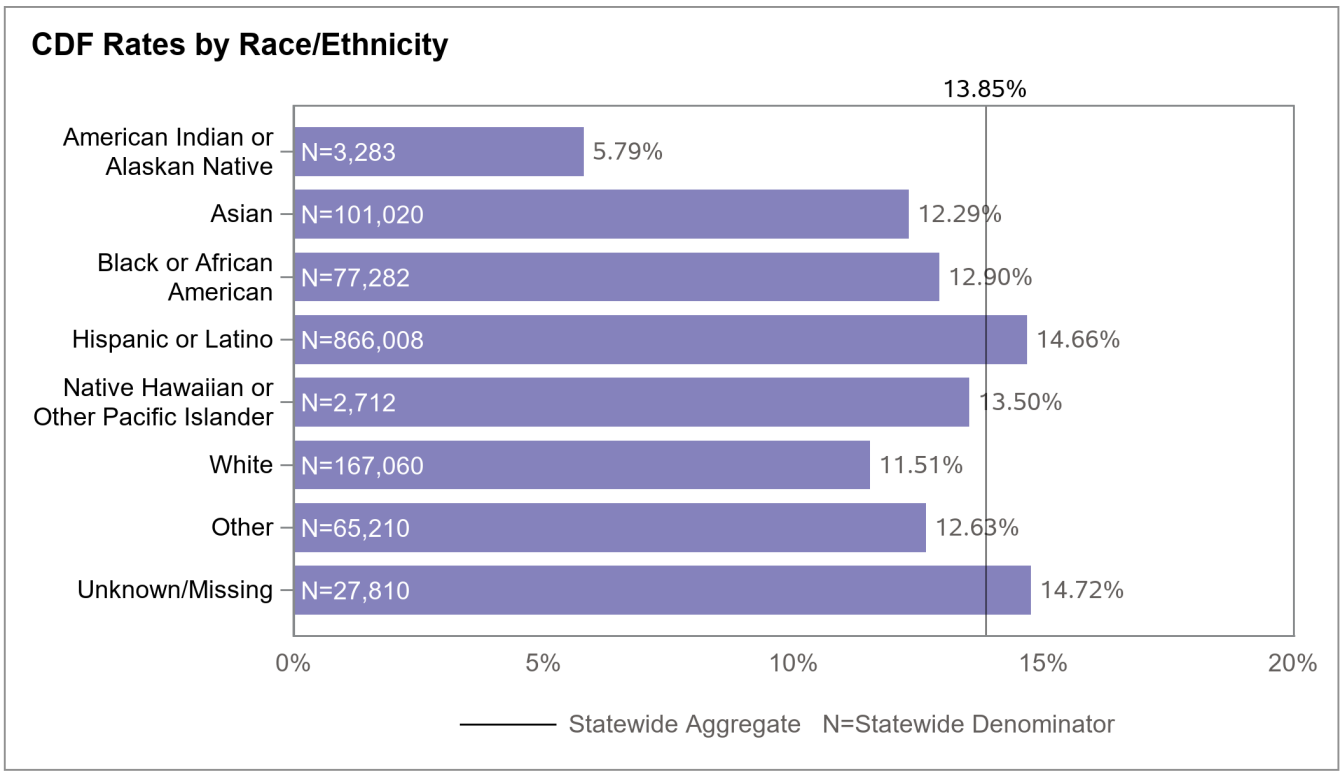


Figure 3.14—Screening for Depression and Follow-Up Plan (CDF)—Statewide Primary Language Results

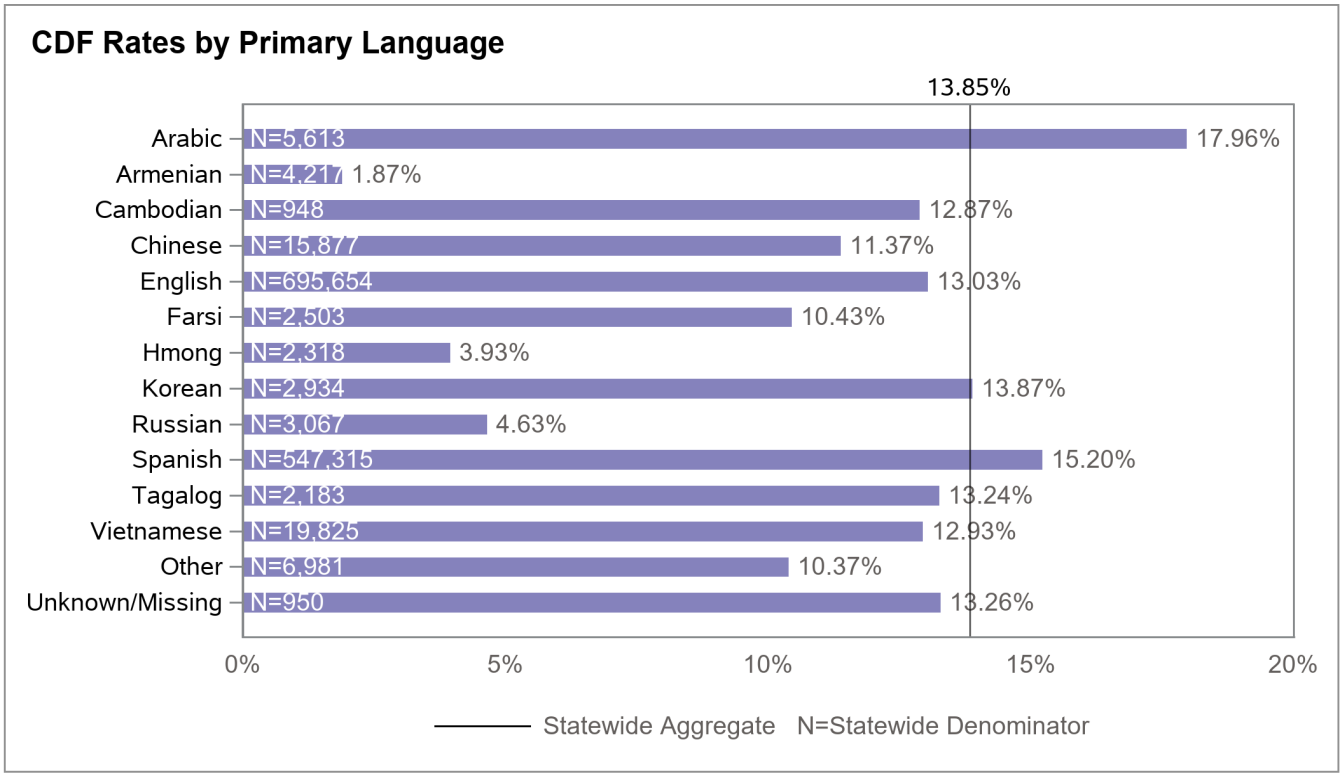


Figure 3.15—Screening for Depression and Follow-Up Plan (CDF)—Statewide Gender Results

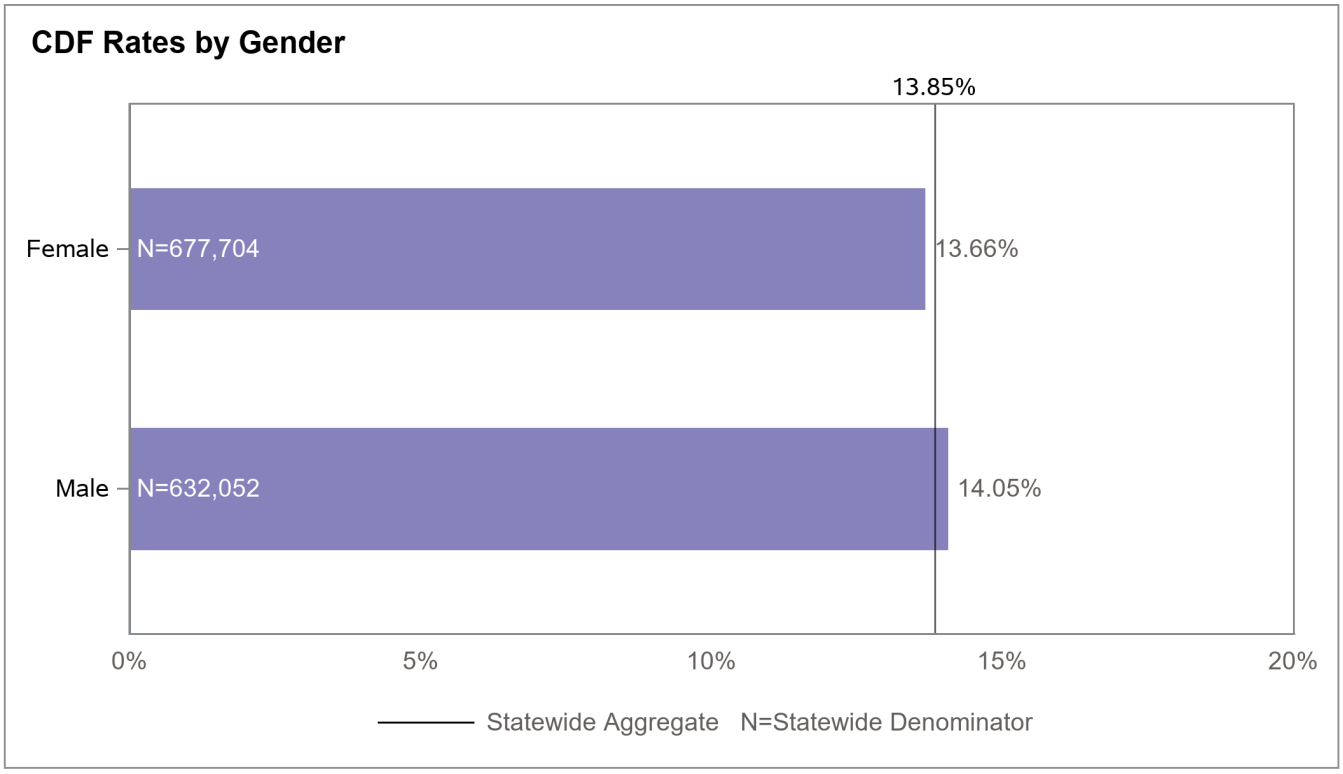
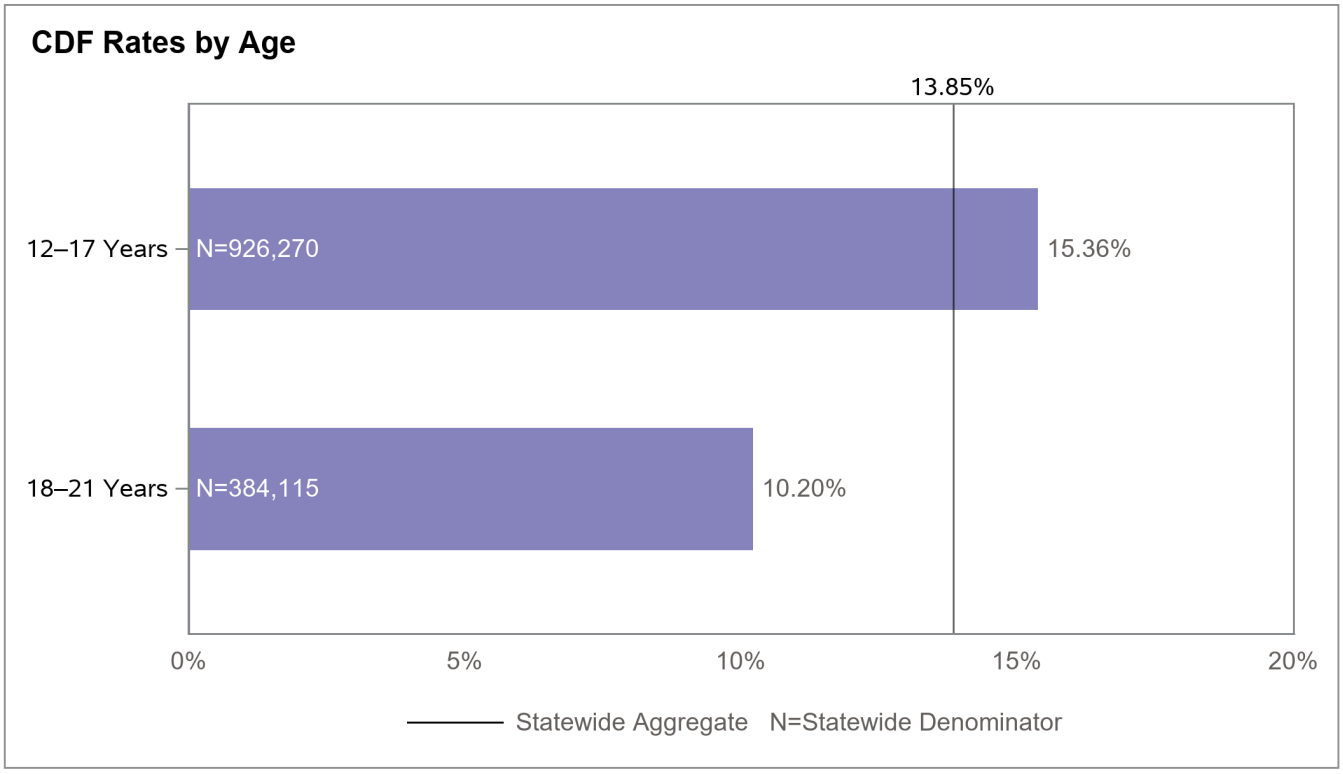


Figure 3.16—Screening for Depression and Follow-Up Plan (CDF)—Statewide Age Results



- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - American Indian or Alaskan Native
  - Asian
  - White
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Armenian
  - Chinese
  - Farsi
  - Hmong
  - Russian
  - Other
- The rate for the 18 to 21 Years age group was below the statewide aggregate rate by more than a 10 percent relative difference.

Figure 3.17—Screening for Depression and Follow-Up Plan (CDF)—Regional-Level Delivery Type Model Results

Note: The Statewide Denominator for the Regional group was 36,814.

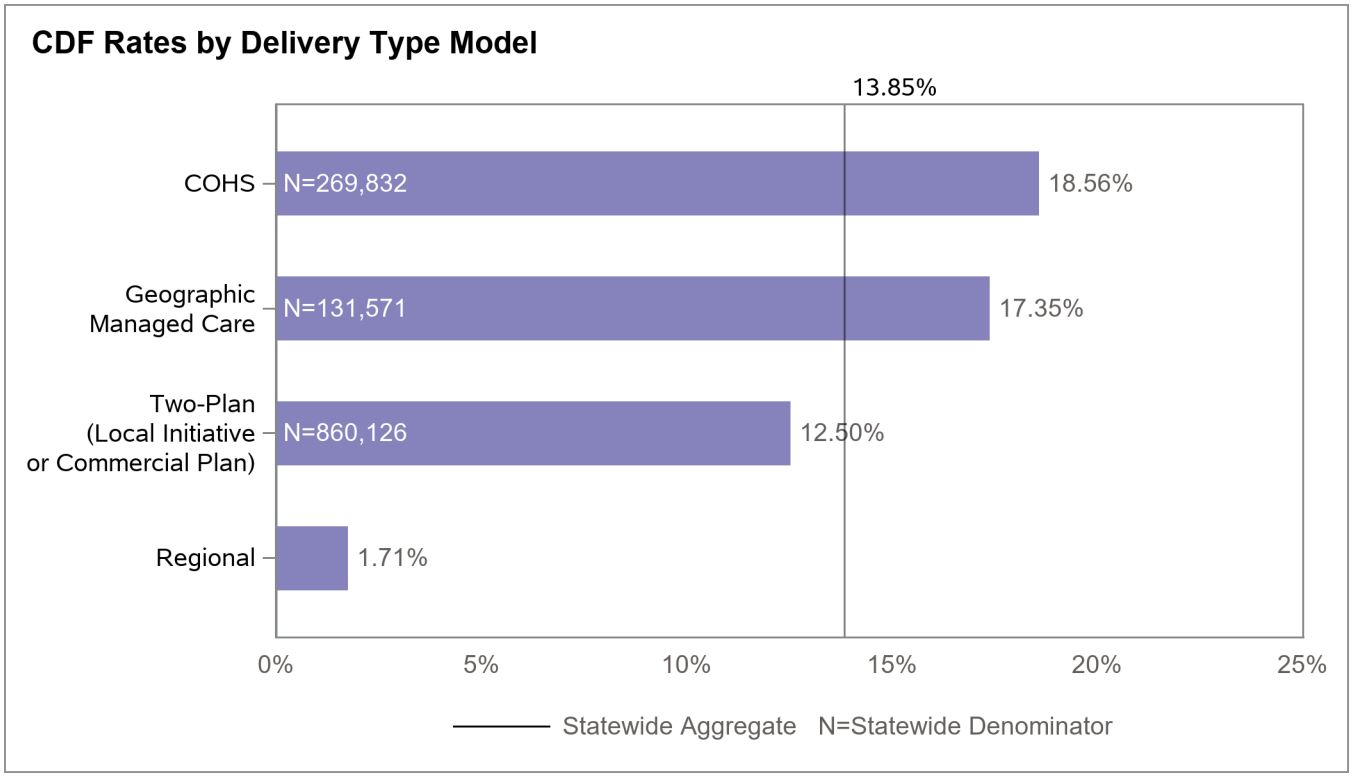
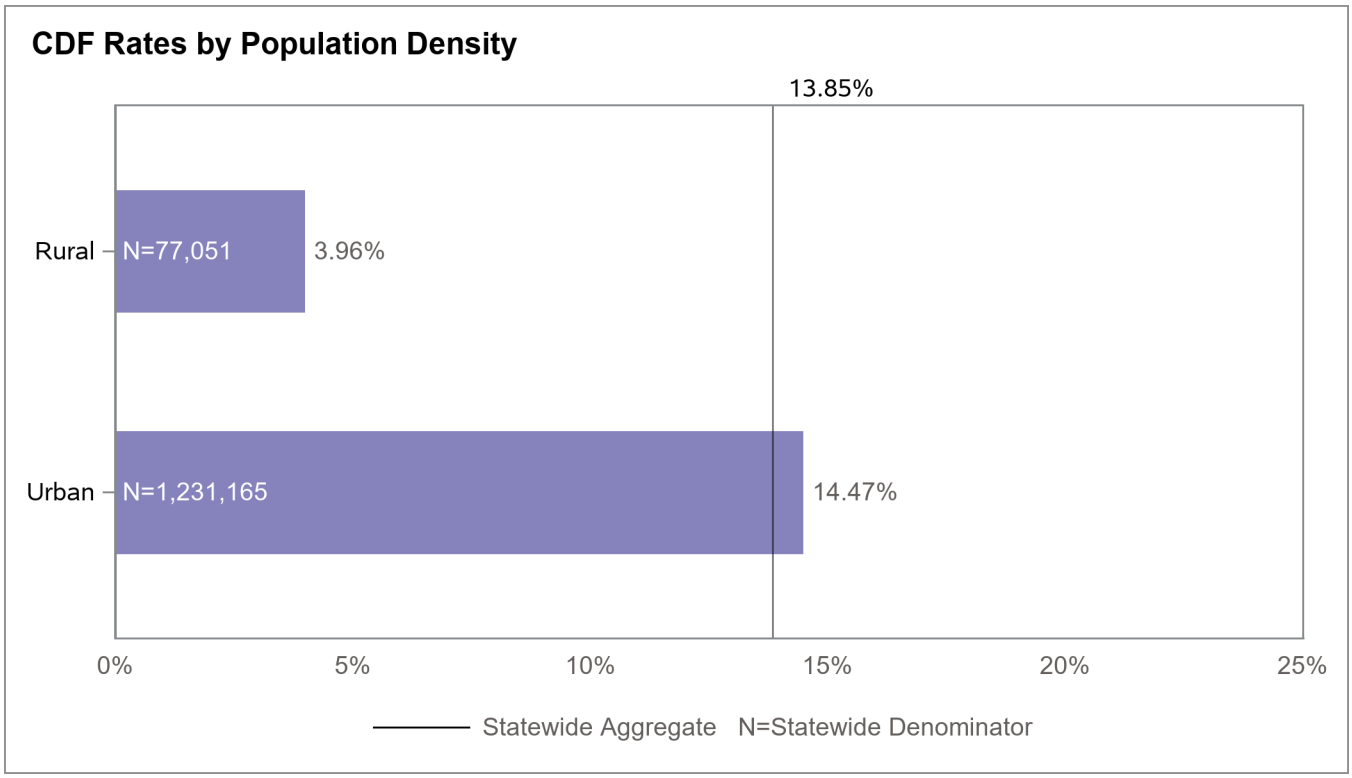


Figure 3.18—Screening for Depression and Follow-Up Plan (CDF)—Regional-Level Population Density Results

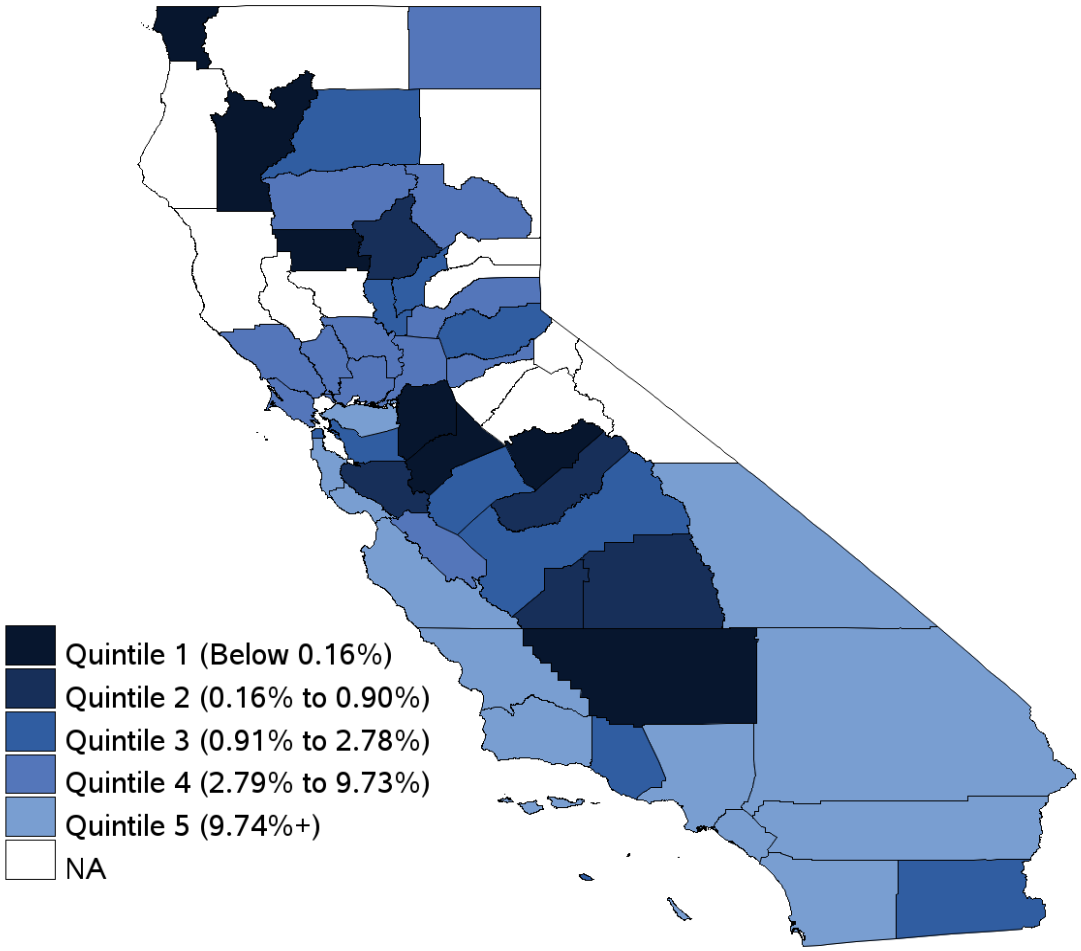


- For calendar year 2019, the *Screening for Depression and Follow-Up Plan* indicator rate for the Regional delivery type model was below the statewide aggregate by more than an 85 percent relative difference.
- The rate for the rural regions was below the rate for the urban regions by more than a 70 percent relative difference.

Figure 3.19—Screening for Depression and Follow-Up Plan (CDF)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



- Del Norte, Glenn, Mariposa, and Trinity counties had *Screening for Depression and Follow-Up Plan* indicator rates of 0.00 percent and had the least favorable rates in the State. As these four counties are rural counties, this finding aligns with the results displayed in Figure 3.18, which shows the rate for members living in rural areas was more than 10 percentage points lower than the rate for members living in urban areas.
- San Bernardino, Santa Barbara, San Luis Obispo, and Riverside counties had four of the nine highest *Screening for Depression and Follow-Up Plan* indicator rates in the State.

