

*Volume 1 of 3*  
**Medi-Cal Managed Care External  
Quality Review Technical Report**  
*July 1, 2018–June 30, 2019*

*Main Report*

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

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## Commonly Used Abbreviations and Acronyms

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

- ◆ **A&I**—Audits and Investigations Division
- ◆ **AHRQ**—Agency for Healthcare Research and Quality
- ◆ **APL**—All Plan Letter
- ◆ **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems<sup>1</sup>
- ◆ **CAP**—corrective action plan
- ◆ **CATI**—computer-assisted telephone interviewing
- ◆ **CCC**—Children with Chronic Conditions
- ◆ **CCI**—Coordinated Care Initiative
- ◆ **CDPH**—California Department of Public Health
- ◆ **CFR**—Code of Federal Regulations
- ◆ **CHIP**—Children’s Health Insurance Program
- ◆ **CMB**—California Medical Board
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **COHS**—County Organized Health System
- ◆ **DHCS**—California Department of Health Care Services
- ◆ **DMC plan**—dental managed care plan
- ◆ **DMHC**—California Department of Managed Health Care
- ◆ **EAS**—External Accountability Set
- ◆ **ECDS**—Electronic Clinical Data Systems
- ◆ **EQR**—external quality review
- ◆ **EQRO**—external quality review organization
- ◆ **FCC**—Family-Centered Care
- ◆ **FFS**—fee-for-service
- ◆ **FMEA**—failure modes and effects analysis
- ◆ **GMC**—Geographic Managed Care
- ◆ **HEDIS®**—Healthcare Effectiveness Data and Information Set<sup>2</sup>
- ◆ **HMO**—health maintenance organization
- ◆ **HPSA**—Health Professional Shortage Area
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **IP**—improvement plan

<sup>1</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

<sup>2</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **IS**—information systems
- ◆ **LARC**—Long-Acting Reversible Contraceptive
- ◆ **MCAS**—Medi-Cal Accountability Set
- ◆ **MCMC**—Medi-Cal Managed Care
- ◆ **MCO**—managed care organization
- ◆ **MCP**—managed care health plan
- ◆ **MLTSS**—Managed Long-Term Services and Supports
- ◆ **MLTSSP**—Managed Long-Term Services and Supports Plan
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **Non-SPD**—Non-Seniors and Persons with Disabilities
- ◆ **OB/GYN**—obstetrics/gynecology
- ◆ **PAHP**—prepaid ambulatory health plan
- ◆ **PCCM**—primary care case management
- ◆ **PCP**—primary care provider
- ◆ **PDSA**—Plan-Do-Study-Act
- ◆ **PIHP**—prepaid inpatient health plan
- ◆ **PIP**—performance improvement project
- ◆ **PSP**—population-specific health plan
- ◆ **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- ◆ **QIP**—quality improvement project
- ◆ **SFY**—State Fiscal Year
- ◆ **SHP**—specialty health plan
- ◆ **SMART**—Specific, Measurable, Achievable, Relevant, and Time-bound
- ◆ **SNF/ICF**—Skilled Nursing Facility/Intermediate Care Facility
- ◆ **SPD**—Seniors and Persons with Disabilities
- ◆ **TPM**—Two-Plan Model
- ◆ **WIC**—Welfare and Institutions Code

## 1. Executive Summary

As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364 and §457.1250,<sup>3</sup> the California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access and quality of care for the Medicaid and Children's Health Insurance Program (CHIP) populations, including:

- ◆ A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.
- ◆ For each external quality review (EQR)-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- ◆ An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- ◆ Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- ◆ Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- ◆ An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR in accordance with §438.364(a)(6).

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<sup>3</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. Accessed on: Dec 2, 2019.

The review period for this *2018–19 Medi-Cal Managed Care External Quality Review Technical Report* is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond this report's review period in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*.

Title 42 CFR §438.2 defines an MCO, in part, as “an entity that has or is seeking to qualify for a comprehensive risk contract.” The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as PAHPs. DHCS designates two of its MCOs as population-specific health plans (PSPs). DHCS' Medi-Cal Managed Care (MCMC) program has one contracted MCO and one PIHP with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable), DHCS' PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. This report will sometimes collectively refer to these Medi-Cal managed care plans as “MCMC plans.”

MCMC provides managed health care services to more than 11 million beneficiaries (as of June 2019)<sup>4</sup> in the State of California through a combination of contracted MCPs, SHPs, PSPs, and DMC plans. During the review period, DHCS contracted with 25 MCPs,<sup>5</sup> two PSPs, and two SHPs to provide health care services in all 58 counties throughout California. Additionally, DHCS contracted with three DMC plans that each operate in Los Angeles and Sacramento counties. A summary of HSAG's assessment of performance and notable results for the July 1, 2018, through June 30, 2019, review period follows.

## Summary of Performance

### *Medi-Cal Managed Care Quality Strategy*

During the review period for this EQR technical report, DHCS' Medical Director Karen Mark, MD, PhD, conducted a presentation for the DHCS Stakeholder Advisory Committee to update the committee on DHCS' comprehensive quality strategy.

The comprehensive quality strategy outlines DHCS' process for developing and maintaining a broader quality strategy to assess the quality of care that all beneficiaries receive, regardless of the delivery system. The strategy defines measurable goals and tracks improvement while adhering to the regulatory managed care requirements outlined in 42 CFR §438.340. The comprehensive quality strategy covers all Medi-Cal managed care delivery systems, including the Medi-Cal managed care plans, county mental health plans, Drug Medi-Cal Organized

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<sup>4</sup> *Medi-Cal Managed Care Enrollment Report*. Available at: <https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report>. Enrollment information is based on the report downloaded on July 26, 2019.

<sup>5</sup> Note: HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS holds just one contract with Kaiser (KP Cal, LLC).

Delivery System, and the dental managed care plans, as well as non-managed care departmental programs. In addition to providing a summary of the comprehensive quality strategy report structure and content, Dr. Mark presented information about the sources DHCS used to develop the CA DHCS comprehensive quality strategy and DHCS' quality improvement infrastructure.

In November 2019, DHCS posted the *State of California Department of Health Care Services Comprehensive Quality Strategy Draft Report for Public Comment*. DHCS plans to release the final version of the comprehensive quality strategy report in early 2020.

## Compliance Reviews

### Managed Care Health Plans, Population-Specific Health Plans, and Specialty Health Plans

In accordance with California Welfare and Institutions Code (CA WIC) §19130(b)(3), DHCS directly conducts compliance reviews of MCPs, PSPs, and SHPs, rather than contracting with the EQRO to conduct reviews on its behalf. HSAG identified the following notable conclusions based on HSAG's review and assessment of all relevant compliance-related documents provided by DHCS (i.e., audit reports, corrective action plan [CAP] responses, and final closeout letters):

- ◆ Findings identified during DHCS Audits & Investigations Division (A&I) audits reflected opportunities for improvement for MCPs, PSPs, and SHPs in the areas of quality and timeliness of, and access to health care.
- ◆ Audit findings within the assessed areas were MCP-, PSP-, and SHP-specific; therefore, HSAG identified no areas for improvement that spanned across all plans.
- ◆ As in previous years, DHCS demonstrated ongoing efforts to follow up on findings as evidenced in the audit reports, CAP responses, and final closeout letters that DHCS submitted to HSAG for review.

### Dental Managed Care Plans

At least once every three years, the Department of Managed Health Care (DMHC) conducts Routine Surveys with DMC plans to assess the plans' compliance with the Knox-Keene Health Care Service Plan Act of 1975 requirements. Additionally, through Interagency Agreement 13-90172 with DHCS, DMHC assesses DMC plans' compliance with the Medi-Cal Dental Managed Care Program Contract as part of DMHC's Routine Surveys. In May 2019, DHCS A&I began conducting its own surveys to assess DMC plan compliance. DHCS A&I audits will eventually replace the DMHC Routine Surveys. The first of DHCS' A&I audits will be reported in the 2019–20 EQR technical report. Based on the DMC plan compliance reviews being in transition from DMHC to DHCS A&I, HSAG drew no conclusions from the compliance review information provided by DHCS as part of this EQR technical report production.

## Performance Measures

HSAG auditors determined that all MCPs, PSPs, SHPs, and Managed Long-Term Services and Supports Plans (MLTSSPs) followed the appropriate performance measure specifications to produce valid rates. DHCS provided HSAG with audited performance measure rates for the DMC plans. As applicable, HSAG conducted analyses of MCMC plans' performance measure results, including performance comparisons between reporting year 2018 and reporting year 2019 using the Chi-square test of statistical significance.<sup>6</sup>

### Medi-Cal Managed Care Health Plans<sup>7</sup>

HSAG observed the following notable aggregate performance measure results for reporting year 2019:

- ◆ For measures for which DHCS held MCPs accountable to meet the minimum performance levels, all MCMC weighted averages were above the minimum performance levels in reporting year 2019.
- ◆ For measures which HSAG included in the performance measure analyses, the MCMC weighted averages for 14 of 19 measures (74 percent) improved significantly from reporting year 2018 to reporting year 2019.
- ◆ The reporting year 2019 MCMC weighted averages were significantly worse than the reporting year 2018 MCMC weighted averages for the following measures:
  - *Asthma Medication Ratio*
  - *Use of Imaging Studies for Low Back Pain*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

### Population-Specific Health Plans and Specialty Health Plans

For PSP and SHP performance measure rates for which a comparison could be made between reporting year 2018 and reporting year 2019, no statistically significant changes occurred. Additionally, all PSP and SHP performance measure rates for performance measures with established minimum performance levels in reporting year 2019 were above the minimum performance levels.

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<sup>6</sup> Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

<sup>7</sup> Note that HSAG's assessment related to performance measures does not include measures for which MCPs were not held accountable to meet the minimum performance levels in reporting year 2019.

## Managed Long-Term Services and Supports Plans

MLTSSPs reported rates for three measures in reporting year 2019. Two of the measures were utilization measures for which higher or lower rates do not necessarily indicate better or worse performance; therefore, HSAG only conducted comparative analysis on one of the measures—*Medication Reconciliation Post-Discharge*. The MCMC weighted average for the *Medication Reconciliation Post-Discharge* measure remained consistent, showing no statistically significant change from reporting year 2018 to reporting year 2019.

## Dental Managed Care Plans

Reporting year 2019 was the first year that DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year data from the previous calendar year (i.e., January 1, 2018, through December 31, 2019); therefore, HSAG could not compare the reporting year 2019 DMC plans' performance measure rates to historical data or DHCS' encounter data, or make conclusions regarding the results.

## Performance Improvement Projects

During the review period, all MCPs, PSPs, and SHPs achieved the required criteria for modules 1, 2, and 3 for their 2017–19 Disparity and DHCS-priority performance improvement projects (PIPs); conducted intervention testing for both PIPs; concluded the PIPs by June 30, 2019; and were on schedule to submit modules 4 and 5 for HSAG's validation by their due dates in September 2019 and October 2019.

Through HSAG's PIP training and technical assistance, DMC plans completed their first intervention progress report for the *Preventive Services Utilization* statewide quality improvement project (QIP) and received HSAG's feedback on their interventions. Additionally, DMC plans selected their individual PIP topics and obtained pertinent information to initiate their 2019–21 rapid-cycle PIPs.

## Validation of Network Adequacy

To assist DHCS with assessing and ensuring network adequacy across contracted MCPs, PSPs, and SHPs, DHCS contracted with HSAG on the following network adequacy activities:

- ◆ Alternative Access Reporting
- ◆ Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) Experience Reporting
- ◆ Timely Access Focused Study

The following are summaries of notable results and conclusions from the network adequacy activities that HSAG concluded prior to producing the final version of this EQR technical report.

## Alternative Access Reporting

As part of DHCS' ongoing monitoring and oversight of MCPs, PSPs, and SHPs, DHCS ensures that MCPs', PSPs', and SHPs' provider networks are adequate to deliver services to beneficiaries. If providers are unavailable or unwilling to service Medi-Cal beneficiaries such that an MCP, PSP, or SHP is unable to meet provider network standards, MCPs, PSPs, and SHPs may request that DHCS allow an alternative provider network access standard for specified provider scenarios (e.g., provider type, geographic area). The DHCS All Plan Letter (APL) 19-002<sup>8</sup> provides MCPs, PSPs, and SHPs with DHCS' clarifying guidance regarding network certification requirements, including requests for alternative access standards.

CA WIC §14197.05<sup>9</sup> requires DHCS' annual EQR technical report to present information related to MCPs' alternative access standard requests. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to process and report on data related to alternative access standards for MCP provider networks.

During the review period, MCPs submitted to DHCS 62,731 alternative access standard requests, and 16,497 distinct combinations of request characteristics appeared in the data supplied by DHCS. Of the distinct combinations of request characteristics, 9,557 or 57.9 percent resulted in an approval from DHCS.

HSAG also conducted analyses related to the following:

- ◆ Distance and driving time between the nearest network provider and furthest beneficiary
- ◆ Time frame for approval or denial of requests
- ◆ Consumer complaints
- ◆ MCPs' processes of ensuring out-of-network access
- ◆ MCPs' contracting efforts

Summaries of the analyses can be found in Section 13 of this report ("Validation of Network Adequacy"). The complete results of the analyses can be found in Appendix GG.

## Skilled Nursing Facilities/Intermediate Care Facilities

CA WIC §14197.05 requires DHCS' annual EQR technical report to present information related to the experience of individuals placed in SNFs/ICFs and the distance that these individuals are placed from their residences.

<sup>8</sup> All Plan Letter 19-002. Available at: <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-002.pdf>. Accessed on: Jan 9, 2020.

<sup>9</sup> CA WIC §14197.05. Available at: [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05). Accessed on: Jan 9, 2020.

HSAG attempted, in collaboration with DHCS, to assess the distance between beneficiaries' places of residence and the SNFs/ICFs in which they were placed during the July 1, 2018, through June 30, 2019, measurement period using data supplied by DHCS to compile the geospatial results by applicable MCP and by CCI or COHS county.

At the time that this EQR technical report was produced, HSAG verified that administrative claims/encounter data would not reliably support the planned analyses to align with CA WIC §14197.05. As a result of data-related limitations, HSAG is working with DHCS to pursue an alternate data source for future SNF/ICF Experience Reporting.

### **Timely Access Focused Study**

Beginning in contract year 2016–17, DHCS contracted with HSAG to conduct an annual focused study to evaluate the extent to which MCPs are meeting urgent and non-urgent wait time standards. Starting in contract year 2018–19, DHCS contracted with HSAG to expand the scope of the Timely Access Focused Study to evaluate the extent to which providers are aware of interpretation service requirements. Additionally, the 2018–19 Timely Access Focused Study evaluated the extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and knowledge of interpretation service requirements. Following are summaries of the notable 2016–17 and 2018–19 contract year results (referred to as Year 1 and Year 2 of the study, respectively).

#### ***Results—Year 1 Timely Access Focused Study***

During Year 1 of the Timely Access Focused Study, HSAG obtained at least one non-urgent appointment time from 6,289 of 13,706 (45.9 percent) providers and at least one urgent appointment time from 3,941 of 9,143 (43.1 percent) providers included in the telephone survey. Of the providers for which HSAG obtained at least one appointment time, 88.4 percent of the non-urgent appointment times and 81.7 percent of the urgent appointment times met DHCS' wait time standards.

#### ***Results—Year 2 Timely Access Focused Study***

At the time that this EQR technical report was produced, results from the first three quarters of Year 2 were available (i.e., January through March 2019, April through June 2019, and July through September 2019). During the first three quarters of Year 2, HSAG obtained at least one non-urgent appointment time from 6,091 of 11,532 providers (52.8 percent) and at least one urgent appointment time from 3,592 of 7,657 providers (46.9 percent) included in the telephone survey. Of the providers for which HSAG obtained at least one appointment time, 86.9 percent of the non-urgent appointment times and 76.9 percent of the urgent appointment times met DHCS' wait time standards. Additionally, during the first three quarters of Year 2, HSAG made calls to each MCP's call center; of the 1,320 total calls placed, 94.0 percent met the wait time standard of 10 minutes.

For both Year 1 and Year 2, the primary reasons HSAG did not obtain at least one appointment time from providers were that both call attempts made during open hours were either not answered or were answered by answering machines.

Note that HSAG makes no comparisons between Year 1 and Year 2 Timely Access Focused Study results based on the Year 2 results in this report only including data covering the first three quarters of calendar year 2019. In the 2019–20 EQR technical report, HSAG will include the final Year 2 results along with applicable comparisons to the Year 1 results.

## Consumer Surveys

During the review period, HSAG administered the standardized survey instrument Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) Children with Chronic Conditions (CCC) measurement sets to a statewide sample of CHIP beneficiaries enrolled in MCPs, and the standardized survey instrument CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set to adult beneficiaries and parents or caretakers of child beneficiaries enrolled in MCPs.

### Children’s Health Insurance Program Survey

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

#### General Child Population

- ◆ The 2019 score was statistically significantly higher than the 2018 score for the *Rating of Personal Doctor* global rating.
- ◆ The following reportable global ratings measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Rating of Health Plan*
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
- ◆ The following reportable composite measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
  - *Customer Service*
- ◆ The following reportable composite measures scored below the NCQA national 25th percentiles:
  - *Getting Care Quickly*
  - *Shared Decision Making*

### **Children with Chronic Conditions Population**

- ◆ The 2019 scores were statistically significantly higher than the 2018 scores for the following reportable global ratings measures:
  - *Rating of Personal Doctor*
  - *Rating of Specialist Seen Most Often*
- ◆ The 2019 scores were statistically significantly higher than the 2018 scores for the following reportable composite measures:
  - *Getting Care Quickly*
  - *Shared Decision Making*
- ◆ The reportable *Rating of Specialist Seen Most Often* measure scored above the NCQA national 90th percentile.
- ◆ The following reportable global ratings measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Rating of Health Plan*
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
- ◆ The following reportable composite measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Getting Needed Care*
  - *Customer Service*
  - *Shared Decision Making*
- ◆ The reportable *Access to Prescription Medicines* CCC composite measure and item scored above the NCQA national 25th percentile but below the 90th percentile.
- ◆ The following reportable composite measures scored below the NCQA national 25th percentiles:
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
- ◆ The following reportable CCC composite measures and items scored below the NCQA national 25th percentiles:
  - *Family-Centered Care (FCC): Personal Doctor Who Knows Child*
  - *FCC: Getting Needed Information*

### **Medicaid Managed Care Survey**

The adult State weighted rates were below the 2018 NCQA adult Medicaid national 25th percentiles for all measures except *Rating of Specialist Seen Most Often*. The child State weighted rates were below the 2018 NCQA child Medicaid national 25th percentiles for all measures except *Rating of Specialist Seen Most Often* and *Customer Service*.

Based on 2019 CAHPS performance across all MCPs, MCPs have the greatest opportunities for improvement on the *Getting Care Quickly*, *Getting Needed Care*, and *How Well Doctors*

*Communicate* measures. Low performance in these areas may point to issues with access to and timeliness of care, as well as communication from providers to members. Note that the experiences of the survey respondent population may differ from those of nonrespondents with respect to their health care services and may vary by MCP. Therefore, the potential for nonresponse bias should be considered when interpreting CAHPS results.

## **Encounter Data Validation**

HSAG conducted the State Fiscal Year (SFY) 2018–19 Encounter Data Validation (EDV) Study to evaluate MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2017, and December 31, 2017, for the 23 MCPs, one PSP, and one SHP included in the study. HSAG assessed the following data elements:

- ◆ *Date of Service*
- ◆ *Diagnosis Code*
- ◆ *Procedure Code*
- ◆ *Procedure Code Modifier*
- ◆ *Rendering Provider Name*

The following are summaries of the key findings from the study.

### **Encounter Data Completeness**

Omissions identified in the medical records (services located in the encounter data but not supported in the medical records) and omissions in the encounter data (services located in the medical records but not in the encounter data) illustrate discrepancies in completeness of DHCS' encounter data. Overall, DHCS' encounter data are relatively complete for the key data elements when compared to the medical records. Below are some significant findings:

- ◆ Among the five data elements assessed for this study, two data elements (i.e., *Date of Service* and *Rendering Provider Name*) had medical record omission rates (services located in the encounter data but not supported in the medical records) of less than 10 percent, which met the EDV study standard. For the remaining three data elements, DHCS encounters were moderately supported by the documentation in the beneficiaries' medical records.
- ◆ Three data elements (i.e., *Date of Service*, *Procedure Code*, and *Procedure Code Modifier*) each had an encounter data omission rate (services located in the medical records but not in the encounter data) of less than 10 percent, which met the EDV study standard. The remaining two data elements had moderate encounter data omission rates.
- ◆ Only the *Date of Service* data element met the EDV study standard for both the medical record omission rate and the encounter data omission rate.

## Encounter Data Accuracy

- ◆ Among the four data elements evaluated for accuracy, three data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) had an accuracy rate greater than 90 percent, which met the EDV study standard. Statewide, 63.5 percent of rendering provider names identified in the electronic encounter data were supported by medical record documentation.
- ◆ Nearly one third (i.e., 30.7 percent) of the dates of service present in both data sources contained matching values for all four key data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Rendering Provider Name*). This number increased to 60.1 percent when the matched values included three data elements—*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*.

When comparing results from the SFY 2017–18 medical record review activity with the 2018–19 results, the extent to which the statewide results met the EDV standards remained the same.

## Focused Studies

During the review period, HSAG conducted focused studies on the following topics to assist DHCS in gaining better understanding of and identifying opportunities for improving care provided to MCMC beneficiaries:

- ◆ Health Disparities
- ◆ Opioid Use

The following are summaries of HSAG’s notable conclusions from the focused studies that HSAG either concluded during the review period or for which HSAG had concluded the analyses and finalized the reports prior to producing the final version of this EQR technical report.

### 2016–17 Medi-Cal Health Disparities Analysis

HSAG conducted the 2016–17 Medi-Cal Health Disparities Analysis on health care disparities in the MCMC population using reporting year 2017 External Accountability Set (EAS) measure rates reported by the 23 full-scope MCPs included in the study. HSAG evaluated the reporting year 2017 EAS measure data at the statewide level. For the 26 EAS measures included in the study, HSAG aggregated the results from the 23 full-scope MCPs to calculate statewide rates for all EAS measures and then stratified these statewide rates by race/ethnicity, primary language, age, and gender. The following are the overall conclusions for the 2016–17 Medi-Cal Health Disparities Analysis:

- ◆ The rates for the Black or African American group were worse than those for the White group for 38 percent of measures in the analysis.
  - All 10 measures for which the Black or African American group rates were worse than those for the White group were related to health outcomes or access to care.

- ◆ The rates for the Native Hawaiian or Other Pacific Islander group and the American Indian or Alaska Native group were worse than those for the White group for 32 percent and 15 percent, respectively, of measures in the analysis.
- ◆ The rates for the Asian group were better than the rates for the White group for 65 percent of the measures included in the analysis.

### 2017–18 Medi-Cal Health Disparities Analysis

For the 2017–18 Medi-Cal Health Disparities Analysis, HSAG evaluated a set of measures at the statewide level, comprised of 28 reporting year 2018 EAS measures; and two measures from the 2017–18 Tobacco Cessation Focused Study and the 2017–18 Long-Acting Reversible Contraceptive (LARC) Utilization Focused Study, both of which DHCS contracted with HSAG to conduct. HSAG aggregated results from the 23 full-scope MCPs included in the study<sup>10</sup> and then stratified the statewide rates for the 30 measures by race/ethnicity, primary language, age, and gender. Although HSAG stratified all study measures by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. The following are the overall conclusions for the 2017–18 Medi-Cal Health Disparities Analysis:

- ◆ The rates for the Black or African American group were worse than those for the White group for approximately 46 percent of measures in the analyses.
  - All 13 measures for which the Black or African American group rates were worse than those for the White group were related to health outcomes or access to care.
- ◆ The rates for the American Indian or Alaska Native group and Native Hawaiian or Other Pacific Islander group were worse than those for the White group for approximately 36 percent and 19 percent, respectively, of measures in the analyses.
- ◆ The rates for the Asian group and Hispanic or Latino group were better than the rates for the White group for approximately 64 percent and 57 percent, respectively, of measures in the analyses.

### Opioid Focused Study

During contract year 2017–18, DHCS contracted with HSAG to conduct an evaluation of opioid use and medication assisted treatment within the State’s MCMC population to determine the need and capacity for addressing opioid overuse. Based on HSAG’s calculation of measures related to the need and capacity for treatment of opioid abuse covering the period of July 1, 2016, through June 30, 2017, HSAG identified the following notable highlights:

- ◆ The low rates observed for the Out-of-Network Buprenorphine Providers measure suggest that the MCPs have included most waived buprenorphine providers in their networks’ geographic regions.

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<sup>10</sup> Note that the *Tobacco Cessation Therapy Use* measure also includes results from one PSP and one SHP.

- ◆ For treatment need measures, eight MCPs had rates at least 10 percent greater than the statewide weighted averages for three or more measures and therefore may have a greater proportion of their populations at increased risk of opioid abuse than other MCPs.
- ◆ Twenty counties had rates for treatment need measures at least 10 percent greater than the statewide weighted averages for four or more measures, suggesting a larger proportion of the population was at increased risk of opioid abuse than in other counties.
- ◆ For treatment capacity measures, only two MCPs had rates at least 20 percent less than the statewide weighted averages on three or more measures (excluding the Out-of-Network Buprenorphine Providers measure). These results suggest that additional research may be necessary.

## **Technical Assistance**

The following are summaries of HSAG's notable conclusions from the technical assistance activities that HSAG conducted during the review period.

### **Technical Assistance Activity for Performance Measures**

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each technical assistance session to ensure the most efficient provision of technical assistance with the greatest likelihood of resulting in enhanced skills and, ultimately, improved performance. As a result of the technical assistance that HSAG provided to DHCS, MCPs, PSPs, and SHPs:

- ◆ DHCS found HSAG's secondary review of Plan-Do-Study-Act (PDSA) cycles and CAPs helpful as it reinforced DHCS' findings and created synergy to provide optimal recommendations to MCPs.
- ◆ MCPs under CAPs became more proficient conducting the rapid-cycle PIP process.
- ◆ MCPs and DHCS gained the most accurate and up-to-date information regarding the two *Depression Screening and Follow-Up for Adolescents and Adults* measures.
- ◆ DHCS has a better understanding of performance measures, which will enable DHCS to make informed decisions regarding future performance measure requirements.
- ◆ DHCS has more in-depth understanding of the various performance measure validation and consumer survey activities.
- ◆ DHCS obtained descriptions of network adequacy work that HSAG has previously conducted, which will assist DHCS in making decisions regarding future network adequacy activities it may want HSAG to conduct.
- ◆ DHCS enhanced its understanding of EQRO activities.

## **Technical Assistance Activity for Quality Improvement Collaboration**

Under the Technical Assistance Activity for Quality Improvement Collaboration, HSAG coordinated with DHCS to plan and facilitate quarterly collaborative discussions with MCPs, PSPs, and SHPs to support MCPs', PSPs', and SHPs' quality improvement efforts. MCPs, PSPs, and SHPs actively participated in the collaborative discussions by asking presenters questions and sharing about their own experiences, challenges, and lessons learned. The post-collaborative discussion surveys revealed that MCPs, PSPs, and SHPs found presentations to be helpful and applicable to their current and future quality improvement work.

## **Recommendations across All Assessed Activities**

As part of the EQR technical report production process, HSAG identified no recommendations for DHCS. Plan-specific recommendations, as applicable, are included in appendices A through FF.

## Purpose of Report

As required by 42 CFR §438.364,<sup>11</sup> DHCS contracts with HSAG, an EQRO, to prepare an annual, independent, technical report that summarizes findings on access and quality of care related to the health care services provided by MCMC plans.

Note: Title 42 CFR §438.2 defines an MCO, in part, as “an entity that has or is seeking to qualify for a comprehensive risk contract.” CMS designates DHCS-contracted MCPs as MCOs and DMC plans as PAHPs. DHCS designates two of its MCOs as PSPs. MCMC has one contracted MCO and one PIHP with specialized populations, which DHCS designates as SHPs. Unless citing Title 42 CFR, this report refers to DHCS’ MCOs as MCPs or PSPs (as applicable), DHCS’ PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. This report will sometimes collectively refer to these Medi-Cal managed care plans as “MCMC plans.”

As described in the CFR, the independent report must summarize findings on access and quality of care for the Medicaid and CHIP populations, including:

- ◆ A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.
- ◆ For each EQR-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- ◆ An assessment of each MCO, PIHP, PAHP, or PCCM entity’s strengths and weaknesses for the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- ◆ Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the

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<sup>11</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, 438, et al. Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. Accessed on: Dec 2, 2019.

quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.

- ◆ Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- ◆ An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

## Quality, Access, and Timeliness

CMS requires that the EQR evaluate the performance of MCOs, PIHPs, PAHPs, and PCCM entities related to the quality and timeliness of, and access to care delivered by the MCOs, PIHPs, PAHPs, and PCCM entities. §438.320 indicates that quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through:

- ◆ Its structural and operational characteristics.
- ◆ The provision of services consistent with current professional, evidence-based knowledge.
- ◆ Interventions for performance improvement.

Additionally, §438.320 indicates that access, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).

This report includes conclusions drawn by HSAG related to MCMC plans' strengths and weaknesses with respect to the quality and timeliness of, and access to the health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). While quality, access, and timeliness are distinct aspects of care, most MCMC plan activities and services cut across more than one area. Collectively, all MCMC plan activities and services affect the quality, access, and timeliness of care delivered to beneficiaries. In this report, when applicable, HSAG indicates instances in which MCMC plan performance affects one specific aspect of care more than another.

