Preventive Services Utilization Report

To evaluate utilization of preventive services and assess for appropriate utilization

Report Overview

- Adult and Pediatric Preventive Services
- Metrics
  - Defining metrics for inclusion will rely on continued assessment
  - Metric Technical Specifications will be developed
  - Avoid duplicative metric reporting
  - Align with existing metrics where possible
- Encounter data will be used to calculate the measures

Preliminary Methodology

- Metrics to identify rate of well visit that occurred at each recommended interval
- Well visit intervals and 60 services recommended at those visits across AAP Bright Futures and USPSTF Grade A & B assessed.
  - 7 services covered via Core Set
  - 24 services able to be assessed from Encounter Data
  - 29 services not able to be assessed from Encounter Data

Metrics Considerations

Pediatric

1. Well Visits by Interval (multiple metrics)
2. Blood pressure
3. Vision Screening
4. Hearing Screening
5. Autism Spectrum Disorder Screening
6. Tobacco, Alcohol, Drug Use Assessment
7. Maternal Depression Screening
8. Immunizations (multiple metrics)
9. Anemia Screening
10. Lead Screening
11. Dyslipidemia Screening
12. HIV Screening
13. Fluoride Varnish Application

Adult

1. AAA Screening
2. Blood Pressure
3. Colorectal Cancer Screening
4. Diabetes Screening
5. Gonorrhea Screening
6. Hep C Screening
7. HIV Screening
8. Lung Cancer Screening
9. Osteoporosis Screening
10. Tobacco use counseling and interventions
11. Unhealthy alcohol use screening

DHCS will review metrics for feasibility

Future Utilization Reports

- Metrics will adjust depending on changes to CMS Core Set or other available metrics
- Data from medical record reviews could be used to assess care not captured through Encounter Data
- Performance benchmarks can be set for metrics
- Trending will be analyzed
- Develop a Managed Care Plan (MCP) level Corrective Action Plan (CAP)/sanction process

Access Assessment Report

Based on network adequacy requirements, showing beneficiaries' access to Medi-Cal Managed Care services.

Background

- Required by California's Section 1115(a) Medicaid Waiver
- DHCS contracted with Health Services Advisory Group (HSAG) to conduct the Assessment
- DHCS and HSAG developed the Assessment Design and formed an Advisory Committee in 2016
- CMS approved the Assessment Design in 2017

Assessment Objectives

1. To assess Medi-Cal managed care health plan (MCP) network adequacy and performance for managed care beneficiaries
2. To assess MCP network compliance with established network standards and timely access requirements
3. To assess compliance with network adequacy requirements across MCPs and lines of business
4. To compare the State's current network monitoring program to the requirements outlined in the Medicaid and CHIP managed care final rule (42 CFR 438)

Access Assessment Framework

Network Performance Measures by Access Dimensions

Network Capacity

- Physician ratios
- Provider statistics

Geographic Distribution

- Time/distance analysis
- Network adequacy

Availability of Services

- Utilization of services
- Appointment availability
- Grievances and appeals/complaints

Network Capacity

- Statewide, between 48% to 62% of non-facility-based providers were active (defined as having provided services to an MCP beneficiary)
- The active rate for facility-based providers was 20%
- Beneficiaries residing in less densely populated regions of the state may face greater challenges accessing health care providers

Network Capacity (continued)

- There seem to be more PCP providers in more densely populated regions
- Results may indicate MCPs are actively pursuing PCP providers in less densely populated regions in order to ensure service availability in those areas
- A large portion of the pediatric PCP providers were OB/GYN specialists

Geographic Distribution

- Most MCPs met the appropriate time/distance standards for at least 99 percent of their beneficiaries
  - 15 miles/30 minutes for KKA
  - 10 miles/30 minutes for MCMC contracts
    - Inpatient - Only 4 MCPs had less than 99% of beneficiaries within the standard
    - Outpatient - Only 2 MCPs had fewer than 99% of beneficiaries within the standard
    - New Patients - Only 2 MCPs had fewer beneficiaries within the standard who were accepting new patients
    - Core Specialty – Beneficiaries in rural and small density regions faced substantially longer time/distance to core specialty providers
  - Beneficiaries residing in less densely populated regions of the state may face greater challenges accessing health care providers

Availability of Services – Utilization

- Telehealth Services
  - Relatively low utilization for adult beneficiaries and almost non-existent for pediatric beneficiaries
  - Primarily in rural and small urbanicity regions
- Non-emergency non-medical transportation
  - Utilized more in densely population regions and less in sparsely populated regions
- Rural regions exhibited lower performance for HEDIS measures
- Rural regions had a higher rate of ambulatory ED visits

Results Summary

- The results of the Access Assessment suggest there are no critical access issues requiring immediate attention
- There are a handful of areas where individual MCPs did not meet standards, but no single MCP consistently performed poorly

Next Steps

- Report to be posted by the end of July
- Once posted on DHCS' website, there will be a 30-day public comment period.