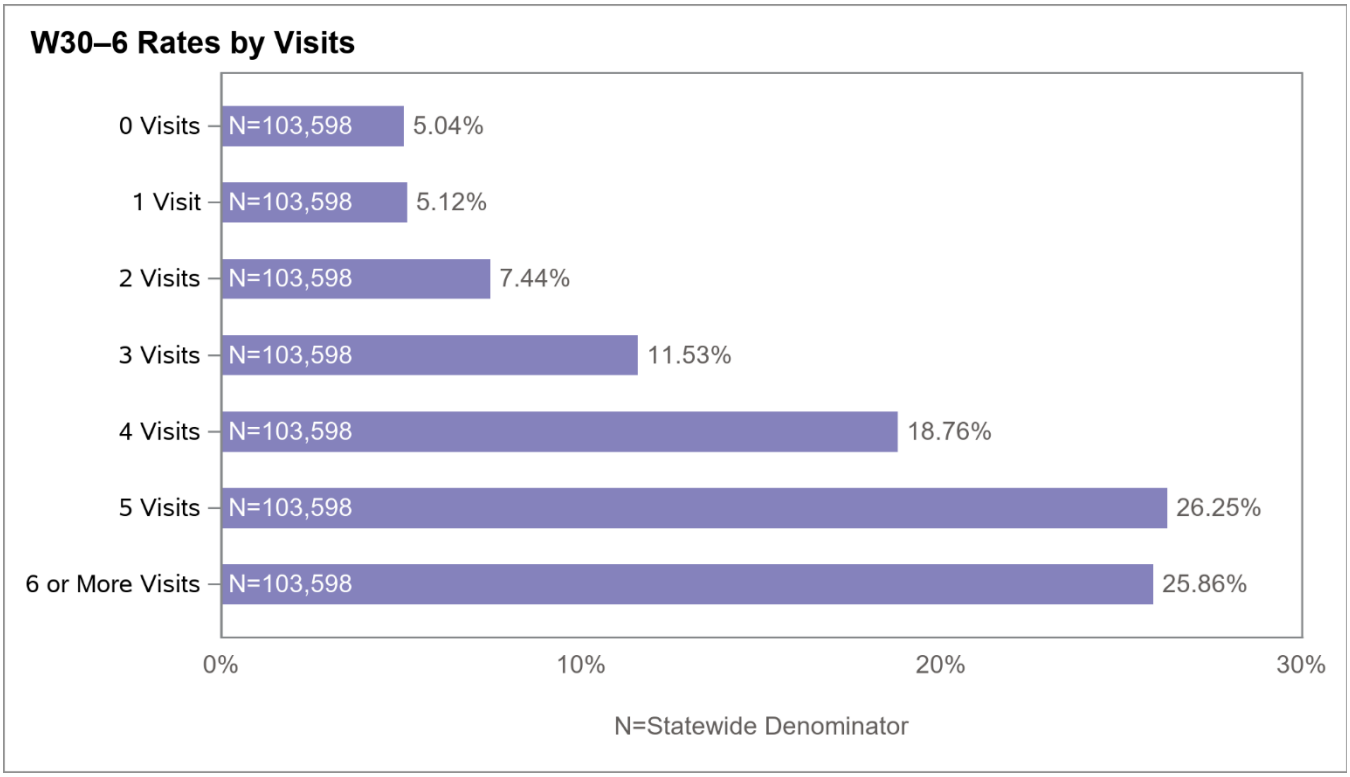
HSAG-Calculated Indicator Results

Figure 3.20 through Figure 3.60 display the statewide and regional results for the six indicators calculated by HSAG.

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 2019 California State Auditor Report identified a gap in DHCS' oversight of well-care visits for children younger than 3 years of age. The introduction of the *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*) indicator captures the previously missed age range. This indicator measures the percentage of children who turned 15 months old during the measurement year who received six or more well-child visits with a PCP. To better understand the number of well-child visits received for all members in the eligible population, Figure 3.20 displays the *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*) indicator rates stratified by the number of well-child visits (i.e., zero visits through six or more visits). Figure 3.21 through Figure 3.26 display the *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*) indicator rates at the statewide and regional levels.

Figure 3.20—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



- More than 70 percent of the eligible population received four or more well-child visits prior to their 15-month birthday. This indicates that while a significant portion of the child population is not numerator compliant (i.e., did not receive six or more well-child visits) for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator, small improvements in the number of visits for members in the four visits and five visits categories could increase the rate substantially.
- Given that the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* technical specifications indicate that multiple well-child visits performed within 14 days of each other must count as only one visit, it is possible that many members who had fewer than six well-child visits may have actually had six or more visits due to this limitation. As a result, MCPs should work with providers to ensure well-child visits are occurring in alignment with the American Academy of Pediatrics Bright Futures Periodicity Schedule.[9]

[9] Bright Futures/American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf. Accessed on: Nov 5, 2020.

Figure 3.21—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

Please note, HSAG calculated this indicator using administrative data only; therefore, exercise caution when comparing the rates to national benchmarks that are based on data which include MRR data.

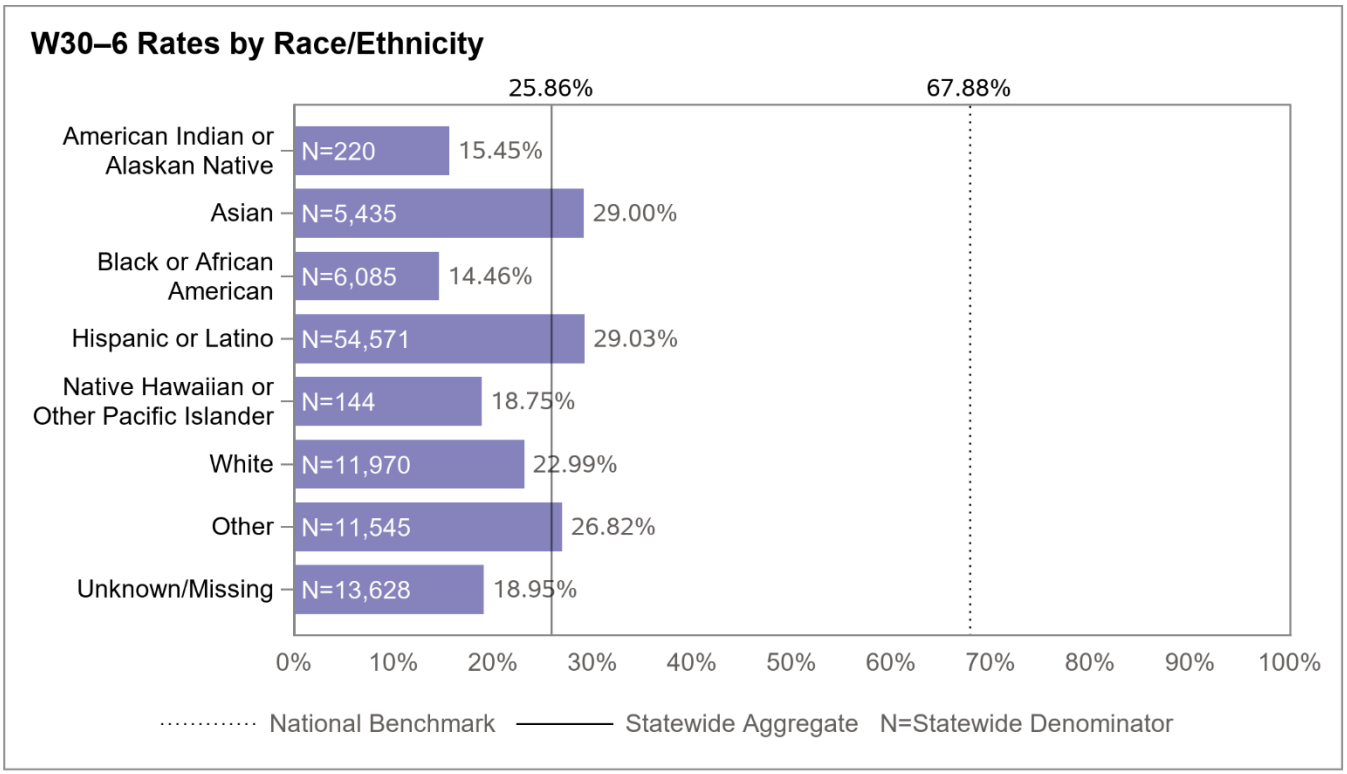


Figure 3.22—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6)—Statewide Primary Language Results

NA indicates the rate had a small denominator (i.e., less than 30).

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.

Please note, HSAG calculated this indicator using administrative data only; therefore, exercise caution when comparing the rates to national benchmarks that are based on data which include MRR data.

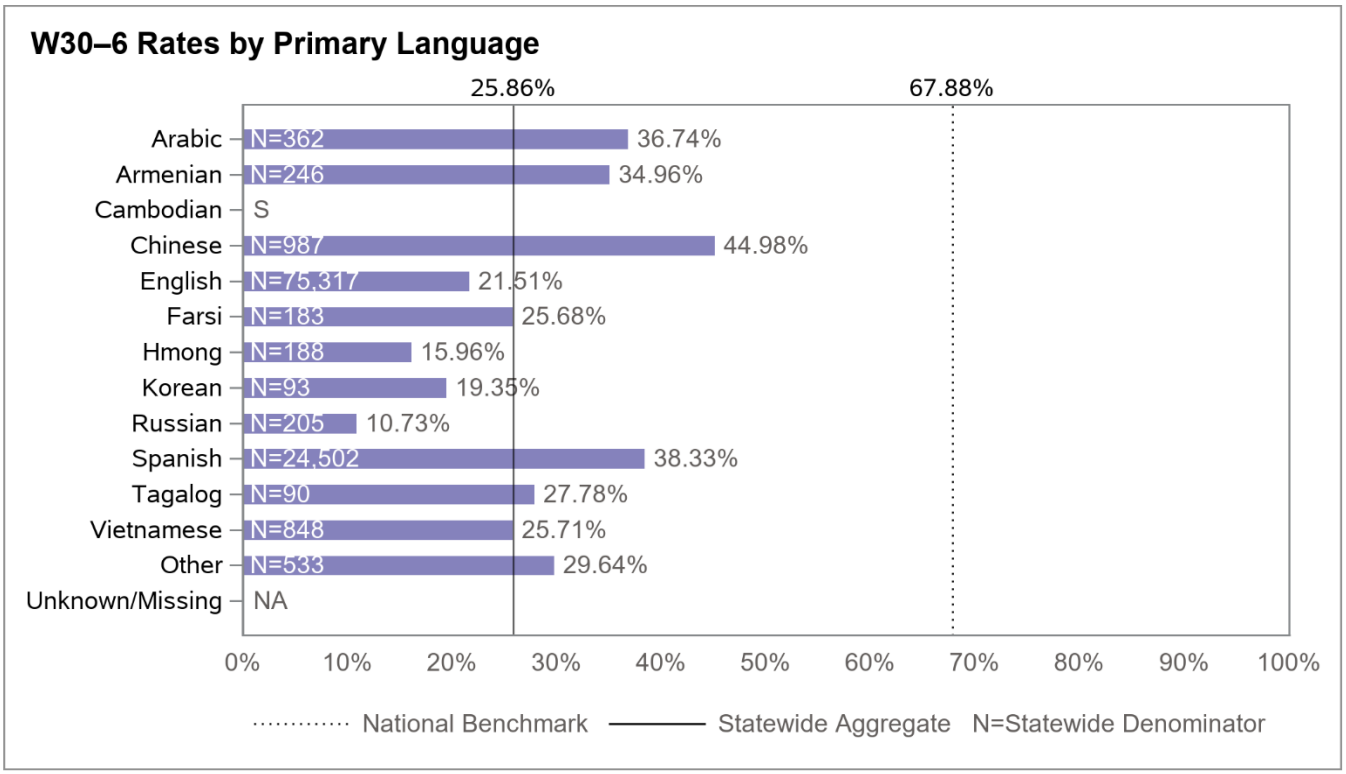
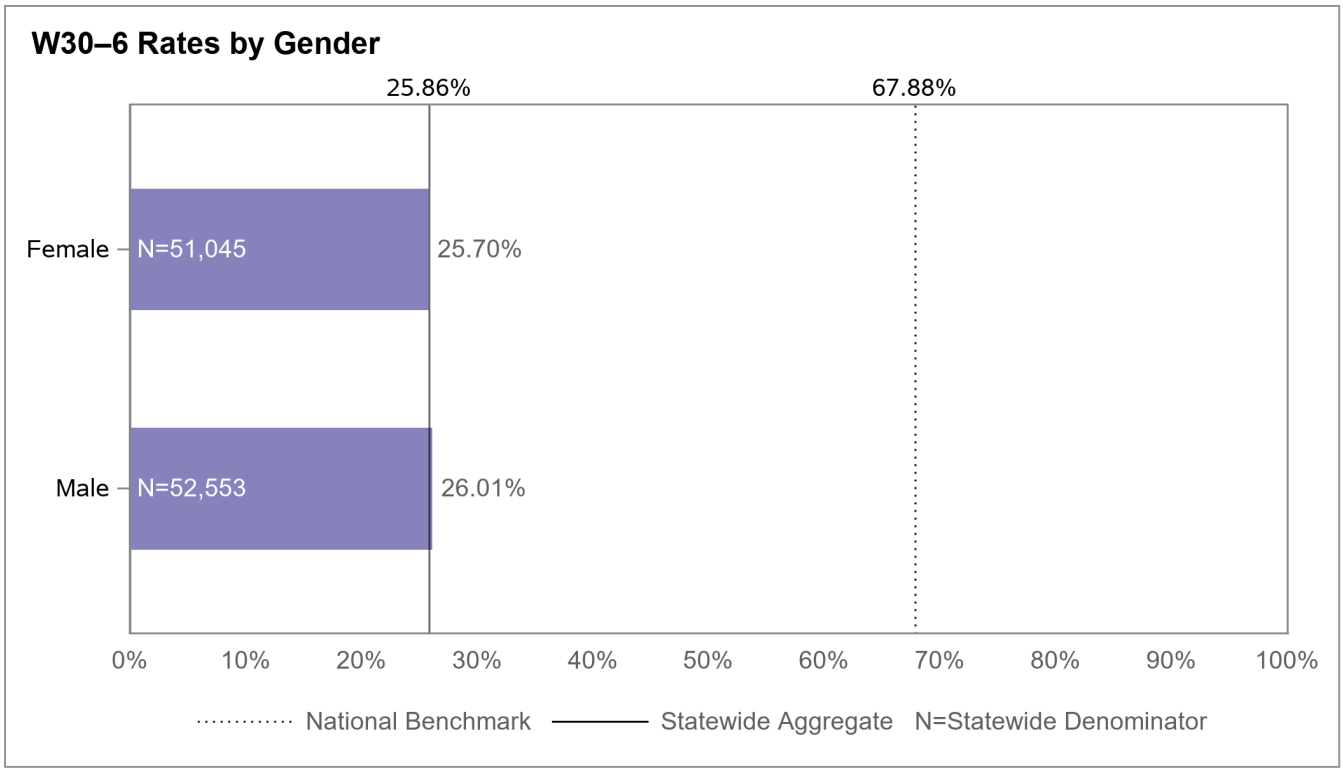


Figure 3.23—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6)—Statewide Gender Results

Please note, HSAG calculated this indicator using administrative data only; therefore, exercise caution when comparing the rates to national benchmarks that are based on data which include MRR data.



- The statewide aggregate rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator was below the national benchmark; however, this finding is more indicative of administrative data completeness rather than performance.
- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - American Indian or Alaskan Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
  - Unknown/Missing
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - English
  - Hmong
  - Korean
  - Russian

Figure 3.24—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)—Regional-Level Delivery Type Model Results

Please note, HSAG calculated this indicator using administrative data only; therefore, exercise caution when comparing the rates to national benchmarks that are based on data which include MRR data.

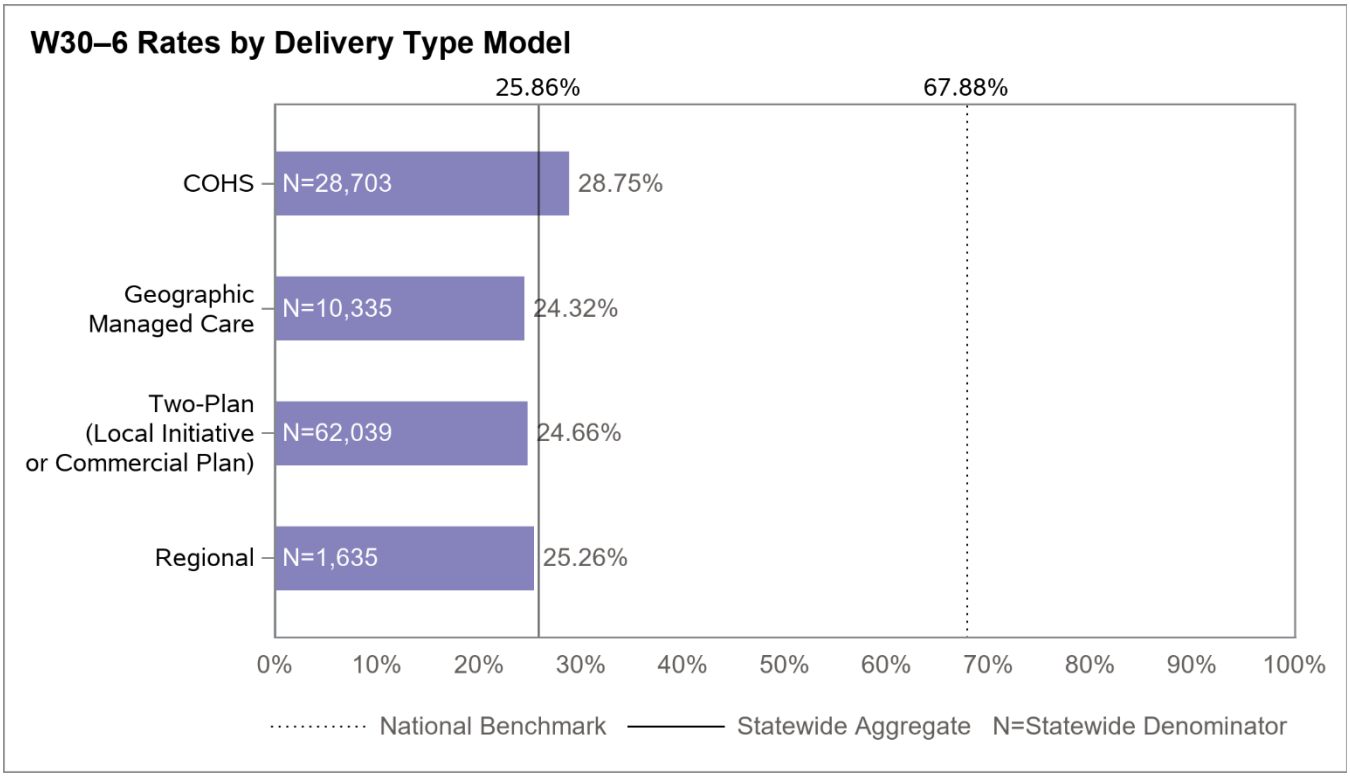
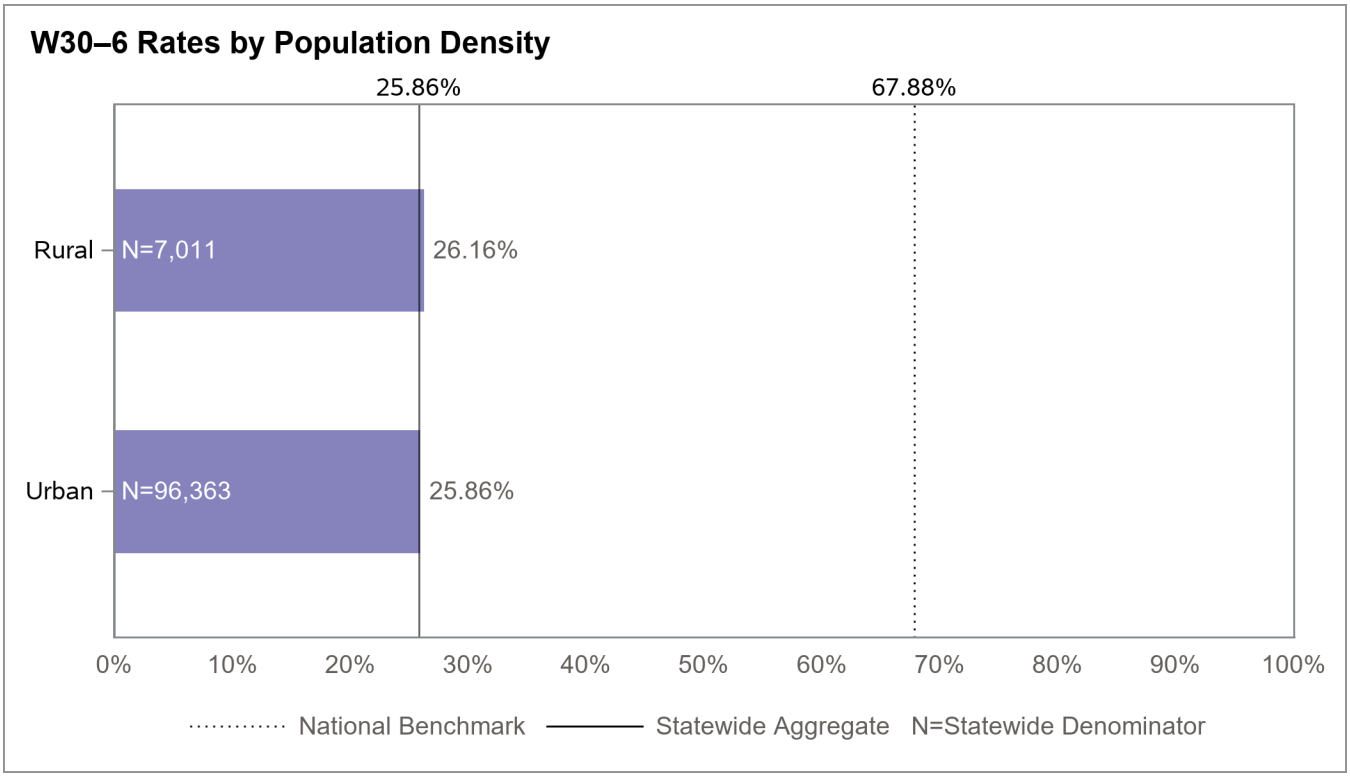


Figure 3.25—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6)—Regional-Level Population Density Results

Please note, HSAG calculated this indicator using administrative data only; therefore, exercise caution when comparing the rates to national benchmarks that are based on data which include MRR data.

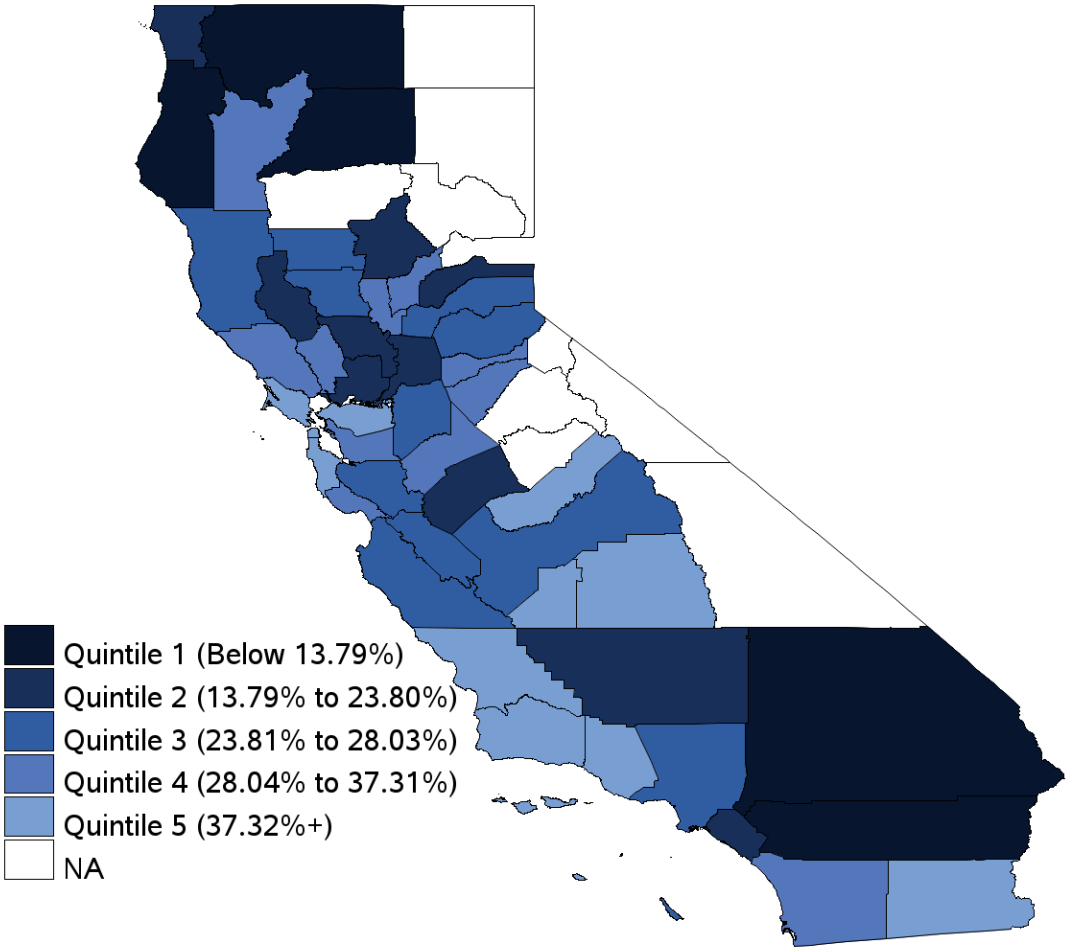


- For calendar year 2019, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rate for the COHS delivery type model was above the statewide aggregate by more than a 10 percent relative difference.