## Summary of Report Content

This report provides:

- ◆ An overview of Medi-Cal Managed Care.
- ◆ A description of DHCS' annual MCMC quality strategy.
- ◆ A description of the scope of EQR activities for the period of July 1, 2018, through June 30, 2019, including the methodology used for data collection and analysis; a description of the

data for each activity; and an aggregate assessment of MCMC plan performance related to each activity, as applicable.

- ◆ A description of HSAG’s assessment related to the four federally mandated EQR-related activities; three of the six optional EQR-related activities; and the technical assistance provided to MCMC plans as set forth in 42 CFR §438.358:
  - Mandatory activities:
    - Health plan compliance reviews
    - Validation of performance measures
    - Validation of PIPs
    - Validation of network adequacy
  - Optional activities:
    - Administration of consumer surveys
    - Encounter data validations
    - Focused studies
  - Technical assistance
- ◆ MCMC plan-specific evaluation reports, included as appendices (A through FF). Each MCMC plan-specific evaluation report provides an assessment of the MCMC plan’s strengths and weaknesses with respect to the quality and timeliness of, and access to health care services as well as recommendations to the MCMC plan for improving quality of health care services for beneficiaries.

The EQR technical report and MCMC plan-specific evaluation reports all align to the same review period—July 1, 2018, through June 30, 2019.

## Medi-Cal Managed Care Overview

In the State of California, DHCS administers the Medicaid program (Medi-Cal) through its fee-for-service (FFS) and managed care delivery systems. In California, the CHIP population is included in Medi-Cal.

MCMC provides managed health care services to more than 11 million beneficiaries (as of June 2019)<sup>12</sup> in the State of California through a combination of contracted MCPs, PSP, SHPs, and DMC plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its MCMC plans, making improvements to care and services, and ensuring that MCMC plans comply with federal and State standards.

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<sup>12</sup> *Medi-Cal Managed Care Enrollment Report*. Available at: <https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report>. Enrollment information is based on the report downloaded on July 26, 2019.

During the review period, DHCS contracted with 25 MCPs,<sup>13</sup> two PSPs, and two SHPs to provide health care services in all 58 counties throughout California and contracted with three DMC plans to provide dental services in Los Angeles and Sacramento counties. DHCS operates MCMC through a health care delivery system that encompasses seven models of managed care for its full-scope services as well as a model for SHPs and two model types for DMC plans. DHCS monitors MCMC plan performance across model types. A link to the MCMC county map, which depicts the location of each model type, may be found at <http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>.

Following is a description of each managed care model type, including the number of beneficiaries served by each model type as of June 2019. HSAG obtained the enrollment information from the *Medi-Cal Managed Care Enrollment Report*.<sup>12</sup>

**County Organized Health System (COHS) model.** A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission. A COHS model has been implemented in 22 counties and operates in each as a single, county-operated health plan. This model does not offer FFS Medi-Cal. As of June 2019, the COHS model was serving about 2.09 million beneficiaries through six health plans in 22 counties.

**Two-Plan Model (TPM).** Under a TPM, beneficiaries may choose between two MCPs; typically, one MCP is a local initiative and the other a commercial plan. DHCS contracts with both plans. The local initiative is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The commercial plan is a private insurance plan that also provides care for Medi-Cal beneficiaries. As of June 2019, the TPM was serving about 6.76 million beneficiaries through 12 health plans in 14 counties. Note that Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan serves as a local initiative in Tulare County and a commercial plan in all other TPM counties.

**Geographic Managed Care (GMC) model.** Under a GMC model, DHCS allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county). As of June 2019, the GMC model had five health plans serving more than 428,000 beneficiaries in Sacramento County and seven health plans serving more than 690,000 beneficiaries in San Diego County.

**Regional model.** This model consists of three commercial health plans that provide services to beneficiaries in the rural counties of the State, primarily in northern and eastern California. The Regional model was implemented in November 2013, bringing MCMC to counties that historically offered only FFS Medi-Cal. As of June 2019, the Regional model was serving more than 291,000 beneficiaries in 18 counties.

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<sup>13</sup> Note: HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS holds just one contract with Kaiser (KP Cal, LLC).

**Imperial model.** This model operates in Imperial County with two commercial health plans. As of June 2019, this model was serving nearly 76,000 beneficiaries.

**San Benito model.** This model operates in San Benito County and provides services to beneficiaries through a commercial plan and FFS Medi-Cal. As of June 2019, the San Benito model was serving more than 7,800 beneficiaries. San Benito is California's only county where enrollment in managed care is not mandatory.

**Population-Specific Health Plan model.** The PSP model operates in Los Angeles, Riverside, San Bernardino, and San Diego counties. The following MCOs are designated as a "Population-Specific Health Plan" model because of their specialized populations:

- ◆ Rady Children's Hospital—San Diego provides pediatric care services in San Diego County. As of June 2019, Rady Children's Hospital—San Diego was serving 368 beneficiaries.
- ◆ SCAN Health Plan provides services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties. As of June 2019, SCAN Health Plan was serving 13,254 beneficiaries.

**Specialty Health Plan model.** SHPs provide health care services to specialized populations. During the review period, DHCS held contracts with two SHPs:

- ◆ AIDS Healthcare Foundation—provides services in Los Angeles County, primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). As of June 2019, AIDS Healthcare Foundation was serving 596 beneficiaries.
- ◆ Family Mosaic Project—provides intensive case management and wraparound services in San Francisco County for MCMC children and adolescents at risk of out-of-home placement. As of June 2019, Family Mosaic Project was serving 29 beneficiaries.

**Dental Managed Care Plans.** Three DMC plans provide dental services in Los Angeles and Sacramento counties. DMC plans operate as PAHPs. In Los Angeles County, beneficiaries have the option to enroll in a DMC plan or to access dental benefits through the dental FFS delivery system. In Sacramento County, the DMC plans operate under a GMC model in which DMC enrollment is mandatory. As of June 2019, DMC plans were serving more than 381,000 beneficiaries in Los Angeles County and more than 417,000 beneficiaries in Sacramento County.

Table 2.1 shows MCMC plan names, model types, reporting units, and the counties in which they provide Medi-Cal services. MCMC plans submit data for some EQR activities at the plan level and submit data for other activities at the reporting unit level. The bundling of counties into a single reporting unit allows a population size to support valid rates.

**Table 2.1—Medi-Cal Managed Care Health Plan Names, Model Types, Reporting Units, and Counties as of June 30, 2019**

\* Kaiser NorCal provides Medi-Cal services in Sacramento County as a GMC model type and in Amador, El Dorado, and Placer counties as a Regional model type; however, the MCP reports performance measure rates for all counties combined. DHCS' decision to have Kaiser NorCal report the combined rates ensures that the MCP has a sufficient sample size to compute accurate performance measure rates that represent the availability and quality of care provided for the population in the region and assists Kaiser NorCal with maximizing operational and financial efficiencies by reducing the number of encounter data validation, improvement plans (IPs), PIPs, and CAHPS survey activities.

\*\* UnitedHealthcare Community Plan exited Sacramento County October 31, 2018.

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
<b>Managed Care Health Plans</b>			
Aetna Better Health of California	GMC	Sacramento	Sacramento
		San Diego	San Diego
Alameda Alliance for Health	TPM— Local Initiative	Alameda	Alameda
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	GMC	Sacramento	Sacramento
	Regional	Region 1	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama
		Region 2	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba
	San Benito	San Benito	San Benito

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
	TPM—CP	Alameda	Alameda
		Contra Costa	Contra Costa
		Fresno	Fresno
		Kings	Kings
		Madera	Madera
		San Francisco	San Francisco
	Santa Clara	Santa Clara	
	TPM—Local Initiative	Tulare	Tulare
Blue Shield of California Promise Health Plan (known as Care1st Health Plan prior to January 1, 2019)	GMC	San Diego	San Diego
California Health & Wellness Plan	Imperial	Imperial	Imperial
	Regional	Region 1	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama
		Region 2	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba
CalOptima	COHS	Orange	Orange
CalViva Health	TPM—Local Initiative	Fresno	Fresno
		Kings	Kings
		Madera	Madera
CenCal Health	COHS	San Luis Obispo	San Luis Obispo
		Santa Barbara	Santa Barbara
Central California Alliance for Health	COHS	Merced	Merced
		Monterey/Santa Cruz	Monterey, Santa Cruz

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
Community Health Group Partnership Plan	GMC	San Diego	San Diego
Contra Costa Health Plan	TPM— Local Initiative	Contra Costa	Contra Costa
Gold Coast Health Plan	COHS	Ventura	Ventura
Health Net Community Solutions, Inc.	GMC	Sacramento	Sacramento
		San Diego	San Diego
	TPM—CP	Kern	Kern
		Los Angeles	Los Angeles
		San Joaquin	San Joaquin
		Stanislaus	Stanislaus
Tulare	Tulare		
Health Plan of San Joaquin	TPM— Local Initiative	San Joaquin	San Joaquin
		Stanislaus	Stanislaus
Health Plan of San Mateo	COHS	San Mateo	San Mateo
Inland Empire Health	TPM— Local Initiative	Riverside/San Bernardino	Riverside, San Bernardino
Kern Health Systems	TPM— Local Initiative	Kern	Kern
Kaiser NorCal (KP Cal, LLC)*	GMC	KP North	Sacramento
	Regional	KP North	Amador, El Dorado, Placer
Kaiser SoCal (KP Cal, LLC)	GMC	San Diego	San Diego
L.A. Care Health Plan	TPM— Local Initiative	Los Angeles	Los Angeles

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
Molina Healthcare of California Partner Plan, Inc.	GMC	Sacramento	Sacramento
		San Diego	San Diego
	Imperial	Imperial	Imperial
	TPM—CP	Riverside/San Bernardino	Riverside, San Bernardino
Partnership HealthPlan of California	COHS	Northeast	Lassen, Modoc, Shasta, Siskiyou, Trinity
		Northwest	Del Norte, Humboldt
		Southeast	Napa, Solano, Yolo
		Southwest	Lake, Marin, Mendocino, Sonoma
San Francisco Health Plan	TPM—Local Initiative	San Francisco	San Francisco
Santa Clara Family Health Plan	TPM—Local Initiative	Santa Clara	Santa Clara
United Healthcare Community Plan**	GMC	Sacramento	Sacramento
		San Diego	San Diego
<b>Population-Specific Health Plans</b>			
Rady Children's Hospital—San Diego	PSP	San Diego	San Diego
SCAN Health Plan	PSP	Los Angeles/Riverside/San Bernardino	Los Angeles, Riverside, San Bernardino
<b>Specialty Health Plans</b>			
AIDS Healthcare Foundation	SHP	Los Angeles	Los Angeles
Family Mosaic Project	SHP	San Francisco	San Francisco

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Counties
<b>Dental Managed Care Plans</b>			
Access Dental Plan	PAHP	Los Angeles	Los Angeles
	PAHP— GMC	Sacramento	Sacramento
Health Net of California	PAHP	Los Angeles	Los Angeles
	PAHP— GMC	Sacramento	Sacramento
LIBERTY Dental Plan of California, Inc.	PAHP	Los Angeles	Los Angeles
	PAHP— GMC	Sacramento	Sacramento

For enrollment information about each county, go to <https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report>.

### 3. Medi-Cal Managed Care Quality Strategy

In accordance with 42 CFR §438.340, each state contracting with an MCO, PIHP, or PAHP, as defined in §438.2 or with a PCCM entity as described in §438.310(c) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity.

To comply with 42 CFR §438.340, DHCS produced a quality strategy report that included a description of how DHCS will assess and improve the quality of health care and services furnished by all managed care entities in the State of California. The report is dated June 29, 2018, and HSAG provided a summary of the report content in the *Medi-Cal Managed Care External Quality Review Technical Report—July 1, 2017–June 30, 2018*.

During the review period for this EQR technical report, DHCS' Medical Director Karen Mark, MD, PhD, conducted a presentation for the DHCS Stakeholder Advisory Committee to update the committee on DHCS' comprehensive quality strategy.

The comprehensive quality strategy outlines DHCS' process for developing and maintaining a broader quality strategy to assess the quality of care that all beneficiaries receive, regardless of the delivery system. The strategy defines measurable goals and tracks improvement while adhering to the regulatory managed care requirements outlined in 42 CFR §438.340. The comprehensive quality strategy covers all Medi-Cal managed care delivery systems, including the Medi-Cal managed care plans, county mental health plans, Drug Medi-Cal Organized Delivery System, and the dental managed care plans, as well as non-managed care departmental programs.

In addition to providing a summary of the comprehensive quality strategy report structure and content, Dr. Mark presented the following information:

- ◆ DHCS reviewed and considered information from the following sources to develop the CA DHCS comprehensive quality strategy:
  - *Medi-Cal Managed Care Quality Strategy Report*
  - *DHCS Strategy for Quality Improvement in Health Care*
  - Stakeholder feedback
  - DHCS Strategic Plan
  - DHCS non-managed care programs
  - CMS Quality Considerations for Medicaid and CHIP Programs
  - Other states' quality strategy reports
- ◆ DHCS developed a quality improvement infrastructure that includes the following:
  - Office of the Medical Director
  - DHCS Clinical Quality Improvement Learning Collaborative
  - CMS Core Set Measure Workgroups

- Program Quality Improvement Efforts
- External Stakeholder Engagement
- Workforce Development
- Monitoring and Reporting Data on Quality Improvement—Data and Performance Dashboards

In November 2019, DHCS posted the *State of California Department of Health Care Services Comprehensive Quality Strategy Draft Report for Public Comment*. DHCS plans to release the final version of the comprehensive quality strategy report in early 2020. Note that while the draft report was posted outside the review dates for this EQR technical report, HSAG includes the information because it was available at the time this report was produced.

Dr. Mark's slide presentation, along with other most recent publicly posted DHCS managed care quality strategy documents, may be found at <https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx>.

## 4. Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Compliance Reviews

The Balanced Budget Act of 1997 as set forth in 42 CFR §438.358 requires that the state or its designee conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM entity's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

### Background

To ensure that MCPs, PSPs, and SHPs meet all federal requirements, DHCS incorporates into its plan contracts specific standards for elements outlined in the CFR.

In accordance with CA WIC §19130(b)(3), DHCS directly conducts compliance reviews of MCPs, PSPs, and SHPs, rather than contracting with the EQRO to conduct reviews on its behalf. DHCS applies the Generally Accepted Government Auditing Standards, also known as the Yellow Book. DHCS has determined that its auditing tools are proprietary. Thus, DHCS cannot provide the EQRO with information that would allow the EQRO to determine whether DHCS' tools assess compliance with all federal and State requirements.

DHCS' compliance review process includes, but is not limited to, a review of MCPs', PSPs' and SHPs' policies and procedures, on-site interviews, on-site provider site visits, and file verification studies. Additionally, DHCS actively engages with these plans throughout the CAP process by providing technical assistance and ongoing monitoring to ensure full remediation of identified deficiencies.

Under DHCS' monitoring protocols, DHCS oversees the CAP process to ensure that MCPs, PSPs, and SHPs address all deficiencies identified in the compliance reviews conducted (i.e., Medical Audits and State Supported Services Audits) by DHCS A&I. DHCS issues final closeout letters to these plans once they have submitted supporting documentation to substantiate that they have fully remediated all identified deficiencies and that the deficiencies are unlikely to recur. However, if corrective action requires more extensive changes to MCP, PSP, and SHP operations and full implementation cannot be reasonably achieved without additional time, DHCS may close some deficiencies on the basis that sufficient progress has been made toward meeting set milestones. In these instances, DHCS may issue closeout letters to these plans with the understanding that progress on full implementation of corrective actions will be assessed in the next audit.

## Compliance Reviews

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

### ***DHCS Audits & Investigations Division Medical Audits***

Prior to 2015, DHCS conducted medical audits of MCPs, PSPs, and SHPs once every three years. These medical audits assessed compliance with contract requirements and State and federal regulations. In January 2015, CA WIC §14456 became law, mandating annual audits for prepaid health plans. In response, DHCS A&I currently conducts on-site medical audits of each MCP, PSP, and SHP annually, alternating between comprehensive full-scope and reduced-scope audits. Additionally, DHCS A&I conducts annual follow-up on the previous year's CAP. DHCS A&I Medical Audits cover the following review categories:

- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

### ***State Supported Services***

DHCS A&I conducts State Supported Services (abortion services) Audits in tandem with its Medical Audits. State Supported Services Audits are conducted in accordance with CA WIC §14456. In conducting this audit, the audit team evaluates the MCP's compliance with the State Supported Services contract and regulations. DHCS A&I conducts these audits annually. Additionally, DHCS A&I conducts follow-up on the previous year's CAP.

## Objectives

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

- ◆ DHCS' compliance with conducting reviews of all MCPs, PSPs, and SHPs within the three-year period prior to the review dates for this report.
- ◆ MCPs', PSPs', and SHPs' compliance with the areas that DHCS reviewed as part of the compliance review process.

## Methodology

As part of the EQR technical report production, DHCS submitted to HSAG all compliance-related documentation for reviews which had occurred within the previous three-year period and that HSAG had not already reported on in previous EQR technical reports.

HSAG determined whether or not DHCS conducted compliance monitoring reviews for all MCPs, PSPs, and SHPs at least once within the three-year period prior to the review dates for this report by assessing the dates of each plan's review. Unless noted, HSAG excluded from its analysis information from compliance reviews conducted earlier than three years prior to the start of the review period (July 1, 2018) and later than the end of the review period (June 30, 2019).

HSAG reviewed all compliance-related information to assess the degree to which MCPs, PSPs, and SHPs are meeting the standards assessed as part of the compliance review process. Additionally, HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about overall plan performance in providing quality, accessible, and timely health care and services to beneficiaries.

In addition to summarizing the aggregated results, HSAG also summarized MCP-, PSP-, and SHP-specific results, including HSAG's recommendations. Plan-specific compliance review results and HSAG's recommendations are included in appendices A through FF.

## Results—Compliance Reviews

HSAG reviewed the dates on which DHCS conducted its most recent compliance reviews of MCPs, PSPs, and SHPs and determined that DHCS conducted a compliance review no earlier than three years from the start of the review period for this report (July 1, 2018) and no later than the end of the review period for this report (June 30, 2019) for all MCPs, one PSP, and both SHPs. DHCS did not conduct a compliance review for Rady Children's Hospital—San Diego (a PSP) within the three years of the review period of this report.

The following is a summary of notable results from HSAG's assessment of the compliance review information submitted by DHCS to HSAG for production of the 2018–19 MCP-, PSP-, and SHP-specific evaluation reports and this EQR technical report. The summary includes new information not reported on in previous review periods.

- ◆ DHCS provided evidence to HSAG of DHCS' ongoing follow-up with MCPs, PSPs, and SHPs regarding findings A&I identified during audits. DHCS provided documentation to HSAG of its follow-up with MCPs, PSPs, and SHPs on CAPs as well as finding-related documentation from these MCPs.
- ◆ HSAG received results from 25 State Supported Services audits of MCPs. A&I identified no findings in 20 of the 25 audits (80 percent), reflecting full compliance with the State Supported Services contract and regulations.

- ◆ Twenty-three of the 26 MCPs, PSPs, and SHPs for which HSAG received A&I Medical Audit results (88 percent) had a finding in at least one review area (e.g., Utilization Management, Access and Availability of Care). Findings were MCP-, PSP-, and SHP-specific, with no findings cutting across most or all MCPs, PSPs, and SHPs.

For the most up-to-date A&I audit reports and related CAP information, go to:  
<http://www.dhcs.ca.gov/services/Pages/MedRevAuditsCAP.aspx>.

## Conclusions—Compliance Reviews

Findings identified during A&I audits reflected opportunities for improvement for MCPs, PSPs, and SHPs in the areas of quality and timeliness of, and access to health care. Audit findings within the assessed areas were MCP-, PSP-, and SHP-specific; therefore, across all MCPs, PSPs, and SHPs, HSAG identified no specific areas for improvement. As in previous years, DHCS demonstrated ongoing efforts to follow up on findings as evidenced in the audit reports, CAP responses, and final closeout letters that DHCS submitted to HSAG for review.

## Recommendations—Compliance Reviews

HSAG has no recommendations for DHCS related to compliance reviews of MCPs, PSPs, and SHPs.

## 5. Dental Managed Care Plan Compliance Reviews

As indicated in the previous section of this report (“Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Compliance Reviews”), the Balanced Budget Act of 1997 as set forth in 42 CFR §438.358 requires that the state or its designee conduct a review within the previous three-year period to determine each MCO’s, PIHP’s, PAHP’s, or PCCM entity’s compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. Also as indicated previously, the EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans’ compliance with the standards established by the state.

### Background

At least once every three years, DMHC conducts Routine Surveys with DMC plans to assess the plans’ compliance with the Knox-Keene Health Care Service Plan Act of 1975 requirements. Additionally, through Interagency Agreement 13-90172 with DHCS, DMHC assesses DMC plans’ compliance with the Medi-Cal Dental Managed Care Program Contract as part of DMHC’s Routine Surveys. In May 2019, DHCS A&I began conducting its own surveys to assess DMC plan compliance. A&I’s audits of DMC plans will eventually replace the DMHC Routine Surveys. The first of DHCS’ A&I surveys will be reported in the 2019–20 EQR technical report.

### Compliance Reviews

#### *Knox-Keene Survey*

When conducting the Routine Survey, DMHC reviews each DMC plan’s procedures for obtaining health care services, procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for ensuring quality of care, and the overall performance of the DMC plan in providing dental care benefits and meeting the dental care needs of beneficiaries in the following areas:

- ◆ Quality Management
- ◆ Grievances and Appeals
- ◆ Access and Availability of Services
- ◆ Utilization Management
- ◆ Language Assistance

## **Medi-Cal Managed Care Survey**

When conducting the Routine Survey, DMHC assesses whether or not each DMC plan is continuously monitoring its associated contracted providers to ensure the providers' adherence with access and availability, grievance and appeals policies and procedures, quality management, and proper utilization management. DMHC reviews the following areas:

- ◆ Provider and Enrollee Ratios
- ◆ Geographic and Timely Access to Care
- ◆ Assignment of Primary Care Dentist Methodology
- ◆ Grievances and Appeals
- ◆ Pay-for-Performance Initiatives
- ◆ Utilization Management
- ◆ Utilization Management in relation to the Quality Management program
- ◆ Specialty Network and Referrals
- ◆ Delegation Oversight
- ◆ Preventive Care Outreach
- ◆ Marketing Practices and Training

## **Objectives**

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

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

## **Methodology**

As part of the EQR technical report production, DHCS submitted to HSAG all compliance-related documentation for the most recent reviews for each DMC plan.

By assessing the dates of each DMC plan's review, HSAG determined whether DHCS conducted a compliance monitoring review at least once for all DMC plans within the three-year period prior to the review dates for this report. Unless noted, HSAG excluded from analysis information from compliance reviews conducted earlier than three years prior to the start of the review period (July 1, 2018) and later than the end of the review period (June 30, 2019).

HSAG reviewed all compliance-related information to determine the degree to which DMC plans met the standards assessed as part of the compliance review process. Additionally,

HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about overall DMC plan performance in providing quality, accessible, and timely dental care services to beneficiaries.

In addition to summarizing the aggregated results, HSAG also summarized DMC plan-specific results, including HSAG's recommendations. DMC plan-specific compliance review results and HSAG's recommendations are included in appendices A through FF.

## Results—Compliance Reviews

HSAG reviewed the dates on which DMHC conducted its most recent routine surveys of DMC plans and determined that DMHC conducted a compliance review no earlier than three years from the start of the review period for this report (July 1, 2018) and no later than the end of the review period for this report (June 30, 2019) for two DMC plans. DMHC did not conduct a Routine Survey for LIBERTY Dental Plan of California, Inc., within the three years prior to the review period of this report; however, as indicated previously, in May 2019, DHCS A&I began conducting its own surveys to assess DMC plan compliance, and the DMC A&I audits will eventually replace the DMHC Routine Surveys.

For the most up-to-date DMHC audit reports, go to:

<https://www.dhcs.ca.gov/services/Pages/Dentalmanagedcare.aspx>.

## Conclusions and Recommendations—Compliance Reviews

Based on the DMC plan compliance reviews being in transition from DMHC to DHCS A&I, HSAG draws no conclusions and HSAG has no recommendations for DHCS related to compliance reviews of DMC plans.

## 6. Performance Measure Validation

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of those entities' quality assessment and performance improvement programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(1)(ii) and (b)(2). The EQR technical report must include information on the validation of MCO, PIHP, PAHP, and PCCM entity performance measures (as required by the state) or MCO, PIHP, PAHP, and PCCM entity performance measures calculated by the state during the preceding 12 months.

### Background

To comply with §438.358, DHCS contracted with HSAG to conduct an independent validation, through HEDIS Compliance Audits™,<sup>14</sup> and performance measure validation for non-HEDIS measures, of the DHCS-selected performance measures calculated and submitted by MCPs, PSPs, and SHPs. Additionally, DHCS contracted with HSAG to conduct an independent validation of the DHCS-selected performance measures calculated and submitted by MLTSSPs, which are part of California's Coordinated Care Initiative (CCI).

HSAG evaluates two aspects of performance measures for each MCP, PSP, SHP, and MLTSSP. First, HSAG assesses the validity of each plan's data using protocols required by CMS.<sup>15</sup> Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about these plans' performance in providing quality, accessible, and timely care and services to beneficiaries.

### Objectives

The purpose of HSAG's performance measure validation is to ensure that MCPs, PSPs, SHPs, and MLTSSPs calculate and report performance measures consistent with the established specifications and that the results can be compared to one another.

HSAG conducts HEDIS Compliance Audits and performance measure validations and analyzes performance measures results to:

- ◆ Evaluate the accuracy of the performance measure data collected.

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<sup>14</sup> HEDIS Compliance Audit™ is a trademark of NCQA.

<sup>15</sup> The 2012 CMS EQR protocols may be found at <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Dec 3, 2019.

- ◆ Determine the extent to which the specific performance measures calculated by MCPs, PSPs, SHPs, and MLTSSPs followed the specifications established for calculation of the performance measures.
- ◆ Identify overall strengths and areas for improvement in the performance measure process.

Note: MCPs, PSPs, SHPs, and MLTSSPs must calculate and report DHCS' required EAS performance measure rates annually for a measurement year (January through December) at the reporting unit level. DHCS defines a "reporting unit level" as a single county, a combined set of counties, or a region as determined and pre-approved by DHCS.

## Methodology

HSAG adheres to NCQA's *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information Systems (IS) capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. All of HSAG's lead auditors are Certified HEDIS Compliance Auditors (CHCAs).

### Performance Measure Validation Activities

Performance measure validation involved three phases: off-site, on-site, and post-on-site.<sup>16</sup> The following provides a summary of HSAG's activities with MCPs, PSPs, SHPs, and MLTSSPs, as applicable, within each of the validation phases.

#### Off-Site Validation Phase (October 2018 through May 2019)

- ◆ Forwarded HEDIS 2019 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- ◆ Conducted annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- ◆ Scheduled on-site visit dates.
- ◆ Conducted kick-off calls to introduce the audit team; discuss the on-site agenda; provide guidance on HEDIS Compliance Audit and performance measure validation processes; and ensure that MCPs, PSPs, SHPs, and MLTSSPs were aware of important deadlines.
- ◆ Conducted CAHPS survey sample frame validation for the MCPs and provided the final survey sample frame validation results report that indicated if the sample frames were approved for reporting.

<sup>16</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf>. Accessed on: Dec 3, 2019.

- ◆ Reviewed completed HEDIS Roadmaps and Information Systems Capabilities Assessment Tool (ISCAT) to assess compliance with the audit standards and provided the IS standard tracking report that listed outstanding items and areas that required additional clarification.
- ◆ Reviewed source code used for calculating the HEDIS performance measure rates to ensure compliance with the technical specifications, unless the MCP, PSP, SHP, or MLTSSP used a vendor with HEDIS Certified Measures<sup>SM</sup>.<sup>17</sup>
- ◆ Reviewed source code used for calculating the non-HEDIS performance measure rates to ensure compliance with the specifications required by the State.
- ◆ Conducted validation for all supplemental data sources intended for reporting, and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- ◆ Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- ◆ Conducted medical record review validation to ensure the integrity of medical record review processes for performance measures that required medical record data for HEDIS reporting.

#### **On-Site Validation Phase (January 2019 through April 2019)**

- ◆ Conducted on-site audits to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- ◆ Provided preliminary audit findings.

#### **Post-On-Site Validation Phase (May 2019 through July 2019)**

- ◆ Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- ◆ Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS 2018 Audit Means, Percentiles, and Ratios. The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- ◆ Compared the final rates to the Patient Level Detail files required by DHCS, ensuring that data matched the final rate submission and met DHCS requirements.
- ◆ Approved the final rates and assigned a final, audited result to each selected measure.
- ◆ Produced and provided final audit reports containing a summary of all audit activities.

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<sup>17</sup> HEDIS Certified Measures<sup>SM</sup> is a service mark of the NCQA.

## **Description of Data Obtained**

Through the methodology, HSAG obtained a number of different information sources to conduct the performance measure validation. These included:

- ◆ HEDIS Roadmap and ISCAT.
- ◆ Source code, computer programming, and query language (if applicable) used to calculate the selected measures.
- ◆ Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- ◆ Re-abstraction of a sample of medical records selected by HSAG auditors.

HSAG also obtained information through interaction, discussion, and formal interviews with key MCP, PSP, SHP, and MLTSSP staff members as well as through observing system demonstrations and data processing.

## **Performance Measure Results Analyses**

Using the validated performance measure rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about MCP, PSP, SHP, and MLTSSP performance in providing accessible, timely, and quality health care services to beneficiaries. To aid in the analyses, HSAG produced spreadsheets with detailed comparative results. Additionally, HSAG submitted to DHCS the spreadsheets for DHCS to use in its assessment of these plans' performance across all performance measures.