Figure 3.26—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)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



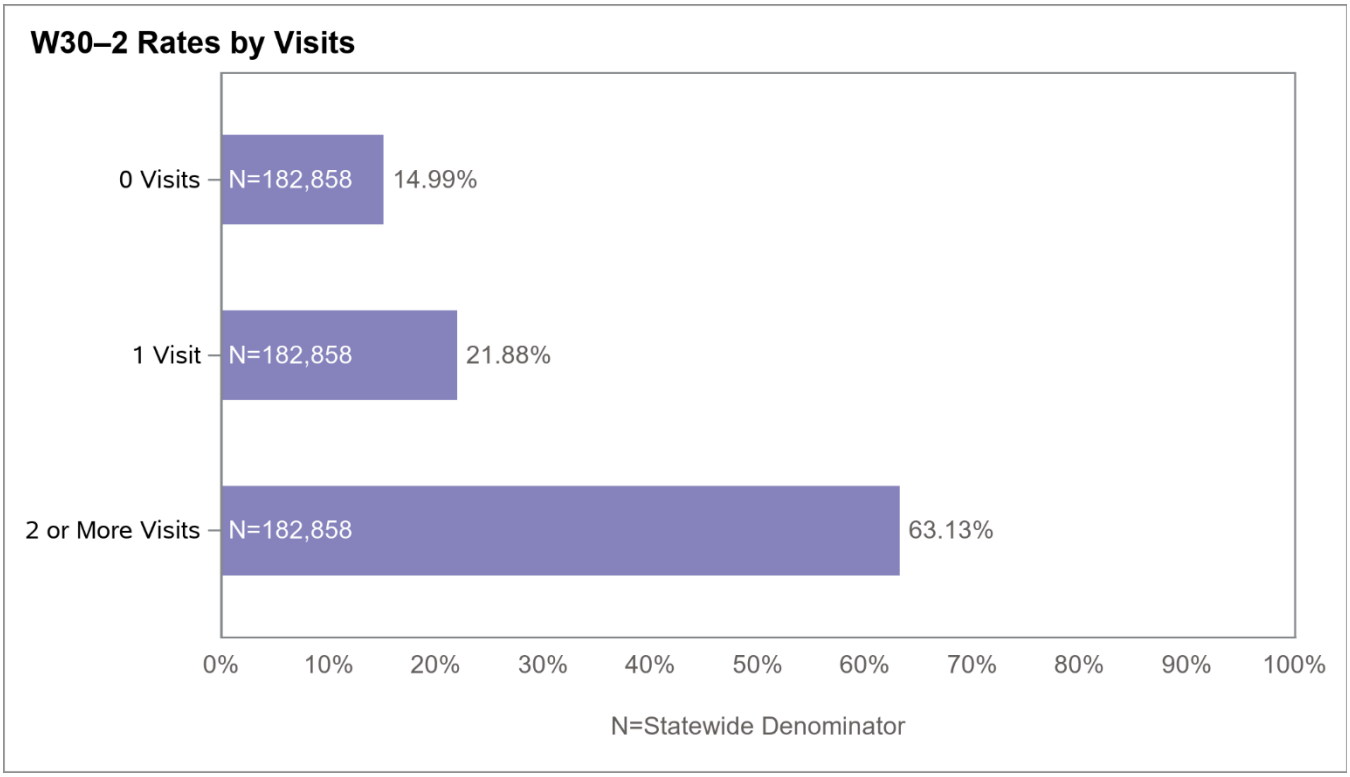
- Shasta, Humboldt, Riverside, and San Bernardino counties had the least favorable *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rates. At least 83 percent of members in these four counties speak English. As shown in Figure 3.22, the rate for English primary language speakers is approximately 4 percentage points below the statewide aggregate rate.
- San Francisco, Ventura, Marin, Contra Costa, and Santa Barbara counties had the most favorable *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rates.
- San Francisco County had the most favorable *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rate. Approximately 34 percent and 31 percent of members in San Francisco County were in the

Asian racial/ethnic group and an Asian primary language group, respectively. As shown in Figure 3.21 and Figure 3.22, the rates for the Asian racial/ethnic group and Asian primary language groups were among the highest racial/ethnic group and primary language group rates, respectively. The rates for the majority of racial/ethnic groups and primary language groups within San Francisco County are comparable to statewide rates, so the favorable rate for San Francisco County is partially due to the racial/ethnic and primary language demographics within this county.

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

The 2019 California State Auditor Report identified a gap in DHCS' oversight of well-care visits for children younger than 3 years of age. The introduction of the *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*) captures the previously missed age range. This indicator measures the percentage of children who turned 30 months old during the measurement year who received two or more well-child visits with a PCP. To better understand the number of well-child visits received for all members in the eligible population, Figure 3.27 displays the *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* (*W30–2*) indicator rates stratified by the number of well-child visits (i.e., zero visits through two or more visits). Figure 3.28 through Figure 3.33 display the *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*) indicator rates at the statewide and regional levels. Please note, national benchmarks are not yet available for this indicator.

Figure 3.27—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



- Over 85 percent of child members who turned 30 months of age during the measurement year received at least one well-child visit between their 15-month and 30-month birthdays.

Figure 3.28—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

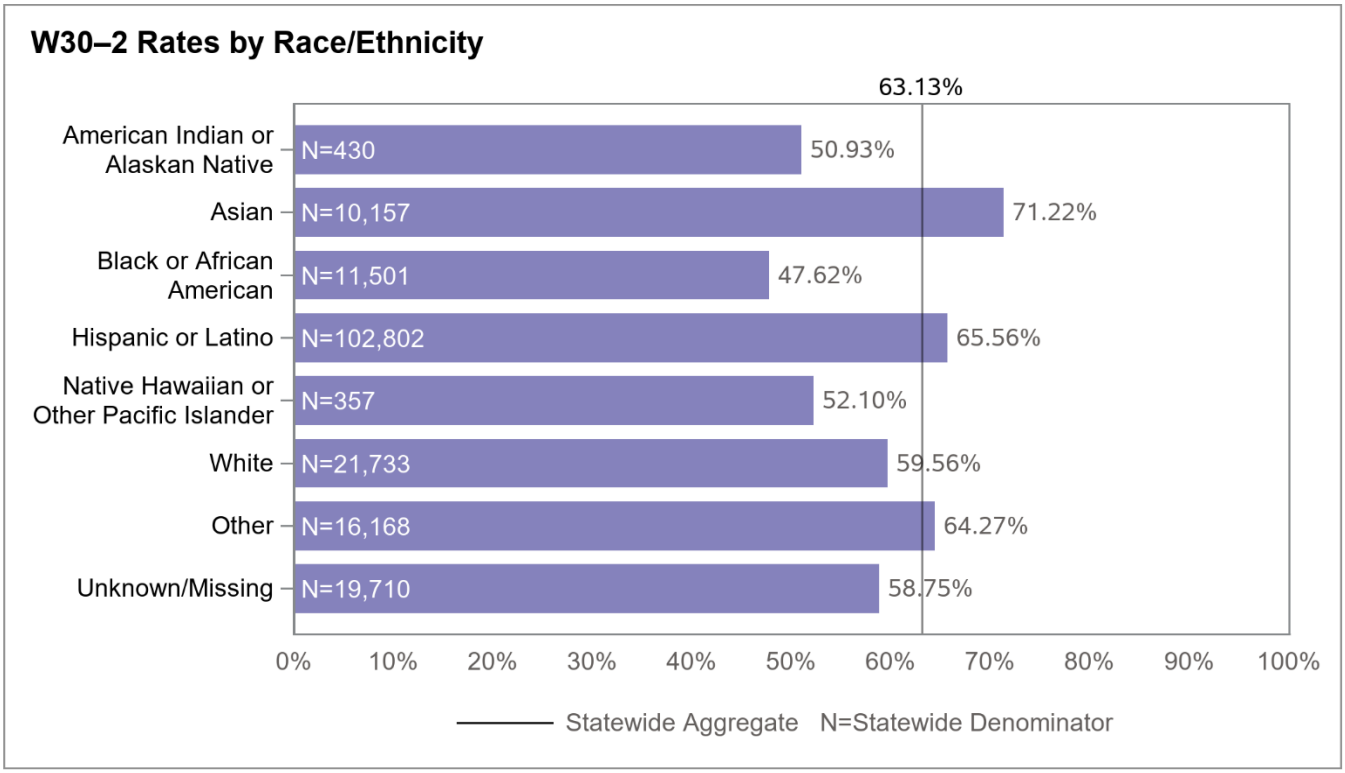


Figure 3.29—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits (W30–2)—Statewide Primary Language Results

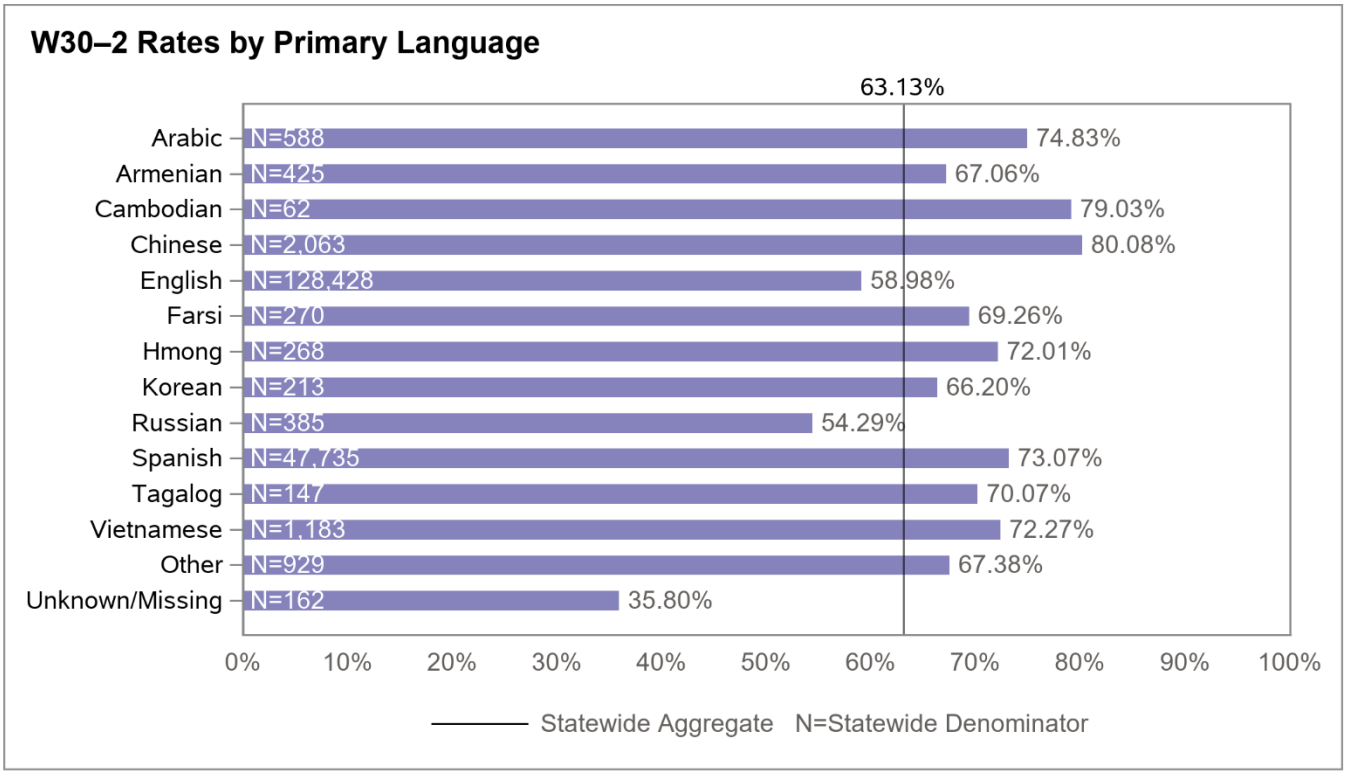
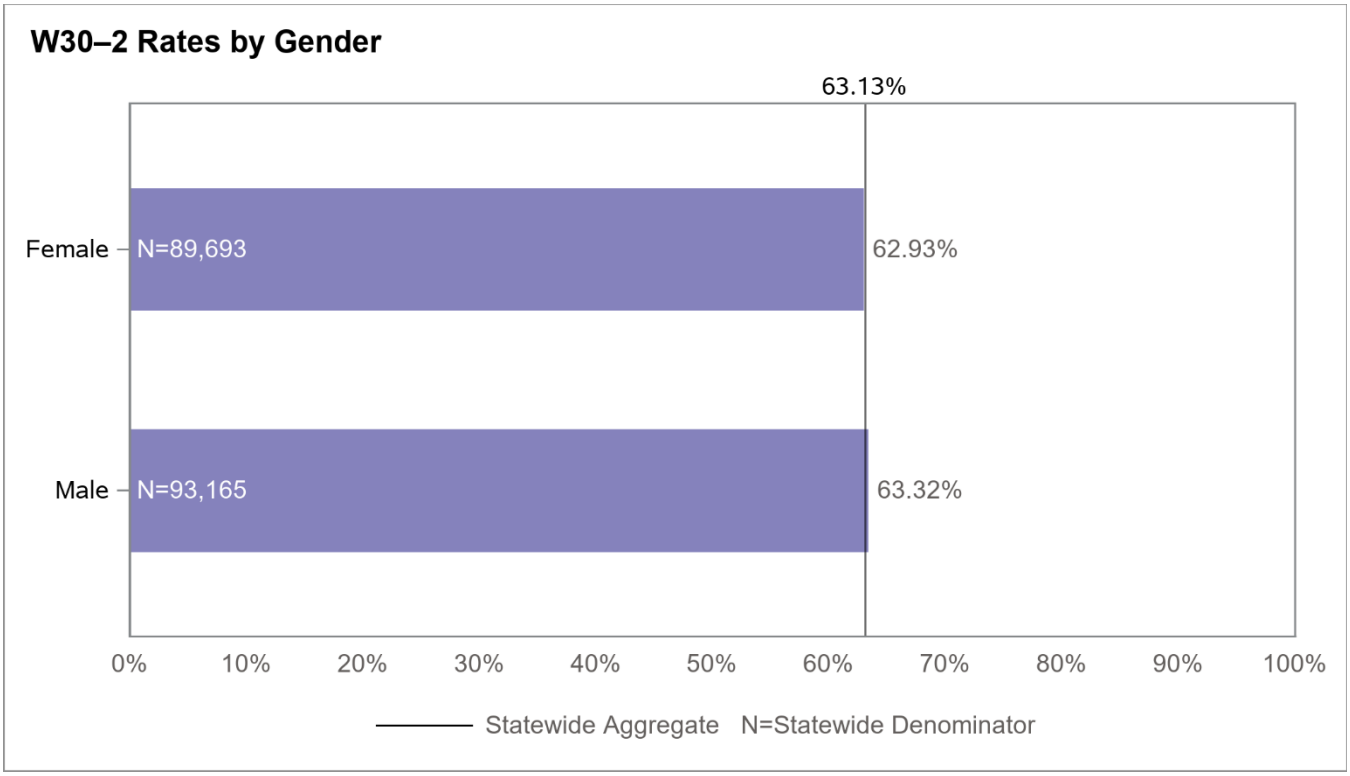


Figure 3.30—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits (W30–2)—Statewide Gender Results



- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Russian
  - Unknown/Missing
- The rates for the Female and Male groups differed by less than 1 percentage point.

Figure 3.31—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)—Regional-Level Delivery Type Model Results

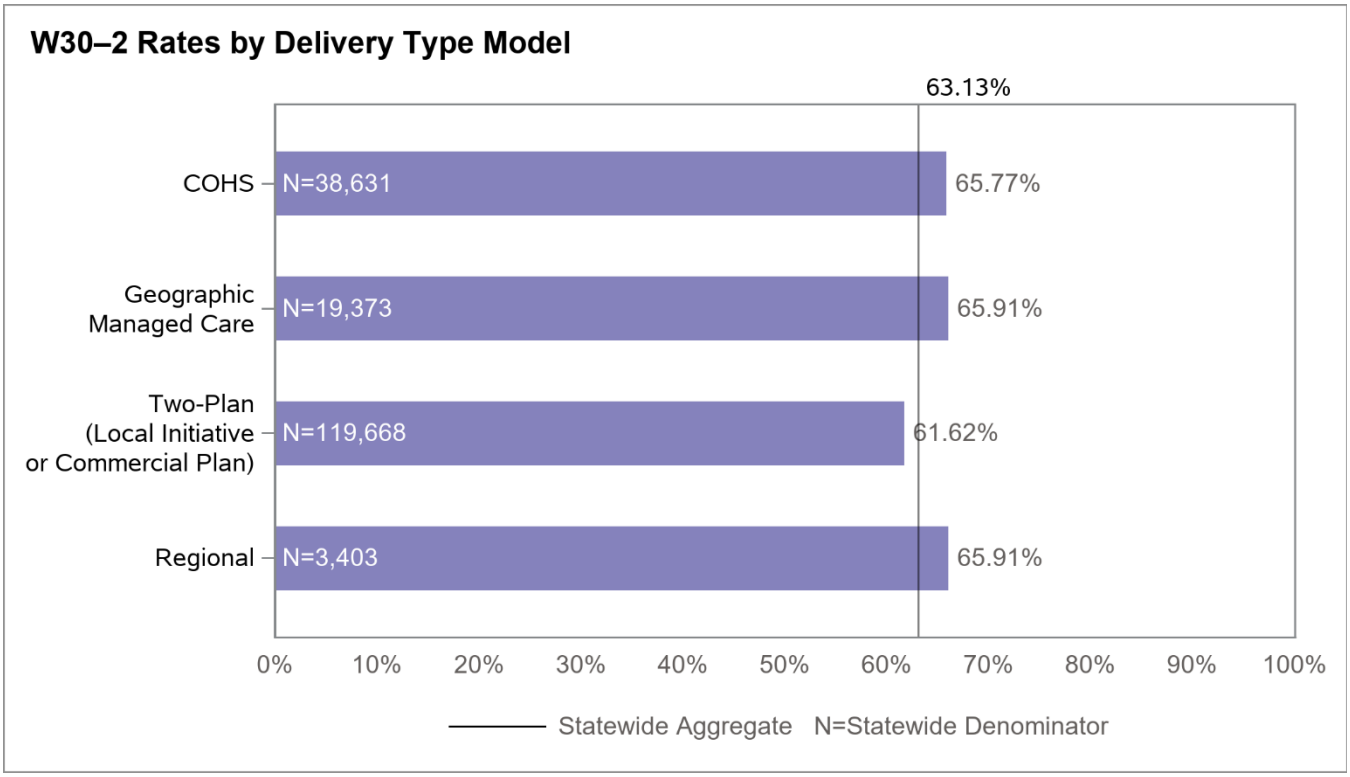
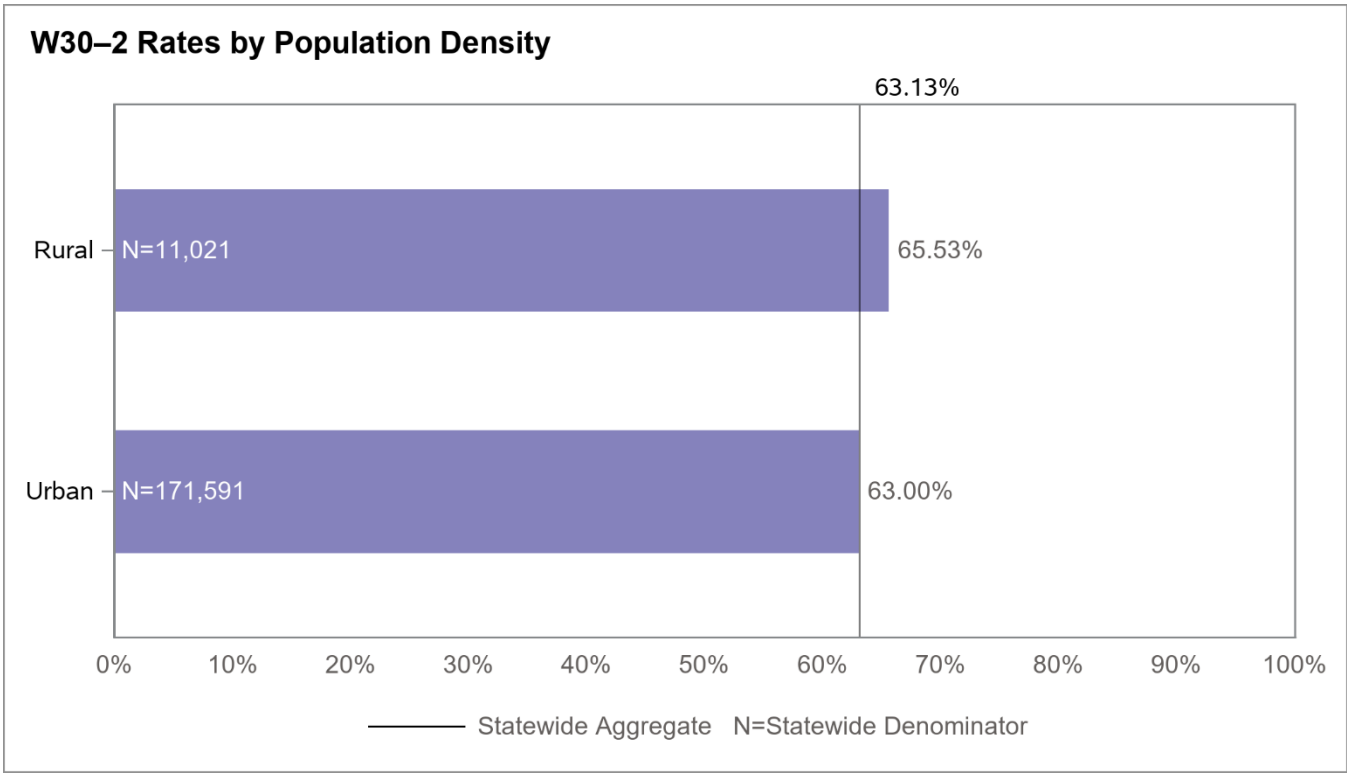


Figure 3.32—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits (W30–2)—Regional-Level Population Density Results

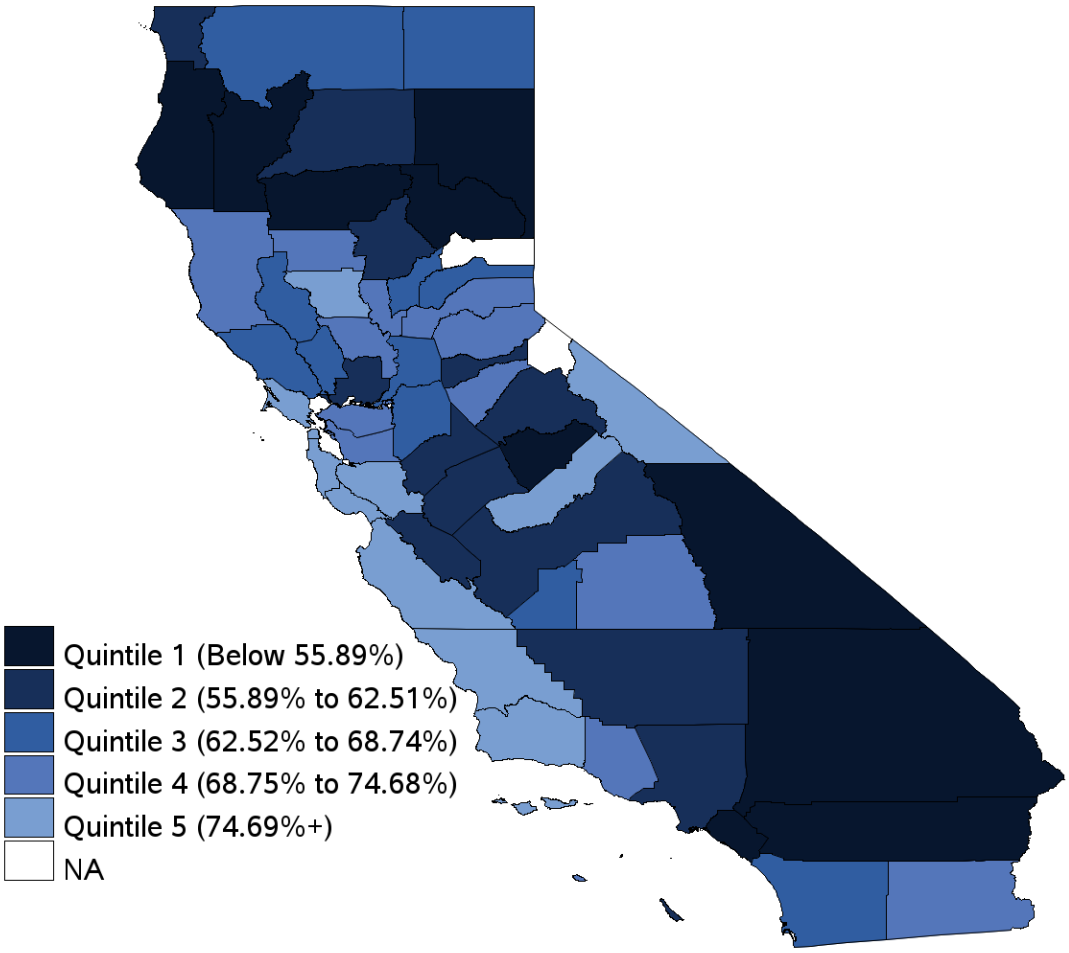


- For calendar year 2019, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits* indicator rates for one of the four (25.0 percent) delivery type models fell below the statewide aggregate rate (i.e., Two-Plan [Local Initiative or Commercial Plan]). Further, the Two-Plan delivery type model accounts for approximately 65 percent of the statewide population for this indicator.
- The rate for the urban regions fell just below the statewide aggregate and had a relative rate difference of 4 percent when compared to the rate for the rural regions.

Figure 3.33—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)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



- Mariposa, Lassen, Humboldt, Plumas, Trinity, Riverside, Tehama, San Bernardino, Orange, and Inyo counties had the 10 least favorable *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* indicator rates. Six of the 10 (60.0 percent) counties were predominantly rural counties and accounted for less than half a percent of the statewide population. Additionally, at least 80 percent of members in these 10 counties spoke English. As shown in Figure 3.29, the rate for the English primary language group was approximately 4 percentage points below the statewide aggregate rate.
- Marin, San Francisco, Santa Cruz, Santa Barbara, Monterey, Mono, Madera, Colusa, and San Luis Obispo counties had nine of the 11 (81.8 percent) most favorable *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* indicator rates in the State. For seven of these nine (77.8 percent)

counties, at least 35 percent of members spoke a non-English primary language (predominately Spanish, but in San Francisco County there was a high proportion of Chinese primary language speakers). As shown in Figure 3.29, the rates for the Chinese and Spanish primary language groups were approximately 17 percentage points and 10 percentage points higher than the statewide aggregate rate, respectively.

Child and Adolescent Well-Care Visits—Total

The *Child and Adolescent Well-Care Visits—Total* (*WCV*) indicator measures the percentage of children ages 3 to 21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Figure 3.34 through Figure 3.40 display the *Child and Adolescent Well-Care Visits—Total* (*WCV*) indicator rates at the statewide and regional levels. Please note, national benchmarks are not yet available for the *Child and Adolescent Well-Care Visits—Total* (*WCV*) indicator. However, HSAG was able to compare the 3 to 6 Years and 12 to 21 Years age groups to national benchmarks (74.70 percent and 57.18 percent, respectively).

Figure 3.34—Child and Adolescent Well-Care Visits—Total (WCV)—Statewide Racial/Ethnic Results

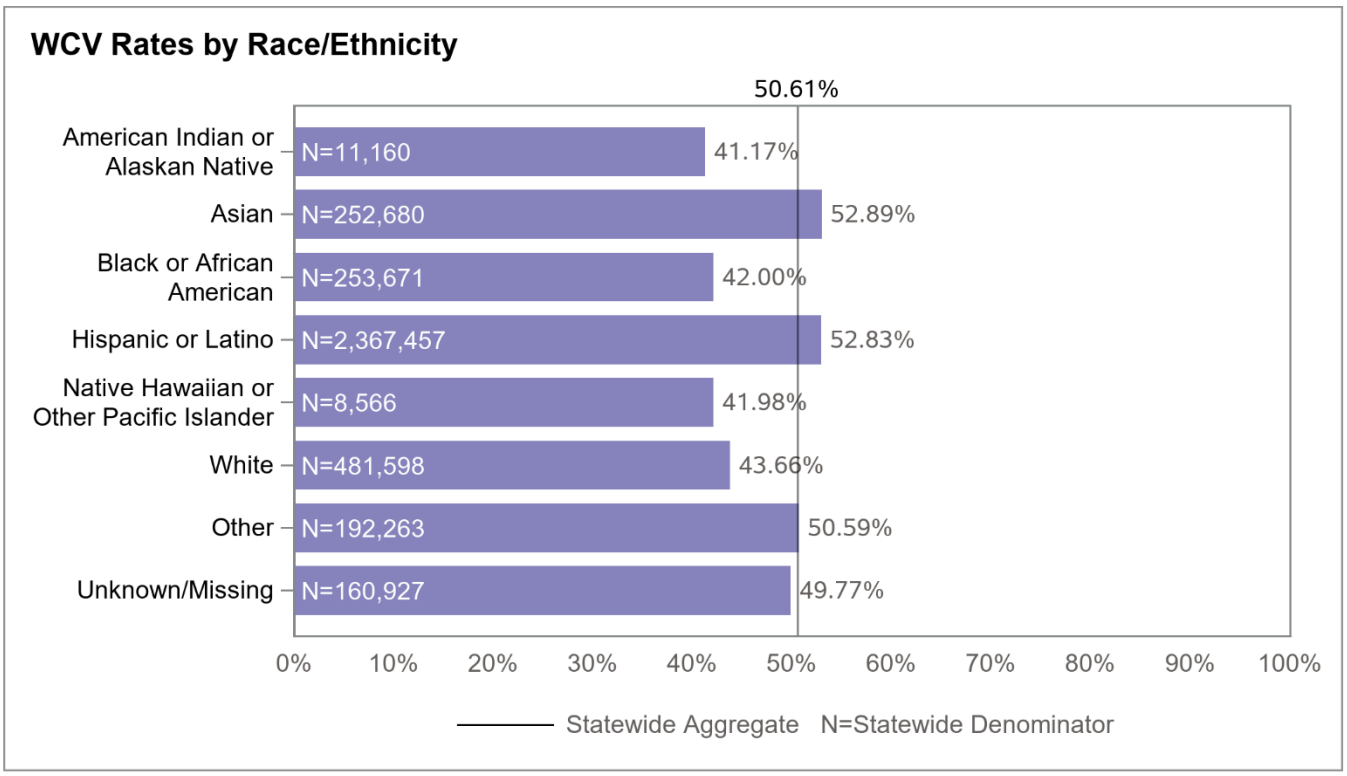


Figure 3.35—Child and Adolescent Well-Care Visits—Total (WCV)—Statewide Primary Language Results

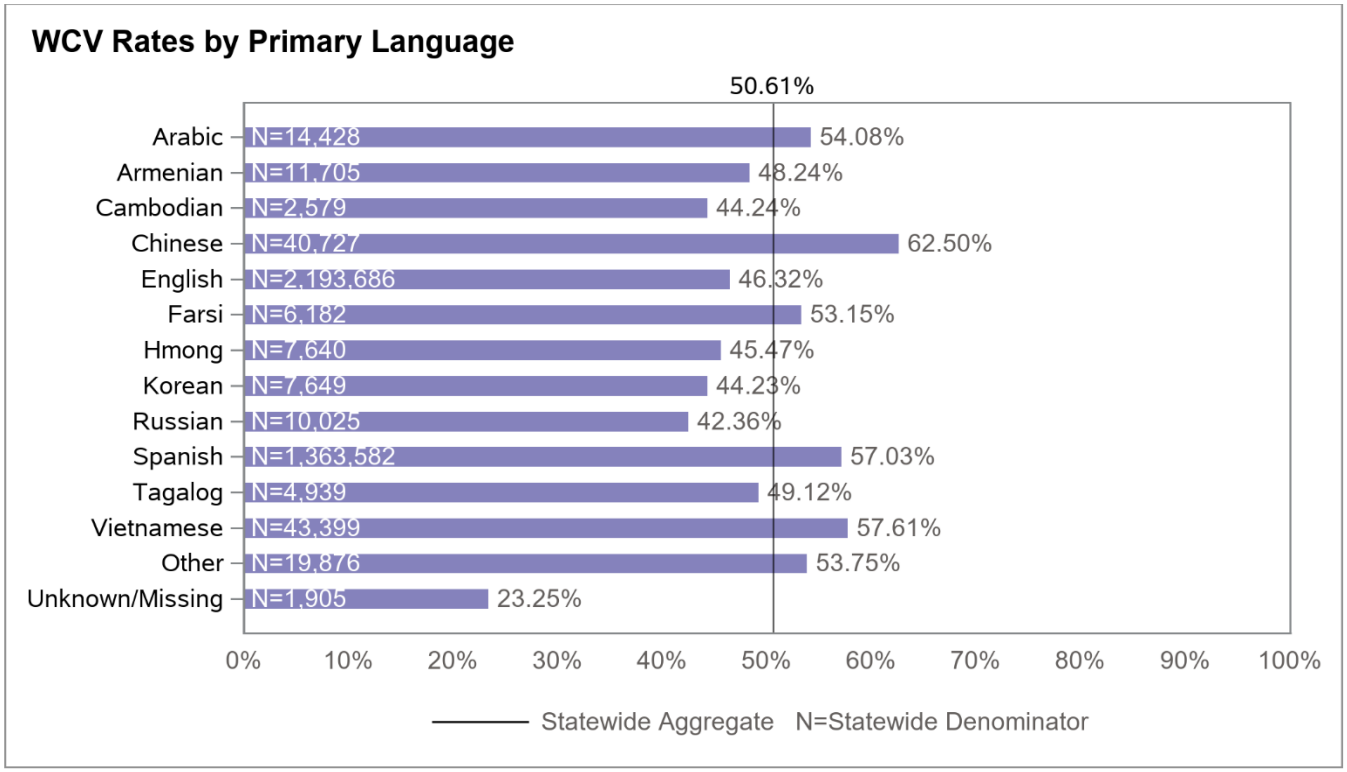


Figure 3.36—Child and Adolescent Well-Care Visits—Total (WCV)—Statewide Gender Results

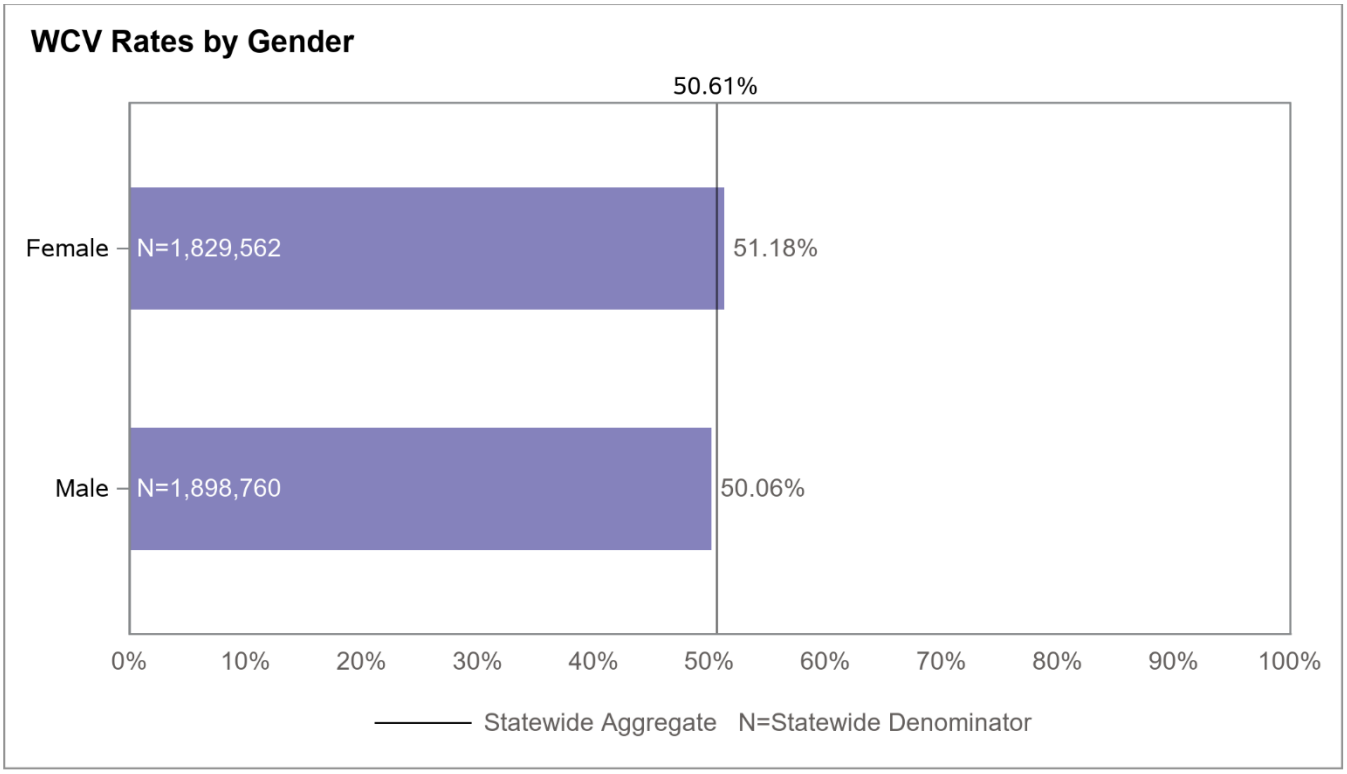
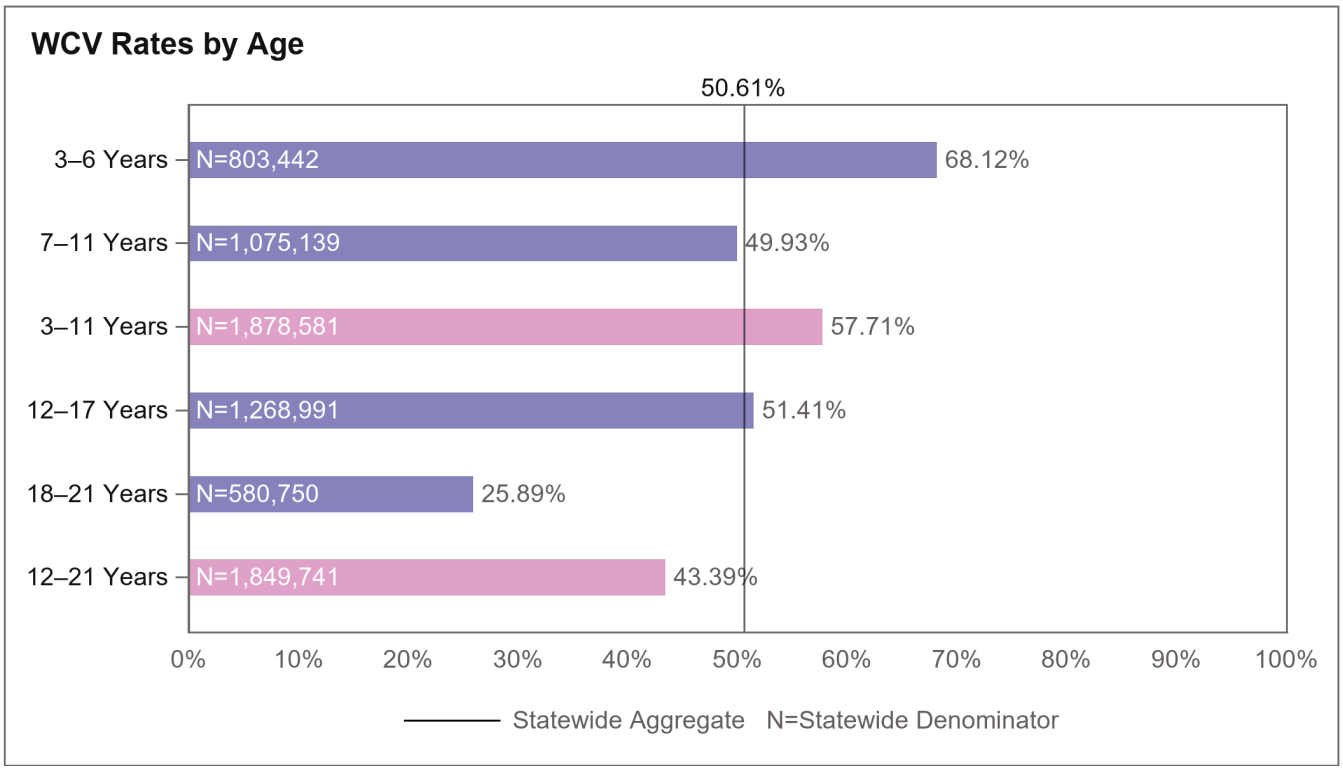


Figure 3.37—Child and Adolescent Well-Care Visits—Total (WCV)—Statewide Age Results

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



- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Cambodian
  - Hmong
  - Korean
  - Russian
  - Unknown/Missing
- The rates for the 3 to 6 Years and 3 to 11 Years age groups were above the statewide aggregate rate by more than a 10 percent relative difference. Conversely, the rate for the 3 to 6 Years age group fell below the applicable national benchmark by more than 5 percentage points. However, exercise caution when interpreting this finding given that the 3

to 6 Years age group was calculated using administrative data only, while the national benchmark also used MRR data.

- The rates for the 18 to 21 Years and 12 to 21 Years age groups were below the statewide aggregate rate by more than a 10 percent relative difference. Further, the 12 to 21 Years age group fell below the applicable national benchmark by more than 13 percentage points.
- This finding indicates that 12-to-21-year-olds were not receiving at least one comprehensive well-care visit with a provider. However, exercise caution when interpreting these findings given that the 12 to 21 Years age group was calculated using administrative data only, while the national benchmark also used MRR data.

Figure 3.38—Child and Adolescent Well-Care Visits—Total (WCV)—Regional-Level Delivery Type Model Results

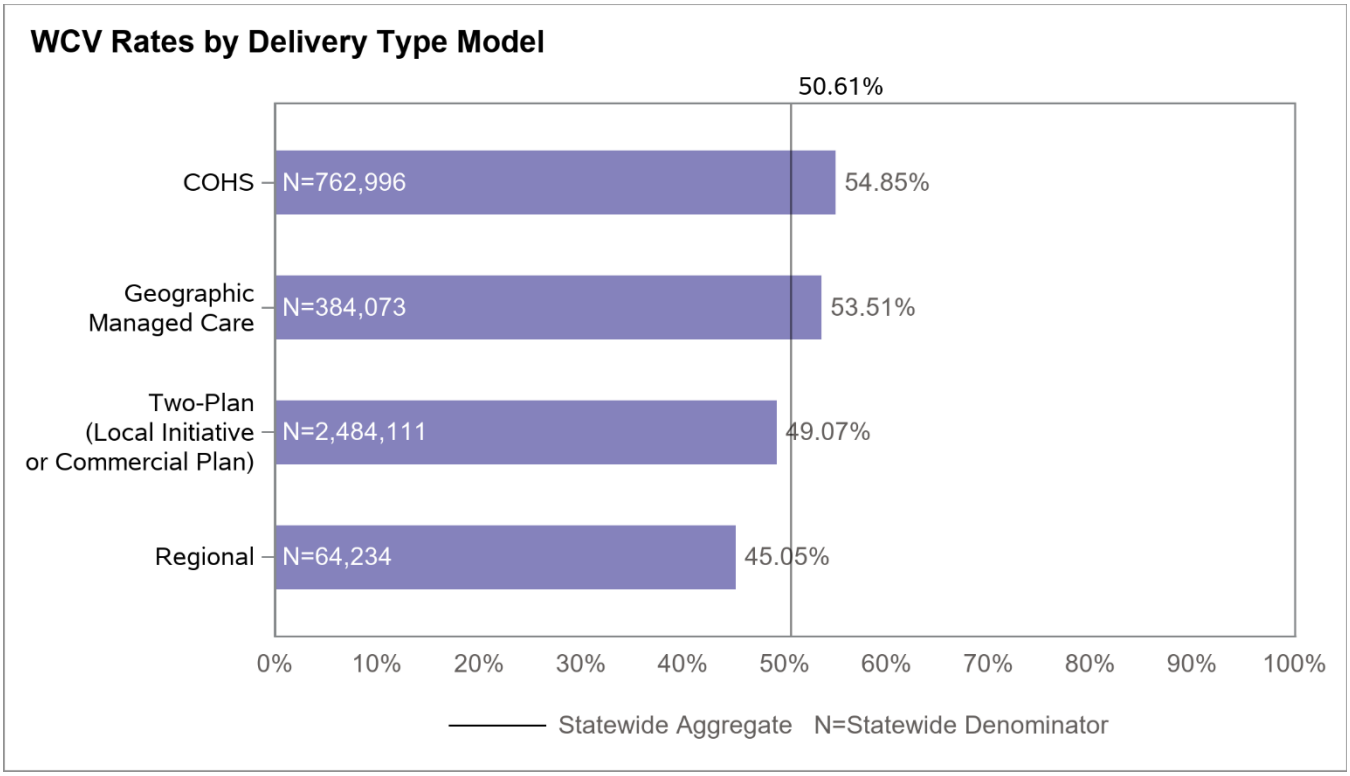
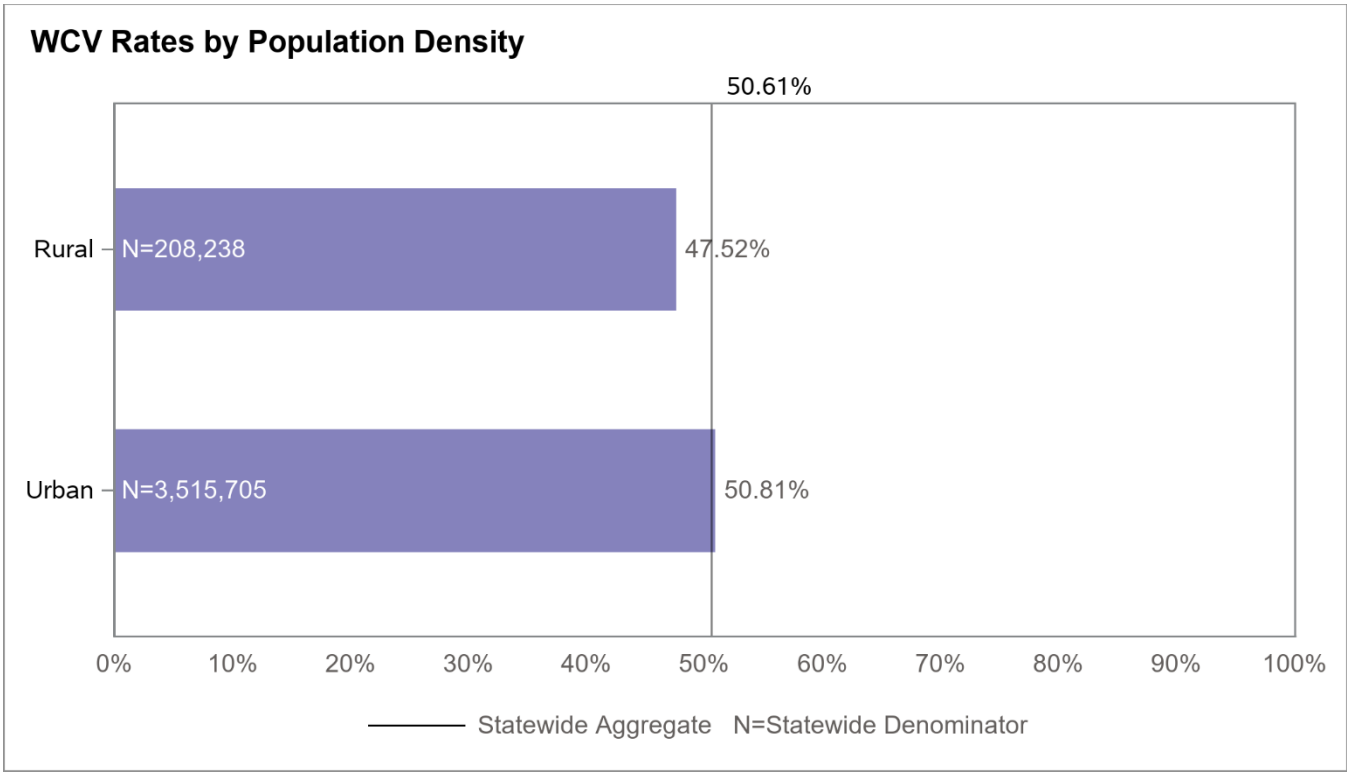


Figure 3.39—Child and Adolescent Well-Care Visits—Total (WCV)—Regional-Level Population Density Results

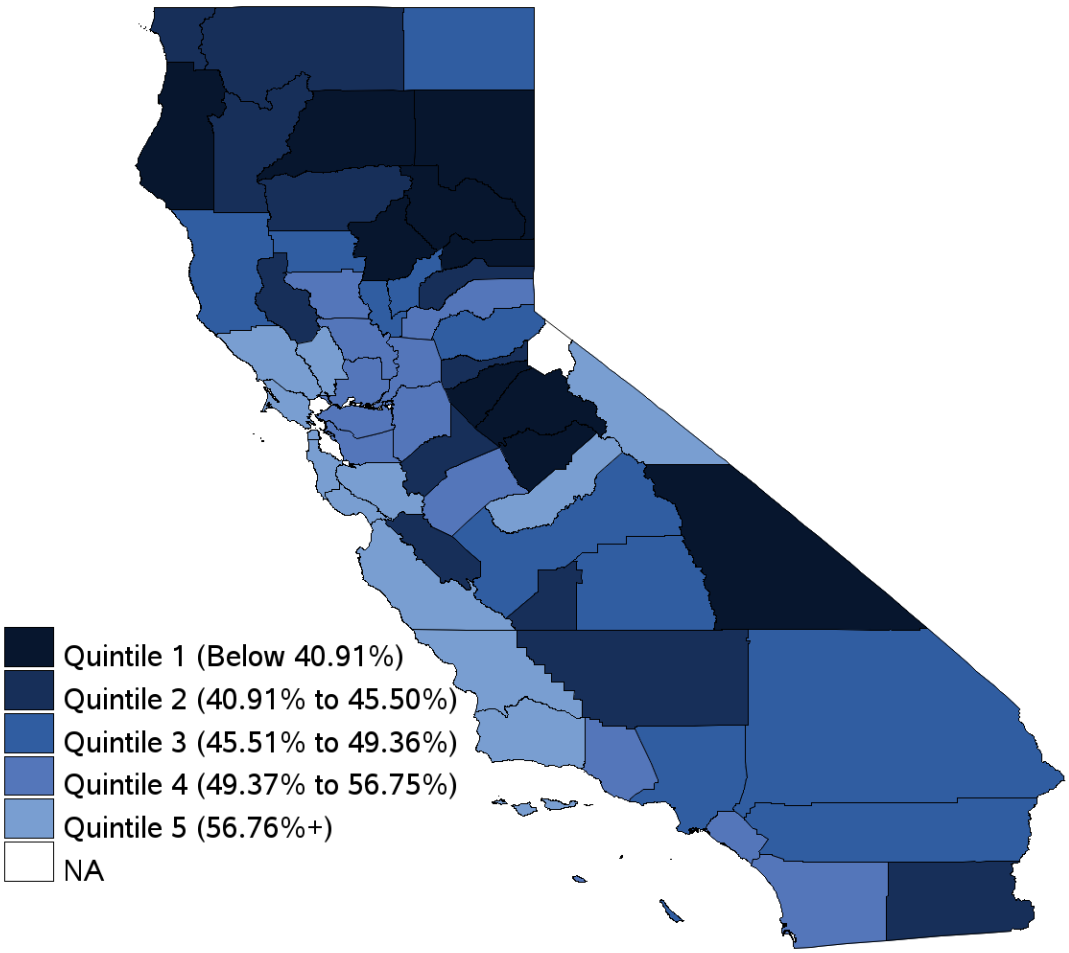


- For calendar year 2019, the *Child and Adolescent Well-Care Visits—Total* indicator rate for the Regional delivery type model fell below the statewide aggregate by more than a 10 percent relative difference.
- The rates for the rural regions and urban regions differed by less than 4 percentage points.