HSAG assessed for trends relative to MCPs', PSPs', and SHPs' performance in comparison to high performance levels and minimum performance levels and for statistically significant improvement or decline in performance from the previous reporting year for MCPs, PSPs, SHPs, and MLTSSPs. HSAG identified strengths; opportunities for improvement; and recommendations based on its assessment of MCP, PSP, SHP, and MLTSSP performance.

Aggregate MCP, PSP, SHP, and MLTSSP performance measure results, findings, and recommendations are included in Section 7, Section 8, Section 9, and Section 10 of this report ("Managed Care Health Plan Performance Measures," "Population-Specific Health Plan Performance Measures," "Specialty Health Plan Performance Measures," and "Managed Long-Term Services and Supports Plan Performance Measures," respectively).

## **Performance Measure Validation Results**

In reporting year 2019, HSAG conducted 28 performance measure validations, with 27 of those being NCQA HEDIS Compliance Audits. The exception was Family Mosaic Project, an SHP that reported non-HEDIS measures and underwent performance measure validation consistent with CMS protocols. These 28 MCPs, PSPs, and SHPs represented 56 separate data submissions for performance measure rates at the reporting unit level. HSAG also

conducted performance measure validations with 25 MCPs for a select set of measures that DHCS required MCPs to stratify by the Seniors and Persons with Disabilities (SPD) and non-SPD populations, and with 13 MLTSSPs for their MLTSS populations.

Each performance measure validation included pre-on-site preparation, survey sample frame validation if applicable, data source review, an on-site visit, medical record review validation when appropriate, primary source validation, query review, preliminary and final rate review, and initial and final audit reports production.

Of the 27 MCPs, PSPs, and SHPs that underwent NCQA HEDIS Compliance Audits, 25 used vendors with HEDIS Certified Measures to calculate and produce HEDIS measure rates. This was the same number as in RY 2018. All five vendors that represented these MCPs, PSPs, and SHPs each achieved full NCQA Measure Certification<sup>SM,18</sup> status for the reported HEDIS measures. HSAG reviewed and approved the source code that Family Mosaic Project, Kaiser NorCal, and Kaiser SoCal each developed internally for measure calculation.

Note the following regarding performance measure validation results:

- ◆ HSAG includes no performance measure validation results for Rady Children’s Hospital—San Diego in this report or in Rady Children’s Hospital—San Diego’s PSP-specific report. While DHCS held a contract with this PSP during the review period for this report, no Rady Children’s Hospital—San Diego beneficiaries met the continuous enrollment criteria for reporting year 2019 performance measure reporting. HSAG will include Rady Children’s Hospital—San Diego in the reporting year 2020 HEDIS Compliance Audit process.
- ◆ UnitedHealthcare Community Plan exited Sacramento County October 31, 2018; beneficiaries served by this MCP in calendar year 2018 therefore did not meet continuous enrollment criteria for reporting year 2019. HSAG includes no performance measure validation results for UnitedHealthcare Community Plan—Sacramento County.
- ◆ Aetna Better Health of California and UnitedHealthcare Community Plan did not have enough eligible members to report rates for the MLTSSP population; therefore, HSAG includes no MLTSSP performance measure validation results for these two MCPs.

### ***Strengths—Performance Measure Validation***

HSAG auditors identified the following strengths during the performance measure validation process:

- ◆ Auditors noted that in general, with few exceptions, MCPs, PSPs, and SHPs have developed integrated teams comprised of necessary staff members from both quality and information technology departments. It was apparent that both areas worked closely together and had a sound understanding of the NCQA HEDIS Compliance Audit process. This multidisciplinary approach is key to reporting accurate and timely performance measure rates.

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<sup>18</sup> NCQA Measure Certification<sup>SM</sup> is a service mark of NCQA.

- ◆ MCPs, PSPs, and SHPs used enrollment data as the primary data source for determining the eligible population for most measures. The routine data transfer and longstanding relationship between MCPs/PSPs/SHPs and DHCS has helped to create best practices and stable processes for acquiring membership data. In addition to smooth and accurate processing by MCPs, PSPs, and SHPs, the data included fewer issues compared to the previous year and retrospective enrollment concerns.
- ◆ In reporting year 2019, MCPs, PSPs, and SHPs continued to increase use of supplemental data sources. These additional data sources offered MCPs, PSPs, and SHPs the opportunity to more accurately capture the services provided to beneficiaries. Reporting hybrid measures along with supplemental data reduced the burden and resources that MCPs, PSPs, and SHPs had to expend to abstract the clinical information. Moreover, measures reported with administrative data only, and for which MCPs, PSPs, and SHPs also included supplemental data, more accurately reflected performance rates for those measures.
- ◆ MCPs, PSPs, and SHPs had rigorous editing processes in place to ensure accurate and complete pharmacy data.
- ◆ Generally, and with few exceptions, MCPs, PSPs, and SHPs receive most claims data electronically and have a very small percentage of claims that require manual data entry, minimizing the potential for errors.

### ***Opportunities for Improvement—Performance Measure Validation***

Due to the continued increase in the number of supplemental data sources used for performance measure calculations, MCPs, PSPs, and SHPs have the opportunity to ensure that comprehensive and ongoing oversight processes are in place.

Challenges and opportunities for improvement were MCP-, PSP-, and SHP-specific, and the HSAG auditors provided feedback to the MCPs, PSPs, and SHPs, as applicable, regarding the challenges and opportunities for improvement. While HSAG identified instances of some MCPs, PSPs, and SHPs being partially compliant with an IS standard, HSAG auditors determined that the identified issues had a minimal impact on performance measure reporting.

### **Recommendations—Performance Measure Validation**

HSAG has no recommendations for DHCS related to performance measure validation.

MCP-, PSP-, SHP-, and MLTSSP-specific performance measure validation findings and recommendations are included in appendices A through FF.

## 7. Managed Care Health Plan Performance Measures

### Requirements

To comply with §438.330, DHCS selects a set of performance measures through which to evaluate the quality of care delivered by MCPs to beneficiaries. DHCS consults with MCPs, HSAG, and stakeholders to determine the performance measures DHCS will require. MCMC's quality strategy describes the program's processes to define, collect, and report MCP-specific performance data, as well as overall MCMC performance data, on DHCS-required measures. MCPs must report county or regional rates unless otherwise approved by DHCS.

### *External Accountability Set*

Through reporting year 2019, DHCS refers to the DHCS-selected performance measures for MCPs as the EAS. Beginning with reporting year 2020, DHCS has added new performance measures to the set and will refer to the DHCS-selected performance measure set as the Medi-Cal Accountability Set (MCAS), instead of EAS.

MCPs' reporting of EAS rates provides DHCS with a standardized method for objectively evaluating MCPs' delivery of services to beneficiaries.

In alignment with the quality strategy report reassessment timeline, DHCS evaluated the EAS every three years using the following criteria:

1. **Meaningful** to the public, the beneficiaries, the State, and the MCPs.
2. **Improves quality of care** or services for the Medi-Cal population.
3. **High population impact** by affecting large numbers of beneficiaries or having substantial impact on smaller, special populations.
4. **Known impact of poor quality** linked with severe health outcomes (morbidity, mortality) or other consequences (high resource use).
5. **Performance improvement needed** based on available data demonstrating opportunity to improve, variation across performance, and disparities in care.
6. **Evidence-based practices available** to demonstrate that the problem is amenable to intervention and that there are pathways to improvement.
7. **Availability of standardized measures and data** that can be collected.
8. **Alignment** with other national and State priority areas.
9. **Health care system value** demonstrated through cost-savings, cost-effectiveness, risk-benefit balance, or health economic benefit.
10. **Avoid negative unintended consequences.**

DHCS also considered other issues when determining whether or not to add or remove measures from the EAS, including:

- ◆ Limiting burden and intrusion on primary care provider (PCP) offices (administrative versus hybrid measures, for instance).
- ◆ Needing to retain measures in the core set for three years for baseline and trend analysis.
- ◆ Considering the impact of adding/deleting measure(s) used in the auto-assignment and default algorithm.

As part of its evaluation of the EAS measures, DHCS sought input from MCP medical directors, external partners, and various stakeholder advisory groups.

DHCS' reporting year<sup>19</sup> 2019 EAS consisted of 17 HEDIS measures. Several required HEDIS measures include more than one indicator, bringing the total number of performance measure rates required for MCP reporting to 30. In this report, HSAG uses "performance measure" or "measure" (rather than indicator) to reference required EAS measures. Collectively, performance measure results reflect the quality and timeliness of and access to care provided by MCPs to beneficiaries.

Table 7.1 lists the reporting year 2019 EAS measures by measure domain. HSAG organized the measures into measure domains based on the health care areas they affect. Organizing the measures by domains allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS.

**Table 7.1—Reporting Year 2019 (Measurement Year 2018) External Accountability Set Measures**

Admin = administrative method, which requires that MCPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MCPs derive the numerator (services provided to beneficiaries in the eligible population) from administrative data sources and auditor-approved supplemental data sources. MCPs may not use medical records to retrieve information. When using the administrative method, MCPs use the entire eligible population as the denominator because NCQA does not allow sampling.

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

ECDS = Electronic Clinical Data Systems method, which expands the use of electronic data for quality measurement. Data sources that MCPs may use to identify the denominator and derive the numerator include, but are not limited to, beneficiary eligibility files, electronic health

<sup>19</sup> The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

records, clinical registries, health information exchange, administrative claims systems, electronic laboratory reports, electronic pharmacy systems, immunization information systems, and disease/case management registries.

\* Member months are a member's "contribution" to the total yearly membership.

Measure	NCQA Method of Data Capture
<b>Preventive Screening and Children's Health Domain</b>	
<i>Childhood Immunization Status—Combination 3</i>	Hybrid
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	Admin
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	Admin
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	Admin
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	Admin
<i>Immunizations for Adolescents—Combination 2</i>	Hybrid
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total</i>	Hybrid
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total</i>	Hybrid
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Hybrid
<b>Preventive Screening and Women's Health Domain</b>	
<i>Breast Cancer Screening</i>	Admin
<i>Cervical Cancer Screening</i>	Hybrid
<i>Prenatal and Postpartum Care—Postpartum Care</i>	Hybrid
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	Hybrid
<b>Care for Chronic Conditions Domain</b>	
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	Admin
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	Admin
<i>Asthma Medication Ratio</i>	Admin

Measure	NCQA Method of Data Capture
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)</i>	Hybrid
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	Hybrid
<i>Comprehensive Diabetes Care—HbA1c Control (&lt;8.0 Percent)</i>	Hybrid
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)</i>	Hybrid
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing</i>	Hybrid
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	Hybrid
<i>Controlling High Blood Pressure</i>	Hybrid
<b>Appropriate Treatment and Utilization Domain</b>	
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	Admin
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	Admin
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	Admin
<i>Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening</i>	ECDS
<i>Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen</i>	ECDS
<i>Plan All-Cause Readmissions</i>	Admin
<i>Use of Imaging Studies for Low Back Pain</i>	Admin

### Seniors and Persons with Disabilities Performance Measure Stratification

In addition to requiring MCPs to report rates for EAS measures in reporting year 2019, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

- ◆ *Ambulatory Care—Emergency Department Visits per 1,000 Member Months*
- ◆ *Ambulatory Care—Outpatient Visits per 1,000 Member Months*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years*
- ◆ *Plan All-Cause Readmissions*

## DHCS-Established Performance Levels

To create a uniform standard for assessing MCPs on performance measures, DHCS established a high performance level and minimum performance level for each HEDIS measure except for the two *Depression Screening and Follow-Up for Adolescents and Adults* measures and the *Plan All-Cause Readmissions* measure. DHCS established no high performance levels and minimum performance levels for these measures because no comparable benchmarks exist.

To establish the high performance levels and minimum performance levels for the reporting year 2019 HEDIS measures, DHCS used NCQA's Quality Compass<sup>®</sup>.<sup>20</sup> HEDIS 2018 national Medicaid benchmarks. The Quality Compass HEDIS 2018 national Medicaid benchmarks reflect the previous year's benchmark percentiles (calendar year 2017).

DHCS based the high performance levels for reporting year 2019 on the national Medicaid 90th percentiles and the minimum performance levels for reporting year 2019 on the national Medicaid 25th percentiles. DHCS uses the established high performance levels as performance goals and recognizes MCPs for outstanding performance. MCPs are contractually required to perform at or above DHCS-established minimum performance levels.

According to DHCS' license agreement with NCQA, HSAG includes in Table 7.2 the benchmarks that DHCS used to establish the high performance levels and minimum performance levels for the reporting year 2019 HEDIS measures.<sup>21</sup>

<sup>20</sup> Quality Compass<sup>®</sup> is a registered trademark of NCQA.

<sup>21</sup> The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the data") is Quality Compass<sup>®</sup> 2018 and is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on the data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

The data comprise audited performance rates and associated benchmarks for HEDIS<sup>®</sup> and HEDIS CAHPS<sup>®</sup> survey measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures, or any data or rates calculated using HEDIS measures and specifications, and NCQA has no liability to anyone who relies on such measures or specifications.

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**Table 7.2—High Performance Level and Minimum Performance Level Benchmark Values for Reporting Year 2019 (Measurement Year 2018)**

Reporting year 2019 high performance level and minimum performance level benchmark values represent NCQA’s Quality Compass HEDIS 2018 Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively, reflecting the measurement year from January 1, 2017, through December 31, 2017.

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

\*\* *Ambulatory Care—Emergency Department Visits per 1,000 Member Months* and *Outpatient Visits per 1,000 Member Months* summarize utilization of ambulatory care for outpatient and emergency department visits. Member months are a member’s “contribution” to the total yearly membership. DHCS establishes minimum performance levels or high performance levels for these utilization measures; however, as a higher or lower rate does not necessarily indicate better or worse performance, rates are not compared to benchmarks.

— DHCS did not establish a high performance level or minimum performance level for this measure because no comparable benchmark exists.

Measure	Reporting Year 2019 High Performance Level	Reporting Year 2019 Minimum Performance Level
<b>Preventive Screening and Children’s Health</b>		
<i>Childhood Immunization Status—Combination 3</i>	79.56%	65.45%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	97.71%	93.64%
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	92.88%	84.39%
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	96.18%	87.73%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	94.75%	85.81%
<i>Immunizations for Adolescents—Combination 2</i>	46.72%	26.28%
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	83.45%	59.85%
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	78.35%	52.31%

Measure	Reporting Year 2019 High Performance Level	Reporting Year 2019 Minimum Performance Level
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	83.70%	67.15%
<b>Preventive Screening and Women's Health</b>		
<i>Breast Cancer Screening</i>	68.94%	51.78%
<i>Cervical Cancer Screening</i>	70.68%	54.26%
<i>Prenatal and Postpartum Care—Postpartum Care</i>	73.97%	59.61%
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	90.75%	76.89%
<b>Care for Chronic Conditions</b>		
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	92.87%	85.97%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	92.90%	86.06%
<i>Asthma Medication Ratio—Total</i>	71.93%	56.85%
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)</i>	77.50%	56.20%
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	68.61%	50.85%
<i>Comprehensive Diabetes Care—HbA1c Control (&lt;8.0 Percent)</i>	59.49%	44.44%
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)*</i>	29.68%	47.20%
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	92.70%	84.93%
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	93.43%	88.56%
<i>Controlling High Blood Pressure</i>	71.04%	49.15%

Measure	Reporting Year 2019 High Performance Level	Reporting Year 2019 Minimum Performance Level
<b>Appropriate Treatment and Utilization</b>		
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months**</i>	82.21	50.63
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	467.96	307.98
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	44.64%	27.63%
<i>Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening</i>	—	—
<i>Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen</i>	—	—
<i>Plan All-Cause Readmissions*</i>	—	—
<i>Use of Imaging Studies for Low Back Pain</i>	79.88%	67.19%

Although DHCS established high performance levels and minimum performance levels for the following measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for the measures for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if the MCPs' rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures:

- ◆ The two *Ambulatory Care* measures—due to these measures being utilization measures, which means that high and low rates do not necessarily indicate better or worse performance.
- ◆ The *Cervical Cancer Screening* measure—due to this measure's HEDIS specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations.
- ◆ All four *Children and Adolescents' Access to Primary Care* measures—due to the small range of variation between the high performance level and minimum performance level threshold for each measure.
- ◆ The *Controlling High Blood Pressure* measure—due to the measure specification changes that NCQA made in reporting year 2019, resulting in NCQA recommending a break in trending for this measure (i.e., the measure was considered a first-year measure in reporting year 2019).

HSAG includes high performance level and minimum performance level information for the following measures in applicable tables in this report; however, based on DHCS not holding MCPs accountable to meet the minimum performance levels or to address declining rates for these measures, HSAG drew no conclusions from the comparative analyses on these measures for reporting year 2019 and did not include these measures in its assessment of MCP performance:

- ◆ The two *Ambulatory Care* measures
- ◆ *Cervical Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care* measures

### ***HEDIS Improvement Plan Process***

Annually, DHCS assesses each MCP's performance measure rates against the established minimum performance levels and requires MCPs to submit to DHCS an IP for each measure with a rate below the minimum performance level (unless the MCP is reporting a rate for the measure for the first time). An IP consists of an MCP's submission of PDSA Cycle Worksheets or completion of PIPs—as determined by DHCS. DHCS reviews each PDSA Cycle Worksheet submission for design soundness and anticipated intervention effectiveness, and HSAG validates the PIP submissions.

The IP process is one way that DHCS and MCPs engage in efforts to improve the quality and timeliness of, and access to care for beneficiaries, including targeting key quality improvement areas as outlined in California's MCMC quality strategy (i.e., immunizations, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs use structured quality improvement resources and a rapid-cycle approach (including the PDSA cycle process) to strengthen these key quality improvement areas. As a result, DHCS may not have required an MCP to submit IPs for all measures with rates below the minimum performance levels. However, MCPs continue to be contractually required to meet minimum performance levels for all EAS measures.

Note the following regarding DHCS' IP requirements based on reporting year 2019 performance measure results and decisions regarding reporting year 2020 performance measure reporting requirements:

- ◆ Due to the small range of variation between the high performance level and minimum performance level thresholds for each measure, DHCS will not require MCPs to submit IPs if they had rates below the minimum performance levels in reporting year 2019 for either of the *Annual Monitoring for Patients on Persistent Medications* measures.
- ◆ For the following eight measures, DHCS will not require MCPs to submit IPs if the rates were below the minimum performance levels in reporting year 2019 because DHCS will not require MCPs to report the measures to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCPs' quality improvement actions related to the measures:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Use of Imaging Studies for Low Back Pain*
- *Both Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measures*

While DHCS will not require MCPs to submit IPs for the 10 measures even if rates are below the minimum performance levels, DHCS and HSAG expect that MCPs will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that MCPs will conduct improvement activities, as applicable, related to these 10 measures.

DHCS provides HSAG with an annual summary of MCPs' IPs for inclusion in the EQR technical report and in MCP-specific evaluation reports.

### ***Corrective Action Plans***

Annually, DHCS assesses each MCP's performance measure rates to determine if the MCP meets any of the following thresholds, which may result in DHCS placing the MCP on a CAP:

- ◆ The rates for three or more EAS measures for which DHCS holds MCPs accountable to meet the minimum performance levels are below the minimum performance levels in the same reporting unit for the last three or more consecutive years.
- ◆ The rates for more than 50 percent of the EAS measures for which DHCS holds MCPs accountable to meet the minimum performance levels are below the minimum performance levels for any reporting unit in the current reporting year.
- ◆ DHCS determines that the imposition of a CAP is necessary because the MCP is out of compliance with EAS requirements as set forth in its DHCS/MCP contract and/or the most recent DHCS Quality Improvement APL related to the quality and performance improvement requirements,<sup>22</sup> or DHCS identifies a serious quality improvement trend or issue that the MCP needs to correct.

To help MCPs avoid being placed on CAPs, DHCS issues an advance warning letter to each MCP at risk of being placed on a CAP in the next reporting year if the MCP's performance does not improve. DHCS will issue an advance warning letter to an MCP if the MCP meets any of the following thresholds:

- ◆ The rates for three or more EAS measures for which DHCS holds MCPs accountable to meet the minimum performance levels are below the minimum performance levels in the same reporting unit for the last two consecutive years.

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<sup>22</sup> DHCS' most recent quality and performance improvement requirements APL may be found at <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>. Accessed on: Dec 5, 2019.

- ◆ The rates for 40 percent or more of EAS measures for which DHCS holds MCPs accountable to meet the minimum performance levels are below the minimum performance levels for any reporting unit in the current reporting year.
- ◆ DHCS identifies a concerning quality improvement trend or issue that DHCS needs to address with the MCP.

DHCS provides HSAG with an annual summary of MCPs' CAPs for inclusion in the EQR technical report and in MCP-specific evaluation reports.

Note that DHCS will modify the CAP process for reporting year 2020.

## Results—Managed Care Health Plan Performance Measures

As noted previously, HSAG includes no MCP performance measure results, findings, or recommendations for UnitedHealthcare Community Plan Sacramento County in this report or in the MCP-specific evaluation report. While DHCS held a contract with UnitedHealthcare Community Plan during the review period for this report, no beneficiaries in Sacramento County met the continuous enrollment criteria for reporting year 2019 performance measure reporting.

HSAG presents the following performance measure results grouped by measure domains in Table 7.3 through Table 7.13:

- ◆ The reporting years 2016–19 MCMC weighted average rates for each EAS measure and a comparison of the current year's rates both to the prior year's rates and to the DHCS-established high performance levels and minimum performance levels.
- ◆ The reporting years 2016–19 MCMC weighted average rates for each EAS measure for which HSAG made a comparison to the corresponding national Medicaid average for the measure and whether the rate was above or below the national Medicaid average for each reporting year.
- ◆ The reporting years 2016–19 MCMC weighted average rate for each EAS measure with a corresponding Healthy People 2020 goal and whether the rate was above or below the Healthy People 2020 goal for that measure.<sup>23</sup>
  - Note that no corresponding Healthy People 2020 goals exist for any of the EAS measures within the Appropriate Treatment and Utilization domain.

Note the following regarding the benchmarks HSAG used for comparisons for Table 7.3 through Table 7.13:

- ◆ High performance levels and minimum performance levels represent the NCQA Quality Compass Medicaid HMO 90th and 25th percentiles, respectively.

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<sup>23</sup> Information about Healthy People 2020 may be found at <https://www.healthypeople.gov/>. Accessed on: Dec 5, 2019.

- ◆ National Medicaid averages—the benchmarks represent the NCQA Quality Compass national Medicaid averages.
- ◆ Healthy People 2020 goals—the benchmarks represent the Healthy People 2020 goals.
  - HSAG acknowledges the limitations of making comparisons to the Healthy People 2020 goals due to the differences in specifications used to derive the statewide MCMC weighted average rates and the Healthy People 2020 goals.

### Preventive Screening and Children’s Health Domain

Table 7.3 through Table 7.5 present the MCMC weighted averages for measures within the Preventive Screening and Children’s Health domain.

Note the following regarding Table 7.3 through Table 7.5:

- ◆ Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of the specification changes rather than a reflection of performance.
- ◆ Although HSAG includes information about the MCPs' performance related to the four *Children and Adolescents’ Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. HSAG therefore drew no conclusions from the comparative analyses on these measures for reporting year 2019 and did not include these measures in its assessment of MCP performance.

#### Table 7.3—Preventive Screening and Children’s Health Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

 = Rate indicates performance above the high performance level.

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

 = Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

 = Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Childhood Immunization Status—Combination 3<sup>^</sup></i>	70.59%	70.70%	70.47%	70.76%	0.29
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	<b>92.40%</b>	93.14%	<b>92.99%</b>	93.39%	0.40
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	<b>84.20%</b>	<b>83.92%</b>	<b>84.43%</b>	84.92%	0.49
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	<b>87.21%</b>	<b>86.29%</b>	<b>86.85%</b>	87.18%	0.33
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	<b>84.56%</b>	<b>83.50%</b>	<b>84.44%</b>	85.02%	0.58
<i>Immunizations for Adolescents—Combination 2</i>	—	26.89%	37.84%	41.65%	3.81

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Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	73.43%	76.48%	78.87%	79.55%	0.68
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	64.57%	68.79%	72.34%	76.60%	4.26
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	71.30%	73.90%	75.44%	73.68%	-1.76

**Table 7.4—Preventive Screening and Children’s Health Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages**

**■** = Rate indicates performance above the national Medicaid average.

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

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

\* A comparison cannot be made because no national benchmarks existed for this measure in reporting year 2017.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Childhood Immunization Status—Combination 3<sup>^</sup></i>	70.59%	70.70%	70.47%	70.76%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	<b>92.40%</b>	<b>93.14%</b>	<b>92.99%</b>	<b>93.39%</b>
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	<b>84.20%</b>	<b>83.92%</b>	<b>84.43%</b>	<b>84.92%</b>
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	<b>87.21%</b>	<b>86.29%</b>	<b>86.85%</b>	<b>87.18%</b>
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	<b>84.56%</b>	<b>83.50%</b>	<b>84.44%</b>	<b>85.02%</b>
<i>Immunizations for Adolescents—Combination 2</i>	—	26.89%*	37.84%	41.65%

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	73.43%	76.48%	78.87%	79.55%
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	64.57%	68.79%	72.34%	76.60%
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	<b>71.30%</b>	73.90%	75.44%	73.68%

**Table 7.5—Preventive Screening and Children’s Health Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to Healthy People 2020 Goals**

 = Rate indicates performance above the Healthy People 2020 goal.

**Bolded Rate** = Rate indicates performance below the Healthy People 2020 goal.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Healthy People 2020 Goal	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total</i>	22.90%	73.43%	76.48%	78.87%	79.55%

Measure	Healthy People 2020 Goal	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total</i>	22.90%	64.57%	68.79%	72.34%	76.60%

### Findings—Preventive Screening and Children’s Health

The MCMC weighted averages for the five measures for which DHCS held MCPs accountable to meet the minimum performance levels in reporting year 2019 within the Preventive Screening and Children’s Health domain were above the minimum performance levels. The MCMC weighted averages for four of the five measures (80 percent) improved significantly from reporting year 2018 to reporting year 2019. The MCMC weighted average for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure declined significantly from reporting year 2018 to reporting year 2019.

The MCMC weighted averages for all five measures within the Preventive Screening and Children’s Health domain for which HSAG provides comparative analysis were above the national Medicaid averages in reporting year 2019.

Aggregate MCP performance remained consistent for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures, with the MCMC weighted averages being above the Healthy People 2020 goals for both measures for all reporting years displayed in Table 7.5.

### High- and Low-Performing Medi-Cal Managed Care Health Plans—Preventive Screening and Children’s Health

HSAG identified the following MCPs as the highest-performing MCPs within the Preventive Screening and Children’s Health domain in reporting year 2019, based on the MCPs having the highest percentage of reported rates across all their reporting units above the high performance levels in reporting year 2019—four of five rates (80 percent):

- ◆ Kaiser NorCal
- ◆ San Francisco Health Plan

HSAG identified California Health & Wellness Plan as the lowest-performing MCP within the Preventive Screening and Children’s Health domain in reporting year 2019, based on the MCP having the highest percentage of reported rates across all three reporting units below the minimum performance levels in reporting year 2019—six of 15 rates (40 percent).

## Preventive Screening and Women’s Health Domain

Table 7.6 through Table 7.8 present the MCMC weighted averages for measures within the Preventive Screening and Women’s Health domain.

Note the following regarding Table 7.6 through Table 7.8:

- ◆ Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of the specification changes rather than a reflection of performance.
- ◆ Although HSAG includes information on MCP performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Based on DHCS’ decisions, HSAG does not include this measure in its assessment of the MCP’s performance.

### Table 7.6—Preventive Screening and Women’s Health Domain—Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

 = Rate indicates performance above the high performance level.

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

 = Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

 = Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years  2018–19 Rate Difference
<i>Breast Cancer Screening<sup>^</sup></i>	—	59.16%	59.29%	61.16%	1.87
<i>Cervical Cancer Screening</i>	<b>53.61%</b>	56.26%	59.86%	62.79%	2.93
<i>Prenatal and Postpartum Care—Postpartum Care</i>	59.29%	63.77%	64.41%	66.72%	2.31
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	79.17%	81.95%	82.74%	84.47%	1.73

**Table 7.7—Preventive Screening and Women’s Health Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages**

 = Rate indicates performance above the national Medicaid average.

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

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

<sup>^</sup> Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Breast Cancer Screening<sup>^</sup></i>	—	59.16%	59.29%	61.16%
<i>Cervical Cancer Screening</i>	<b>53.61%</b>	56.26%	59.86%	62.79%

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Prenatal and Postpartum Care—Postpartum Care</i>	<b>59.29%</b>	63.77%	64.41%	66.72%
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	<b>79.17%</b>	81.95%	82.74%	84.47%

**Table 7.8—Preventive Screening and Women’s Health Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to Healthy People 2020 Goals**

 = Rate indicates performance above the Healthy People 2020 goal.

**Bolded Rate** = Rate indicates performance below the Healthy People 2020 goal.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

\* Note that the Healthy People 2020 Goal for this measure changed in 2019. Prior to 2019 the goal was 77.90 percent; therefore, reporting year 2016, 2017, and 2018 rates were compared to 77.90 percent.

Measure	Healthy People 2020 Goal	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Breast Cancer Screening</i> <sup>^</sup>	81.10%	—	<b>59.16%</b>	<b>59.29%</b>	<b>61.16%</b>
<i>Cervical Cancer Screening</i>	93.00%	<b>53.61%</b>	<b>56.26%</b>	<b>59.86%</b>	<b>62.79%</b>
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	84.80%*	79.17%	81.95%	82.74%	<b>84.47%</b>

## Findings—Preventive Screening and Women’s Health

The MCMC weighted averages for the three measures within the Preventive Screening and Women’s Health domain for which DHCS held MCPs accountable to meet the minimum performance levels in reporting year 2019 improved significantly from reporting year 2018 to reporting year 2019, and no MCMC weighted averages were below the minimum performance levels in reporting year 2019.