Figure 3.40—Child and Adolescent Well-Care Visits—Total (WCV)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



- Plumas, Sierra, Mariposa, Lassen, Tuolumne, Butte, Calaveras, Shasta, Humboldt, and Inyo counties had the least favorable *Child and Adolescent Well-Care Visits—Total* indicator rates. Within nine of these 10 (90.0 percent) counties, at least 86 percent of members speak English and at least 50 percent of members are of the White race/ethnicity. Both of these percentages are substantially higher than the statewide aggregate rates of 63.36 percent (English) and 13.65 percent (White). As shown in Figure 3.34 and Figure 3.35, the rate for the English primary language group was approximately 4 percentage points lower than the statewide aggregate rate, and the rate for the White racial/ethnic group was approximately 7 percentage points lower than the statewide aggregate rate, respectively.
- Santa Barbara, Monterey, San Francisco, Santa Cruz, Madera, San Luis Obispo, Sonoma, Napa, Mono, and Marin counties had 10 of the 12 (83.3 percent) most favorable *Child and*

Adolescent Well-Care Visits—Total indicator rates in the State. In nine of the 10 (90.0 percent) counties, at least 46 percent of members spoke a non-English primary language (predominantly Spanish, but in San Francisco County there was a high proportion of Chinese primary language speakers). As shown in Figure 3.35, the rates for the Chinese and Spanish primary language groups were approximately 12 percentage points and 6 percentage points higher than the statewide aggregate rate, respectively.

Alcohol Use Screening

The *Alcohol Use Screening* (*AUS*) indicator measures the percentage of children ages 18 to 21 years who had one or more screenings for alcohol use during the measurement year. Figure 3.41 through Figure 3.46 display the *Alcohol Use Screening* (*AUS*) indicator rates at the statewide and regional levels. Due to a lack of reporting within administrative data sources (i.e., MRR or EHR data could be necessary to capture this information), exercise caution when evaluating results as they may be more indicative of data completeness rather than performance. Please note, national benchmarks are not available for this indicator.

Figure 3.41—Alcohol Use Screening (AUS)—Statewide Racial/Ethnic Results

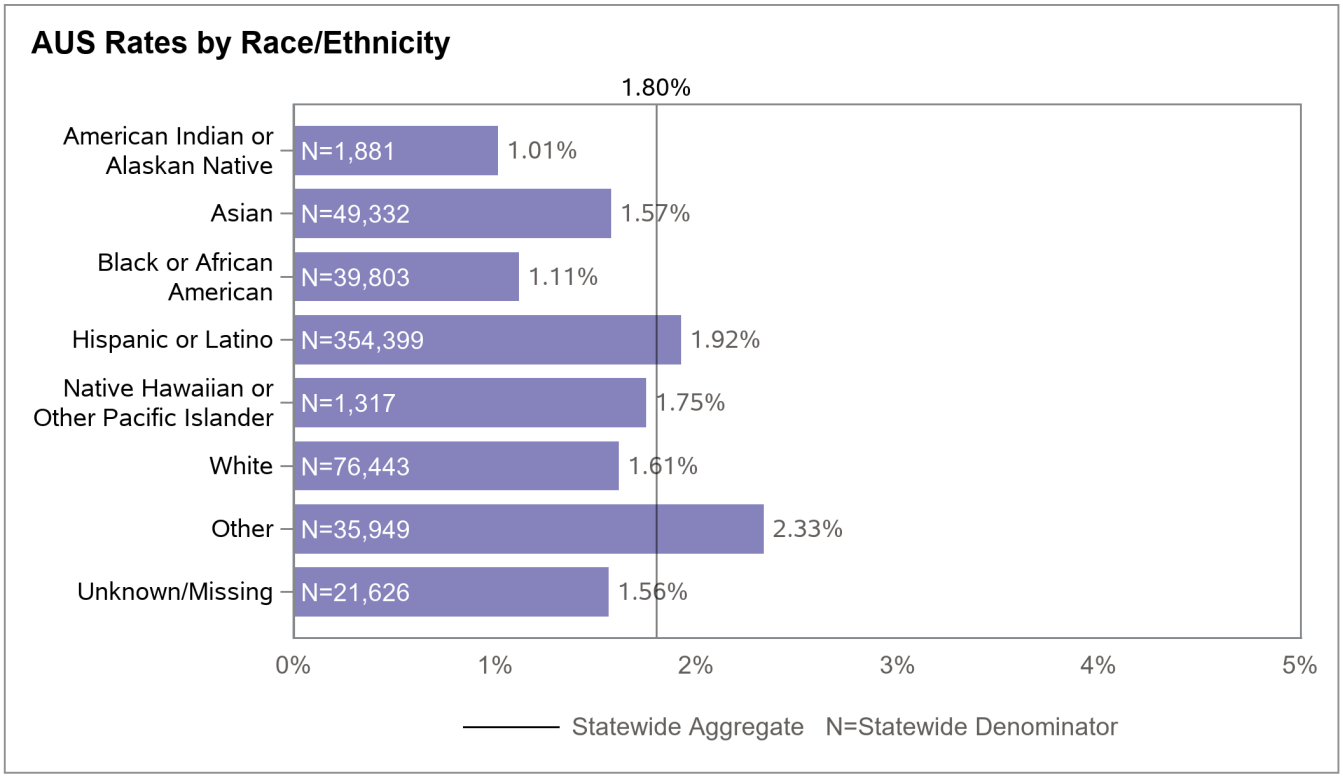


Figure 3.42—Alcohol Use Screening (AUS)—Statewide Primary Language Results

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.

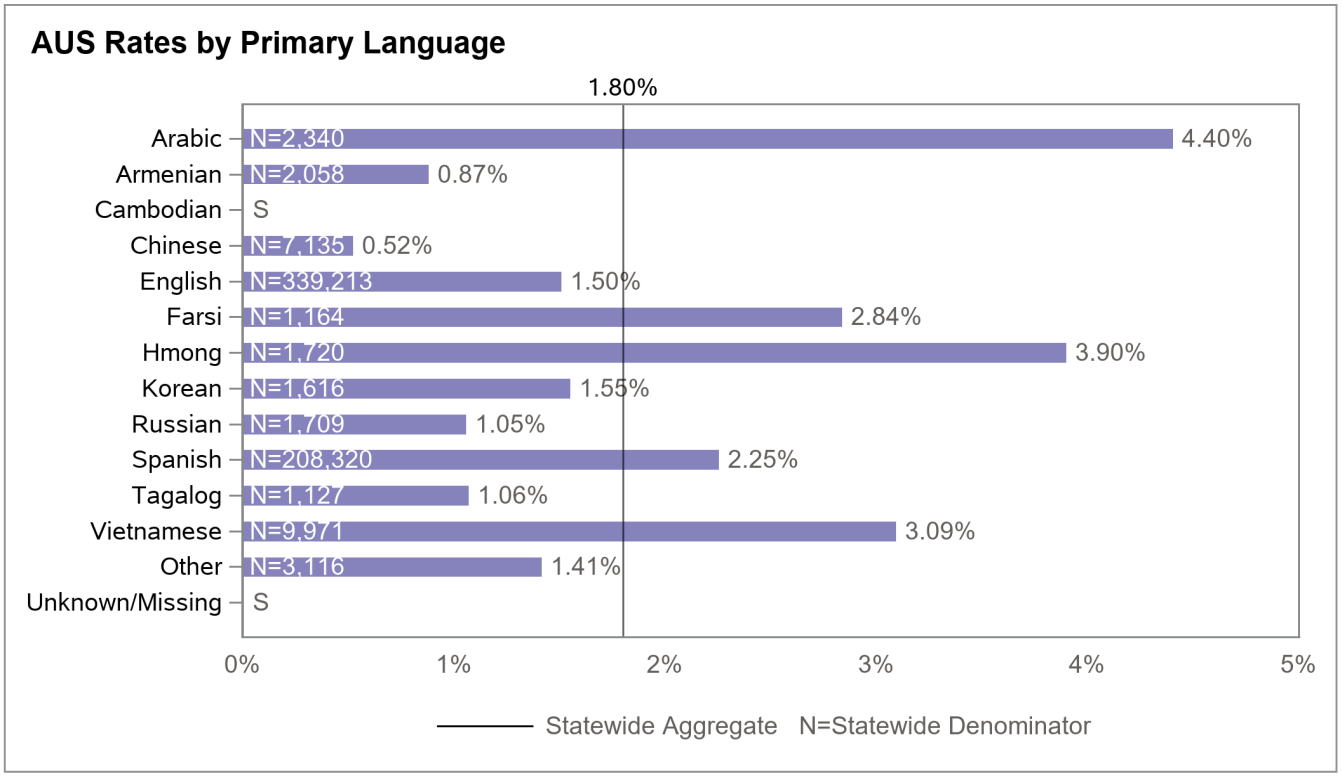
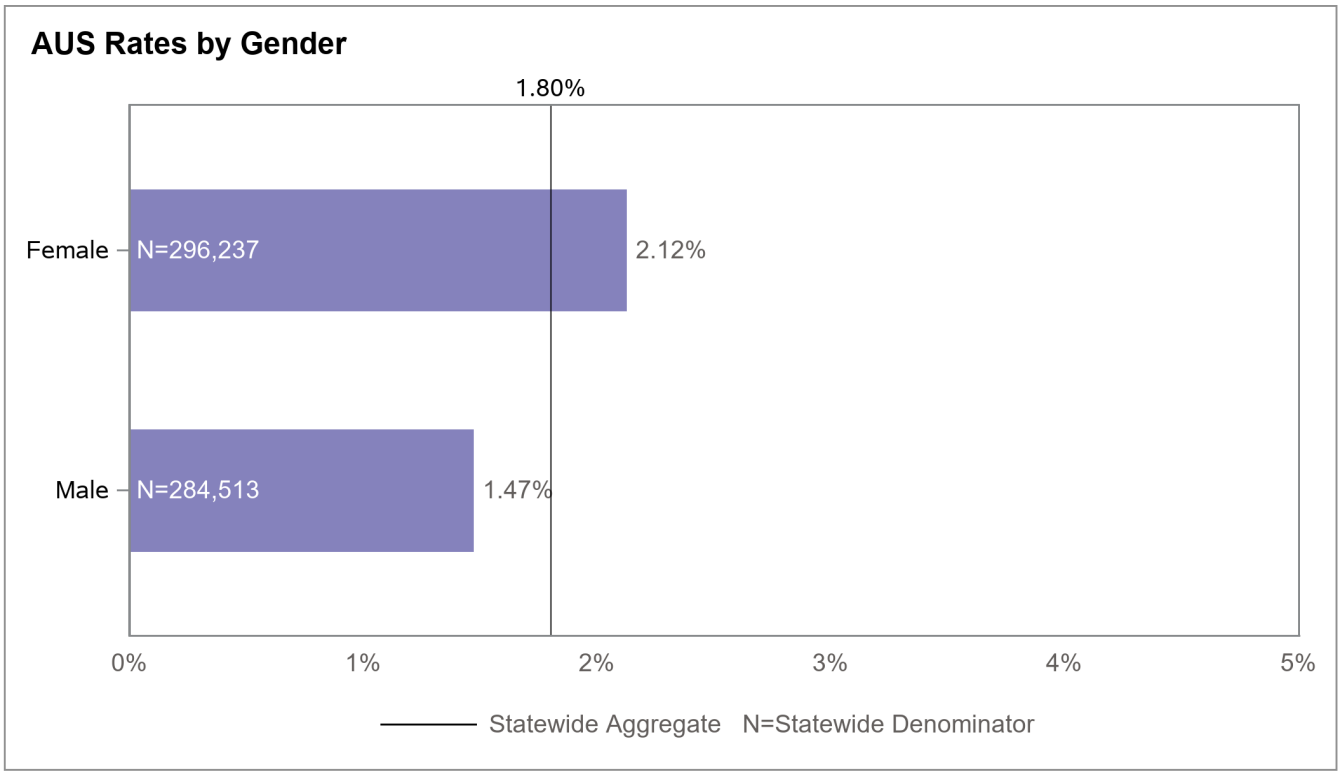


Figure 3.43—Alcohol Use Screening (AUS)—Statewide Gender Results



- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - White
  - Unknown/Missing
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Armenian
  - Chinese
  - English
  - Korean
  - Russian
  - Tagalog
  - Other
- The rate for the Male group was below the statewide aggregate rate by more than a 10 percent relative difference.

Figure 3.44—Alcohol Use Screening (AUS)—Regional-Level Delivery Type Model Results

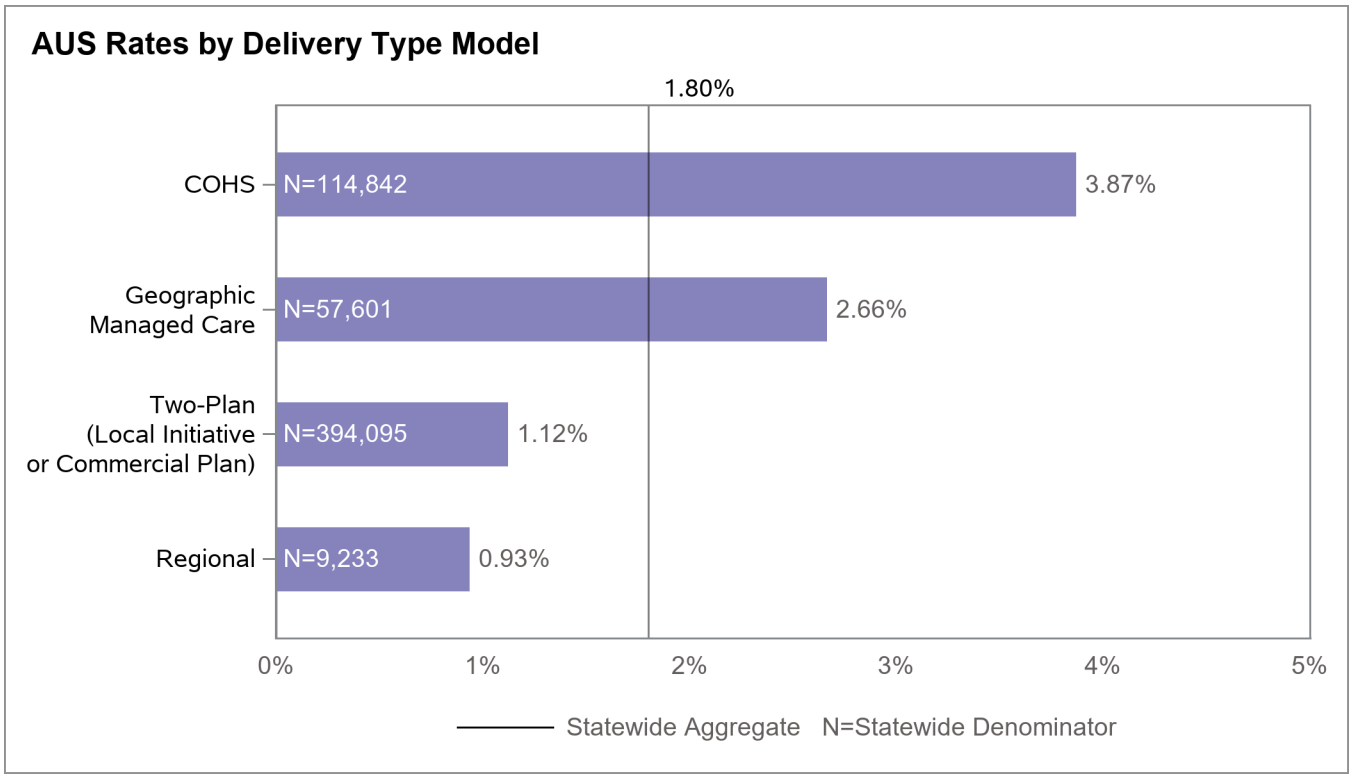
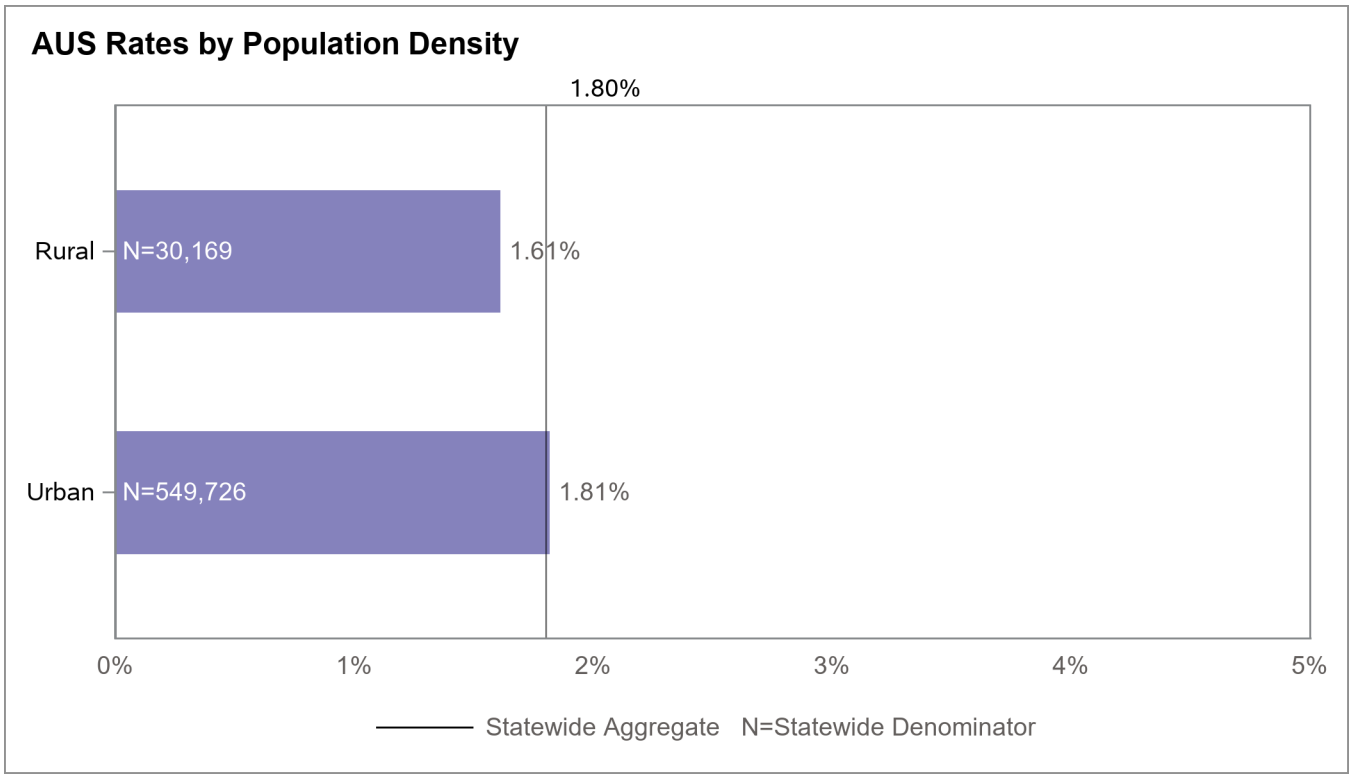


Figure 3.45—Alcohol Use Screening (AUS)—Regional-Level Population Density Results



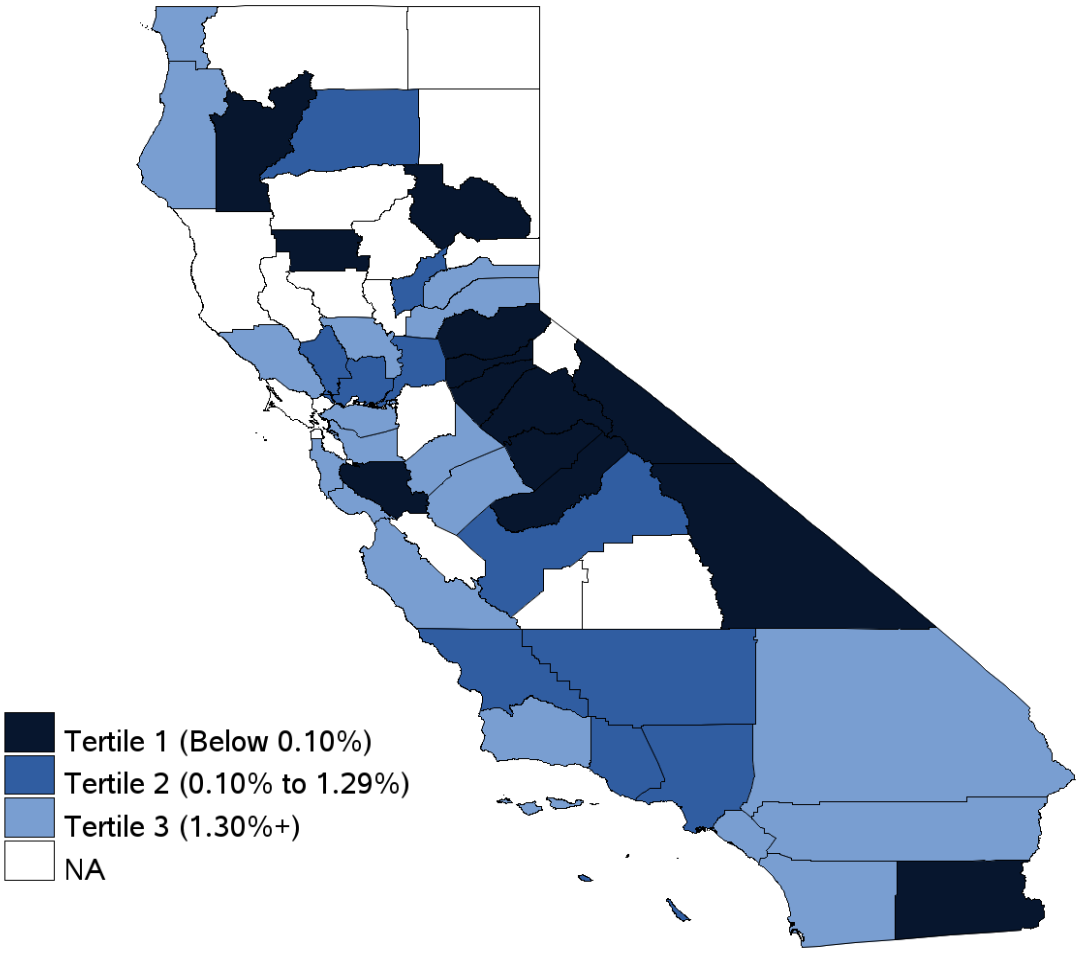
- For calendar year 2019, the *Alcohol Use Screening* indicator rates for the Two-Plan and Regional delivery type models were below the statewide aggregate by more than a 35 percent relative difference.
- The rate for the rural regions was below the rate for the urban regions by more than a 10 percent relative difference. However, the rates for these regions differed by less than half of a percentage point.

Figure 3.46—Alcohol Use Screening (AUS)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Due to limited administrative data and the distribution of the county-level rates, the county-level results for the *Alcohol Use Screening* (*AUS*) indicator are displayed using tertiles rather than quintiles.

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



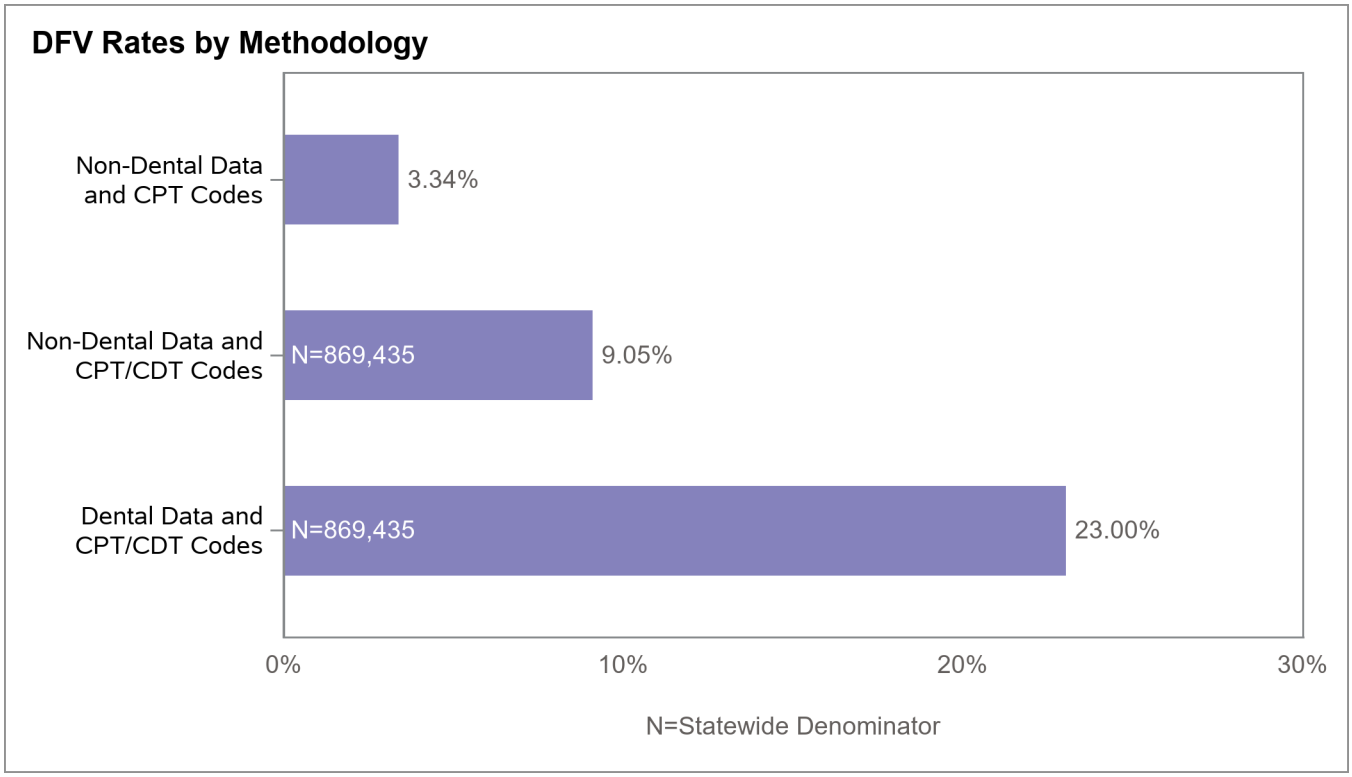
- Amador, Calaveras, El Dorado, Glenn, Imperial, Inyo, Madera, Mariposa, Mono, Plumas, Trinity, and Tuolumne counties had *Alcohol Use Screening* indicator rates of 0.00 percent and had the least favorable rates in the State.
- Santa Cruz, Monterey, Sonoma, Del Norte, and Orange counties had the most favorable *Alcohol Use Screening* indicator rates in the State.

Dental Fluoride Varnish

The *Dental Fluoride Varnish (DFV)* indicator measures the percentage of children 6 months of age as of January 1 of the measurement year to 5 years of age as of December 31 of the measurement year who had one or more applications of dental fluoride varnish administered by a medical provider during the measurement year. Figure 3.47 presents the *Dental Fluoride Varnish (DFV)* indicator rates using three different methodologies: (1) using only the CPT code and excluding dental data, (2) using both CPT and Code on Dental Procedures and Nomenclature (CDT) codes and excluding dental data, and (3) using both CPT and CDT codes and including dental data. Figure 3.48 through Figure 3.53 display the *Dental Fluoride Varnish (DFV)* indicator rates at the statewide and regional levels, using methodology (3) above. Therefore, exercise caution when interpreting results given that only a small percentage of dental fluoride varnish applications occur in non-dental settings. Please note, national benchmarks are not available for this indicator.

Figure 3.47—Dental Fluoride Varnish (DFV)—Statewide Results Using Different Methodologies

Note: The statewide denominator for the non-dental data and CPT codes methodology was 869,435.



- While the percentage of members receiving dental fluoride varnish treatments is 23 percent, only about 3 percent of members received treatments from a non-dental provider. This finding indicates MCPs have an opportunity to work with medical providers to ensure members receive dental fluoride treatments.

Figure 3.48—Dental Fluoride Varnish (DFV)—Statewide Racial/Ethnic Results

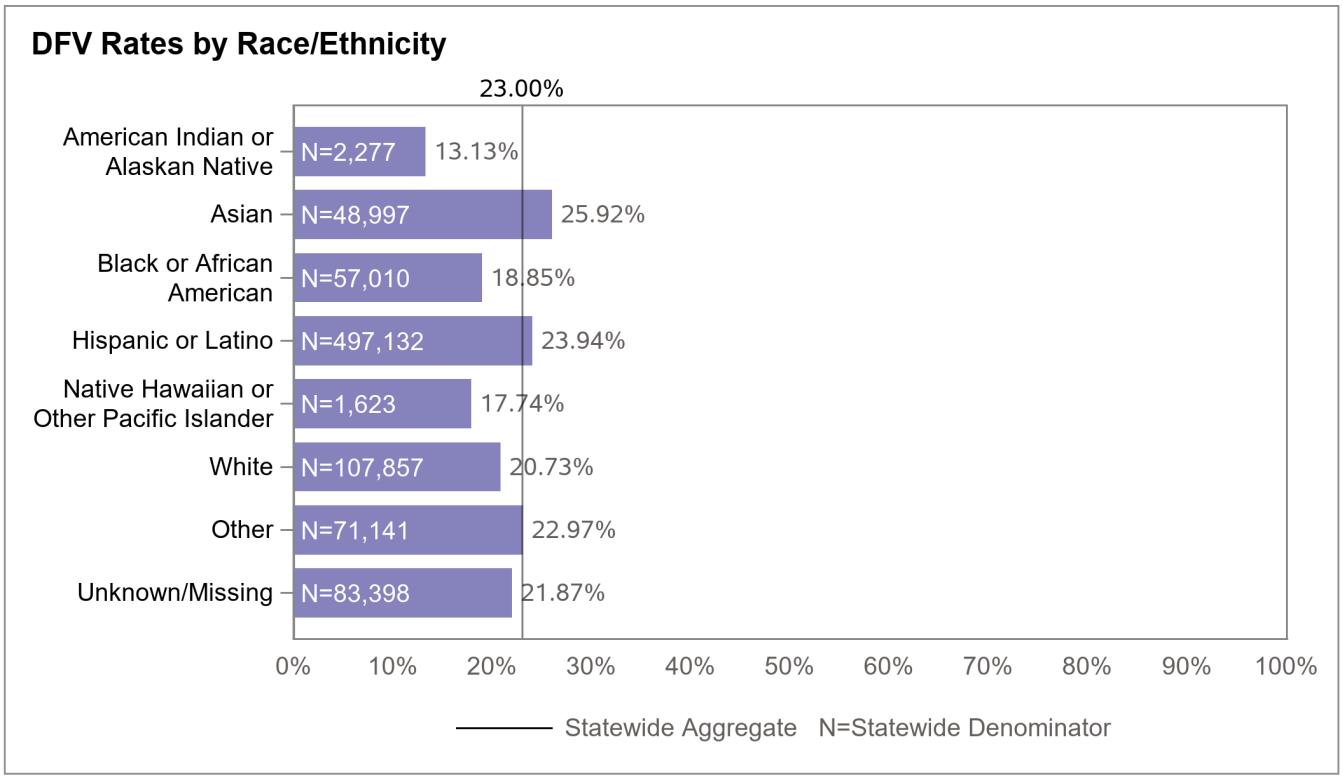


Figure 3.49—Dental Fluoride Varnish (DFV)—Statewide Primary Language Results

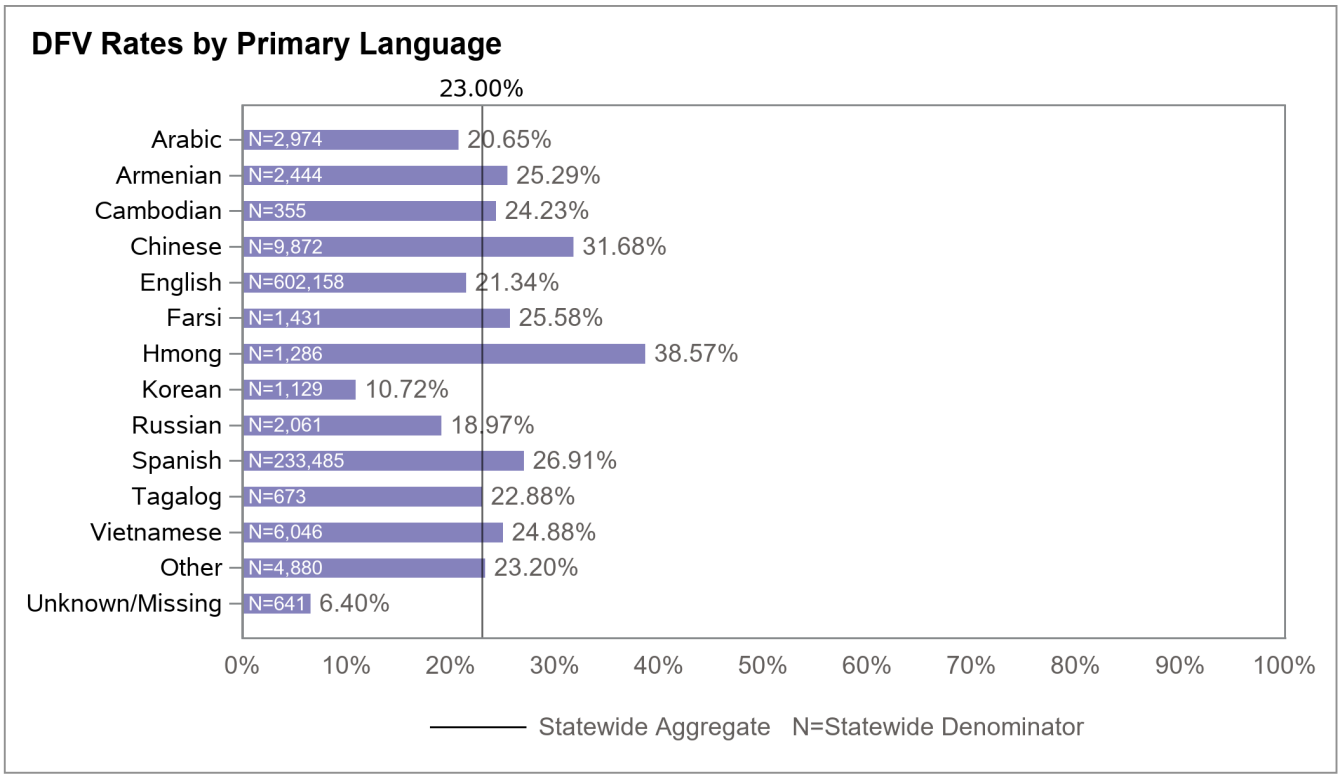
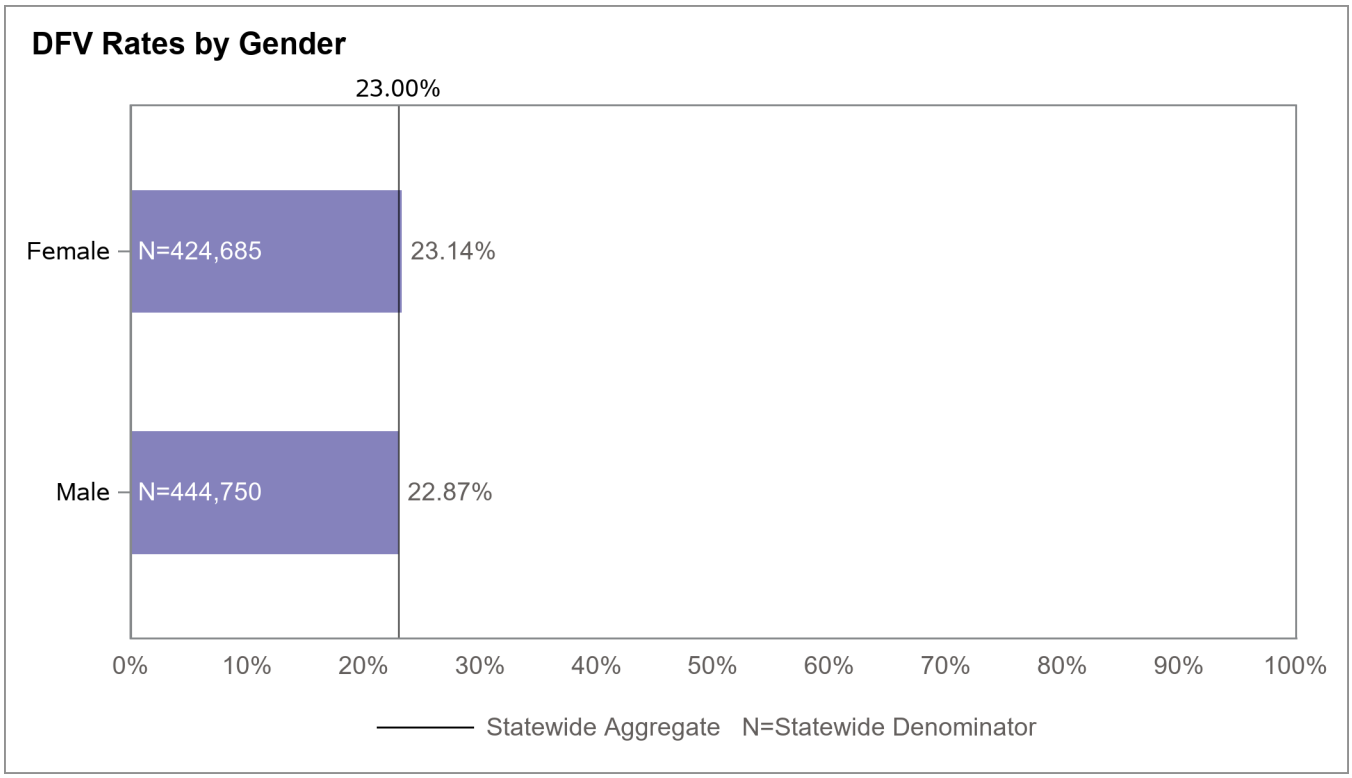


Figure 3.50—Dental Fluoride Varnish (DFV)—Statewide Gender Results



- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Arabic
  - Korean
  - Russian
  - Unknown/Missing
- The rates for the Female and Male groups differed by less than 1 percentage point.

Figure 3.51—Dental Fluoride Varnish (DFV)—Regional-Level Delivery Type Model Results

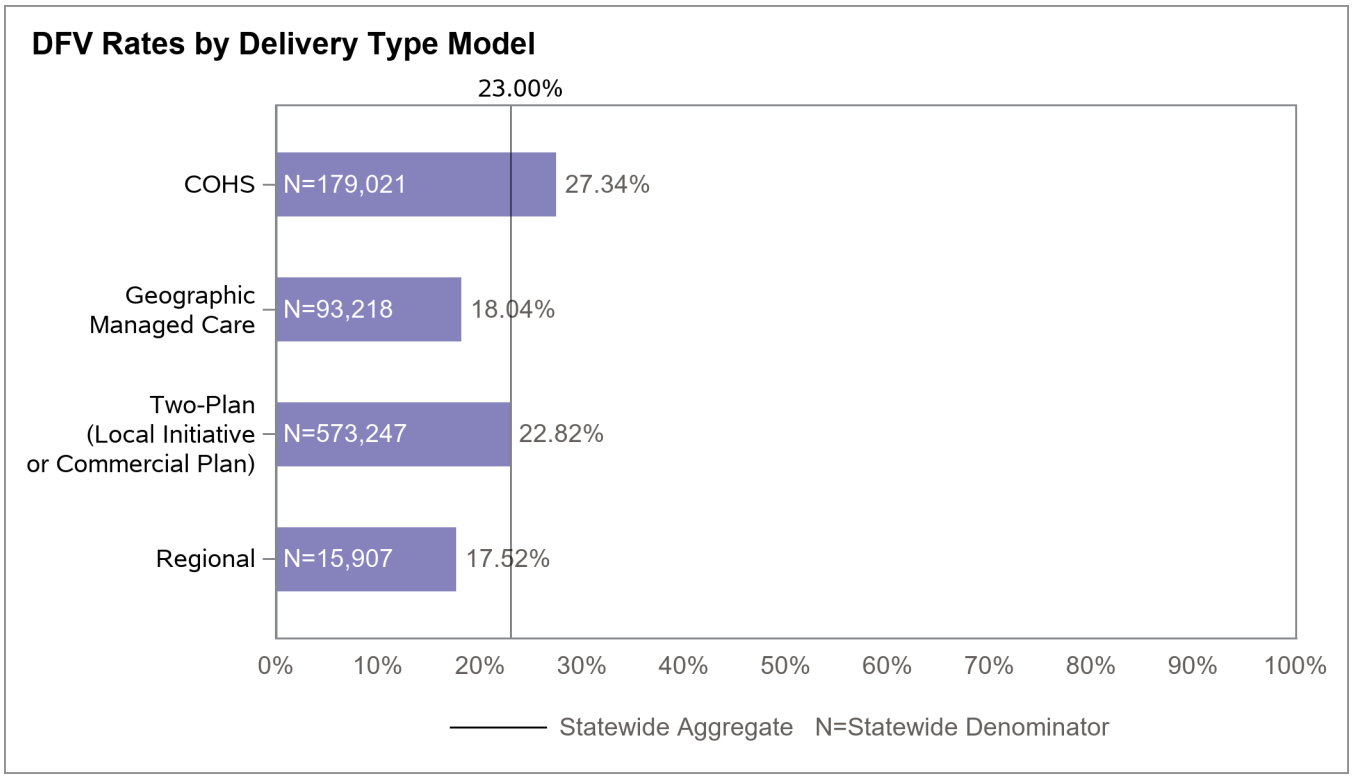
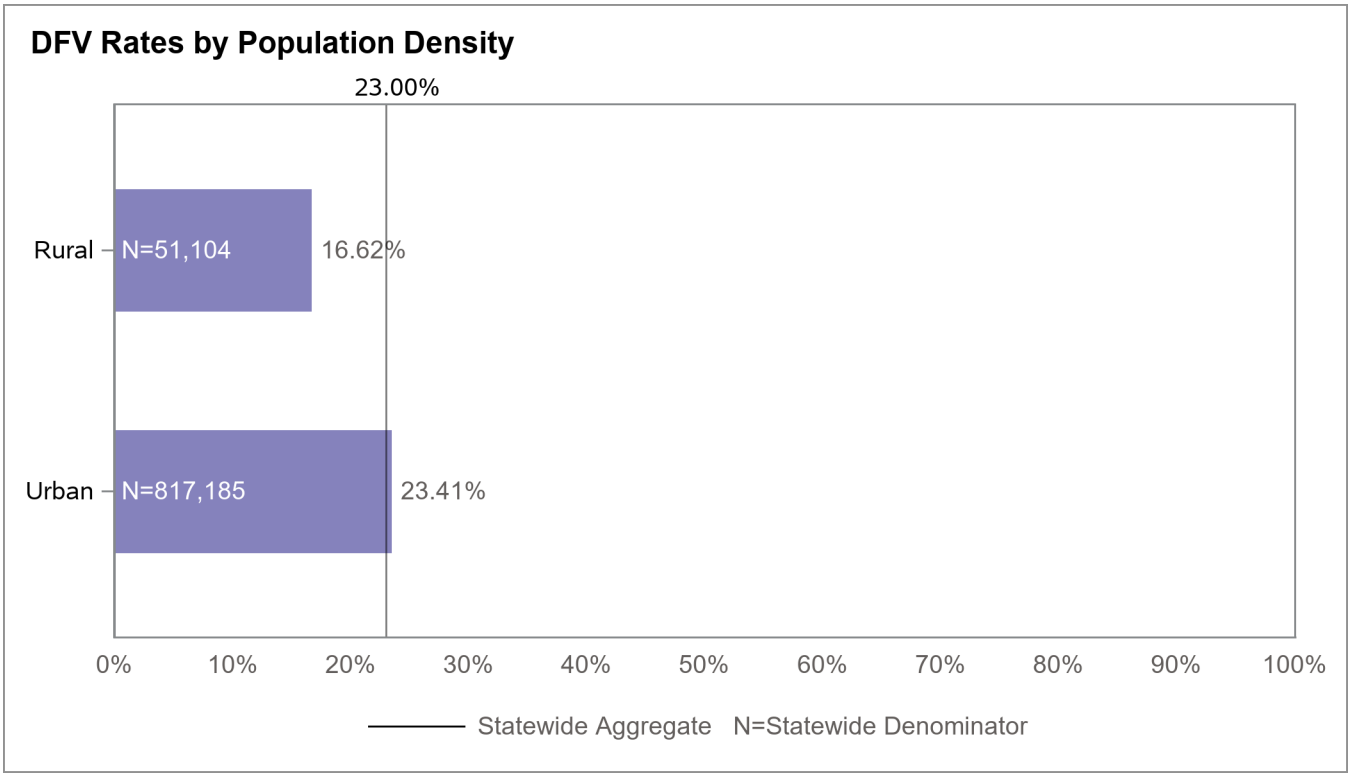


Figure 3.52—Dental Fluoride Varnish (DFV)—Regional-Level Population Density Results

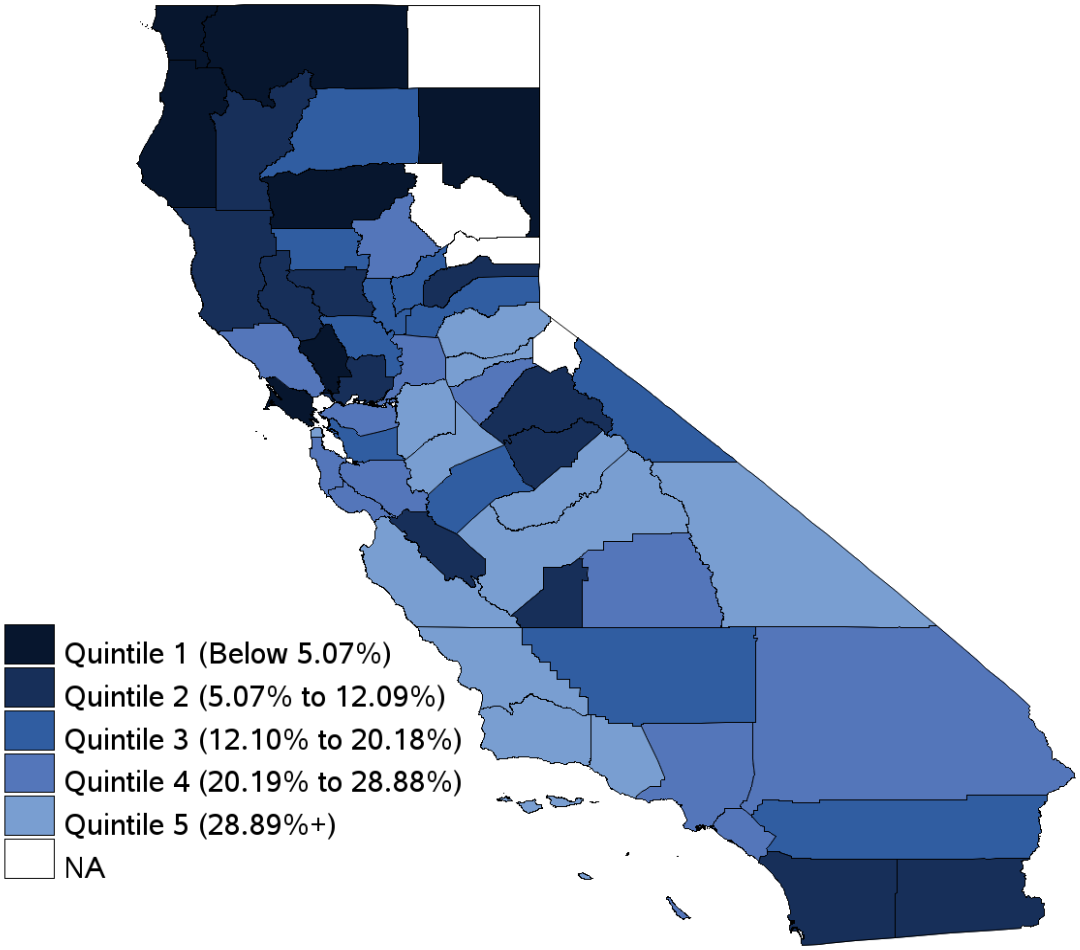


- For calendar year 2019, the *Dental Fluoride Varnish* indicator rate for the COHS delivery type model was above the statewide aggregate by more than a 15 percent relative difference. Conversely, the rates for the Geographic Managed Care and Regional delivery type models were below the statewide aggregate by more than a 20 percent relative difference. Of note, counties that have a Geographic Managed Care delivery model are the only counties that have dental managed care.
- The rate for the rural regions was below the rate for the urban regions by more than a 25 percent relative difference.