The MCMC weighted averages for all measures within this domain were above the national Medicaid averages in reporting year 2019.

Aggregate MCP performance in comparison to the Healthy People 2020 goals remained consistent for the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. The MCMC weighted averages for these two measures were below the Healthy People 2020 goals for all reporting years for which rates are displayed in Table 7.8.

The MCMC weighted average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure improved by 1.73 percentage points from reporting year 2018 to reporting year 2019; however, the Healthy People 2020 goal for this measure increased by 6.9 percentage points in 2019, resulting in the MCMC weighted average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure moving to below the Healthy People 2020 goal for reporting year 2019.

## High- and Low-Performing Medi-Cal Managed Care Health Plans—Preventive Screening and Women’s Health

HSAG identified the following MCPs as the highest-performing MCPs within the Preventive Screening and Women’s Health domain in reporting year 2019, based on the MCPs having the highest percentage of reported rates within this domain above the high performance levels in reporting year 2019—three of three rates (100 percent):

- ◆ Kaiser NorCal
- ◆ Kaiser SoCal

HSAG identified California Health & Wellness Plan as the lowest-performing MCP within the Preventive Screening and Women’s Health domain in reporting year 2019, based on the MCP having the highest percentage of reported rates across all three reporting units below the minimum performance levels in reporting year 2019—two of nine rates (22 percent).

## Care for Chronic Conditions Domain

Table 7.9 through Table 7.11 present the MCMC weighted averages for measures within the Care for Chronic Conditions domain.

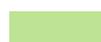
Note the following regarding Table 7.9 through Table 7.11:

- ◆ NCQA made changes to the specifications for the following measures in reporting year 2019 and released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of the specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- ◆ For the *Controlling High Blood Pressure* measure:
  - Due to specification changes that NCQA made in reporting year 2019, NCQA recommended a break in trending for the *Controlling High Blood Pressure* measure; therefore, this measure was considered a first year measure in reporting year 2019.
  - HSAG only displays the reporting year 2019 rate for this measure in Table 7.9; however, because DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure in reporting year 2019, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

### Table 7.9—Care for Chronic Conditions Domain—Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

 = Rate indicates performance above the high performance level.

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

 = Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

 = Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.60%	87.59%	88.24%	88.47%	0.23
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.23%	87.09%	87.88%	88.24%	0.36
<i>Asthma Medication Ratio<sup>^</sup></i>	—	60.14%	61.71%	60.73%	-0.98
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)<sup>^</sup></i>	60.51%	63.38%	66.40%	67.37%	0.97
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed<sup>^</sup></i>	55.29%	57.06%	60.87%	62.56%	1.69
<i>Comprehensive Diabetes Care—HbA1c Control (&lt;8.0 Percent)<sup>^</sup></i>	49.71%	51.67%	53.50%	54.62%	1.12
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)<sup>*^</sup></i>	39.74%	37.75%	34.91%	33.90%	-1.01
<i>Comprehensive Diabetes Care—HbA1c Testing<sup>^</sup></i>	85.62%	86.82%	87.20%	88.22%	1.02

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy<sup>^</sup></i>	90.73%	90.35%	90.92%	91.03%	0.11
<i>Controlling High Blood Pressure</i>	—	—	—	64.79%	Not Comparable

**Table 7.10—Care for Chronic Conditions Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages**

 = Rate indicates performance above the national Medicaid average.

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

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

<sup>^</sup> Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	<b>86.60%</b>	87.59%	88.24%	88.47%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	<b>86.23%</b>	<b>87.09%</b>	<b>87.88%</b>	<b>88.24%</b>
<i>Asthma Medication Ratio<sup>^</sup></i>	—	60.14%	61.71%	<b>60.73%</b>

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)<sup>^</sup></i>	<b>60.51%</b>	63.38%	66.40%	67.37%
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed<sup>^</sup></i>	55.29%	57.06%	60.87%	62.56%
<i>Comprehensive Diabetes Care—HbA1c Control (&lt;8.0 Percent)<sup>^</sup></i>	49.71%	51.67%	53.50%	54.62%
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)<sup>*^</sup></i>	39.74%	37.75%	34.91%	33.90%
<i>Comprehensive Diabetes Care—HbA1c Testing<sup>^</sup></i>	<b>85.62%</b>	86.82%	87.20%	88.22%
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy<sup>^</sup></i>	90.73%	90.35%	90.92%	91.03%

**Table 7.11—Care for Chronic Conditions Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to Healthy People 2020 Goals**

 = Rate indicates performance above the Healthy People 2020 goal.

**Bolded Rate** = Rate indicates performance below the Healthy People 2020 goal.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

<sup>^</sup> Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

<sup>\*</sup> A lower rate indicates better performance for this measure.

Measure	Healthy People 2020 Goal	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)^</i>	57.00%	60.51%	63.38%	66.40%	67.37%
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^</i>	58.70%	<b>55.29%</b>	<b>57.06%</b>	60.87%	62.56%
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)*^</i>	16.20%	<b>39.74%</b>	<b>37.75%</b>	<b>34.91%</b>	<b>33.90%</b>

### Findings—Care for Chronic Conditions

The MCMC weighted averages for the nine measures for which DHCS held MCPs accountable to meet the minimum performance levels in reporting year 2019 within the Care for Chronic Conditions domain were above the minimum performance levels. The MCMC weighted averages for seven of the nine measures (78 percent) improved significantly from reporting year 2018 to reporting year 2019. The MCMC weighted average for the *Asthma Medication Ratio* measure declined significantly from reporting year 2018 to reporting year 2019; however, the significant decline may be the result of the NCQA specification changes rather than a reflection of MCP performance.

For the nine measures within the Care for Chronic Conditions domain for which HSAG could make comparisons between the national Medicaid averages and the reporting year 2019 MCMC weighted averages, the MCMC weighted averages for seven of nine measures (78 percent) were above the national Medicaid averages. The reporting year 2019 MCMC weighted averages were below the national Medicaid averages for the following two measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Asthma Medication Ratio*

The MCMC weighted averages for the following two measures were above the Healthy People 2020 goals in reporting year 2019:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)—for all reporting years displayed in Table 7.11.*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*

The MCMC weighted averages for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure were worse than the Healthy People 2020 goal for all reporting years displayed in Table 7.11.

## High- and Low-Performing Medi-Cal Managed Care Health Plans—Care for Chronic Conditions

HSAG identified Kaiser SoCal as the highest-performing MCP in reporting year 2019 within the Care for Chronic Conditions domain, based on the MCP having the highest percentage of reported rates within this domain above the high performance levels in reporting year 2019—six of nine rates (67 percent).

HSAG identified the following MCPs as the lowest-performing MCPs within the Care for Chronic Conditions domain in reporting year 2019, based on the MCPs having the highest percentage of reported rates across all their reporting units below the minimum performance levels in reporting year 2019 (30 percent):

- ◆ Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—32 of 108 rates
- ◆ California Health & Wellness Plan—8 of 27 rates

## Appropriate Treatment and Utilization Domain

Table 7.12 and Table 7.13 present the MCMC weighted averages for measures within the Appropriate Treatment and Utilization domain. Note the following regarding Table 7.12 and Table 7.13:

- ◆ The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures because higher or lower rates do not necessarily indicate better or worse performance. HSAG does not compare performance for these measures against high performance levels and minimum performance levels or against the national Medicaid and commercial averages. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG does not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of the specification changes.
- ◆ Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of the specification changes rather than a reflection of performance.
- ◆ HSAG did not assess MCPs' performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures based on the following:

- DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
- Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new ECDS reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- ◆ Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

**Table 7.12—Appropriate Treatment and Utilization Domain—Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results**

 = Rate indicates performance above the high performance level.

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

 = Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

 = Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

\* Member months are a member's "contribution" to the total yearly membership.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

MANAGED CARE HEALTH PLAN PERFORMANCE MEASURES

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	44.94	43.32	44.10	42.71	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	281.57	268.58	284.64	309.15	Not Tested
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^</i>	28.73%	31.00%	33.87%	34.40%	0.53
<i>Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening</i>	—	—	—	0.80%	Not Comparable
<i>Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen</i>	—	—	—	16.30%	Not Comparable
<i>Plan All-Cause Readmissions**</i>	—	—	—	16.92%	Not Comparable
<i>Use of Imaging Studies for Low Back Pain</i>	77.60%	72.87%	74.52%	74.07%	-0.45

**Table 7.13—Appropriate Treatment and Utilization Domain Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages**

 = Rate indicates performance above the national Medicaid average.

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

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis<sup>^</sup></i>	28.73%	31.00%	33.87%	34.40%
<i>Use of Imaging Studies for Low Back Pain</i>	77.60%	<b>72.87%</b>	74.52%	74.07%

**Findings—Appropriate Treatment and Utilization**

The MCMC weighted averages for the two measures within the Appropriate Treatment and Utilization domain for which DHCS held MCPs accountable to meet the minimum performance levels in reporting year 2019 were above the minimum performance levels. The MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure declined significantly from reporting year 2018 to reporting year 2019.

Aggregate MCP performance compared to the national Medicaid average for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure remained consistent, with the MCMC weighted averages for this measure being above the national Medicaid averages for all reporting years displayed in Table 7.13. The MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure was above the national Medicaid average in reporting year 2019.

## High- and Low-Performing Medi-Cal Managed Care Health Plans—Appropriate Treatment and Utilization

HSAG identified the following MCPs as the highest-performing MCPs within the Appropriate Treatment and Utilization domain in reporting year 2019, based on the MCPs having the highest percentage of reported rates across all their reporting units above the high performance levels in reporting year 2019—two of two rates (100 percent):

- ◆ Health Plan of San Mateo
- ◆ Kaiser NorCal
- ◆ Kaiser SoCal
- ◆ San Francisco Health Plan

HSAG identified Blue Shield of California Promise Health Plan as the lowest-performing MCP within the Appropriate Treatment and Utilization domain in reporting year 2019, based on the MCP having the highest percentage of reported rates below the minimum performance levels in reporting year 2019—one of two rates (50 percent).

## Results—Seniors and Persons with Disabilities

Table 7.14 presents the SPD and non-SPD MCMC weighted averages, a comparison of the SPD and non-SPD MCMC weighted averages, and the total MCMC weighted averages for all measures MCPs stratified by SPD and non-SPD populations for reporting year 2019.

### Table 7.14—Reporting Year 2019 (Measurement Year 2018) Medi-Cal Managed Care Weighted Averages Comparison and Results for Measures Stratified by the SPD Population

 = Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

 = Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the total statewide results, including the SPD and non-SPD populations. Please note, if no data are available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

\* Member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	69.42	40.63	Not Tested	42.71
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	571.65	288.68	Not Tested	309.15
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.73%	87.52%	3.22	88.47%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.17%	86.88%	4.29	88.24%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	92.73%	93.39%	-0.67	93.39%
<i>Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	86.65%	84.89%	1.76	84.92%
<i>Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	88.97%	87.11%	1.86	87.18%
<i>Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	84.98%	85.02%	-0.04	85.02%
<i>Plan All-Cause Readmissions**</i>	23.51%	13.80%	9.71	16.92%

### Seniors and Persons with Disabilities Findings

HSAG observed the following notable comparisons between the MCMC weighted averages for the SPD population and MCMC weighted averages for the non-SPD population in reporting year 2019:

- ◆ The reporting year 2019 MCMC weighted averages for the SPD population were significantly better than the reporting year 2019 MCMC weighted averages for the non-SPD population for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures
  - *Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years*

- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- ◆ For the *Plan All-Cause Readmissions* measure, the reporting year 2019 MCMC weighted average for the SPD population was significantly worse than the reporting year 2019 MCMC weighted average for the non-SPD population. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

## HEDIS Improvement Plans

During the review period, 11 of the 23 MCPs that reported rates in reporting year 2018 (48 percent) had IPs in progress for performance measures with rates below the minimum performance levels in reporting year 2018. MCPs submitted PDSA Cycle Worksheets or Quality Improvement Summaries to DHCS describing efforts to improve their performance on measures with rates below the minimum performance levels, or conducted PIPs to improve performance. Triennially, at minimum, DHCS monitored MCPs on quality improvement activities and progress being made on improving performance. Additionally, DHCS provided technical assistance to MCPs as needed, in collaboration with HSAG.

DHCS provided IP summary information to HSAG which showed that nine of the 11 MCPs with IPs in progress during the review period (82 percent) had at least one measure with a rate that improved from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019. Six of the 11 MCPs (55 percent) will no longer be required to conduct IPs in 2019.

Based on reporting year 2019 performance measure results, six MCPs will be required to either continue conducting existing IPs or submit new IPs in 2019.

As indicated previously under the “HEDIS Improvement Plan Process” heading within this section of the report, note the following regarding DHCS’ IP requirements based on reporting year 2019 performance measure results and decisions regarding reporting year 2020 performance measure reporting requirements:

- ◆ Due to the small range of variation between the high performance level and minimum performance level thresholds for each measure, DHCS will not require MCPs to submit IPs if they had rates below the minimum performance levels for either of the *Annual Monitoring for Patients on Persistent Medications* measures.
- ◆ For the following eight measures, DHCS will not require MCPs to submit IPs if the rates were below the minimum performance levels because DHCS will not require MCPs to report the measures to DHCS in reporting year 2020 and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCPs’ quality improvement actions related to the measures:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Use of Imaging Studies for Low Back Pain*
- *Both Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

While DHCS will not require MCPs to submit IPs for the 10 measures if rates are below the minimum performance levels, DHCS and HSAG expect that MCPs will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that MCPs will conduct improvement activities, as applicable, related to these 10 measures.

MCP-specific information related to IPs are included within the MCP-specific evaluation reports, located in appendices A through FF.

## HEDIS Corrective Action Plans

DHCS had five MCPs under Quality of Care CAPs during the review period for this report. All five MCPs conducted a variety of quality improvement activities including strategies focused on data, providers, and beneficiaries. While all five MCPs demonstrated improvement from reporting year 2018 to reporting year 2019, all five MCPs showed continued opportunities for improvement. A detailed summary of the MCPs' progress on their CAPs is included in their individual MCP-specific evaluation reports, located in the following appendices:

- ◆ California Health & Wellness Plan—Appendix G
- ◆ CalViva Health—Appendix I
- ◆ Health Net Community Solutions, Inc.—Appendix P
- ◆ Health Plan of San Joaquin—Appendix R
- ◆ Partnership HealthPlan of California—Appendix AA

Based on reporting year 2019 performance measure results, CalViva Health met the MCP's CAP goals and will therefore no longer be on a CAP. The following MCPs will remain on a Quality of Care CAP:

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

DHCS issued no new CAPs based on reporting year 2019 performance measure results.

## Conclusions—Managed Care Health Plan Performance Measures

### Aggregate Performance

DHCS' EAS includes measures that assess the quality and timeliness of and access to care that MCPs provide to beneficiaries, and reflect prevention, screening, health care, and utilization services. The DHCS-established minimum performance levels and DHCS' processes for monitoring MCPs make DHCS' performance expectations clear and provide a framework from which DHCS and MCPs may prioritize improvement efforts.

HSAG observed the following notable aggregate performance measure results for reporting year 2019:

- ◆ For measures for which DHCS held MCPs accountable to meet the minimum performance levels, all MCMC weighted averages were above the minimum performance levels in reporting year 2019.
- ◆ For measures for which HSAG included in the performance measure analyses, the MCMC weighted averages for 14 of 19 measures (74 percent) improved significantly from reporting year 2018 to reporting year 2019.
- ◆ The reporting year 2019 MCMC weighted averages were significantly worse than the reporting year 2018 MCMC weighted averages for the following measures:
  - *Asthma Medication Ratio*
  - *Use of Imaging Studies for Low Back Pain*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

### DHCS Initiatives to Support MCPs in Improving Care

Throughout the review period, DHCS supported MCPs' efforts to provide quality, accessible, and timely health care to beneficiaries, including:

- ◆ Provided technical assistance to MCPs in collaboration with HSAG on implementation of rapid-cycle quality improvement strategies for measures with rates below the minimum performance levels and measures with year-over-year declining rates.
- ◆ Assisted MCPs with prioritizing areas in need of improvement and identifying performance measures for MCPs to use as focus areas for PIPs and IPs.
- ◆ Conducted monthly technical assistance calls and quarterly in-person leadership meetings with MCPs on CAPs to improve performance related to measures for which these MCPs had multiple years of performance below the minimum performance levels.
- ◆ Conducted technical assistance calls for MCPs not engaged in a CAP, as needed.
- ◆ Provided opportunities through quarterly collaborative discussions for DHCS and other State agencies (e.g., California Department of Public Health [CDPH]) to provide MCPs with information on resources and for MCPs to share information with each other about quality improvement efforts, successes, and lessons learned.

- ◆ Produced and disseminated to MCPs quality improvement briefs highlighting MCP promising practices and provided resources related to the following measures for which MCPs have opportunities for improvement:
  - *Breast Cancer Screening*
  - *Use of Imaging Studies for Low Back Pain*
- ◆ Conducted the annual MCP quality improvement survey to obtain feedback to help improve DHCS' quality improvement processes, including DHCS' strategies for providing relevant quality improvement technical assistance and support to MCPs.
- ◆ Launched the DHCS Quality Improvement Toolkit, which provides information about resources, promising practices to improve quality of care, ways to improve performance on measures, and ways to promote health equity.
- ◆ Conducted two DHCS Quality Improvement Overview trainings for MCP quality improvement staff to familiarize new MCP staff with DHCS quality improvement requirements, technical assistance, and available resources and tools.

## Recommendations—Managed Care Health Plan Performance Measures

As noted previously within this report, DHCS has well-established, ongoing processes to monitor MCPs' performance and to support low-performing MCPs in identifying the causes for their declining performance or performance below the minimum performance levels (e.g., IP and CAP processes). DHCS, in collaboration with HSAG as needed, works with MCPs to identify strategies to address the root causes for declining performance or performance below the minimum performance levels. Based on DHCS already having processes in place to monitor and support MCPs' performance improvement, reporting year 2019 MCP aggregated performance measure results, and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG has no recommendations for DHCS in the area of performance measures related to MCPs.

As noted previously, the reporting year 2019 MCMC weighted averages were significantly worse than the reporting year 2018 MCMC weighted averages for the following three measures:

- ◆ *Asthma Medication Ratio*
- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

While HSAG has no recommendations for DHCS related to these three measures, in the MCP-specific evaluation reports, HSAG made recommendations to MCPs with rates for these three measures that were below the minimum performance levels or that declined significantly from reporting year 2018 to reporting year 2019. Note the following regarding HSAG's MCP-specific

recommendations related to the *Asthma Medication Ratio* and *Use of Imaging Studies for Low Back Pain* measures:

- ◆ Declining performance related to the *Asthma Medication Ratio* measure from reporting year 2018 to reporting year 2019 may be due to NCQA's specification changes and unrelated to MCP performance.
- ◆ HSAG made no formal recommendations to MCPs for the *Use of Imaging Studies for Low Back Pain* measure because DHCS will not require MCPs to report the measure to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCPs' quality improvement actions related to the measure. In the applicable MCP-specific evaluation reports, HSAG indicated that DHCS and HSAG expect that the MCPs will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCPs will conduct improvement activities, as applicable, related to this measure.

MCP-specific performance measure results, findings, and recommendations are included in the applicable appendices at the end of this report (appendices A through FF).

## 8. Population-Specific Health Plan Performance Measures

### Requirements

To comply with §438.330, DHCS selects performance measures through which to evaluate the quality of care PSPs delivered to beneficiaries. Rady Children’s Hospital—San Diego and SCAN Health Plan provide services to specialized populations; DHCS therefore has different performance measure requirements for these PSPs than exist for the MCPs.

#### ***Rady Children’s Hospital—San Diego***

No Rady Children’s Hospital—San Diego beneficiaries met the continuous enrollment criteria for reporting year 2019 performance measure reporting; therefore, HSAG includes no performance measure information in this report or in Rady Children’s Hospital—San Diego’s PSP-specific evaluation report. HSAG will include Rady Children’s Hospital—San Diego in the reporting year 2020 HEDIS Compliance Audit process and performance measure information for this PSP in the 2019–20 EQR technical report and in Rady Children’s Hospital—San Diego’s 2019–20 PSP-specific evaluation report.

#### ***SCAN Health Plan***

Due to the specialized populations that SCAN serves, rather than requiring the PSP to report rates for the EAS measures, DHCS collaborates with SCAN to select two measures appropriate to the PSP’s Medi-Cal population. For reporting year 2019, DHCS required SCAN Health Plan to report rates for the following two performance measures:

- ◆ *Colorectal Cancer Screening*
- ◆ *Osteoporosis Management in Women Who Had a Fracture*

The NCQA method of data capture for the *Colorectal Cancer Screening* measure is hybrid, which requires the PSP to identify the eligible population using administrative data, then extract a systematic sample of beneficiaries from the eligible population, which becomes the denominator. The PSP uses administrative data to identify services provided to these beneficiaries. When administrative data do not show evidence that the PSP provided the service, the PSP reviews medical records for those beneficiaries to derive the numerator. The NCQA method of data capture for the *Osteoporosis Management in Women Who Had a Fracture* measure is administrative, which requires the PSP to identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, the PSP derives the numerator, or services provided to beneficiaries in the eligible population, from administrative data sources and auditor-approved supplemental data sources. The PSP cannot use medical records to retrieve information. When using the administrative method, the PSP uses the entire eligible population as the denominator because NCQA does not allow sampling.

### DHCS-Established Performance Levels

For the *Colorectal Cancer Screening* measure, DHCS established the reporting year 2019 high performance level and minimum performance level based on the HEDIS 2018 national commercial HMO 90th and 25th percentiles, respectively, from NCQA Quality Compass because no Medicaid benchmarks exist for this measure. For the *Osteoporosis Management in Women Who Had a Fracture* measure, DHCS established the reporting year 2019 high performance level and minimum performance level based on the HEDIS 2018 national Medicare 90th and 25th percentiles, respectively, from NCQA Quality Compass.

According to DHCS’ license agreement with NCQA, HSAG includes in Table 8.1 the benchmarks that DHCS used to establish the high performance levels and minimum performance levels for the reporting year 2019 HEDIS measures.

**Table 8.1—High Performance Level and Minimum Performance Level Benchmark Values for Reporting Year 2019 (Measurement Year 2018)**

Measure	Reporting Year 2019 High Performance Level	Reporting Year 2019 Minimum Performance Level
<i>Colorectal Cancer Screening</i>	79.00%	55.96%
<i>Osteoporosis Management in Women Who Had a Fracture</i>	78.62%	28.30%

As was indicated in Section 7 of this report (“Managed Care Health Plan Performance Measures”) regarding MCPs, SCAN Health Plan is contractually required to perform at or above DHCS-established minimum performance levels; and DHCS uses the established high performance levels as performance goals, recognizing SCAN Health Plan for outstanding performance, as applicable. DHCS assesses SCAN Health Plan’s performance measure rates against the established minimum performance levels and requires the PSP to submit to DHCS an IP for each measure with a rate below the minimum performance level. An IP consists of the PSP’s submission of PDSA Cycle Worksheets or completion of PIPs—as determined by DHCS. DHCS reviews each PDSA Cycle Worksheet submission for design soundness and anticipated intervention effectiveness, and HSAG validates the PIP submissions.

Note that DHCS will not require SCAN Health Plan to submit IPs if the rates for the *Colorectal Cancer Screening* or *Osteoporosis Management in Women Who Had a Fracture* measures were below the minimum performance levels for reporting year 2019 because DHCS will not require SCAN Health Plan to report the measures to DHCS in reporting year 2020. DHCS and HSAG will therefore have no way to follow up on the outcomes of the PSP’s quality improvement actions related to the measures. While DHCS will not require SCAN Health Plan to submit IPs for the two measures if rates were below the minimum performance levels, DHCS and HSAG expect that SCAN Health Plan will continue to engage in continuous quality

improvement strategies to ensure beneficiaries are receiving needed health care services and that the PSP will conduct improvement activities, as applicable, related to these two measures.

## Results and Findings—Population-Specific Health Plan Performance Measures

### SCAN Health Plan—Results

Table 8.2 displays SCAN Health Plan’s performance measure results for reporting years 2017 through 2019. The reporting year is the year in which the PSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all three years.

**Table 8.2—Multi-Year Performance Measure Results  
SCAN Health Plan—Los Angeles/Riverside/San Bernardino Counties**

-  = Rate indicates performance above the high performance level.
- Bolded Rate** = Rate indicates performance below the minimum performance level.
-  = Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.
-  = Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing PSP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Colorectal Cancer Screening</i> <sup>^</sup>	73.24%	77.44%	76.69%	-0.75
<i>Osteoporosis Management in Women Who Had a Fracture</i> <sup>^</sup>	—	51.72%	53.70%	1.98

### **SCAN Health Plan—Findings**

The rates for the *Colorectal Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture* measures showed no statistically significant changes from reporting year 2018 and reporting year 2019. The rates for both measures were between the high performance levels and minimum performance levels in reporting year 2019.

### **Recommendations—Population-Specific Health Plan Performance Measures**

Based on PSP reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG has no recommendations for DHCS in the area of performance measures related to PSPs.

PSP-specific performance measure results, findings, and recommendations are included in the applicable appendices at the end of this report (appendices A through FF).

## 9. Specialty Health Plan Performance Measures

### Requirements

To comply with §438.330, DHCS selects performance measures through which to evaluate the quality of care delivered by the contracted SHPs to beneficiaries. Due to the specialized populations that SHPs serve, rather than requiring SHPs to report rates for the EAS measures, DHCS collaborates with each SHP to select two measures appropriate to the SHP’s Medi-Cal population. SHPs may select HEDIS measures or develop SHP-specific measures. SHPs must report county or regional rates unless otherwise approved by DHCS. Table 9.1 lists the reporting year 2019 performance measures for each SHP.

**Table 9.1—Reporting Year 2019 (Measurement Year 2018) Specialty Health Plan Performance Measures**

\* HEDIS measure

\*\* Non-HEDIS measure; SHP designed the measure in collaboration with DHCS and HSAG to evaluate performance elements specific to the SHP.

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

Specialty Health Plan	Measure	NCQA Method of Data Capture
AIDS Healthcare Foundation	<i>Colorectal Cancer Screening*</i>	Hybrid***
	<i>Controlling High Blood Pressure*</i>	Hybrid***
Family Mosaic Project	<i>Promotion of Positive Pro-Social Activity**</i>	Not Applicable
	<i>School Attendance**</i>	Not Applicable

### DHCS-Established Performance Levels

For the *Colorectal Cancer Screening* measure, DHCS established the reporting year 2019 high performance level and minimum performance level based on the HEDIS 2018 national commercial HMO 90th and 25th percentiles, respectively, from NCQA’s Quality Compass because no Medicaid benchmarks exist for this measure. For the *Controlling High Blood Pressure* measure, DHCS established the reporting year 2019 high performance level and minimum performance level based on the HEDIS 2018 national Medicaid 90th and 25th percentiles, respectively, from NCQA’s Quality Compass.

No national benchmarks exist for non-HEDIS measures; therefore, DHCS did not establish performance levels for the *Promotion of Positive Pro-Social Activity* and *School Attendance* measures.

According to DHCS' license agreement with NCQA, HSAG includes in Table 9.2 the benchmarks that DHCS used to establish the high performance levels and minimum performance levels for the reporting year 2019 HEDIS measures.

**Table 9.2—High Performance Level and Minimum Performance Level Benchmark Values for Reporting Year 2019 (Measurement Year 2018)**

Measure	Reporting Year 2019 High Performance Level	Reporting Year 2019 Minimum Performance Level
<i>Colorectal Cancer Screening</i>	79.00%	55.96%
<i>Controlling High Blood Pressure</i>	71.04%	49.15%

As applicable, SHPs are contractually required to perform at or above DHCS-established minimum performance levels; and DHCS uses the established high performance levels as performance goals, recognizing SHPs for outstanding performance. DHCS assesses each SHP's performance measure rates against the established minimum performance levels and requires SHPs to submit to DHCS an IP for each measure with a rate below the minimum performance level. As with MCPs, IPs consist of an SHP's submission of PDSA Cycle Worksheets or completion of PIPs—as determined by DHCS.

Note the following regarding performance measure results:

- ◆ DHCS will not require AIDS Healthcare Foundation to submit an IP if the rate for the *Colorectal Cancer Screening* was below the minimum performance level for reporting year 2019 because DHCS will not require AIDS Healthcare Foundation to report the measure to DHCS in reporting year 2020. DHCS and HSAG will therefore have no way to follow up on the outcomes of the SHP's quality improvement actions related to the measure. While DHCS will not require AIDS Healthcare Foundation to submit an IP for the measure if the rate was below the minimum performance level, DHCS and HSAG expect that AIDS Healthcare Foundation will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the SHP will conduct improvement activities, as applicable, related to this measure.
- ◆ For the *Controlling High Blood Pressure* measure:
  - Due to specification changes that NCQA made in reporting year 2019, NCQA recommended a break in trending for the *Controlling High Blood Pressure* measure; therefore, this measure was considered a first-year measure in reporting year 2019.

- HSAG only displays the reporting year 2019 rate for this measure in Table 9.3; however, because DHCS did not hold AIDS Healthcare Foundation accountable to meet the established minimum performance level for this measure in reporting year 2019, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of SHP performance.

## Results and Findings—Specialty Health Plan Performance Measures

### AIDS Healthcare Foundation

#### Results

Table 9.3 displays AIDS Healthcare Foundation’s performance measure results for reporting years 2017 through 2019. The reporting year is the year in which the SHP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all three years.

#### Table 9.3—Multi-Year Performance Measure Results AIDS Healthcare Foundation—Los Angeles County

 = Rate indicates performance above the high performance level.