Figure 3.53—Dental Fluoride Varnish (DFV)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



- Siskiyou, Del Norte, Marin, Lassen, Napa, Tehama, and Humboldt counties had the least favorable *Dental Fluoride Varnish* indicator rates in the State. All seven of these counties are located in northern California and each have relatively small populations, with each county accounting for less than 0.5 percent of the total statewide population. Additionally, five of the seven (71.4 percent) counties are predominantly rural. This finding aligns with the results displayed in Figure 3.52, which shows that the rate for members living in rural regions was below the rate for members living in urban regions by a relative difference of more than 25 percent.
- Santa Barbara, Monterey, and San Luis Obispo counties had three of the four most favorable *Dental Fluoride Varnish* indicator rates in the State, and all three counties use the COHS delivery type system. Additionally, these three counties account for nearly 20 percent of the statewide COHS delivery type model group. This finding aligns with the results displayed in Figure 3.51, which shows that the rate for the COHS delivery type

model group was above the statewide aggregate rate by a relative difference of more than 15 percent.

- Santa Barbara, Monterey, San Luis Obispo, Ventura, San Francisco, San Mateo, Santa Cruz, Contra Costa, Sonoma, and Santa Clara counties are all located in the Central Coast and San Francisco Bay Area regions and had *Dental Fluoride Varnish* indicator rates in the top 40 percent of county-level rates, five of which were within the top 20 percent. This indicates that favorable *Dental Fluoride Varnish* indicator rates correspond to geographical location within the State.

Tobacco Use Screening

The *Tobacco Use Screening (TUS)* indicator measures the percentage of children ages 12 to 21 years who had one or more screenings for tobacco use during the measurement year. Figure 3.54 through Figure 3.60 display the *Tobacco Use Screening (TUS)* indicator rates at the statewide and regional levels. Due to a lack of reporting within administrative data sources (i.e., MRR or EHR data could be necessary to capture this information), exercise caution when evaluating results as they may be more indicative of data completeness rather than performance. Please note, national benchmarks are not available for this indicator.

Figure 3.54—Tobacco Use Screening (TUS)—Statewide Racial/Ethnic Results

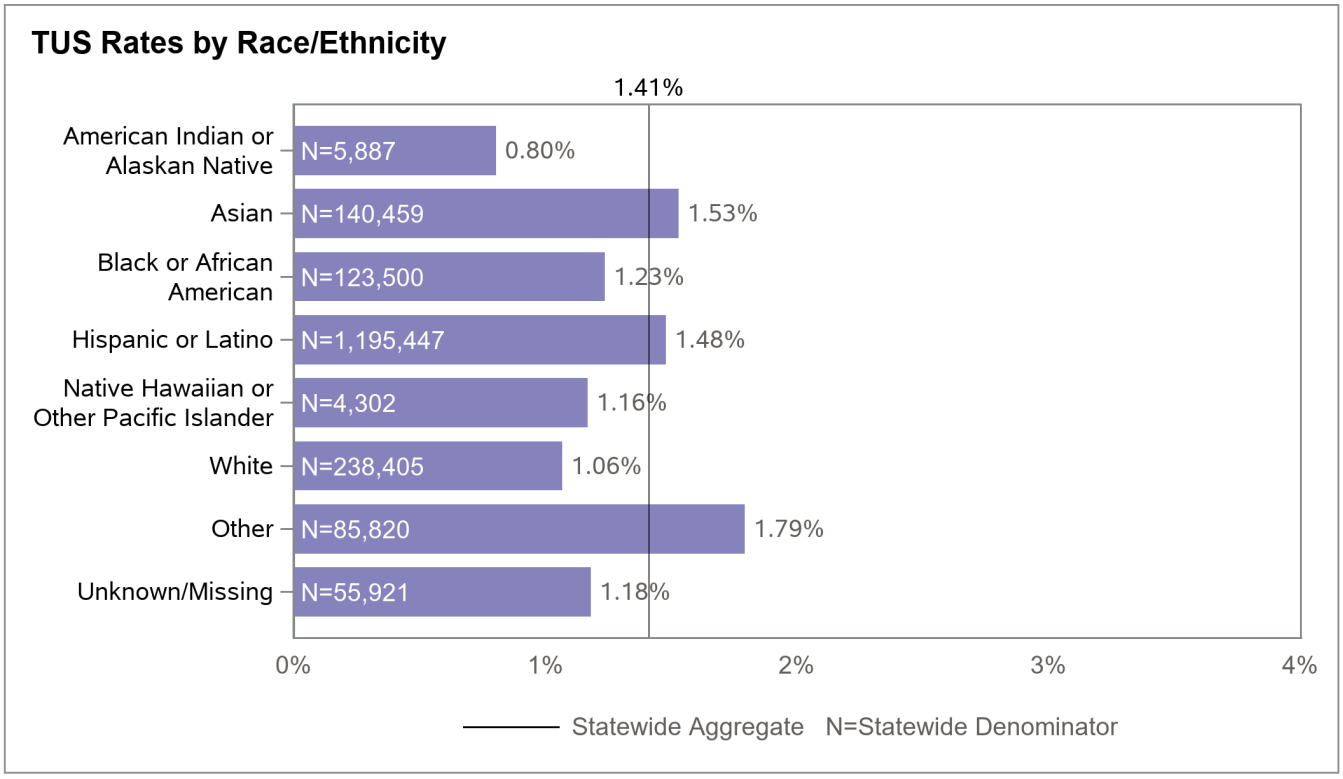


Figure 3.55—Tobacco Use Screening (TUS)—Statewide Primary Language Results

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.

Note: The Statewide Denominator for the Chinese primary language group was 20,631.

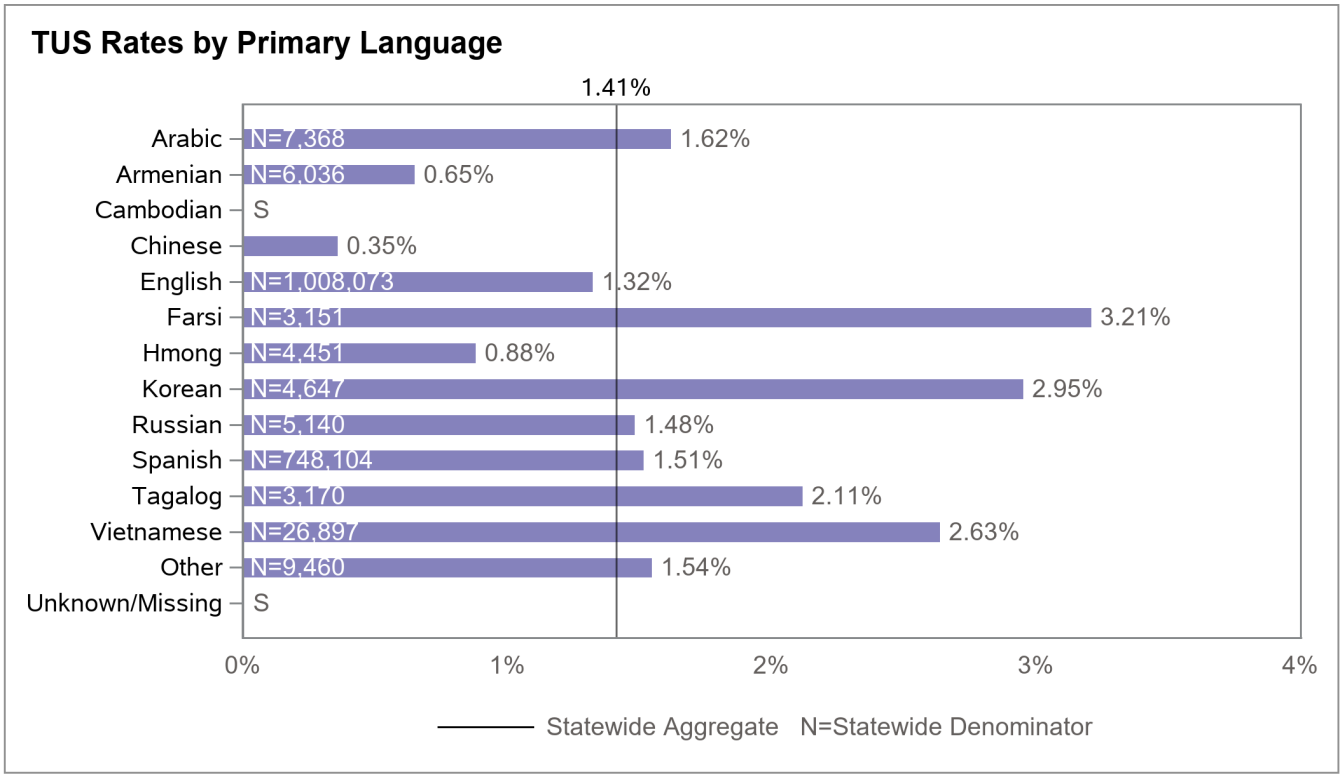


Figure 3.56—Tobacco Use Screening (TUS)—Statewide Gender Results

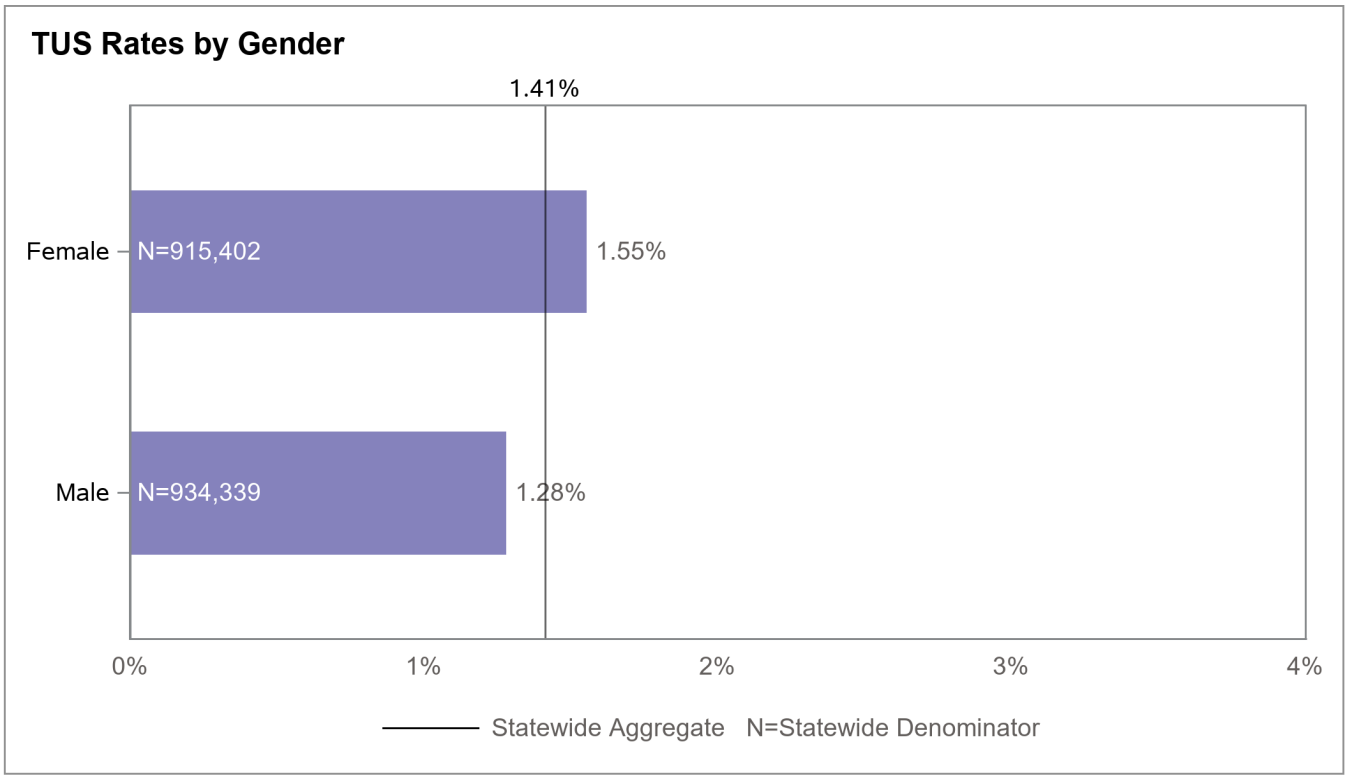
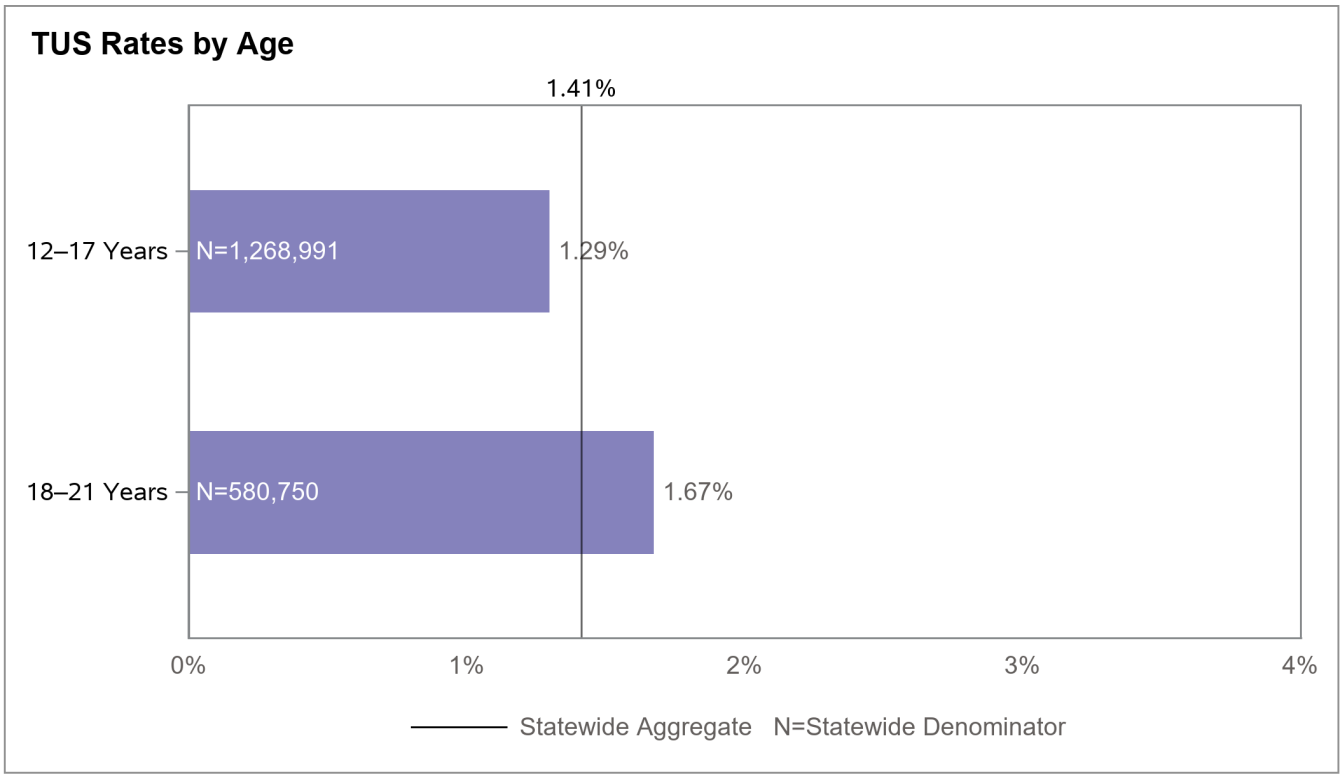


Figure 3.57—Tobacco Use Screening (TUS)—Statewide Age Results



- The rates for the following racial/ethnic groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
  - Unknown/Missing
- The rates for the following primary language groups were below the statewide aggregate rate by more than a 10 percent relative difference:
  - Armenian
  - Chinese
  - Hmong
- The rate for the 18 to 21 Years age group was above the statewide aggregate rate by more than a 10 percent relative difference.

Figure 3.58—Tobacco Use Screening (TUS)—Regional-Level Delivery Type Model Results

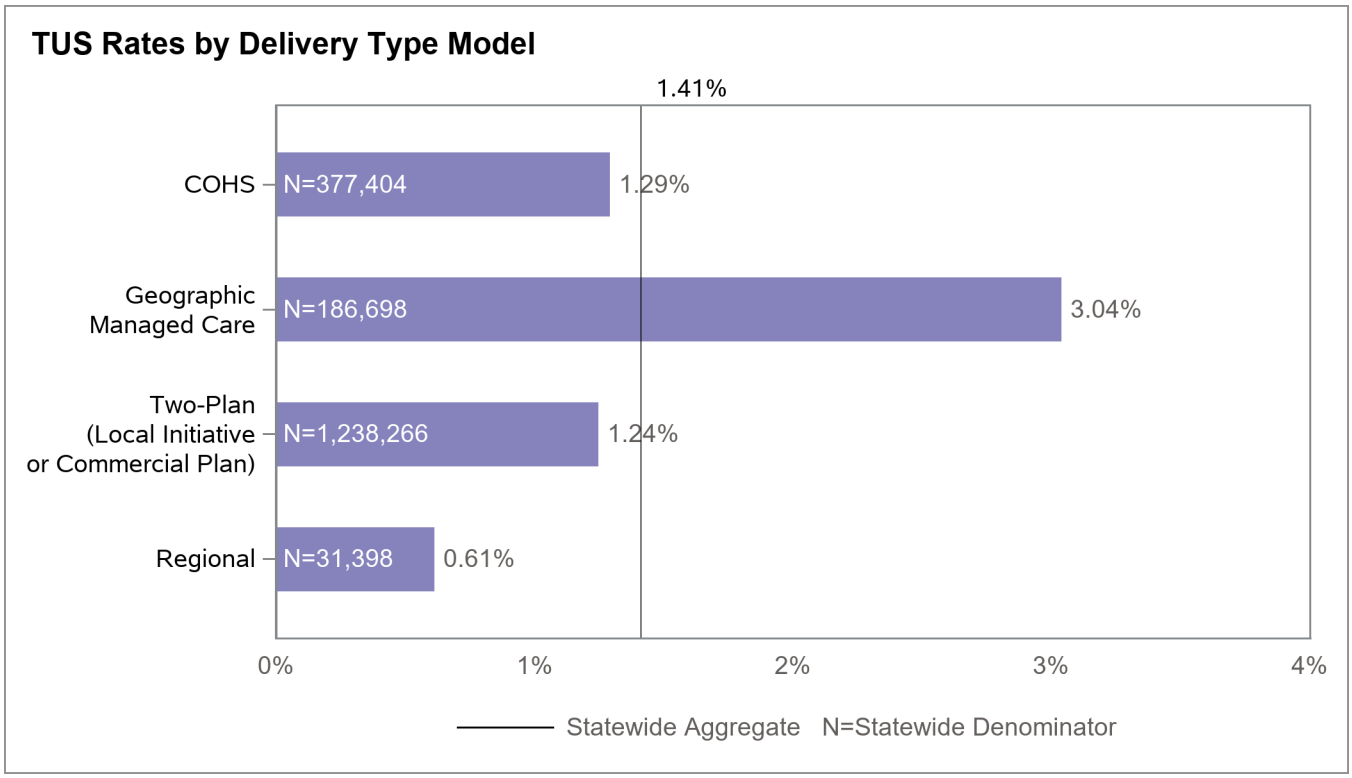
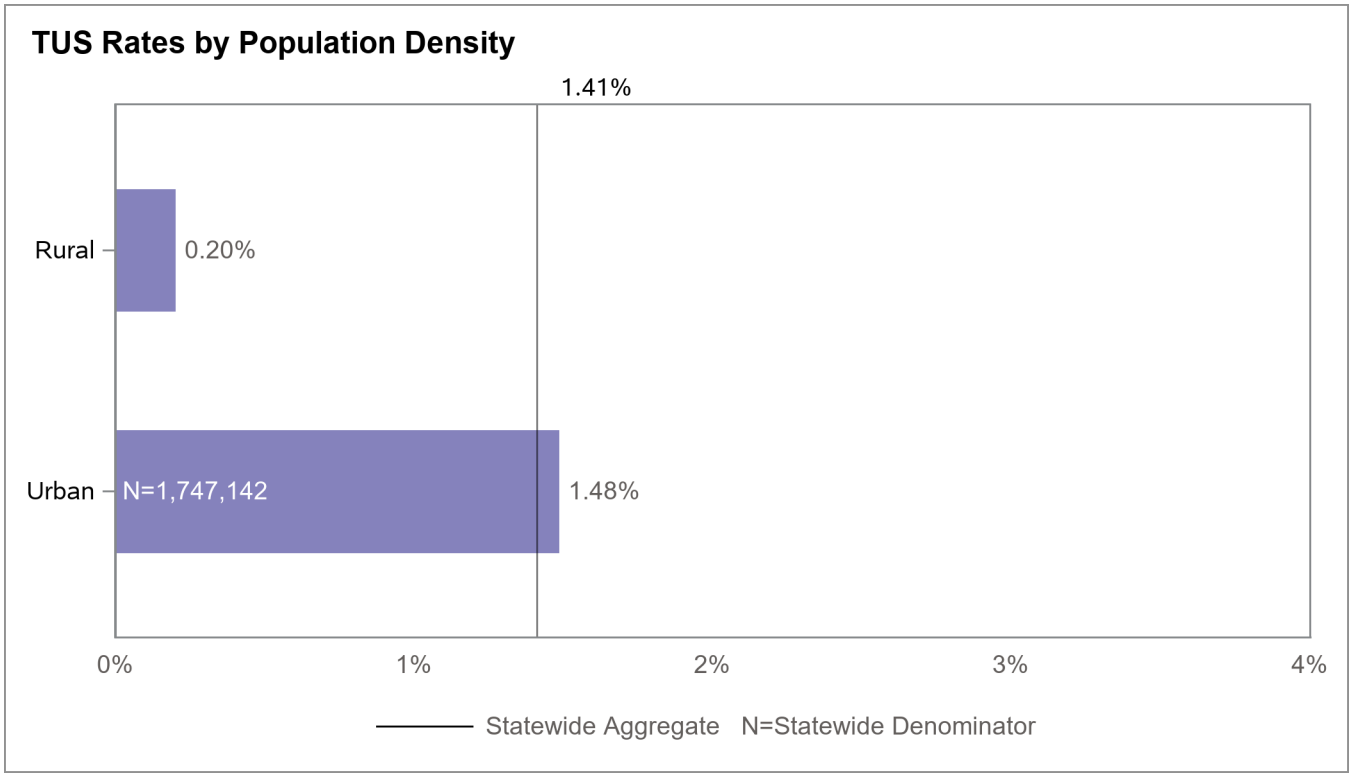


Figure 3.59—Tobacco Use Screening (TUS)—Regional-Level Population Density Results

Note: The statewide denominator for the Rural group was 100,314.

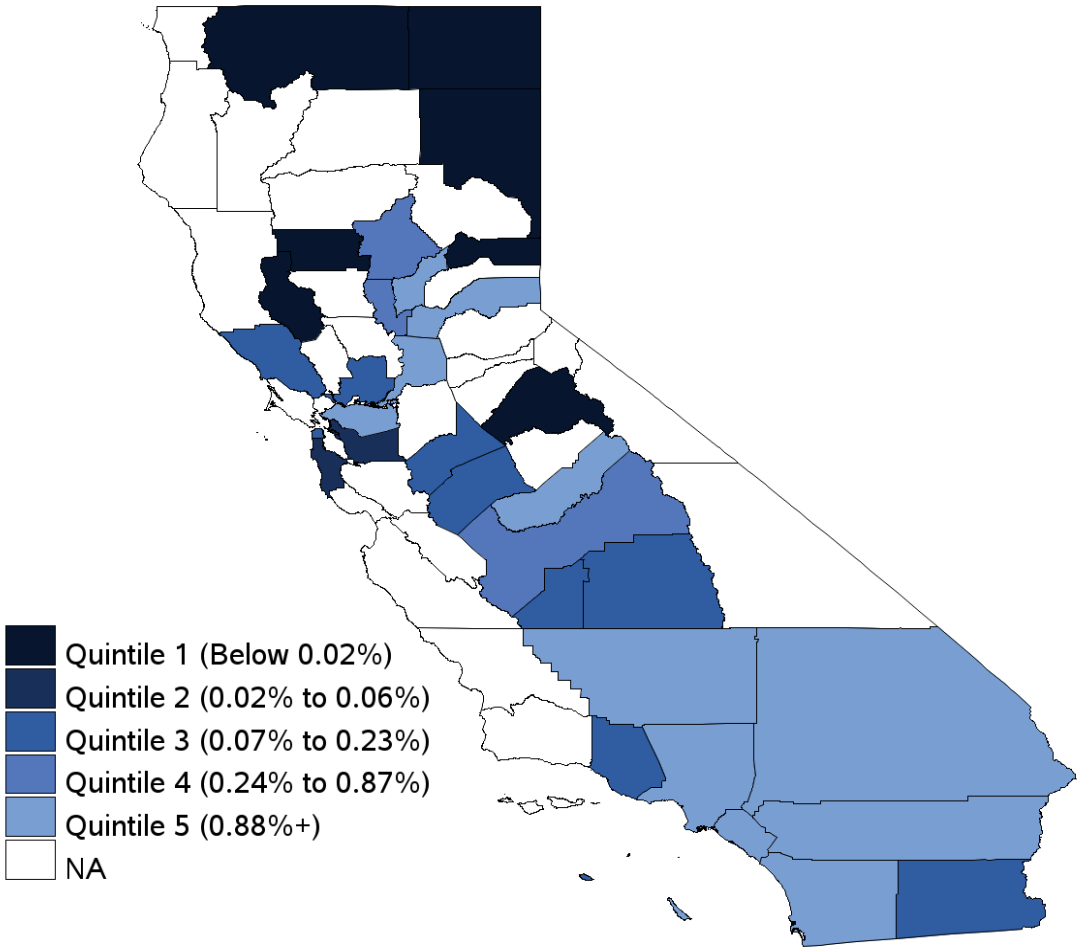


- For calendar year 2019, the *Tobacco Use Screening* indicator rate for the Geographic Managed Care delivery type model was above the statewide aggregate by more than a 110 percent relative difference.
- The rate for the rural regions was below the rate for the urban regions by more than an 85 percent relative difference.