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

 = Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

 = Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing SHP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Colorectal Cancer Screening</i> <sup>^</sup>	58.26%	58.45%	56.41%	-2.04
<i>Controlling High Blood Pressure</i>	—	—	56.86%	Not Comparable

## Findings

The *Colorectal Cancer Screening* measure rate showed no statistically significant changes from reporting year 2018 and reporting year 2019, and the rate was between the high performance level and minimum performance level in reporting year 2019.

## Family Mosaic Project—Results

Table 9.4 displays FMP’s performance measure results for reporting years 2018 and 2019. The reporting year is the year in which the SHP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that while FMP reported rates for the *Promotion of Positive Pro-Social Activity* and *School Attendance* measures prior to reporting year 2018, because of specification changes made to both measures in reporting year 2018, the measures were considered first-year measures in reporting year 2018.

### Table 9.4—Multi-Year Performance Measure Results Family Mosaic Project—San Francisco County

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

NA = The SHP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>School Attendance</i>	NA	NA	Not Comparable
<i>Promotion of Positive Pro-Social Activity</i>	NA	NA	Not Comparable

## Recommendations—Specialty Health Plan Performance Measures

Based on SHP reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG has no recommendations for DHCS in the area of performance measures related to SHPs.

SHP-specific performance measure results, findings, and recommendations are included in the applicable appendices at the end of this report (appendices A through FF).

## 10. Managed Long-Term Services and Supports Plan Performance Measures

As part of the CCI, DHCS holds contracts with 13 MLTSSPs to provide long-term support services and Medicare wraparound benefits to dual eligible beneficiaries who have opted out of Cal MediConnect<sup>24</sup> or who are not eligible for Cal MediConnect. Table 10.1 lists MLTSSPs and the counties in which they operate.

**Table 10.1—Managed Long-Term Services and Supports Plans**

Managed Long-Term Services and Supports Plans	Counties
Aetna Better Care of California	Sacramento and San Diego
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Santa Clara
Blue Shield of California Promise Health Plan	San Diego
CalOptima	Orange
Community Health Group Partnership Plan	San Diego
Health Net Community Solutions, Inc.	Los Angeles and San Diego
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	Riverside and San Bernardino
Kaiser SoCal (KP Cal, LLC)	San Diego
L.A. Care Health Plan	Los Angeles
Molina Healthcare of California Partner Plan, Inc.	Riverside, San Bernardino, and San Diego
Santa Clara Family Health Plan	Santa Clara
UnitedHealthcare Community Plan	Sacramento and San Diego

Note that UnitedHealthcare Community Plan exited Sacramento County October 31, 2018; beneficiaries served by this MLTSSP in calendar year 2018 therefore did not meet continuous

<sup>24</sup> Cal MediConnect—All of a beneficiary’s medical, behavioral health, long-term institutional, and home- and community-based services are combined into a single health plan. This allows providers to better coordinate care and to simplify for beneficiaries the process of obtaining appropriate, timely, accessible care.

enrollment criteria for reporting year 2019. HSAG includes no MLTSSP performance measure results, findings, or recommendations for UnitedHealthcare Community Plan Sacramento County in this report or in the MCP-specific evaluation report.

## Requirements

In reporting year 2019, DHCS required the MLTSSPs to report rates for three HEDIS measures. Table 10.2 lists the HEDIS performance measures that DHCS required MLTSSPs to report for reporting year 2019.

**Table 10.2— Reporting Year 2019 (Measurement Year 2018) Managed Long-Term Services and Supports Plan Performance Measures**

Admin = administrative method, which requires that MLTSSPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MLTSSPs derive the numerator, or services provided to beneficiaries in the eligible population, from administrative data sources and auditor-approved supplemental data sources. MLTSSPs cannot use medical records to retrieve information. When using the administrative method, MLTSSPs use the entire eligible population as the denominator because NCQA does not allow sampling.

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

\* Member months are a member’s “contribution” to the total yearly membership.

Measure	NCQA Method of Data Capture
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	Admin
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	Admin
<i>Medication Reconciliation Post-Discharge</i>	Hybrid

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

Table 10.3 presents the MLTSSP weighted averages for each required performance measure for reporting years 2016 through 2019 and compares the reporting year 2019 rates to the reporting year 2018 rates. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

**Table 10.3—Multi-Year Statewide Weighted Average Performance Measure Results for Managed Long-Term Services and Supports Plans**

 = Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

 = Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018

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

\* Member months are a member's “contribution” to the total yearly membership.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Ambulatory Care— Emergency Department Visits per 1,000 Member Months*</i>	53.20	34.14	51.87	50.92	Not Tested
<i>Ambulatory Care— Outpatient Visits per 1,000 Member Months*</i>	407.10	307.31	440.39	496.34	Not Tested

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
<i>Medication Reconciliation Post-Discharge</i>	10.95%	19.71%	21.74%	21.59%	-0.15

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

The MCMC weighted average for the *Medication Reconciliation Post-Discharge* measure remained consistent, showing no statistically significant change from reporting year 2018 to reporting year 2019.

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

Based on reporting year 2019 MLTSSP aggregated performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG has no recommendations for DHCS in the area of performance measures related to MLTSSPs.

MLTSSP-specific performance measure results and findings are included in the applicable appendices at the end of this report (appendices A through FF).

## 11. Dental Managed Care Plan Performance Measures

### Requirements

DHCS requires DMC plans to submit quarterly self-reported performance measure rates for each reporting unit (i.e., Los Angeles County and Sacramento County). To provide ongoing, consistent comparison over time, DMC plans use a rolling 12-month methodology to display rates for a full year within each quarterly performance measure rate report.

Reporting year 2019 was the first year that DHCS required DMC plans to submit both reporting units’ audited performance measure rates reflecting measurement year data from the previous calendar year (i.e., January 1, 2018, through December 31, 2019). DHCS required DMC plans to submit the reporting year 2019 audited rates in April 2019.

### Results—Dental Managed Care Plan Performance Measures

Table 11.1 presents the reporting year 2019 DMC plan statewide weighted averages for each required performance measure. To allow HSAG to provide a meaningful display of DMC plan performance, HSAG organized the performance measures according to the health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Note that HSAG could not compare reporting year 2019 DMC plans’ performance measure rates to historical data or DHCS’ encounter data since reporting year 2019 was the first year that DMC plans were required to report audited performance measure rates; therefore, HSAG makes no conclusions or recommendations related to DMC plans’ reporting year 2019 performance measure results.

**Table 11.1—Reporting Year 2019 (Measurement Year 2018) Statewide Weighted Average Performance Measure Results for Dental Managed Care Plans**

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Reporting Year 2019 Rate
<b>Access to Care</b>	
<i>Annual Dental Visits—0–20 Years</i>	39.28%
<i>Annual Dental Visits—21+ Years</i>	18.95%
<i>Continuity of Care—0–20 Years</i>	63.68%
<i>Continuity of Care—21+ Years</i>	32.21%
<i>Exam/Oral Health Evaluations—0–20 Years</i>	34.48%

*DENTAL MANAGED CARE PLAN PERFORMANCE MEASURES*

Measure	Reporting Year 2019 Rate
<i>Exam/Oral Health Evaluations—21+ Years</i>	14.08%
<i>General Anesthesia—0–20 Years</i>	65.17%
<i>General Anesthesia—21+ Years</i>	34.84%
<i>Overall Utilization of Dental Services—One Year—0–20 Years</i>	42.57%
<i>Overall Utilization of Dental Services—One Year—21+ Years</i>	19.17%
<i>Use of Dental Treatment Services—0–20 Years</i>	19.52%
<i>Use of Dental Treatment Services—21+ Years</i>	12.56%
<i>Usual Source of Care—0–20 Years</i>	32.93%
<i>Usual Source of Care—21+ Years</i>	8.80%
<b>Preventive Care</b>	
<i>Preventive Services to Filling—0–20 Years</i>	82.51%
<i>Preventive Services to Filling—21+ Years</i>	36.01%
<i>Sealants to Restoration Ratio (Surfaces)—6–9 Years</i>	5.42
<i>Sealants to Restoration Ratio (Surfaces)—10–14 Years</i>	2.39
<i>Treatment/Prevention of Caries—0–20 Years</i>	38.58%
<i>Treatment/Prevention of Caries—21+ Years</i>	7.48%
<i>Use of Preventive Services—0–20 Years</i>	33.61%
<i>Use of Preventive Services—21+ Years</i>	7.84%
<i>Use of Sealants—6–9 Years</i>	13.75%
<i>Use of Sealants—10–14 Years</i>	6.76%

## 12. Performance Improvement Projects

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.358(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- ◆ Measuring performance using objective quality indicators
- ◆ Implementing system interventions to achieve quality improvement
- ◆ Evaluating effectiveness of the interventions
- ◆ Planning and initiating activities for increasing and sustaining improvement

The EQR technical report must include information on the validation of performance improvement projects required by the state and underway during the preceding 12 months.

### Background

To comply with the CMS requirements, since 2008 DHCS has contracted with HSAG to conduct an independent validation of PIPs submitted by MCPs, PSPs, and SHPs. HSAG uses a two-pronged approach. First, HSAG provides training and technical assistance to these plans on how to design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. Then, HSAG assesses the validity and reliability of PIP submissions to draw conclusions about the quality and timeliness of, and access to, care furnished by these plans.

Beginning in January 2019, DHCS contracted with HSAG to work on quality improvement projects (QIPs) with DHCS and DMC plans. DHCS requested that HSAG provide technical assistance to DMC plans and to DHCS related to the statewide QIP. Additionally, DHCS requested that HSAG conduct DMC plan training about HSAG's rapid-cycle PIP process, to transition DMC plans to conducting their individual QIPs using that process.

### ***Managed Care Health Plan, Population-Specific Health Plan, and Specialty Health Plan Requirements***

DHCS requires that each MCP, PSP, and SHP conduct a minimum of two DHCS-approved PIPs per each Medi-Cal contract held with DHCS. If an MCP, PSP, or SHP holds multiple contracts with DHCS and the areas in need of improvement are similar across contracts, DHCS may approve the plan to conduct the same two PIPs across all contracts (i.e., conduct two PIPs total).

Beginning in July 2017, DHCS set two new categories of PIP topic selection for MCPs, PSPs, and SHPs. For MCPs, DHCS required that the first PIP topic involve an identified health

disparity (Disparity PIP). DHCS required that the second PIP topic be related to the MCP's performance on a metric related to one of the four MCMC quality strategy priority areas (DHCS-priority PIP). DHCS set the following DHCS-priority PIP topic selection criteria:

- ◆ DHCS required an MCP to choose *Childhood Immunizations—Combination 3* as its topic if the MCP performed below the minimum performance level on the measure in reporting year 2017 or performed below the statewide MCMC average, with declining performance on the measure having occurred in reporting year 2017.

If not required to choose *Childhood Immunizations—Combination 3* as a topic based on the criteria listed above, DHCS required that the MCP focus the DHCS-priority PIP topic on:

- *Controlling High Blood Pressure, Comprehensive Diabetes Care, or Prenatal and Postpartum Care—Postpartum Care* if the MCP performed below the minimum performance levels on any of these measures in reporting year 2017. If an MCP performed below the minimum performance levels for more than one of these measures in reporting year 2017, DHCS required that the MCP choose the measure for which it has performed below the minimum performance level for consecutive years or the measure for which the MCP's performance has been significantly declining for consecutive years.

Or:

- If in reporting year 2017 an MCP performed above the minimum performance level and MCMC average for *Childhood Immunizations—Combination 3* and above the minimum performance levels for *Controlling High Blood Pressure, Comprehensive Diabetes Care, and Prenatal and Postpartum Care—Postpartum Care*, DHCS required that the MCP choose a PIP topic for any area in need of improvement.

For PSPs and SHPs, when Disparity PIP topics were not applicable, DHCS required that SHPs identify two topics using the topic selection criteria for DHCS-priority PIPs.

The SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date for the MCP, PSP, and SHP PIPs was June 30, 2019.

## ***Dental Managed Care Plan Requirements***

DHCS requires DMC plans to conduct or participate in two QIPs each year. One QIP must be the statewide QIP, and the second individual QIP must be for a topic about which DMC plans have consulted with DHCS.

## **Dental Managed Care Plan Statewide Quality Improvement Projects**

DHCS requires DMC plans to conduct a statewide QIP to increase preventive services among children ages 1 to 20 by 10 percentage points by the end of 2023. Prior to January 2019, DHCS required DMC plans to submit quarterly progress reports for the *Preventive Services Utilization* statewide QIP, and DHCS provided feedback to DMC plans on the submissions. After discussions with HSAG in January and February of 2019, DHCS modified the statewide

QIP requirements to require DMC plans to submit two reports annually—one intervention progress report to HSAG and an annual QIP submission to DHCS.

### **Dental Managed Care Plan Performance Improvement Projects**

Beginning in February 2019, DHCS required DMC plans to convert their individual QIPs to rapid-cycle PIPs and to follow HSAG’s rapid-cycle PIP process. With the transition of DMC plans’ individual QIPs to HSAG’s rapid-cycle PIP process, HSAG refers to DMC plans’ individual QIPs as individual PIPs.

### ***Performance Improvement Projects Approach***

HSAG’s rapid-cycle PIP approach places emphasis on improving both health care outcomes and processes through the integration of quality improvement science. This approach guides MCMC plans through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility for adjusting throughout the improvement process. By piloting changes on a smaller scale, MCMC plans have opportunities to determine the effectiveness of several changes prior to expanding the successful interventions. The following modules guide these plans through the rapid-cycle PIP approach:

- ◆ Module 1: PIP Initiation
- ◆ Module 2: SMART Aim Data Collection
- ◆ Module 3: Intervention Determination
- ◆ Module 4: Plan-Do-Study-Act (PDSA)
- ◆ Module 5: PIP Conclusions

The rapid-cycle PIP approach requires up-front preparation to allow for a more structured, scientific approach to quality improvement. Modules 1 through 3 create the basic infrastructure to help MCMC plans identify interventions to test. Through an iterative process, these plans have opportunities to revise modules 1 through 3 to achieve all validation criteria. Once the plans achieve all validation criteria for modules 1 through 3 and receive feedback on the Plan portion of Module 4, they test interventions. For each intervention it tests on a small scale using the PDSA cycle, each MCMC plan must submit a separate Module 4.

Once MCMC plans complete intervention testing, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon). MCMC plans complete Module 5 after testing all interventions and finalizing analyses of the PDSA cycles. Module 5 summarizes the results of the tested interventions. At the end of the PIP, the plans identify successful interventions that may be implemented on a larger scale to achieve the desired health care outcomes.

## Objectives

The purpose of HSAG's PIP validation is to ensure that MCMC plans, DHCS, and stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies conducted through the PIPs.

HSAG evaluates two key components of each PIP:

- ◆ Technical structure, to determine whether a PIP's initiation (i.e., topic rationale, PIP team, global aim, SMART aim, key driver diagram, and data collection methodology) is based on sound methodology and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- ◆ Conducting of quality improvement activities. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing, evaluation using PDSA cycles, sustainability, and spreading successful change. This component evaluates how well MCMC plans execute quality improvement activities and whether the PIP achieves and sustains the desired aim.

## Methodology

Based on the agreed-upon timeline, MCMC plans submit each module of the PIP to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to these plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. HSAG conducts PIP validation in accordance with the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012*.<sup>25</sup> Following are the validation criteria that HSAG uses for each module:

### Module 1—PIP Initiation

- ◆ The topic and narrowed focus were supported by the data and were aligned with the State's quality strategy.
- ◆ The MCMC plan identified team members from both internal plan staff and external partners, including representation for the narrowed focus.
- ◆ The SMART Aim included all required components; and the MCMC plan developed the SMART Aim based on literature review; plan data; and/or experience.
- ◆ The Global Aim, SMART Aim, key drivers, and potential interventions were aligned and stated accurately.

<sup>25</sup> The CMS protocols may be found at <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Dec 16, 2019.

## **Module 2—SMART Aim Data Collection**

- ◆ The SMART Aim measure included all of the following components:
  - Well-defined numerator and denominator
  - Appropriate baseline measurement period
  - Appropriate measurement intervals for the SMART Aim
  - Appropriate SMART Aim goal based on the baseline rate and denominator size
- ◆ The SMART Aim data collection methodology supported the rapid-cycle process and included the following:
  - Data source(s).
  - Step-by-step process that was in alignment with the baseline data collection methodology.
  - List of team members responsible for collecting the data.
- ◆ If used, the data collection tool(s) was appropriate and captured all required data elements.
- ◆ The run/control chart included the titles, SMART Aim goal, baseline percentage, and data collection interval.

## **Module 3—Intervention Determination**

- ◆ The MCMC plan documented the team members responsible for completing the process map and failure modes and effects analysis (FMEA).
- ◆ The process map illustrated a step-by-step flow of the current overall process. The sub-processes identified in the process map as opportunities for improvement were numbered and clearly referenced in the FMEA table.
- ◆ The MCMC plan included a description of the process and rationale used for selecting the subprocesses for the FMEA table.
- ◆ The FMEA table included:
  - Subprocesses that aligned with the opportunities for improvement identified in the process map.
  - Failure modes, causes, and effects for each subprocess listed in the table.
- ◆ The MCMC plan described its failure mode priority ranking process.
- ◆ The interventions listed in the Intervention Determination Table were appropriate based on the ranked failure modes.
- ◆ The MCMC plan considered the intervention’s reliability and sustainability as part of its intervention selection process.

## **Module 4—Plan-Do-Study-Act (PDSA)**

- ◆ The tested intervention addressed at least one or more of the key drivers or identified failures, and the MCMC plan explained how the intervention fits into the theory of change.

- ◆ The MCMC plan documented an appropriate intervention plan (who, what, where, and how).
- ◆ The intervention effectiveness measure was methodologically sound and appropriate for the tested intervention.
- ◆ The MCMC plan provided a complete and accurate summary of the intervention testing results.
- ◆ The MCMC plan's decision to adopt, adapt, or abandon the intervention was supported by appropriate rationale and intervention testing results.

### **Module 5—PIP Conclusions**

- ◆ The MCMC plan demonstrated evidence of having achieved the SMART Aim goal.
- ◆ If the SMART Aim goal was achieved, the improvement was clearly linked to the tested intervention(s).
- ◆ The narrative summary of the overall findings and interpretation of results was accurate and complete.
- ◆ The MCMC plan documented lessons learned.
- ◆ If the SMART Aim goal was achieved, the MCMC plan documented a plan for sustaining the improvement beyond the SMART Aim end date.
- ◆ The MCMC plan provided the final key driver diagram, FMEA, and Intervention Determination Table.

Once a PIP reaches completion, HSAG assesses the validity and reliability of the results to determine whether or not key stakeholders may have confidence in the reported PIP findings. HSAG assigns the following confidence levels for each PIP:

- ◆ High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- ◆ Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings; however, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ◆ Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ◆ Reported PIP results were not credible—the PIP methodology was not executed as approved.

After validating each PIP module, HSAG provides written feedback to MCMC plans summarizing HSAG's findings and whether or not the plans achieved all validation criteria.

Once these plans achieve all validation criteria for modules 1 through 3, HSAG conducts a pre-validation review on each plan's Plan portion of Module 4 and provides feedback for the plans to consider prior to beginning intervention testing. HSAG requests status updates from the plans throughout the intervention testing phase of the PIP process and, when needed, provides technical assistance.

HSAG validated up to the point of PIP progression for each MCP, PSP, and SHP as of June 30, 2019; results of the validation activities completed by June 30, 2019, are included in this report.

While DMC plans began the rapid-cycle PIP process for their individual PIPs, these plans had no PIP module submissions during the review period for this report; therefore, HSAG includes no validation results for the DMC plans.

## Results—Performance Improvement Projects

### *Managed Care Health Plans, Population-Specific Health Plans, and Specialty Health Plans*

During the review period, HSAG validated the following numbers of PIP modules and notified MCPs, PSPs, SHPs, and DHCS of the validation results:

- ◆ Module 1—one initial submission and four resubmissions
- ◆ Module 2—one initial submission and six resubmissions
- ◆ Module 3—19 initial submissions and 51 resubmissions

HSAG pre-validated 71 Plan portions of PIP Module 4 submissions to ensure that MCPs, PSPs, and SHPs were on track to complete the intervention testing phase of the PIP process. Additionally, HSAG completed Module 4 progress update check-ins with MCPs, PSPs, and SHPs to follow up on the status of intervention testing.

Throughout the review period, HSAG provided technical assistance via conference calls and email communications to address the following areas for which MCPs, PSPs, and SHPs requested technical assistance:

- ◆ Guidance on HSAG's rapid-cycle PIP process, submission requirements, and validation criteria.
- ◆ Clarification on HSAG's validation findings on PIP modules.
- ◆ Assistance with the rolling 12-month data calculation methodology.
- ◆ Consultation on intervention implementation strategies and challenges.

Table 12.1 lists MCPs', PSPs', and SHPs' PIP topics.

**Table 12.1—Managed Care Health Plan/Population-Specific Health Plan/Specialty Health Plan Performance Improvement Project Topics**

\* PIP conducted as part of CAP process.

<b>MCP/PSP/SHP Name</b>	<b>PIP Topic</b>
AIDS Healthcare Foundation	<i>Colorectal Cancer Screening</i>
	<i>Diabetes Retinal Eye Exam</i>
Alameda Alliance for Health	<i>Children/Adolescent Access to Primary Care Physicians</i>
	<i>Diabetes Care HbA1c Testing Among African-American Males</i>
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	<i>Asthma Medication Ratio Among African Americans</i>
	<i>Postpartum Care</i>
Blue Shield of California Promise Health Plan	<i>Childhood Immunization Status—Combination 3 Among Non-Hispanics</i>
	<i>Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life</i>
California Health & Wellness Plan	<i>Childhood Immunization Status—Combination 3*</i>
	<i>Controlling Blood Pressure Among Hispanics*</i>
CalOptima	<i>Adult’s Access to Preventive/Ambulatory Health Services</i>
	<i>Diabetes Care Poor HbA1c Control in Santa Ana City</i>
CalViva Health	<i>Childhood Immunization Status—Combination 3*</i>
	<i>Postpartum Care in Fresno County*</i>
GenCal Health	<i>Childhood Immunization Status—Combination 3</i>
	<i>Human Papillomavirus Vaccination Among Adolescents in Santa Barbara County</i>
Central California Alliance for Health	<i>Childhood Immunization Status—Combination 3</i>
	<i>Opioid Overdose Deaths in Merced County</i>
Community Health Group Partnership Plan	<i>Annual Provider Visits Among Males 20 to 30 Years of Age</i>
	<i>Childhood Immunization Status—Combination 3</i>
Contra Costa Health Plan	<i>Controlling Blood Pressure Among African Americans</i>
	<i>Diabetes Nephropathy Screening</i>
Family Mosaic Project	<i>Improving Client Access and Use of Recreational Activities</i>
	<i>Reducing Physical Health Issues</i>

<b>MCP/PSP/SHP Name</b>	<b>PIP Topic</b>
Gold Coast Health Plan	<i>Childhood Immunization Status—Combination 3</i>
	<i>Diabetes Care Poor HbA1c Control Among Non-English-Speaking Hispanics/Latinos</i>
Health Net Community Solutions, Inc.	<i>Cervical Cancer Screening Among Mandarin Speaking Chinese*</i>
	<i>Childhood Immunization Status—Combination 3*</i>
Health Plan of San Joaquin	<i>Cervical Cancer Screening Among White Women 24 to 64 Years of Age in Stanislaus County*</i>
	<i>Childhood Immunization Status—Combination 3*</i>
Health Plan of San Mateo	<i>Asthma Medication Ratio</i>
	<i>Cervical Cancer Screening Among English-Speaking Population</i>
Inland Empire Health Plan	<i>Asthma Medication Ratio</i>
	<i>Childhood Immunization Status—Combination 10 Among African Americans in Riverside County</i>
Kaiser NorCal	<i>Contraception Use Among Adolescent Women in South Sacramento</i>
	<i>Initial Health Assessment</i>
Kaiser SoCal	<i>Adolescent Vaccinations</i>
	<i>Depression Screening Among Hispanics/Latinos</i>
Kern Family Health Care	<i>Childhood Immunization Status—Combination 3 Among African Americans</i>
	<i>Use of Imaging Studies for Lower Back Pain</i>
L.A. Care Health Plan	<i>Childhood Immunization Status—Combination 3</i>
	<i>Diabetes Medication Adherence Among African Americans</i>
Molina Healthcare of California Partner Plan, Inc.	<i>Childhood Immunization Status—Combination 3</i>
	<i>Postpartum Care Among African Americans in Riverside/San Bernardino Counties</i>
Partnership HealthPlan of California	<i>Childhood Immunization Status—Combination 3*</i>
	<i>Diabetes Nephropathy Screening in Southwest Region*</i>
San Francisco Health Plan	<i>Immunizations for Adolescents—Combination 2</i>
	<i>Postpartum Care Among African Americans</i>
Santa Clara Family Health Plan	<i>Childhood Immunization Status—Combination 3 Among Vietnamese</i>
	<i>Controlling High Blood Pressure</i>
SCAN Health Plan	<i>Cholesterol Medication Adherence</i>
	<i>Statin Use in Persons with Diabetes in San Bernardino County</i>

## Dental Managed Care Plans

In collaboration with DHCS, HSAG conducted the Statewide QIP Intervention Progress Report Overview webinar in March 2019 to provide DMC plans information on the report submission requirements. In April 2019, DMC plans submitted their *Preventive Services Utilization* statewide QIP intervention progress reports to HSAG for review; and in May 2019, HSAG sent feedback to DMC plans and DHCS on the intervention progress reports.

For DMC plans' individual PIPs, HSAG conducted the Rapid-Cycle PIP Process Overview webinar in April 2019 to provide DMC plans with information about the key concepts of the rapid-cycle PIP framework as well as submission requirements and validation criteria for PIP modules. HSAG also provided technical assistance to DMC plans through their individual PIP topic selection process.

Table 12.2 lists DMC plans' individual PIP topics.

**Table 12.2—Dental Managed Care Plan Performance Improvement Project Topics**

DMC Plan Name	PIP Topic
Access Dental Plan	<i>Increasing an Annual Dental Visit for Children, Ages 5–18</i>
Health Net of California	<i>Dental Care among Beneficiaries Living with Diabetes</i>
LIBERTY Dental Plan of California, Inc.	<i>Dental Care among Beneficiaries Living with Diabetes</i>

MCMC-specific information related to PIPs is included within the MCMC plan-specific evaluation reports, located in appendices A through FF.

## Conclusions—Performance Improvement Projects

During the review period, all MCPs, PSPs, and SHPs achieved the required criteria for modules 1, 2, and 3 for their 2017–19 Disparity and DHCS-priority PIPs; conducted intervention testing for both PIPs; concluded the PIPs by June 30, 2019; and were on schedule to submit modules 4 and 5 for HSAG's validation by their due dates in September 2019 and October 2019. The modules 4 and 5 submission due dates are outside of the review period of this EQR technical report; therefore, HSAG includes no aggregate PIP outcomes information in this report. HSAG will include aggregate PIP outcomes information for the 2017–19 Disparity and DHCS-priority PIPs in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*.

Through HSAG's PIP training and technical assistance, DMC plans completed their first intervention progress report for the *Preventive Services Utilization* statewide QIP and received HSAG's feedback on their interventions. Additionally, DMC plans selected their individual PIP topics and obtained pertinent information to initiate their new rapid-cycle PIPs.

## **Recommendations—Performance Improvement Projects**

HSAG has no recommendations for DHCS related to PIPs.

## 13. Validation of Network Adequacy

Validation of network adequacy is a mandatory EQR activity; and states must begin conducting this activity, described at 42 CFR §438.358(b)(1)(iv), no later than one year from CMS' issuance of the associated EQR protocol. While CMS originally planned to release the protocol in 2018, it had not yet been released at the time that this EQR technical report was produced.

To assist DHCS with assessing and ensuring network adequacy across contracted MCPs, PSPs, and SHPs, DHCS contracted with HSAG on the following network adequacy activities:

- ◆ Alternative Access Reporting
- ◆ SNF/ICF Experience Reporting
- ◆ Timely Access Focused Study

### Alternative Access Reporting

As part of DHCS' ongoing monitoring and oversight of MCPs, PSPs, and SHPs, DHCS ensures that MCPs', PSPs', and SHPs' provider networks are adequate to deliver services to beneficiaries. If providers are unavailable or unwilling to service Medi-Cal beneficiaries such that an MCP, PSP, or SHP is unable to meet provider network standards, MCPs, PSPs, and SHPs may request that DHCS allow an alternative provider network access standard for specified provider scenarios (e.g., provider type, geographic area). The DHCS APL 19-002<sup>26</sup> provides MCPs, PSPs, and SHPs with DHCS' clarifying guidance regarding network certification requirements, including requests for alternative access standards.

Due to their delivery structure, some MCPs may be eligible to petition DHCS to consider an alternative to the time and distance standard.<sup>27</sup> This alternative is used by PSPs and SHPs (AIDS Healthcare Foundation, Family Mosaic Project, Rady Children's Hospital—San Diego, and SCAN Health Plan) as this process allows for each MCP, PSP, and SHP to justify its capability to deliver the appropriate level of care within its specialized delivery structure. If DHCS agrees that the MCP is delivering the appropriate level of care at that time, there would be no need for the MCP, PSP, and SHP to submit additional data regarding the network for time and distance standards.

DHCS reviews each MCP's, PSP's, and SHP's alternative access standard request to determine that the requesting MCP, PSP, or SHP has adequately described its delivery

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<sup>26</sup> All Plan Letter 19-002. Available at:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-002.pdf>. Accessed on: Jan 9, 2020.

<sup>27</sup> CA WIC §14197(e)(1)(B).

structure to exhibit a clinically integrated health care model/network consisting of, but not limited to either of the following:

- ◆ **Medical Home:** A team-based health care delivery model led by a health care team in a centralized facility to provide comprehensive and continuous medical care to patients with a goal to obtain maximal health outcomes.
- ◆ **Specialty Services for Specialty Population:** A limited but comprehensive network that renders services specific to the diagnoses of the beneficiaries and ensures that care coordination and support services are available across the continuum of care regardless of location.

This alternative to the time and distance standard does not preclude MCPs, PSPs, and SHPs from meeting the other Annual Network Certification components. DHCS reserves the right to revoke an approved alternative access standard request if concerns regarding quality of care are discovered through avenues including but not limited to grievances and appeals reporting and timely access survey results.

Additionally, CA WIC §14197.05<sup>28</sup> requires DHCS' annual EQR technical report to present information related to MCPs' alternative access standard requests. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to process and report on data related to alternative access standards for MCP provider networks.

## ***Reporting Elements***

The following reporting elements are defined by CA WIC §14197.05 for inclusion in the annual EQR technical report:

- ◆ The number of requests for alternative access standards in the plan service area for time and distance, categorized by all provider types, including specialists, and by adult and pediatric.
- ◆ The number of allowable exceptions for the appointment time standard, if known, categorized by all provider types, including specialists, and by adult and pediatric.
- ◆ Distance and driving time between the nearest network provider and ZIP Code of the beneficiary furthest from that provider for requests for alternative access standards.
- ◆ The approximate number of beneficiaries impacted by alternative access standards or allowable exceptions.
- ◆ Percentage of providers in the plan service area, by provider and specialty type, that are under a contract with a Medi-Cal MCP.

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<sup>28</sup> CA WIC §14197.05. Available at: [https://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05](https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05). Accessed on: Jan 9, 2020.

- ◆ The number of requests for alternative access standards approved or denied by ZIP Code and provider and specialty type, and the reasons for the approval or denial of the request for alternative access standards.
- ◆ The process of ensuring out-of-network access.
- ◆ Descriptions of contracting efforts and explanation for why a contract was not executed.
- ◆ Time frame for approval or denial of a request for alternative access standards by DHCS.
- ◆ Consumer complaints, if any.

## Methodology

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

- ◆ MCPs' alternative access standards request data.<sup>29</sup>
- ◆ DHCS' alternative access standards administrative data (i.e., a Microsoft Excel workbook).
- ◆ DHCS' quarterly grievance reports data from 2018 Quarter 3 through 2019 Quarter 1 on beneficiaries' complaints related to access to providers (e.g., no providers in the area who accept the beneficiary's MCP, the beneficiary is unable to obtain an appointment with a contracted provider).
- ◆ Medi-Cal Managed Care Office of the Ombudsman data on beneficiary grievances and appeals related to access to providers, and specifically to time and distance standards (e.g., no providers in the area who accept the beneficiary's MCP, the beneficiary is unable to obtain an appointment with a contracted provider). The reporting period for the Ombudsman data is July 1, 2018, through June 30, 2019.

MCPs were required to submit alternative access standard requests to DHCS no later than March 19, 2018, for those standards to be effective on July 1, 2018. Approved alternative access standards are valid for the July 1, 2018, through June 30, 2019, contract year. The analysis is based on alternative access standard requests submitted to DHCS between February 1, 2018, and January 31, 2019.

Note the following:

- ◆ MCPs did not invoke the advanced access exception during the reporting period; therefore, no exceptions for the appointment time standard exist, and this reporting element is not included in the analysis.
- ◆ HSAG previously determined that the percentage of providers in the service plan area by provider and specialty type who are under a contract with a Medi-Cal MCP (i.e., the penetration rate) could not be calculated due to a lack of information in data sources outside of the control of DHCS—the 274 Provider Demographic files and California Medical Board (CMB) licensing data that would allow the identification of the number of providers

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<sup>29</sup> MCPs are allowed to use the Alternative Access Standard Request Template for time and distance standards only.

servicing a specific county. During the analysis, HSAG found that the physician's license number field in the 274 provider data was unreliable and that only a small fraction of physicians could be identified across both the CMB and 274 provider datasets. As a result, HSAG was unable to accurately identify and reconcile across the two datasets all practicing physician locations. This issue resulted in inaccurate, unreliable MCP-level penetration rates as locations included in the numerator (274 provider data) were not necessarily included in the denominator (CMB data).

- HSAG identified substantial differences in the number of specialties that physicians could report from these two data sources. This variance also rendered specialty-level penetration rates unreliable and inaccurate. As reflected in the CMB data, physicians were limited to only two specialties, whereas in the 274 provider data, there was no effective limit to the number of specialties that a physician could report. This, combined with the inability to accurately connect licensure data to the 274 provider data, resulted in unreliable, inaccurate penetration rates, specifically in that physicians may have appeared in the numerator but not in the denominator. Without the ability to accurately connect the two datasets, HSAG could not ensure physicians appeared in both the numerator and denominator. For these reasons, the percentage of providers in a service plan area under contract with a Medi-Cal MCP is not included in the analysis.

## **Results—Alternative Access Reporting**

### **Number of Requests, Approvals, and Denials**

The alternative access standard requests were tabulated and stratified by the following characteristics: MCP, county, ZIP Code, provider type (including specialty), and adult or pediatric focus.<sup>30</sup> For each combination of the strata, HSAG tabulated the total number of requests submitted, and then identified the final disposition of the request as approved or denied. Regardless of the number of requests submitted for a given MCP, county, ZIP Code, provider type, or adult or pediatric combination, there is only one final approval or denial for that combination of characteristics.

There were 62,731 requests submitted to DHCS, and 16,497 distinct combinations of request characteristics appeared in the data supplied by DHCS. Of the distinct combinations of request characteristics, 9,557 or 57.9 percent resulted in an approval from DHCS. The complete results for the analysis of the total number of requests submitted and the number approved or denied can be found in Appendix GG.

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<sup>30</sup> DHCS identified an adult/pediatric designation for mental health (non-psychiatry) outpatient services, core specialists, and PCPs. Hospitals, pharmacies, OB/GYN, and OB/GYN PCPs were identified with an N/A for the adult/pediatric designation.

## Reasons for the Approval or Denial of Alternative Access Standard Requests

DHCS approves or denies alternative access standard requests for multiple reasons. The most common reasons for DHCS to approve an alternative access standard request include:

- ◆ The alternative access standard request is within five miles of the standard.
- ◆ No closer in-network or out-of-network provider was located than the MCP indicated in its request.
- ◆ DHCS identified closer providers, yet all had been contacted by the MCP and the MCP clearly explained why those providers could not be added to its network.
- ◆ The alternative access standard request is for a PCP or mental health provider and is in a designated Health Professional Shortage Area (HPSA).

The most common reasons for DHCS to deny an alternative access standard request included:

- ◆ An in-network or out-of-network provider existed within the time or distance standard.
- ◆ An in-network provider existed outside the time or distance standard yet was closer than the alternative access standard request.
- ◆ An out-of-network provider existed outside the time or distance standard yet was closer than the alternative access standard request, as long as the closer provider found was not one of the providers the MCP contacted and clearly explained why those providers could not be added to the MCP's network.
- ◆ The alternative access standard request is incomplete or insufficient.
- ◆ The alternative access standard request is a PO Box or a unique ZIP Code (i.e., a high-volume mail receiver that receives mail in one location and distributes the mail internally such as a large organization, government building, or university).
- ◆ The alternative access standard request was no longer needed as the MCP was meeting time and distance standards.
- ◆ The alternative access standard request was sent in error or a duplicate request was submitted.

## Distance and Driving Time Between Nearest Network Provider and Furthest Beneficiary

For each MCP and ZIP Code for which alternative access standard requests were submitted, HSAG calculated the median distance and drive time between the nearest network provider and the beneficiary ZIP Code furthest from that network provider, as well as the median number of beneficiaries impacted. Because each MCP and ZIP Code combination may have multiple requests across provider types, HSAG also calculated the range of distances, drive times, and beneficiaries impacted across requests. The medians for each data element were calculated using all requests submitted, and not using only the approved requests. DHCS did not approve all requests included in this analysis, nor did DHCS approve all requests with the distance and drive times initially submitted.

The shortest median distance was 4.0 miles for Alameda Alliance for Health and ZIP Code 94605, while the longest median distance was 572.2 miles for California Health & Wellness Plan and ZIP Code 96022. The shortest median drive time was 8.0 minutes for Alameda Alliance for Health and ZIP Code 94605, while the longest median drive time was 1,101.6 minutes for California Health & Wellness Plan and ZIP Code 95927. The smallest median number of impacted beneficiaries was 0.0 individuals in 876 combinations of MCPs and ZIP Codes, while the largest median number of impacted beneficiaries was 34,521 individuals for Central California Alliance for Health and ZIP Code 93905. The complete results for the analysis of distances, drive times, and impacted beneficiaries can be found in Appendix GG.

### **Time Frame for Approval or Denial of Requests**

For each MCP, HSAG calculated the time between the initial alternative access standard request submitted by the MCP, and the final decision for approval or denial made by DHCS. For each MCP, HSAG then determined the maximum number of days to approval or denial for each distinct request submitted. Denials include alternative access standard requests for which the final disposition was “denial,” “partial approval,” or “no longer needed.”

In accordance with WIC 14197(e)(3), DHCS must approve or deny an alternative access standard request within 90 days of submission. DHCS may stop the 90-day review time frame on one or more occasions as necessary if an incomplete MCP submission is received or if additional information is needed from the MCP. Upon submission of the additional information to DHCS, the 90-day time frame would resume at the same point in time it was previously stopped, unless fewer than 30 days remain. In these instances, DHCS must approve or deny the alternative access standard request within 30 days of submission of the additional information.

Across all MCPs, the maximum number of days to approval or denial was 334 days for requests submitted between March 1, 2018, and June 30, 2018, and 208 days for requests submitted between July 1, 2018, and January 31, 2019. The complete results for the analysis of the time between an alternative access standard request and approval or denial can be found in Appendix GG.

### **Consumer Complaints**

HSAG reviewed two sources of data for consumer complaints: the number of calls made to the Medi-Cal Managed Care Office of the Ombudsman, and DHCS’ quarterly grievance reports from 2018 Quarter 3 through 2019 Quarter 2 on beneficiaries’ complaints related to access to providers, and specifically to time and distance standards. HSAG reviewed the ombudsman’s data stratified by MCP; however, the data did not include a county-level identifier for the location of the beneficiary. The ombudsman’s data identified counts of calls associated with “Access to Care.” In contrast, the DHCS grievance data included a county-level identifier and were stratified according to MCP and county. The grievance data identified counts of beneficiaries noting a lack of PCP or specialist availability.

On average, the Ombudsman Office received 4.1 calls for each MCP, with a low of 1.0 calls and a high of 18.0 calls. On average, there were 83.1 grievances for each MCP and county. The lowest number of grievances was 1.0, and the highest number of grievances was 995.0. The complete results for the analysis of consumer complaints can be found in Appendix GG.

### Process of Ensuring Out-of-Network Access

DHCS sets the requirements for MCPs to provide out-of-network access. Specifically, MCPs must provide for out-of-network access if their network is unable to provide medically necessary covered services within timely access standards. Additionally, MCPs must provide for the completion of covered services by a terminated or out-of-network provider at the request of a beneficiary in accordance with the continuity of care requirements in the California Health and Safety Code Section 1373.96. In addition to the aforementioned requirements, MCPs that are under a CAP for failing to meet time and distance standards must also ensure subcontractors and delegated entities adhere to the out-of-network access requirements, submit a policy or procedure to ensure there is a consistent process for out-of-network access compliance, and demonstrate their ability to effectively provide out-of-network access information to beneficiaries.

HSAG reviewed the data submitted by MCPs in the alternative access standard requests related to processes to ensure out-of-network access. The following processes not included in the DHCS-defined approach were described by MCPs:

- ◆ Providing transportation to an out-of-network provider when beneficiaries' needs cannot be met for time and distance, appointment time, or cultural and linguistic needs.
- ◆ Approving and paying for services provided to beneficiaries admitted through the emergency department of non-participating hospitals.
- ◆ Allowing beneficiaries to access providers outside the MCP service area in case of emergency or urgent care, or with prior authorization by the MCP.
- ◆ Implementing a mail order pharmacy for beneficiaries whose closest pharmacy is outside the time and distance standards.

### Contracting Efforts

MCPs engage in a variety of different contracting efforts to ensure network adequacy related to time and distance standards across geography, provider specialties, and adult and pediatric care. HSAG reviewed the alternative access standard request data for information provided by MCPs about contracting efforts and synthesized this information with data provided by DHCS on themes and trends in contracting efforts.

The contracting efforts that MCPs reported to DHCS include the following:

- ◆ Provider was unwilling to accept the MCP contract or Medi-Cal FFS rates.
- ◆ Provider refused to contract with the MCP.

- ◆ Provider did not meet the MCP’s professional standards or credentialing requirements, or had a disqualifying quality of care issue.
- ◆ Provider was currently in contracting negotiations with the MCP.<sup>31</sup>

The contracting efforts that the MCPs reported in the alternative access standard requests included the following:

- ◆ Provider could not be found.
- ◆ Provider retired.
- ◆ Provider was deceased.
- ◆ Plan will be performing outreach to an alternate provider for contracting.
- ◆ Provider specializes in different services than needed.
- ◆ Provider delivers limited services.
- ◆ Population too sparse to find providers.
- ◆ No beneficiaries living within the ZIP Code.
- ◆ Very small number of beneficiaries impacted (e.g., less than 0.01 percent of membership).
- ◆ Providers cannot contract due to competing contracts.
- ◆ Provider employed by hospital and does not have private practice.
- ◆ Closest provider is already contracted with plan.
- ◆ Closer providers are not much closer than currently contracted provider.
- ◆ Closer provider is not within time and distance standards.
- ◆ ZIP Code contains geographic barriers (e.g., islands) that prevent ever being within the time and distance standards for a hospital.
- ◆ Plan working to incentivize providers to locate in rural areas through additional funding.
- ◆ Provider not accepting any new Medi-Cal patients.

### Considerations for DHCS

HSAG identified the following actions for DHCS to consider that may improve access and alternative access reporting:

- ◆ Develop and maintain a list of provider practice locations of identified Medi-Cal contracted providers.
  - One of the reporting elements required under CA WIC §14197.05 is the percentage of providers in a plan service area, by provider and specialty type, that are under a contract with an MCP. Due to data limitations, HSAG was unable to accurately identify a complete list of county-level physician practices. Developing and maintaining a list of provider practice locations of identified Medi-Cal contracted providers will improve DHCS’ ability to provide MCPs with more accurate and current information regarding eligible providers.

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<sup>31</sup> If applicable, the rationale must detail the targeted time frame for execution.

- ◆ Collect data on barriers to meeting standards in a structured data element to identify key areas on which to focus to improve access.
  - MCPs provided numerous descriptions of contracting efforts, including issues encountered during those contracting efforts. This information was captured in unstructured text. While HSAG reviewed and summarized the qualitative data for this report, revising the alternative access request template to include categories identified by MCPs would allow DHCS to engage in more reliable quality improvement analyses over time to evaluate progress in reducing barriers.
- ◆ Identify ZIP Codes for which geographic complications prevent meeting time and distance standards.
  - MCPs identified several ZIP Codes for which geographic features prevent meeting time and distance standards (e.g., islands and mountains may impose travel restrictions that prevent meeting time and distance standards). Identifying these ZIP Codes in advance and establishing special variances in the standards for such specific circumstances could reduce the burden of submitting and reviewing alternative access standard requests for both MCPs and DHCS.

## Skilled Nursing Facilities/Intermediate Care Facilities Experience Reporting

DHCS requires that MCPs provide coordination of care for beneficiaries requiring long-term care (LTC) services, including services at SNFs/ICFs. The DHCS APL 17-017<sup>32</sup> provides MCPs with DHCS' clarifying guidance regarding requirements for LTC coordination and disenrollment from managed care, when applicable.

CA WIC §14197.05 requires DHCS' annual EQR technical report to present information related to the experience of individuals placed in SNFs/ICFs and the distance that these individuals are placed from their residences. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to develop a methodology to assess this SNF/ICF information, and subsequently worked with DHCS to obtain the necessary data and conduct the analyses.

### Methodology

The following is a high-level summary of the steps that HSAG attempted, in collaboration with DHCS, to assess the distance between beneficiaries' places of residence and the SNFs/ICFs in which they are placed during the July 1, 2018, through June 30, 2019, measurement period:

1. Used provider data supplied by DHCS to identify SNFs/ICFs contracted with MCPs serving Medi-Cal beneficiaries.

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<sup>32</sup> All Plan Letter 17-017. Available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-017.pdf>. Accessed on: Dec 16, 2019.

2. Used administrative claims/encounter data supplied by DHCS to identify all SNF/ICF stays of any length during the measurement period.
  - a. SNF/ICF services are covered by FFS for beneficiaries served by MCPs outside of those MCPs with CCI and COHS contracts. As such, administrative claims/encounter data were limited to SNF/ICF stays among beneficiaries in CCI or COHS counties and covered by the MCPs within the CCI or COHS counties.
3. Used administrative beneficiary data supplied by DHCS to obtain information on the place of residence for each beneficiary with a SNF or ICF stay during the measurement period.
4. Using Quest Analytics Suite software, calculated the driving distance between each beneficiary's place of residence and SNF/ICF location for each applicable LTC stay.

In compliance with CA WIC §14197.05, HSAG intended to compile the geospatial results by applicable MCP and by CCI or COHS county.

### ***Results—Skilled Nursing Facilities/Intermediate Care Facilities Experience Reporting***

DHCS supplied the requested study data to HSAG during November 2019 and participated in discussions with HSAG regarding limitations to reliably identifying contracted SNF/ICF providers and beneficiary residences with SNF/ICF stays prior to placement in a SNF/ICF from the administrative data. At the time that this EQR technical report was produced, HSAG verified that administrative claims/encounter data would not reliably support the planned analyses to align with CA WIC §14197.05. As a result of data-related limitations, HSAG is working with DHCS to pursue an alternate data source for future SNF/ICF Experience Reporting.

Moving forward, DHCS and HSAG will focus on obtaining reliable data for provider addresses and beneficiary residential addresses before and during a stay in a SNF/ICF. In addition to the sources used according to the methodology section above, DHCS and HSAG are considering the following data sources to support the assessment and ensure reliability:

- ◆ The federally mandated minimum data set (MDS)
- ◆ Eligibility and enrollment information based on one month so that a single beneficiary address can be identified
- ◆ The California Health and Human Services Open Data Portal and other publicly available sources

Additionally, DHCS and HSAG will research opportunities to capture patient experience by analyzing the MDS for anti-psychotic drug use, length of inpatient hospitalization due to no availability in a SNF/ICF near the beneficiary's residence, readmission rates to the SNF/ICF from the hospital or home, information related to discharge planning and social determinants of health, and other publicly available sources.

After consideration of potential additional data sources, DHCS and HSAG will finalize the study and data methodology for the 2019–20 EQR technical report, which will ensure that the experience of individuals placed in a SNF/ICF is assessed and that the distance these individuals are placed from their place of residence is captured.

## Timely Access Focused Study

DHCS requires MCPs to ensure that participating providers offer appointments that meet the wait time standards described in Table 13.1. Beginning in contract year 2016–17 (referred to as Year 1 of the study), DHCS contracted with HSAG to conduct an annual focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 13.1. Additionally, Table 13.1 shows the provider type and specialty criteria that HSAG used for each appointment type.

**Table 13.1—California Department of Health Care Services Timely Access Standards**

Appointment Type	Criteria for Provider Type/Specialty	Wait Time Standard	
		Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	PCPs and PCP extenders	10 business days	48 hours
Specialist appointment (adult and pediatric)	Cardiologists/interventional cardiologists; dermatologists; endocrinologists; gastroenterologists; general surgeons; hematologists; HIV/AIDS specialists and infectious disease specialists; nephrologists; neurologists; oncologists; ophthalmologists; orthopedic surgeons; otolaryngologists and ear, nose, and throat (ENT) specialists; physical medicine and rehabilitation specialists; psychiatrists; and pulmonologists	15 business days	96 hours
Appointment with a mental health care provider (who is not a physician) (adult and pediatric)	Non-physician mental health providers (psychologists, licensed clinical social workers, and marriage and family therapists)	10 business days	96 hours

Appointment Type	Criteria for Provider Type/Specialty	Wait Time Standard	
		Non-Urgent Appointments	Urgent Appointments
First prenatal visits	Obstetrics/gynecology (OB/GYN) and midwife (certified nurse midwife and licensed nurse midwife)	10 business days	Not applicable
Appointment with ancillary providers	Physical therapy appointments, magnetic resonance imaging (MRI) appointments, mammogram appointments	15 business days	Not applicable

Starting in contract year 2018–19 (referred to as Year 2 of the study), DHCS contracted with HSAG to expand the scope of the Timely Access Focused Study to evaluate the extent to which providers are aware of interpretation service requirements. Additionally, the Timely Access Focused Study evaluated the extent to which the MCPs’ call centers are meeting DHCS’ 10-minute wait time standard and knowledge of interpretation service requirements.

### Methodology

HSAG routinely conducts the Timely Access Focused Study to evaluate MCPs’ wait time standard compliance. HSAG collaborates with DHCS to perform the following key quarterly activities that are primarily based on the most recent provider data submitted to DHCS by MCPs:

- ◆ Submit data requirement document to DHCS for provider data extraction.
- ◆ Review provider data extracted by DHCS and work with DHCS to define the study population (i.e., eligible providers for each appointment type), as appropriate.
- ◆ Select sample providers.
- ◆ Conduct telephone surveys to sample providers and call centers, if applicable.
- ◆ Calculate results for the study indicators.
- ◆ Submit deliverables to DHCS.

### Calls to Providers

Annually, HSAG surveys a sample of 411 providers across all provider types and specialties per MCP reporting unit, with approximately 25 percent of the total sample being surveyed each quarter. HSAG uses oversampling if the initial sampled provider is ineligible for the study based on the call results or is unwilling to participate.

HSAG’s trained callers make phone calls to selected provider offices, including both samples and oversamples, during standard operating hours (i.e., 9 a.m. to 5 p.m. Pacific Time). In most cases, calls are placed directly to provider offices to gather information; for Kaiser NorCal and Kaiser SoCal providers, however, HSAG has a separate process for collecting appointment availability information. Because HSAG does not have access to these two MCPs’ automated appointment scheduling systems, HSAG’s callers must contact Kaiser NorCal’s and Kaiser SoCal’s scheduling staff members to obtain needed information.

If a non-Kaiser provider is selected for more than one reporting unit, HSAG contacts the provider separately for each reporting unit. If two or more sampled non-Kaiser providers are in the same office, HSAG makes a separate call to each provider. HSAG saves all information collected during the phone calls in an electronic tool for further analysis.

### **Calls to Managed Care Health Plan Call Centers**

Beginning in 2018–19, HSAG was slated to make 73 calls to each MCP’s call center annually. To minimize the interruption to the call centers, HSAG makes 19 calls per MCP for the first quarter, then 18 calls per quarter for the remaining three quarters. For each quarter, the survey calls are made over a six-week period. Therefore, HSAG’s trained callers make a call to each call center no more than once per day during normal business hours (i.e., 9 a.m. to 5 p.m. Pacific Time), with the call time varying from day to day. The callers end the call if the hold time reaches 10 minutes.

### **Study Indicators**

Following telephone survey completion each quarter, HSAG exports the abstraction data from the electronic tool, reviews the data, and conducts the analyses. HSAG used the following measures to assess and report Year 1 survey results (contract year 2016–17) for each provider category at the statewide, MCP, and reporting unit levels:

- ◆ Measure 1—Percentage of sampled providers replaced by oversample and the distribution of replacement reasons
- ◆ Measure 2—Percentage of providers with “Accepting New Patient” status in the provider data confirmed by the call
- ◆ Measure 3—Percentage of providers accepting new patients
- ◆ Measure 4—Percentage of providers with appointment times collected and the distribution of reasons why appointment times were not collected
- ◆ Measure 5—Percentage of providers meeting wait time standards based on the first, second, and third appointment times
- ◆ Measure 6—Minimum, median, maximum, and mean waiting times based on the first, second, and third appointment times
- ◆ Measure 7—Percentage of providers contracted with other MCPs in the same county or region
- ◆ Measure 8—Percentage of providers in DHCS’ provider data, but not contracted with MCPs according to the survey

- ◆ Measure 9—Percentage of providers contracted with MCPs according to the survey but not in DHCS' provider data
  - Note: This measure is only applicable to a reporting unit if one or more reporting units are operating in the same county or region.
- ◆ Measure 10—Percentage of providers with different appointment times for adults and children

The following measures were added beginning Year 2 of the study (contract year 2018–19):

- ◆ Measure 11—Percentage of providers who are aware that patients are entitled to receive interpretation of services in any language according to the survey response
- ◆ Measure 12—Percentage of providers with site language(s) in the provider data confirmed according to the survey response and the distribution of reasons why site language(s) were not confirmed
- ◆ Measure 13—Percentage of providers with provider language(s) in the provider data confirmed according to the survey response and the distribution of reasons why provider language(s) were not confirmed
- ◆ Call Center Measure 1—Percentage of calls meeting the wait time standard of 10 minutes
- ◆ Call Center Measure 2—Percentage of calls to the call centers where the call center staff are aware that beneficiaries are entitled to receive interpretation services in any language
- ◆ Call Center Measure 3—List of languages the call center speaks according to the survey response

## **Results—Year 1 Timely Access Focused Study**

### **Calls to Providers**

During Year 1 of the Timely Access Focused Study, HSAG obtained at least one non-urgent appointment time from 6,289 of 13,706 providers (45.9 percent) and at least one urgent appointment time from 3,941 of 9,143 providers (43.1 percent) included in the telephone survey. The primary reasons HSAG did not obtain at least one appointment time were that both call attempts made during open hours were either not answered or were answered by answering machines.

Table 13.2 presents cumulative Year 1 results for providers' compliance with wait time standards at the statewide level for providers for whom HSAG obtained at least one appointment time.

### **Table 13.2—Year 1 Timely Access Focused Study Statewide Provider Compliance for Wait Time Standards**

The rate is determined by the total number of providers with an appointment time obtained for the designated appointment that meet the appointment wait time standards.

Provider Type	First Available Appointment Meeting Wait Time Standard	
	Non-Urgent Appointment	Urgent Appointment
	Rate	Rate
Primary Care Provider	90.8%	85.0%
Specialist	78.7%	72.7%
Non-Physician Mental Health Provider	92.0%	86.5%
OB/GYN	86.7%	Not Applicable
Ancillary Provider	95.6%	Not Applicable
<b>All Providers</b>	<b>88.4%</b>	<b>81.7%</b>

### Quarterly Reports and Raw Data

After each quarterly provider survey calls, HSAG produced and submitted to DHCS reports and raw data files at the statewide aggregate and MCP levels.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required each MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and determined if DHCS would require that the MCP take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

### Results—Year 2 Timely Access Focused Study

At the time that this EQR technical report was produced, results from the first three quarters of Year 2 were available (i.e., January through March 2019, April through June 2019, and July through September 2019). Following is a summary of the cumulative results for these three quarters.

#### Calls to Providers

During the first three quarters of Year 2 of the Timely Access Focused Study, HSAG obtained at least one non-urgent appointment time from 6,091 of 11,532 providers (52.8 percent) and at least one urgent appointment time from 3,592 of 7,657 providers (46.9 percent) included in the telephone survey. The primary reasons HSAG did not obtain at least one appointment time were that both call attempts made during open hours either were not answered or were answered by answering machines.

Table 13.3 presents cumulative Year 2 results from the first three quarters for providers' compliance with wait time standards at the statewide level for providers for which HSAG obtained at least one appointment time.

**Table 13.3—Cumulative First Three Quarters of Year 2 Timely Access Focused Study Statewide Provider Compliance for Wait Time Standards**

The rate is determined by the total number of providers with an appointment time obtained for the designated appointment that met the appointment wait time standards.

Provider Type	First Available Appointment Meeting Wait Time Standard	
	Non-Urgent Appointment	Urgent Appointment
	Rate	Rate
Primary Care Provider	90.1%	80.7%
Specialist	72.6%	66.6%
Non-Physician Mental Health Provider	89.4%	83.7%
OB/GYN	89.5%	Not Applicable
Ancillary Provider	94.3%	Not Applicable
<b>All Providers</b>	<b>86.9%</b>	<b>76.9%</b>

**Calls to Managed Care Health Plan Call Centers**

During the first three quarters of Year 2, HSAG made calls to each MCP's call center; of the 1,320 total calls placed, 94.0 percent met the wait time standard of 10 minutes.

**Quarterly Reports and Raw Data**

Following completion of the provider survey and MCP call center calls each quarter, HSAG produced and submitted to DHCS reports and raw data files at the statewide aggregate and MCP levels.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCPs to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP, then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

Note that HSAG makes no comparisons between Year 1 and Year 2 Timely Access Focused Study results based on the Year 2 results in this report only including data covering the first three quarters of calendar year 2019. In the 2019–20 EQR technical report, HSAG will include the final Year 2 results along with applicable comparisons to the Year 1 results.

## **Recommendations across All Validation of Network Adequacy Activities**

As part of the EQR technical report production process, HSAG identified no recommendations for DHCS related to Validation of Network Adequacy activities.

## 14. Consumer Surveys

Administration of consumer surveys of quality of care is one of the optional EQR activities described at 42 CFR §438.358(c)(2).

### Background

DHCS assesses perceptions and experiences of beneficiaries as part of its evaluation of the quality of health care services provided by MCPs to their beneficiaries. To assist with this assessment, DHCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Surveys for the CHIP and Medi-Cal populations. The 2019 CAHPS surveys included beneficiaries assigned to 25 MCPs.