Figure 3.60—Tobacco Use Screening (TUS)—County-Level Results

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Please refer to Table 2.3 in the Reader's Guide for a list of MCPs operating in each county.



- Glenn, Lake, Lassen, Modoc, Sierra, Siskiyou, and Tuolumne counties had *Tobacco Use Screening* indicator rates of 0.00 percent and had the least favorable rates in the State.
- San Diego, San Bernardino, Orange, Sacramento, Riverside, Placer, Contra Costa, Los Angeles, Kern, and Yuba counties had the most favorable *Tobacco Use Screening* indicator rates in the State.

Appendix A. Additional Population Characteristics

Appendix A presents tables containing additional characteristics of the target population. The tables display the counts and percentages of the target population stratified by county and MCP reporting unit.

Table A.1—County-Level Population

*The percentage for the Statewide pediatric population (i.e., 21 years of age and younger as of December 31, 2019) is based on all Medi-Cal managed care members enrolled during calendar year 2019.

County	Count	Percentage
Statewide Pediatric Population*	6,733,328	40.21%
Alameda	195,084	2.90%
Alpine	151	0.00%
Amador	4,074	0.06%
Butte	35,788	0.53%
Calaveras	5,772	0.09%
Colusa	5,919	0.09%
Contra Costa	141,562	2.10%
Del Norte	5,704	0.08%
El Dorado	19,014	0.28%
Fresno	265,466	3.94%
Glenn	7,059	0.10%
Humboldt	23,669	0.35%
Imperial	50,585	0.75%
Inyo	3,010	0.04%
Kern	244,117	3.63%
Kings	34,944	0.52%
Lake	14,564	0.22%
Lassen	4,141	0.06%
Los Angeles	1,829,377	27.17%
Madera	41,600	0.62%
Marin	21,836	0.32%

County	Count	Percentage
Mariposa	2,154	0.03%
Mendocino	19,192	0.29%
Merced	79,224	1.18%
Modoc	1,566	0.02%
Mono	1,911	0.03%
Monterey	106,482	1.58%
Napa	17,469	0.26%
Nevada	11,788	0.18%
Orange	449,239	6.67%
Placer	33,931	0.50%
Plumas	2,932	0.04%
Riverside	484,856	7.20%
Sacramento	277,746	4.12%
San Benito	10,836	0.16%
San Bernardino	493,541	7.33%
San Diego	460,693	6.84%
San Francisco	67,269	1.00%
San Joaquin	165,985	2.47%
San Luis Obispo	31,699	0.47%
San Mateo	69,715	1.04%
Santa Barbara	86,775	1.29%
Santa Clara	191,441	2.84%
Santa Cruz	36,997	0.55%
Shasta	31,282	0.46%
Sierra	335	0.00%
Siskiyou	8,443	0.13%
Solano	62,017	0.92%
Sonoma	62,899	0.93%
Stanislaus	128,962	1.92%

County	Count	Percentage
Sutter	21,769	0.32%
Tehama	14,903	0.22%
Trinity	1,975	0.03%
Tulare	145,686	2.16%
Tuolumne	6,402	0.10%
Ventura	128,645	1.91%
Yolo	29,543	0.44%
Yuba	17,767	0.26%
Unknown/Missing	15,823	0.23%

Table A.2—MCP Reporting Unit-Level Population

The counts displayed in the table are based on the MCP with whom each member was most recently enrolled while 21 years of age or younger. The Statewide pediatric population count will not align with those displayed in other tables of the report due to this methodology.

*The percentage for the Statewide pediatric population (i.e., 21 years of age and younger as of December 31, 2019) is based on all Medi-Cal managed care members enrolled during calendar year 2019.

MCP Reporting Unit	Count	Percentage
Statewide Pediatric Population*	6,308,075	37.67%
Aetna Better Health of California—Sacramento	4,814	0.08%
Aetna Better Health of California—San Diego	5,947	0.09%
Alameda Alliance for Health—Alameda	143,799	2.28%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Alameda	34,953	0.55%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Contra Costa	19,314	0.31%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Fresno	69,566	1.10%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Kings	13,650	0.22%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Madera	13,892	0.22%

MCP Reporting Unit	Count	Percentage
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Region 1	42,670	0.68%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Region 2	55,702	0.88%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Sacramento	109,566	1.74%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—San Benito	6,639	0.11%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—San Francisco	6,910	0.11%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Santa Clara	34,898	0.55%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Tulare	65,305	1.04%
Blue Shield of California Promise Health Plan—San Diego	35,281	0.56%
California Health & Wellness Plan—Imperial	40,370	0.64%
California Health & Wellness Plan—Region 1	9,198	0.15%
California Health & Wellness Plan—Region 2	12,366	0.20%
CalOptima—Orange	452,136	7.17%
CalViva Health—Fresno	189,491	3.00%
CalViva Health—Kings	19,709	0.31%
CalViva Health—Madera	26,903	0.43%
CenCal Health—San Luis Obispo	31,958	0.51%
CenCal Health—Santa Barbara	86,835	1.38%
Central California Alliance for Health—Merced	84,074	1.33%
Central California Alliance for Health—Monterey/Santa Cruz	144,659	2.29%
Community Health Group Partnership Plan—San Diego	165,257	2.62%
Contra Costa Health Plan—Contra Costa	107,188	1.70%
Gold Coast Health Plan—Ventura	127,825	2.03%
Health Net Community Solutions, Inc.—Kern	43,390	0.69%

MCP Reporting Unit	Count	Percentage
Health Net Community Solutions, Inc.—Los Angeles	530,723	8.41%
Health Net Community Solutions, Inc.—Sacramento	64,246	1.02%
Health Net Community Solutions, Inc.—San Diego	44,376	0.70%
Health Net Community Solutions, Inc.—San Joaquin	13,055	0.21%
Health Net Community Solutions, Inc.—Stanislaus	41,209	0.65%
Health Net Community Solutions, Inc.—Tulare	74,903	1.19%
Health Plan of San Joaquin—San Joaquin	146,450	2.32%
Health Plan of San Joaquin—Stanislaus	85,081	1.35%
Health Plan of San Mateo—San Mateo	69,442	1.10%
Inland Empire Health Plan—Riverside/San Bernardino	819,065	12.98%
Kaiser NorCal (KP Cal, LLC)—KP North	69,530	1.10%
Kaiser SoCal (KP Cal, LLC)—San Diego	30,981	0.49%
Kern Health Systems, DBA Kern Family Health Care—Kern	182,217	2.89%
L.A. Care Health Plan—Los Angeles	1,142,960	18.12%
Molina Healthcare of California—Imperial	8,132	0.13%
Molina Healthcare of California—Riverside/ San Bernardino	97,810	1.55%
Molina Healthcare of California—Sacramento	28,127	0.45%
Molina Healthcare of California—San Diego	132,600	2.10%
Partnership HealthPlan of California—Northeast	48,846	0.77%
Partnership HealthPlan of California—Northwest	30,992	0.49%
Partnership HealthPlan of California—Southeast	113,963	1.81%
Partnership HealthPlan of California—Southwest	119,528	1.89%
San Francisco Health Plan—San Francisco	57,601	0.91%
Santa Clara Family Health Plan—Santa Clara	145,240	2.30%
United Healthcare Community Plan—San Diego	6,381	0.10%

Appendix B. Methodology

Overview

At the request of the Joint Legislative Audit Committee, the California State Auditor published an audit report in March 2019 regarding the California Department of Health Care Services' (DHCS') oversight of the delivery of preventive services to children enrolled in California's Medicaid managed care program (Medi-Cal). The audit report recommended that DHCS expand the performance measures it collects and reports on to ensure all age groups receive preventive services from the managed care health plans (MCPs).[10] In response to this recommendation, DHCS requested that Health Services Advisory Group, Inc. (HSAG), develop additional administrative performance measures to assess the utilization of services by pediatric Medi-Cal managed care members and analyze additional child and adolescent performance measures either calculated by HSAG or reported by the 25 full-scope MCPs for reporting year 2020 from the Managed Care Accountability Set (MCAS). MCAS measures reflect clinical quality, timeliness, and access to 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 in the Preventive Services Report to assist with assessing pediatric members' access to preventive services.

For the 2019–20 contract year, HSAG evaluated measure data collected for reporting year 2020, which consists of data collected during calendar year 2019, also known as Healthcare Effectiveness Data and Information Set (HEDIS®) measurement year 2019.[11] The indicator set for this analysis included a total of three MCP-calculated MCAS indicators and six HSAG-calculated indicators (i.e., administrative indicators calculated by HSAG for DHCS). For each MCP-calculated MCAS indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the HEDIS specification for the Medicaid population or by the Centers for Medicare & Medicaid Services (CMS) Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). For the HSAG-calculated indicators, HSAG developed specifications for three of the indicators and followed the applicable technical specifications for the remaining three indicators.

[10] 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: Aug 12, 2020.

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

Preventive Services Indicators and Data Sources

MCP-Calculated MCAS Indicators and Data Sources

Table B.1 displays the MCP-calculated MCAS indicators included in the Preventive Services analysis, the reporting methodology for each indicator ("A" indicates administrative), and the age groups for each indicator.

Table B.1—MCP-Calculated MCAS Indicators, Methodology, and Age Groups

Indicators	Methodology	Age Groups
MCP-Calculated MCAS Indicators		
Chlamydia Screening in Women—16 to 20 Years	A	16 to 20 Years
Developmental Screening in the First Three Years of Life	A	1 Year 2 Years 3 Years
Screening for Depression and Follow-Up Plan—12 to 17 Years	A	12 to 17 Years

For the MCP-calculated MCAS indicators listed in Table B.1, HSAG received the CA-required patient-level detail file from each Medi-Cal MCP for each HEDIS reporting unit. The reporting year 2020 patient-level detail files followed HSAG's patient-level detail file instructions and included the Medi-Cal client identification number, date of birth, and member months for members included in the audited MCP-calculated MCAS indicator rates. Additionally, the patient-level detail files indicated whether a member was included in the numerator and/or denominator for each applicable MCP-calculated MCAS indicator. HSAG validated the patient-level detail files to ensure the numerator and denominator counts matched what was reported by MCPs in the audited HEDIS Interactive Data Submission System (IDSS) files and non-HEDIS Microsoft (MS) Excel reporting files. Please note, it is possible that some or all MCPs included non-certified eligible members in the reporting year 2020 rates. HSAG used these patient-level detail files, along with supplemental files (e.g., demographic data provided by DHCS), to perform the measure analysis. HSAG obtained the following demographic information from DHCS' Management Information System/Decision Support System data system:

- CA-required demographic file
  - Member's Medi-Cal client identification number
  - Date of birth
  - ZIP Code
  - Gender
  - Race/Ethnicity
  - Primary language
  - County

To stratify the MCP-calculated MCAS indicator rates, HSAG first combined the patient-level detail files provided by MCPs with the demographic file provided by DHCS. The following outlines HSAG's process for matching members in the indicator files:

Step 1: Records with missing demographic information for every field were deleted from the demographic file.

Step 2: For records missing some demographic values (e.g., race/ethnicity, language, gender, or county) in the most recent record, HSAG obtained the demographic values from another record in the demographic file using the following logic:

- HSAG prioritized records from the same reporting unit as the patient-level detail file. If there were no records within the same reporting unit, then HSAG used records from other reporting units to retrieve missing information.
- HSAG prioritized the most recent non-missing observation within the measurement year using the following logic:
  - HSAG first tried to recover the missing demographic values from the most recent non-missing observation within calendar year 2019.
  - If HSAG could not recover the missing demographic values from a record within calendar year 2019, then the most recent non-missing observation from calendar year 2018 was used.
- If HSAG could not obtain data for the missing demographic values, then a value of "Unknown/Missing" was assigned.

Step 3: HSAG combined the demographic file with the patient-level detail file by Medi-Cal client identification number and prioritized matches within the same reporting unit first, using records from other reporting units when necessary following the same logic as in Step 2. If a client identification number had multiple records in the demographic file with a date of birth within 10 years of each other, then the most recent non-missing demographic information was used. Additionally, to avoid combining a parent record with a child record that contained the same client identification number, HSAG only considered a client identification number to match if the date of birth in the demographic file was within 10 years of the date of birth recorded in the patient-level detail file. If HSAG could not obtain county data from the demographic file, then HSAG did the following:

- If the county code was missing or "Unknown," then HSAG imputed the county based on the ZIP Code from the demographic file. If the ZIP Code and the county were missing, then HSAG assigned a county of "Unknown/Missing."

HSAG-Calculated Indicators and Data Sources

Table B.2 displays the HSAG-calculated indicators included in the Preventive Services analysis, the reporting methodology for each indicator ("A" indicates administrative), the applicable technical specifications, and the age groups for each indicator. Please refer to the HSAG-Calculated Indicator Specifications section for additional information on the HSAG-developed indicators.

Table B.2—HSAG-Calculated Indicators, Methodology, Specifications, and Age Groups

Indicators	Methodology	Specifications	Age Groups
HSAG-Calculated Indicators			
Alcohol Use Screening	A	HSAG-Developed	18 to 21 Years
Child and Adolescent Well-Care Visits	A	HEDIS Measurement Year 2020	3 to 6 Years 7 to 11 Years 3 to 11 Years 12 to 17 Years 18 to 21 Years 12 to 21 Years
Dental Fluoride Varnish	A	HSAG-Developed	6 Months to 5 Years
Tobacco Use Screening	A	HSAG-Developed	12 to 21 Years
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and *Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits*	A	HEDIS Measurement Year 2020	15 Months 30 Months

For the HSAG-calculated indicators listed in Table B.2, HSAG received from DHCS claims/encounter data; member enrollment, eligibility, and demographic data; and provider files. Upon receipt of the data from DHCS, HSAG evaluated the data files and performed preliminary file validation. HSAG verified that the data were complete and accurate by ensuring correct formatting, confirming reasonable value ranges for critical data fields, assessing monthly enrollment and claim counts, and identifying fields with a high volume of missing values. HSAG maintained an issue log to document any data issues identified throughout the review process. Upon completion of this review, HSAG communicated with DHCS and discussed the extent to which the identified data issues may affect the integrity of the analyses.

Once DHCS confirmed HSAG had complete and valid data, HSAG proceeded with calculating the HSAG-calculated indicators. Using the approved applicable specifications for the HSAG-calculated indicators, HSAG developed programming code in SAS. Each HSAG-calculated

indicator was assigned a lead programming analyst and a validating analyst. The lead programming analyst developed the primary code based on the approved specifications. After the lead programming analyst completed the analyses, the validating analyst independently validated the results, which ensured that the generated results were accurate and complete. Specifically, the validating analyst used the approved specifications to develop his or her own program code and compared the results with those generated by the lead programming analyst. This separate program run process allowed for a more comprehensive and thorough validation to identify any issues with the lead programming analyst's results. The validating analyst maintained a validation log and communicated to the lead programming analyst any issues or discrepancies. Once the indicator rates were validated, the lead programming analyst also compared the indicator rates to any applicable benchmarks or similar indicator results for reasonability.

HSAG also produced patient-level detail files for the HSAG-calculated indicators as part of the calculation. The patient-level detail files included the Medi-Cal client identification number and date of birth and indicated whether a member was included in the numerator and/or denominator for each applicable HSAG-calculated indicator. Since DHCS provided demographic data for each member, HSAG also included the following data elements in the HSAG-calculated patient-level detail files:

- Date of birth
- ZIP Code
- Gender
- Race/Ethnicity
- Primary language
- County

HSAG-Calculated Indicator Specifications

For the Preventive Services Report, HSAG was tasked with developing detailed measure specifications, including code sets, for three of the HSAG-calculated indicators. Although the detailed specifications are available in a separate document, the following is a high-level overview of the three HSAG-calculated indicators for which HSAG developed specifications.

Alcohol Use Screening

The *Alcohol Use Screening* indicator measures the percentage of children ages 18 to 21 years who had one or more screenings for alcohol use during the measurement year. The specifications for this indicator align with DHCS' value-based payment program specifications; however, HSAG added continuous enrollment and age determination criteria.

Dental Fluoride Varnish

The *Dental Fluoride Varnish* indicator measures the percentage of children 6 months of age as of January 1 of the measurement year to 5 years of age as of December 31 of the measurement year who had one or more applications of dental fluoride varnish administered by a medical provider during the measurement year. This indicator is also part of DHCS' value-based payment program.

Tobacco Use Screening

The *Tobacco Use Screening* indicator measures the percentage of children ages 12 to 21 years who had one or more screenings for tobacco use during the measurement year. The specifications for this indicator align with DHCS' value-based payment program specifications; however, HSAG added continuous enrollment and age determination criteria.

Analyses

Using the MCP-calculated and HSAG-calculated data sources, HSAG performed statewide-level, regional-level, and MCP reporting unit-level analyses for the applicable indicators. HSAG produced a formal report that presents statewide and regional results for the MCP-calculated and HSAG-calculated indicators, with MCP reporting unit-level results for select indicators presented in an addendum to the report in February 2021. Since the report is public-facing, HSAG suppressed results with small denominators (fewer than 30) or small numerators (fewer than 11).

Statewide-Level Analysis

HSAG calculated statewide rates for the three MCP-calculated MCAS indicators listed in Table B.1 and the six HSAG-calculated indicators listed in Table B.2. When available, HSAG also compared the statewide indicator rates to national benchmarks (e.g., the National Committee for Quality Assurance's [NCQA's] Quality Compass® national Medicaid Health Maintenance Organization percentiles) to contextualize statewide rates.[12]

HSAG also stratified the statewide indicator rates by the demographic stratifications outlined in Table B.3.

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

Table B.3—Statewide Stratifications

*Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of June 2017. All non-threshold languages were included in the "Other" primary language group.

Stratification	Groups
Demographic	
Race/ethnicity	Hispanic or Latino, White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other, and Unknown/Missing (see Table B.4 for more detail)
Primary language*	English, Spanish, Arabic, Armenian, Cambodian, Chinese (Mandarin or Cantonese), Farsi, Hmong, Korean, Russian, Tagalog, Vietnamese, Other, and Unknown/Missing
Age	Vary depending on indicator specifications (see Table B.1 and Table B.2 for more detail)
Gender	Male and Female

Table B.4 displays the individual racial/ethnic groups that comprise the Asian and Native Hawaiian or Other Pacific Islander racial/ethnic demographic stratifications. Racial/ethnic stratifications were based on data collection guidance from the federal Office of Management and Budget as well as the U.S. Department of Health and Human Services.

Table B.4—Asian and Native Hawaiian or Other Pacific Islander Racial/Ethnic Stratification Groups

*Some "Other Pacific Islanders" who would not be considered part of the Asian racial/ethnic group were included in the Asian racial/ethnic group due to limitations of existing data fields (i.e., the data do not allow HSAG to parse out racial/ethnic groups that may not be considered Asian).

Stratification	Groups
Asian	Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Laotian, Vietnamese, and Other Asian or Pacific Islander*
Native Hawaiian or Other Pacific Islander	Hawaiian, Guamanian, and Samoan

For the statewide-level analysis, HSAG presents the statewide rates for each MCP-calculated and HSAG-calculated indicator in separate tables for each indicator. Each table displays the numerators, denominators, and rates for all applicable demographic stratifications.

Regional-Level Analysis

HSAG also calculated regional-level rates for the three MCP-calculated MCAS indicators listed in Table B.1 and the six HSAG-calculated indicators listed in Table B.2. The regional stratifications are listed in Table B.5.

Table B.5—Regional Stratification Groups

*The Imperial and San Benito delivery models are not included in the delivery type model analysis since the rates for those models are represented in the county stratifications.

^ HSAG determined rural or urban population density based on the classification of ZIP Codes in the Rural-Urban Commuting Area Codes data created by the United States Department of Agriculture.

Stratification	Groups
County	Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba
Delivery Type Model*	County Organized Health Systems, Geographic Managed Care, Two-Plan (i.e., Local Initiative or Commercial Plan), Regional
Population Density^	Urban, Rural

For the regional analysis, HSAG presents the delivery type model-level, population density-level, and delivery system-level rates for each MCP-calculated and HSAG-calculated indicator in separate tables for each indicator. Each table displays the numerators, denominators, and rates. HSAG presents the county-level rates using a map of California which includes shading to indicate performance. To highlight regional performance differences, HSAG shaded each county using a color gradient based on how the rate for each county compared to the performance quintiles. For each indicator, HSAG calculated performance quintiles based on county performance (i.e., 20th percentile, 40th percentile, 60th percentile, and 80th percentile). HSAG then determined into which quintile each county fell (e.g., below the 20th percentile, between the 20th and 40th percentiles). HSAG shaded each county based on the corresponding quintiles as

displayed in Table B.6. Please note, HSAG shaded counties with numerators less than 11 or denominators less than 30 white to indicate the rate was suppressed.

Table B.6—Quintile Thresholds and Corresponding Colors

Quintile	Performance Thresholds and Corresponding Colors
NA	Small denominator or suppressed rate
Quintile 1 (least favorable rates)	Below the 20th percentile
Quintile 2	At or above the 20th percentile but below the 40th percentile
Quintile 3	At or above the 40th percentile but below the 60th percentile
Quintile 4	At or above the 60th percentile but below the 80th percentile
Quintile 5 (most favorable rates)	At or above the 80th percentile

MCP Reporting Unit-Level Analysis

HSAG calculated MCP reporting unit-level results for the following indicators:

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

The MCP reporting-unit level results will be included in an addendum to the 2020 Preventive Services Report in February 2021. HSAG included a member in an MCP reporting unit's rate calculation if the member met the indicator's continuous enrollment criteria with the MCP reporting unit. For the six HSAG-calculated indicators, HSAG calculated rates for the 56 MCP reporting units as displayed in Table B.7.

Table B.7—MCP Reporting Units

MCP Name	Reporting Units
Aetna Better Health of California	Sacramento, San Diego
Alameda Alliance for Health	Alameda
Blue Cross of California Partnership Plan, Inc., DBA Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Alameda, Contra Costa, Fresno, Kings, Madera, Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties), Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties), Sacramento, San Benito, San Francisco, Santa Clara, Tulare
Blue Shield of California Promise Health Plan (prior to January 1, 2019, known as Care1st Health Plan)	San Diego
California Health & Wellness Plan	Imperial, Region 1, Region 2
CalOptima	Orange
CalViva Health	Fresno, Kings, Madera
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey/Santa Cruz
Community Health Group Partnership Plan	San Diego
Contra Costa Health Plan	Contra Costa
Gold Coast Health Plan	Ventura
Health Net Community Solutions, Inc.	Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare
Health Plan of San Joaquin	San Joaquin, Stanislaus
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	Riverside/San Bernardino
Kaiser NorCal (KP Cal, LLC)	KP North (Amador, El Dorado, Placer, and Sacramento counties)
Kaiser SoCal (KP Cal, LLC)	San Diego
Kern Health Systems, DBA Kern Family Health Care, DBA Kern Family Health Care	Kern
L.A. Care Health Plan	Los Angeles

MCP Name	Reporting Units
Molina Healthcare of California	Imperial, Riverside/San Bernardino, Sacramento, San Diego
Partnership HealthPlan of California	Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity counties), Northwest (Del Norte and Humboldt counties), Southeast (Napa, Solano, and Yolo counties), Southwest (Lake, Marin, Mendocino, and Sonoma counties)
San Francisco Health Plan	San Francisco
Santa Clara Family Health Plan	Santa Clara
UnitedHealthcare Community Plan	San Diego

Caveats

Administrative Data Incompleteness

For the *Alcohol Use Screening* and *Tobacco Use Screening* indicators, the administrative rates may be artificially low due to a lack of reporting within administrative data sources (i.e., medical record review [MRR] or electronic health record [EHR] data could be necessary to capture this information).

Data Run Out

HSAG calculated all administrative measure rates using claims data provided by DHCS. DHCS provided a data refresh in September 2020; however, the eight-month run-out time period may not be sufficient for the data to be complete enough for measure calculation.

Demographic Characteristic Assignment

Members' demographic characteristics may change as their records are updated over time. For instance, a member may relocate and change ZIP Codes during the reporting year. HSAG assigned demographic characteristics using the most recent non-missing record for each member. Therefore, members' assigned demographic characteristics may not always reflect their demographic characteristics at the time of the indicator events.

Discrepancies with the EQR Technical Report

While the 3 to 6 Years and 12 to 21 Years age groups for *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicators follow the HEDIS measure specifications for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Adolescent Well-Care Visits*, and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* indicators, respectively, the HSAG-calculated indicator rates will not match rates reported in the EQR technical report, since the EQR technical report presents weighted statewide rates derived from MCPs' reported MCAS rates. HSAG calculated administrative rates for the 3 to 6 Years and 12 to 21 Years age groups for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicators for use in this report, while the rates for their corresponding HEDIS 2020 indicators in the EQR technical report were based on the hybrid rates reported by most MCPs.

Indicator Specification Development

HSAG developed specifications for *Alcohol Use Screening*, *Dental Fluoride Varnish*, and *Tobacco Use Screening* in alignment with DHCS' value-based purchasing model without testing the frequency of the codes billed to indicate numerator compliance. As a result, the rates for these indicators may be incomplete due to provider billing practices.