During the review period of this report, DHCS contracted with HSAG to administer CAHPS surveys to Medi-Cal populations that fall under two separate titles of the Social Security Act of 1935, Section 1932:

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

### Objective

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

### Children’s Health Insurance Program Survey

#### *Methodology—Children’s Health Insurance Program Survey*

During the review period, HSAG administered the standardized survey instrument CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS CCC measurement sets to a statewide sample of CHIP beneficiaries enrolled in MCPs.

Table 14.1 lists the global ratings, composite measures, and CCC composite measures and items included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the CCC measurement set.

**Table 14.1—Children’s Health Insurance Program CAHPS Measures**

<b>Global Ratings</b>	<b>Composite Measures</b>	<b>CCC Composite Measures and Items</b>
<i>Rating of Health Plan</i>	<i>Getting Needed Care</i>	<i>Access to Specialized Services</i>
<i>Rating of All Health Care</i>	<i>Getting Care Quickly</i>	<i>FCC: Personal Doctor Who Knows Child</i>
<i>Rating of Personal Doctor</i>	<i>How Well Doctors Communicate</i>	<i>Coordination of Care (COC) for Children with Chronic Conditions</i>
<i>Rating of Specialist Seen Most Often</i>	<i>Customer Service</i>	<i>Access to Prescription Medicines</i>
	<i>Shared Decision Making</i>	<i>FCC: Getting Needed Information</i>

### **Survey Sampling Procedures—Children’s Health Insurance Program Survey**

CHIP beneficiaries eligible for sampling included those who were enrolled in the California CHIP at the time the sample was drawn and who were continuously enrolled in CHIP for at least five of the last six months of 2018 (July through December) and were 17 years of age or younger (as of December 31, 2018).

For the CHIP population, HSAG selected a random sample of CHIP beneficiaries for surveying. For the general child population, HSAG selected a random sample of 2,850 CHIP beneficiaries for the CAHPS 5.0 general child sample. After selecting child beneficiaries for the CAHPS general child sample, HSAG selected a sample of 2,665 child beneficiaries for the CCC supplemental sample, which represented the population of children who were more likely to have a chronic condition.

### **Survey Administration—Children’s Health Insurance Program Survey**

HSAG designed the survey administration protocol to achieve a high response rate, thus minimizing the potential effects of nonresponse bias. The survey process allowed two methods by which surveys could be completed. The first, or mail phase, consisted of an English or Spanish version of the survey being mailed to the sampled beneficiaries. All nonrespondents received a reminder postcard, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of conducting computer-assisted telephone

interviewing (CATI) of sampled beneficiaries who had not mailed in a completed survey. HSAG attempted up to three CATI calls for each nonrespondent.<sup>33</sup>

### ***Survey Analyses—Children’s Health Insurance Program Survey***

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS 2019, Volume 3: Specifications for Survey Measures*. Based on NCQA’s recommendations and HSAG’s extensive experience evaluating CAHPS data, HSAG conducted the following types of analyses to comprehensively assess beneficiary experience:

- ◆ Response Rates
- ◆ Respondent Demographics
- ◆ Top-Box Scores<sup>34</sup>
- ◆ Trend Analysis

### ***Results—Children’s Health Insurance Program Survey***

HSAG mailed 5,515 child surveys to the CHIP sample of beneficiaries selected for surveying. Of these, 1,357 child surveys (25 percent) were completed for the CHIP sample. HSAG used these completed surveys to calculate the CAHPS survey results. Detailed results are available in the *2019 CAHPS CHIP Survey Summary Report*.

#### **General Child Results**

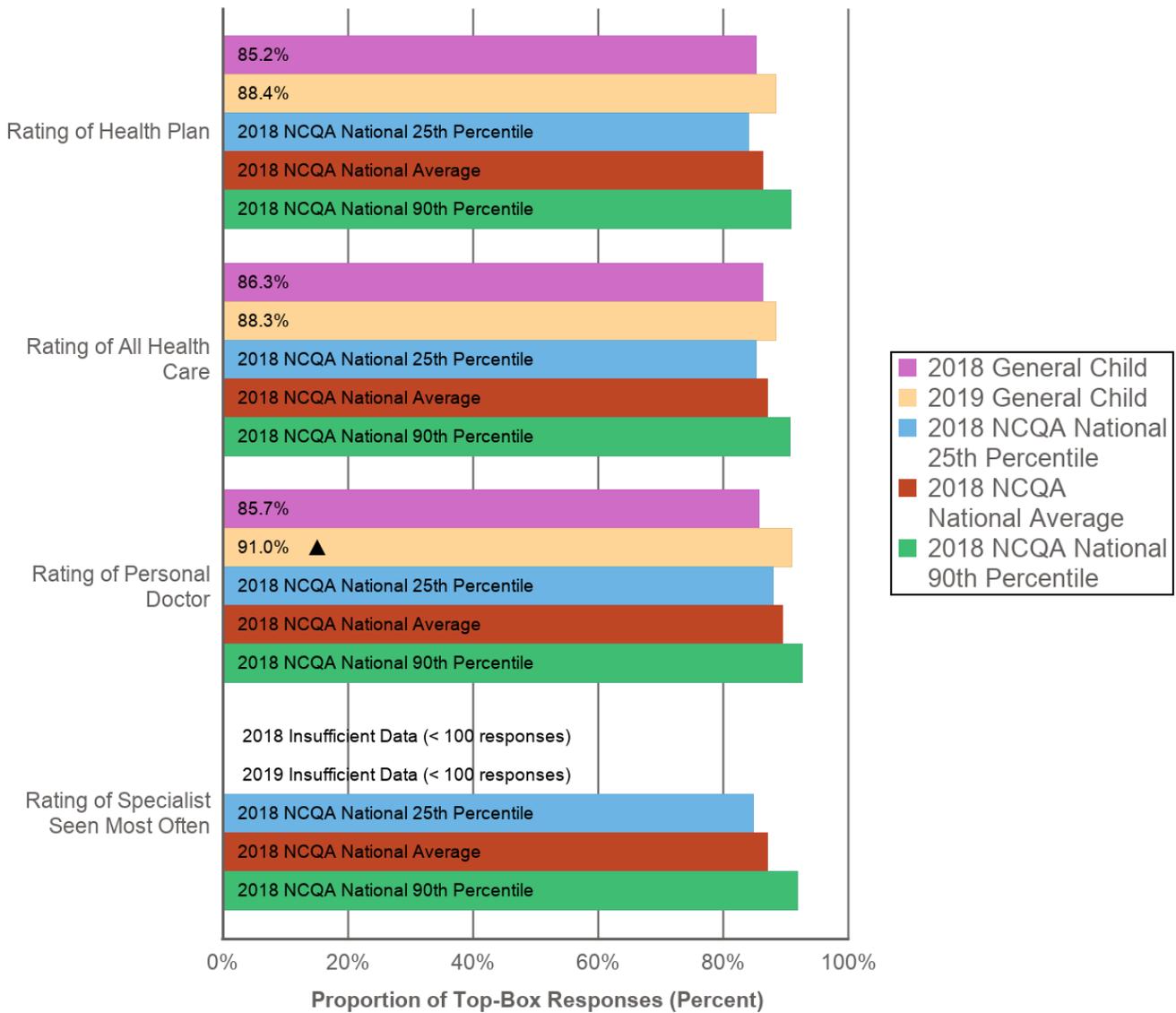
Figure 14.1 displays the 2018 and 2019 general child population top-box scores for the four global ratings, and the 2018 NCQA child Medicaid national averages, 25th percentiles, and 90th percentiles.

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<sup>33</sup> National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2019 Survey Measures*. Washington, DC: NCQA Publication, 2018.

<sup>34</sup> The percentage of survey respondents who chose the most positive score for a given item’s response scale.

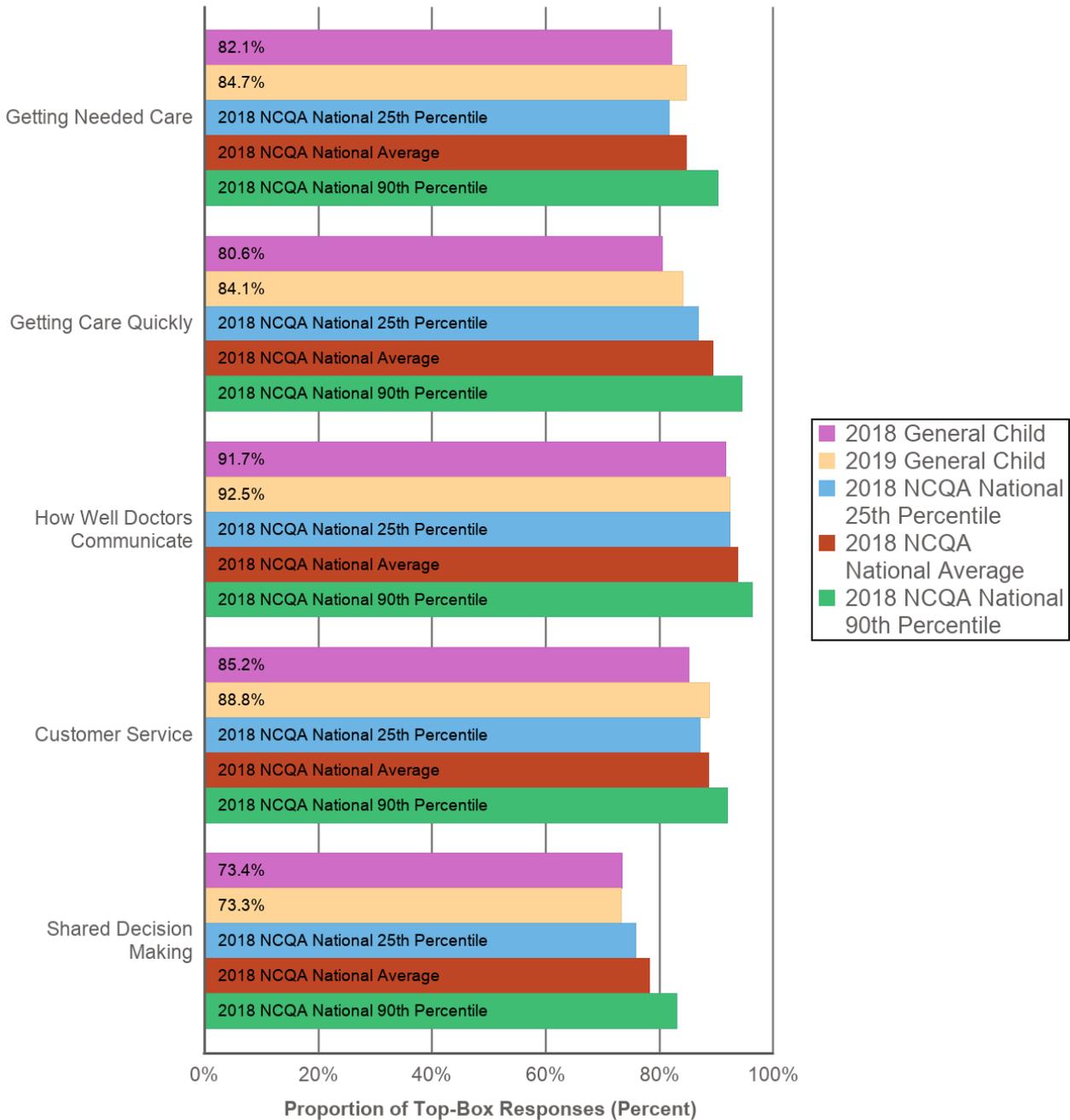
**Figure 14.1—Global Ratings: General Child Top-Box Scores**



▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.  
 ▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.  
 If no statistically significant differences were found, no indicator (▲ or ▼) appears on the figure.

Figure 14.2 displays the 2018 and 2019 general child population top-box scores for the five composite measures, and the 2018 NCQA child Medicaid national averages, 25th percentiles, and 90th percentiles.

**Figure 14.2—Composite Measures: General Child Top-Box Scores**

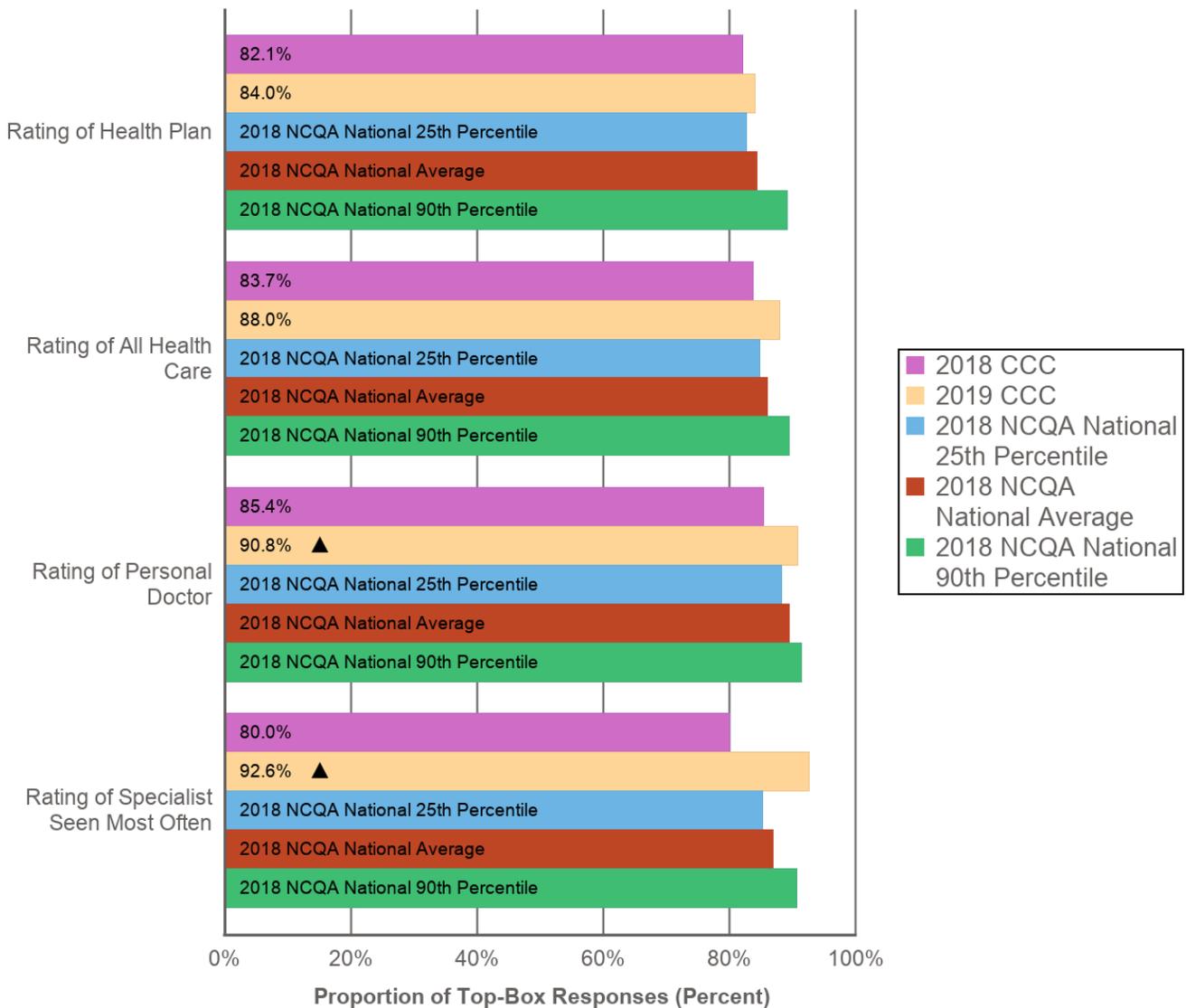


▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.  
 ▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.  
 If no statistically significant differences were found, no indicator (▲ or ▼) appears on the figure.

### Children with Chronic Conditions Results

Figure 14.3 displays the 2018 and 2019 CCC population top-box scores for the four global ratings, and the 2018 NCQA CCC Medicaid national averages, 25th percentiles, and 90th percentiles.

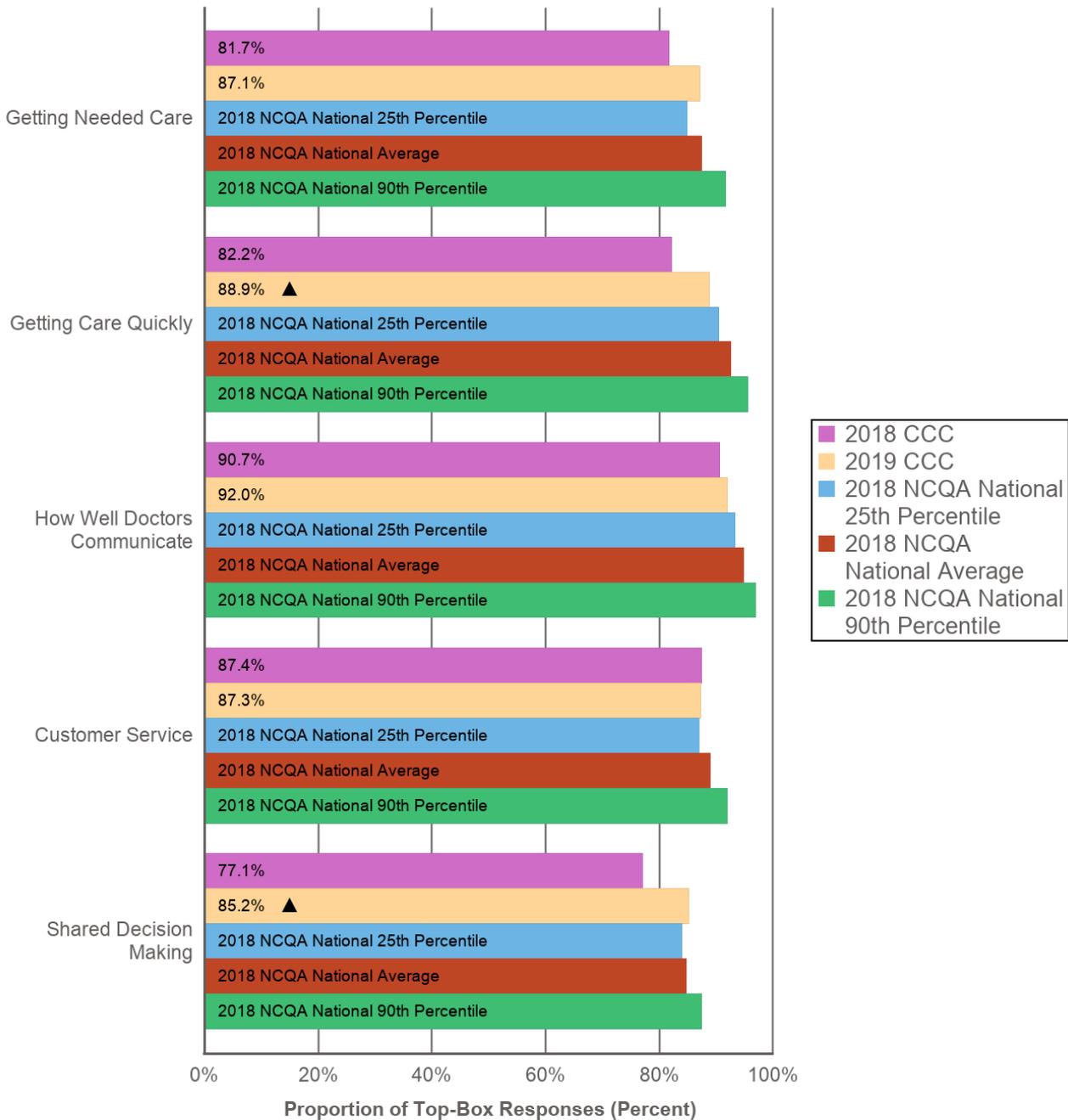
**Figure 14.3—Global Ratings: CCC Top-Box Scores**



▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.  
 ▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.  
 If no statistically significant differences were found, no indicator (▲ or ▼) appears on the figure.

Figure 14.4 displays the 2018 and 2019 CCC population top-box scores for the five composite measures, and the 2018 NCQA CCC Medicaid national averages, 25th percentiles, and 90th percentiles.

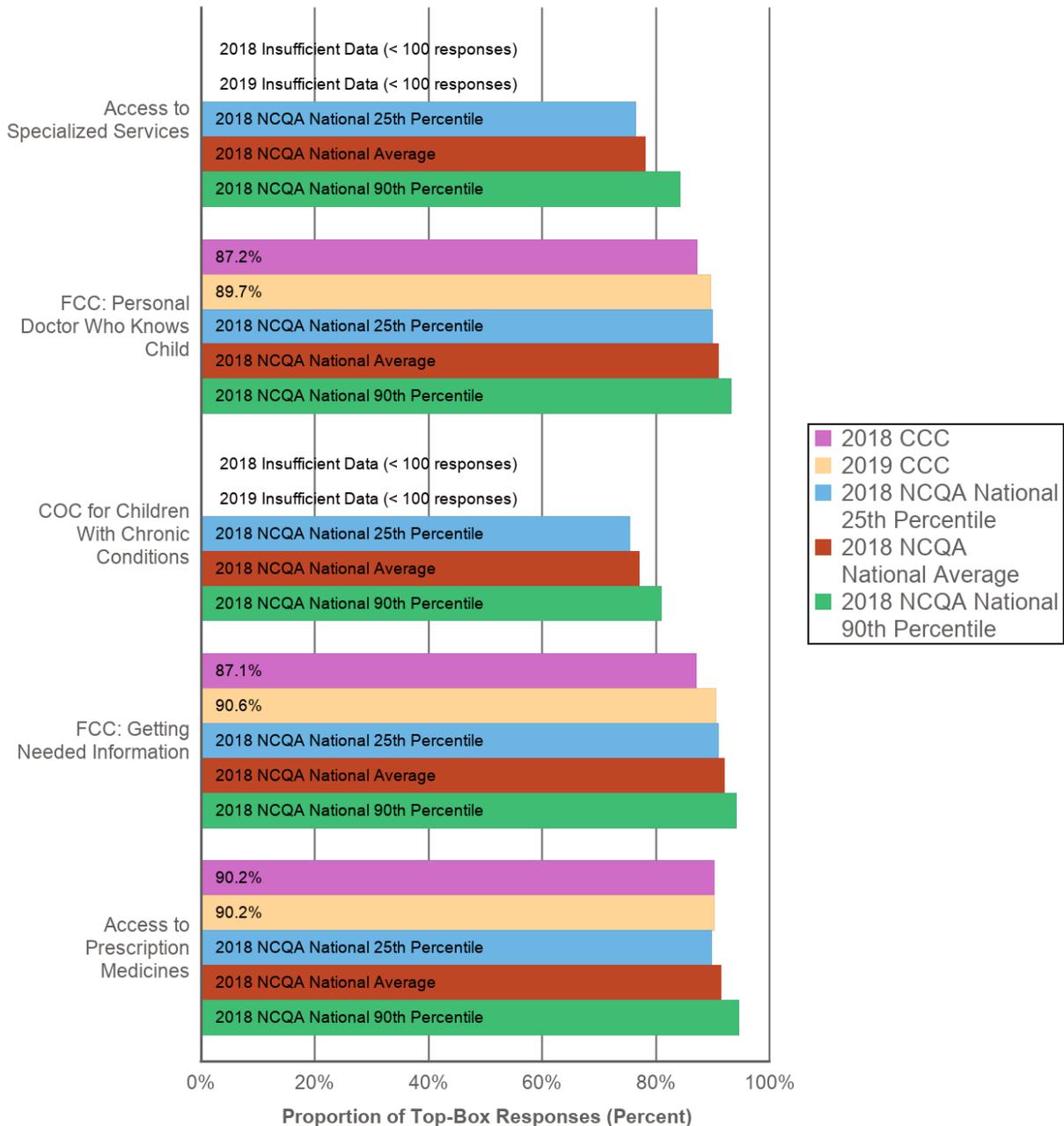
**Figure 14.4—Composite Measures: CCC Top-Box Scores**



▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.  
 ▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.  
 If no statistically significant differences were found, no indicator (▲ or ▼) appears on the figure.

Figure 14.5 displays the 2018 and 2019 CCC population top-box scores for the CCC composite measures and items, and the 2018 NCQA CCC Medicaid national averages, 25th percentiles, and 90th percentiles.

**Figure 14.5—CCC Composite Measures and Items: CCC Top-Box Scores**



▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.  
 ▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.  
 If no statistically significant differences were found, no indicator (▲ or ▼) appears on the figure.

## Medicaid Managed Care Survey

### *Methodology—Medicaid Managed Care Survey*

During the review period, HSAG administered the standardized survey instrument CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set to adult beneficiaries and parents or caretakers of child beneficiaries enrolled in the MCPs that participated in the survey.

Table 14.2 lists the global ratings and composite measures included in the CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set.

**Table 14.2—Medicaid Managed Care CAHPS Measures**

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

### *Survey Sampling Procedures—Medicaid Managed Care Survey*

The beneficiaries eligible for sampling included those who were MCMC beneficiaries at the time HSAG drew the sample and who were continuously enrolled in the same MCP for at least five of the last six months of 2018 (July through December) with no more than a 45-day gap in enrollment. The adult beneficiaries eligible for sampling included those who were 18 years of age or older, and the child beneficiaries eligible for sampling included those who were 17 years of age or younger (as of December 31, 2018). DHCS provided HSAG with a CAHPS sample frame for each MCP from which HSAG selected the adult and child samples. Additionally, HSAG conducted a general oversample and county- or region-level oversample, where appropriate, to accommodate MCP-level and reporting unit-level reporting, respectively. HSAG selected a systematic sample of at least 1,350 eligible adult beneficiaries and at least 1,650 eligible child beneficiaries from each participating MCP for inclusion in the surveys.

### *Survey Administration—Medicaid Managed Care Survey*

HSAG designed the survey administration protocol to achieve a high response rate from beneficiaries, thus minimizing the potential effects of nonresponse bias. The survey process allowed beneficiaries two methods by which they could complete the surveys. The first, or mail phase, consisted of an English or Spanish survey being mailed to the sampled beneficiaries. All nonrespondents received a reminder postcard, followed by a second survey mailing and

reminder postcard. The second phase, or telephone phase, consisted of conducting CATI of sampled beneficiaries who had not mailed in a completed survey. HSAG attempted up to three CATI calls to each nonrespondent. HSAG administered the adult and child Medicaid CAHPS surveys according to NCQA's *HEDIS 2019, Volume 3: Specifications for Survey Measures*. Based on DHCS' request that HSAG submit the data from these surveys to NCQA, HSAG was limited in the modifications it could make to the administration methodology to improve survey response rates (e.g., sampling with replacement for those members with incorrect addresses/telephone numbers, extending the survey field).

### **Survey Analyses—Medicaid Managed Care Survey**

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS 2019, Volume 3: Specifications for Survey Measures*. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG conducted the following types of analyses to comprehensively assess beneficiary experience:

- ◆ Response Rates
- ◆ Respondent Demographics
- ◆ State Weighted Rates
- ◆ State Comparisons

### **Results—Medicaid Managed Care Survey**

HSAG mailed 62,154 adult surveys and 51,803 child surveys to the sample of beneficiaries selected for surveying. Of these, 10,929 adult surveys (18 percent) and 9,100 child surveys (18 percent) were completed. HSAG used these completed surveys to calculate the MCMC CAHPS survey results.

In this EQR technical report, HSAG summarizes the adult and child State weighted averages (i.e., top-box scores) compared to NCQA national Medicaid benchmarks. Detailed results and comparisons across MCPs are available in the *2019 CAHPS Medicaid Managed Care Survey Summary Report*.

**Global Ratings**

Figure 14.6 shows the 2019 adult State weighted rates (i.e., top-box scores) and the 2018 NCQA adult Medicaid 25th percentiles, national averages, and 90th percentiles for the four global ratings.

**Figure 14.6—Global Ratings: Adult Top-Box Scores (State Level)**

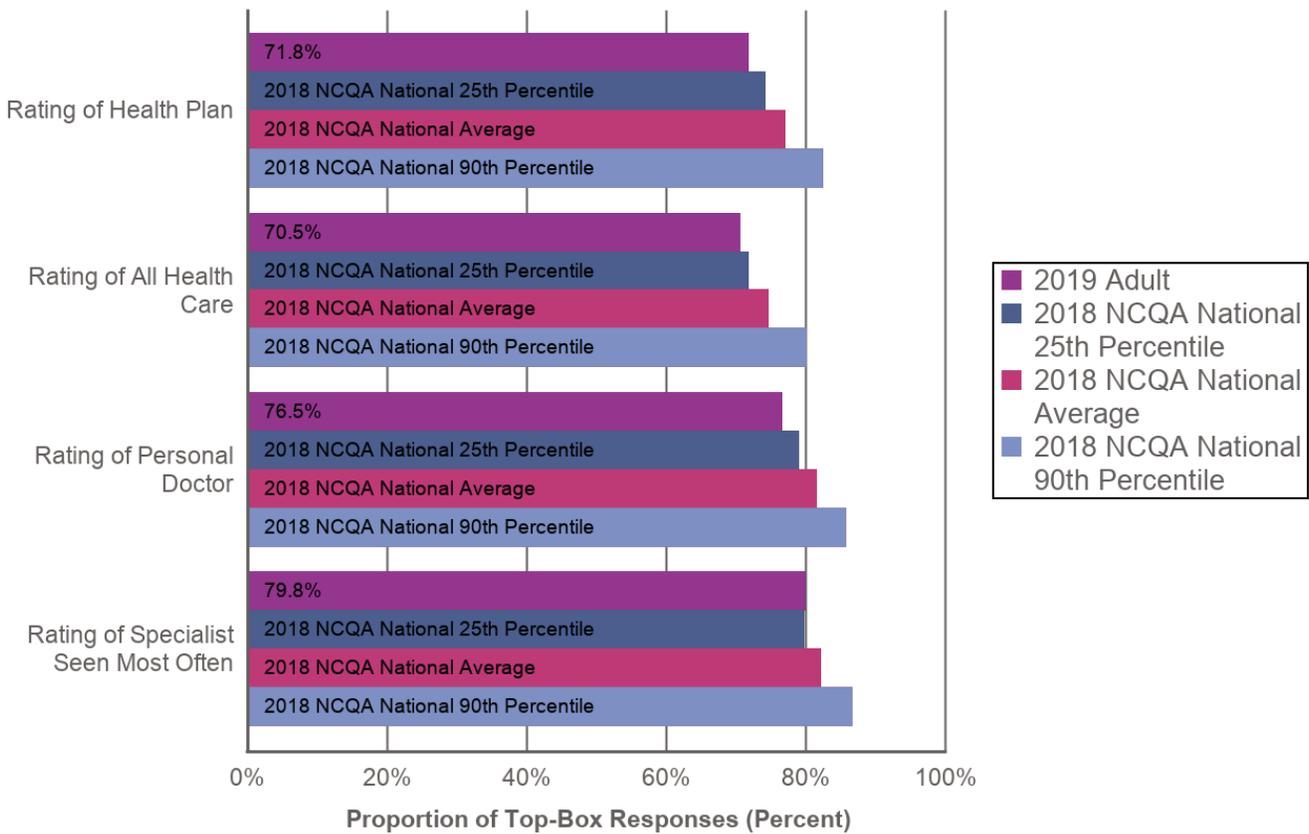
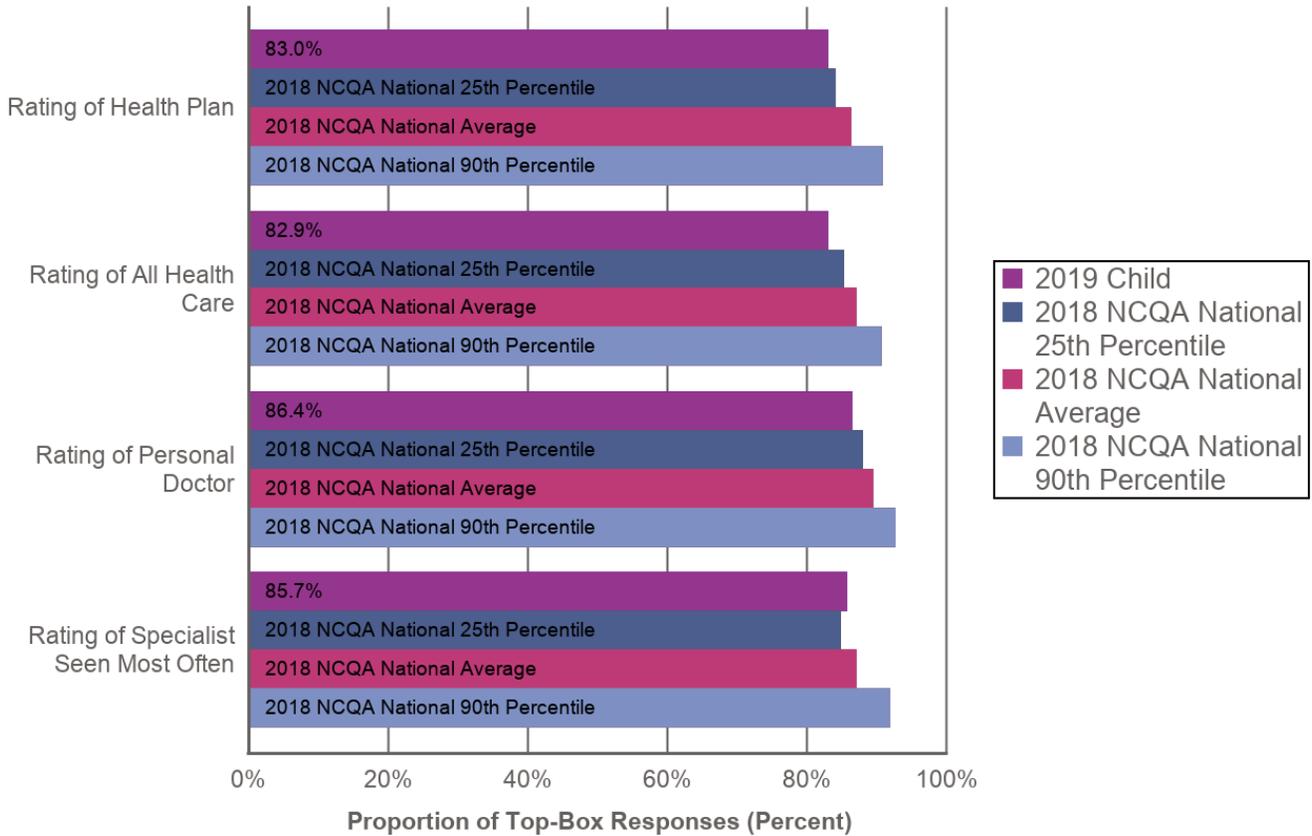


Figure 14.7 shows the 2019 child State weighted rates (i.e., top-box scores) and the 2018 NCQA child Medicaid 25th percentiles, national averages, and 90th percentiles for the four global ratings.

**Figure 14.7—Global Ratings: Child Top-Box Scores (State Level)**



**Composite Measures**

Figure 14.8 shows the 2019 adult State weighted rates (i.e., top-box scores) and the 2018 NCQA adult Medicaid 25th percentiles, national averages, and 90th percentiles for the five composite measures.

**Figure 14.8—Composite Measures: Adult Top-Box Scores (State Level)**

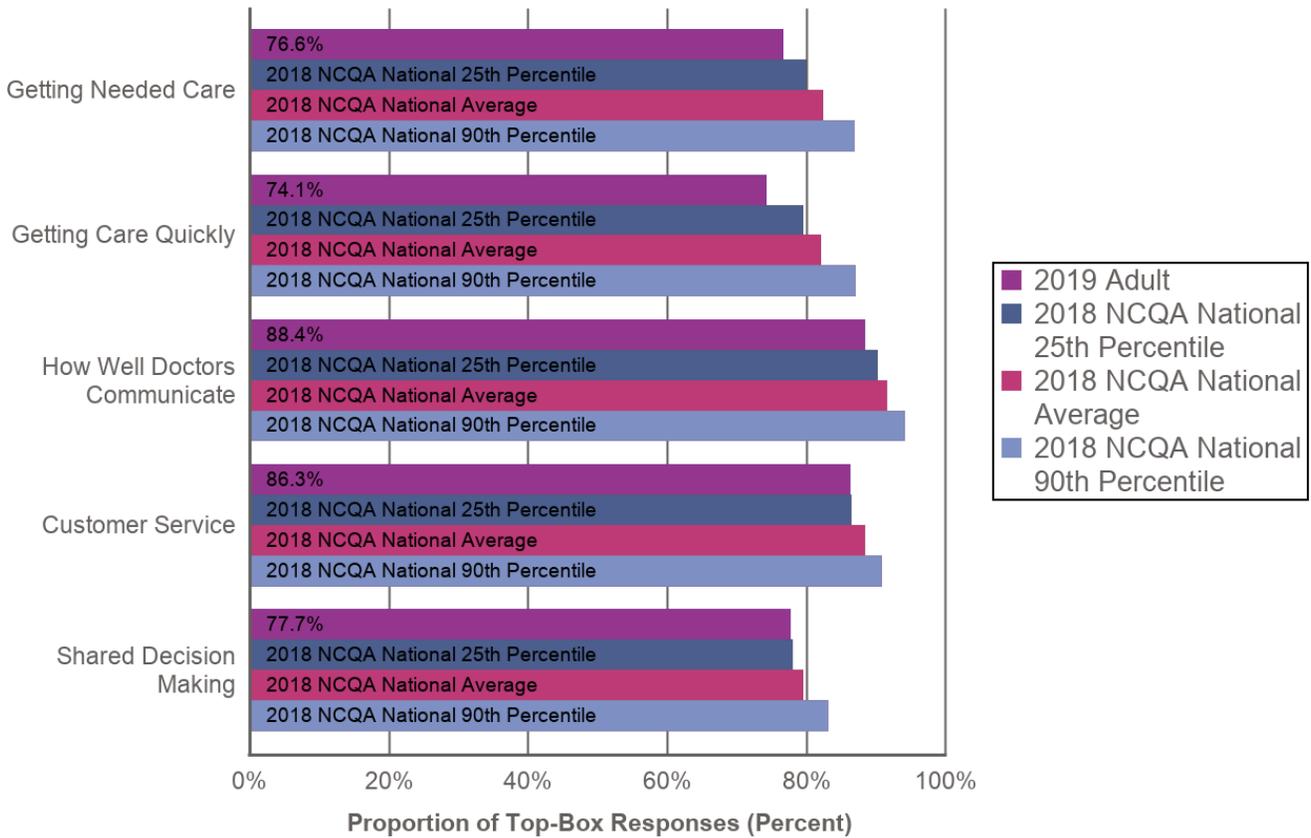
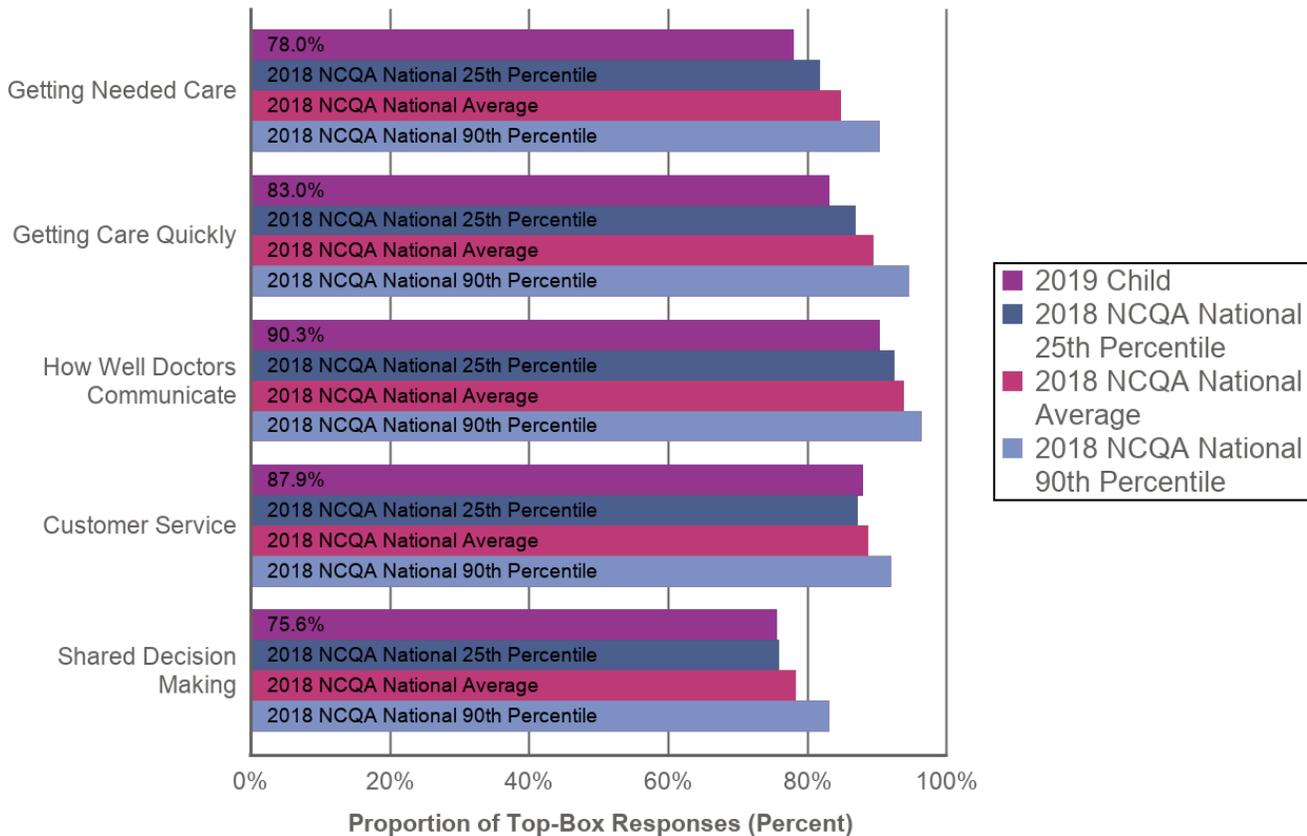


Figure 14.9 shows the 2019 child State weighted rates (i.e., top-box scores) and the 2018 NCQA child Medicaid 25th percentiles, national averages, and 90th percentiles for the five composite measures.

**Figure 14.9—Composite Measures: Child Top-Box Scores (State Level)**



## Conclusions—Consumer Surveys

### Children’s Health Insurance Program Survey

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

#### General Child Population

- ◆ The 2019 score was statistically significantly higher than the 2018 score for the *Rating of Personal Doctor* global rating.
- ◆ The following reportable global ratings measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Rating of Health Plan*
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*

- ◆ The following reportable composite measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
  - *Customer Service*
- ◆ The following reportable composite measures scored below the NCQA national 25th percentiles:
  - *Getting Care Quickly*
  - *Shared Decision Making*

### **Children with Chronic Conditions Population**

- ◆ The 2019 scores were statistically significantly higher than the 2018 scores for the following reportable global ratings measures:
  - *Rating of Personal Doctor*
  - *Rating of Specialist Seen Most Often*
- ◆ The 2019 scores were statistically significantly higher than the 2018 scores for the following reportable composite measures:
  - *Getting Care Quickly*
  - *Shared Decision Making*
- ◆ The reportable *Rating of Specialist Seen Most Often* measure scored above the NCQA national 90th percentile.
- ◆ The following reportable global ratings measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Rating of Health Plan*
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
- ◆ The following reportable composite measures scored above the NCQA national 25th percentiles but below the 90th percentiles:
  - *Getting Needed Care*
  - *Customer Service*
  - *Shared Decision Making*
- ◆ The reportable *Access to Prescription Medicines* CCC composite measure and item scored above the NCQA national 25th percentile but below the 90th percentile.
- ◆ The following reportable composite measures scored below the NCQA national 25th percentiles:
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*

- ◆ The following reportable CCC composite measures and items scored below the NCQA national 25th percentiles:
  - *FCC: Personal Doctor Who Knows Child*
  - *FCC: Getting Needed Information*

### **Medicaid Managed Care Survey**

The adult State weighted rates were below the 2018 NCQA adult Medicaid national 25th percentiles for all measures except *Rating of Specialist Seen Most Often*. The child State weighted rates were below the 2018 NCQA child Medicaid national 25th percentiles for all measures except *Rating of Specialist Seen Most Often* and *Customer Service*.

Based on 2019 CAHPS performance across all MCPs, MCPs have the greatest opportunities for improvement on the *Getting Care Quickly*, *Getting Needed Care*, and *How Well Doctors Communicate* measures. Low performance in these areas may point to issues with access to and timeliness of care, as well as communication from providers to members.

### **Recommendations—Consumer Surveys**

In the 2019 CHIP and Medicaid managed care CAHPS survey reports, HSAG suggested that DHCS consider working with MCPs to identify the causes for the incomplete and inaccurate beneficiary contact information and determine the actions needed to improve the completeness and accuracy of these data. Improving the completeness and accuracy of beneficiary contact information may decrease the number of undeliverable surveys and increase the response rates. As part of the EQR technical report production process, HSAG identified no recommendations for DHCS in the area of consumer surveys.

## 15. Encounter Data Validation

Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity is one of the optional EQR activities described at 42 CFR §438.310(c)(2).

### Background

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DHCS requires MCPs and SHPs to submit high-quality encounter data. DHCS relies on the quality of the encounter data to accurately and effectively monitor and improve quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS' overall management and oversight of MCMC.

The *SFY 2018–19 Encounter Data Validation Study Report* includes the detailed methodology, study results, conclusions, and recommendations. Following is a summary of the SFY 2018–19 EDV Study.

Note: HSAG concluded the SFY 2018–19 EDV Study outside the review period for this EQR technical report; however, HSAG includes a summary of the study because the information was available at the time this EQR technical report was produced.

### Objective

The objective of the SFY 2018–19 EDV Study was to examine, through a review of medical records, the completeness and accuracy of the professional encounter data submitted to DHCS by the 23 MCPs, one PSP, and one SHP included in the study.<sup>35</sup>

### Methodology

Medical and clinical records are considered the “gold standard” for documenting access to and quality of health care services. During SFY 2018–19, HSAG evaluated MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2017, and December 31, 2017. The study answered the following question:

- ◆ Are the data elements *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Rendering Provider Name*, found on the professional encounters, complete and accurate when compared to information contained within the medical records?

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<sup>35</sup> Note that HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs; however, DHCS only holds one contract with Kaiser (KP Cal, LLC).

HSAG conducted the following actions to answer the study question:

- ◆ Identified the eligible population and generated samples from data extracted from the DHCS data warehouse.
- ◆ Assisted MCPs and PSPs to procure medical records from providers, as appropriate.
- ◆ Reviewed medical records against DHCS encounter data.
- ◆ Calculated study indicator results.

## Key Findings from Medical Record Review

Table 15.1 displays the statewide results for each study indicator. Rates shaded in gray and denoted with a cross (+) indicate having met the EDV study standards. The symbol “—” indicates that the study indicator is not applicable for a data element. Of note, for the medical record omission rate and encounter data omission rate, lower values indicate better performance.

**Table 15.1—Statewide Results for Encounter Data Validation Study Indicators**

\*This data element is calculated based on the results from the *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements.

Key Data Elements	Medical Record Omission Rate	Encounter Data Omission Rate	Element Accuracy Rate
<b>EDV Study Standards</b>	<b>Less than 10 percent</b>	<b>Less than 10 percent</b>	<b>More than 90 percent</b>
Date of Service	8.1% <sup>+</sup>	7.1% <sup>+</sup>	—
Diagnosis Code	18.4%	11.8%	98.4% <sup>+</sup>
Procedure Code	25.4%	8.2% <sup>+</sup>	96.2% <sup>+</sup>
Procedure Code Modifier	35.3%	3.7% <sup>+</sup>	99.8% <sup>+</sup>
Rendering Provider Name	8.1% <sup>+</sup>	22.3%	63.5%
All-Element Accuracy	—	—	30.7%
All-Element Accuracy Excluding Rendering Provider Name*	—	—	60.1%

## Encounter Data Completeness

Omissions identified in the medical records (services located in the encounter data but not supported in the medical records) and omissions in the encounter data (services located in the medical records but not in the encounter data) illustrate discrepancies in completeness of DHCS' encounter data. Overall, DHCS' encounter data are relatively complete for the key data elements when compared to the medical records. Below are some significant findings:

- ◆ Among the five data elements assessed for this study, two data elements (i.e., *Date of Service* and *Rendering Provider Name*) had medical record omission rates (services located in the encounter data but not supported in the medical records) of less than 10 percent, which met the EDV study standard. For the remaining three data elements, DHCS encounters were moderately supported by the documentation in the beneficiaries' medical records. As shown in Table 15.1, 18.4 percent of the diagnosis codes, 25.4 percent of the procedure codes, and 35.3 percent of the procedure code modifiers identified in the electronic encounter data were not supported by the corresponding medical records.
- ◆ Three data elements (i.e., *Date of Service*, *Procedure Code*, and *Procedure Code Modifier*) each had an encounter data omission rate (services located in the medical records but not in the encounter data) of less than 10 percent, which met the EDV study standard. The remaining two data elements had moderate encounter data omission rates (i.e., 11.8 percent of the diagnosis codes and 22.3 percent of the rendering provider names identified in the beneficiaries' medical records were not found in DHCS' data warehouse).
- ◆ Only the *Date of Service* data element met the EDV study standard for both the medical record omission rate and the encounter data omission rate.

## Encounter Data Accuracy

- ◆ Among the four data elements evaluated for accuracy, three data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) had an accuracy rate greater than 90 percent, which met the EDV study standard. Statewide, 63.5 percent of rendering provider names identified in the electronic encounter data were supported by medical record documentation.
- ◆ Nearly one third (i.e., 30.7 percent) of the dates of service present in both data sources contained matching values for all four key data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Rendering Provider Name*). This number increased to 60.1 percent when the matched values included three data elements—*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*.

When comparing results from the SFY 2017–18 medical record review activity with 2018–19 results, the status for meeting the EDV standards remained the same for all statewide results.

## Recommendations

Based on the 2018–19 EDV study findings, HSAG has no new recommendations for DHCS in the area of EDV studies.

Note that HSAG submitted the recommendations from the 2017–18 EDV study to DHCS in November 2018; therefore, any subsequent changes that DHCS and/or MCPs/PSPs made likely did not impact the 2018–19 EDV study results, which relate to physician services rendered between January 1, 2017, and December 31, 2017. HSAG anticipates that DHCS and HSAG will observe the effects from DHCS' improvement efforts in future EDV studies.

## 16. Focused Studies

Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time is one of the optional external quality review activities described at 42 CFR §438.358(c)(5).

### Background

DHCS contracts with HSAG to conduct focused studies to gain better understanding of and identify opportunities for improving care provided to beneficiaries. HSAG conducted activities related to the following focused studies during the review period:

- ◆ Health Disparities
- ◆ Opioid Use
- ◆ Timely Access (Note that information on the activities related to the Timely Access Focused Study are included in Section 12 of this report (“Validation of Network Adequacy”).

### *HSAG’s Approach to Focused Studies*

HSAG conducts each focused study in accordance with CMS’ *EQR Protocol 8, Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.<sup>36</sup>

### Study Design

HSAG defines the scope of work and expected objectives for the focused study topic. HSAG then conducts an in-depth literature review to identify the best practices for the populations under study and develops a study proposal encompassing the study question, study population, measurement period(s), data sources, study indicators, data collection process, and analytic plan. Each focused study may require the adaptation of standard health care quality measures for applicability to special populations; therefore, HSAG’s analytic plan details the technical specification for these measures to ensure methodological soundness and reliable calculability for the populations under study.

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<sup>36</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-8.pdf>. Accessed on: Dec 16, 2019.

## Data Collection

As much as possible, HSAG uses administrative data to conduct focused studies. While medical record review may provide valuable insight into selected focused study topics, HSAG uses this approach sparingly in order to provide focused study results within a single contract year. After finalizing the methodology for each focused study, HSAG works with DHCS to develop study-specific data submission file layout.

## Data Analyses

HSAG conducts statistical analyses according to the approved analytic plan. Primary analysis addresses the study question and provides results for the study indicators. HSAG also performs a secondary analysis to examine variation among subgroups (e.g., male and female), patterns of care and outcomes, impact of explanatory variables on indicators, and correlation among variables. In designing each focused study, HSAG addresses and minimizes each threat to internal and external validity to the extent possible. A staff member not involved in initial calculation of results validates all final results.

## Final Report

At the end of each focused study, HSAG produces a report in the format and with the content approved by DHCS. In addition to presenting the findings associated with the study question(s), the report discusses the implications of the results in light of the policy environment within the State and presents actionable recommendations to improve the delivery of health care to beneficiaries.

## 2016–17 Medi-Cal Health Disparities Analysis

DHCS contracted with HSAG to conduct a focused study on health care disparities in the MCMC population using reporting year 2017 EAS measure rates reported by the 23 full-scope MCPs. The *2016 Health Disparities Report* includes the detailed study methodology and findings. Following are summaries of the study methodology and findings.

### ***Methodology for 2016–17 Medi-Cal Health Disparities Analysis***

For the 2016–17 Medi-Cal Health Disparities Analysis, HSAG evaluated the reporting year 2017 EAS measure data at the statewide level. For reporting year 2017, DHCS required MCPs to report 28 EAS measures as well as demographic information about their beneficiaries, including the demographic characteristics chosen for the 2016–17 Medi-Cal Health Disparities Analysis. HSAG did not include the two *Screening for Clinical Depression and Follow-Up Plan* measures in the health disparities analysis due to unreliable data and inconsistent reporting by MCPs, reducing the number of measures evaluated for the 2016–17 Medi-Cal Health Disparities Analysis to 26. HSAG aggregated EAS results from 23 full-scope MCPs to calculate statewide rates for all EAS measures and then stratified these statewide rates by race/ethnicity, primary language, age, and gender.

Although HSAG stratified all EAS measures by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. HSAG used the following race/ethnic stratification 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:

- ◆ Hispanic or Latino
- ◆ White
- ◆ Black for African American
- ◆ Asian
- ◆ American Indian or Alaska Native
- ◆ Native Hawaiian or Other Pacific Islander (Note that some “Other Pacific Islanders” were erroneously included in the “Asian” group due to limitations of existing fields.)
- ◆ Other
- ◆ Unknown/Missing

To ensure the methodology aligned with national standards, HSAG utilized CMS’ *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.<sup>37</sup> The detailed study methodology, including cautions, limitations, and definition of “health disparity,” can be found in the *2016 Health Disparities Report*.

### **Key Findings for 2016–17 Medi-Cal Health Disparities Analysis**

Health disparities were identified when measure rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group’s measure rate was similar to the White group, then no health disparity was identified. Figure 16.1 displays the percentage and number of EAS measures (out of 26 possible measures) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

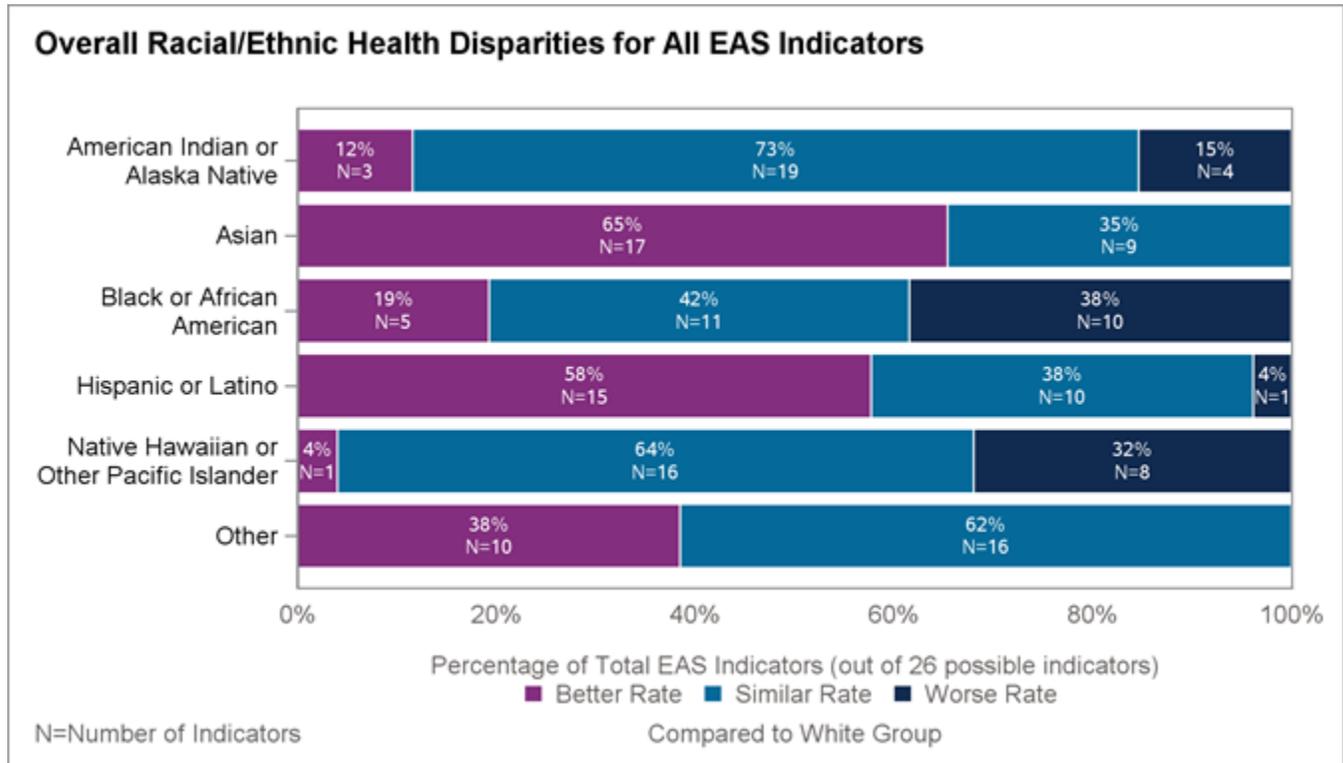
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<sup>37</sup> CMS Office of Minority Health and RAND Corporation. *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage*. Baltimore, MD. 2017.

**Figure 16.1—2016–17 Overall Racial/Ethnic Health Disparities**

Note: The *Ambulatory Care* measures were not included in the racial/ethnic health disparities analysis.

For the Native Hawaiian or Other Pacific Islander group, one measure (*Immunizations for Adolescents—Combination 2*) was excluded from the measure count due to a small numerator (i.e., less than 11).



The following are the overall conclusions for the 2016–17 Medi-Cal health disparities analysis:

- ◆ The rates for the Black or African American group were worse than those for the White group for 38 percent of measures in the analysis.
  - All 10 measures for which the Black or African American group rates were worse than those for the White group were related to health outcomes or access to care.
- ◆ The rates for the Native Hawaiian or Other Pacific Islander group and the American Indian or Alaska Native group were worse than those for the White group for 32 percent and 15 percent, respectively, of measures in the analysis.
- ◆ The rates for the Asian group were better than the rates for the White group for 65 percent of the measures included in the analysis.

## 2017–18 Medi-Cal Health Disparities Analysis

DHCS contracted with HSAG to conduct a focused study on health care disparities in the MCMC population using reporting year 2018 EAS measure rates reported by the 23 full-scope MCPs. While HSAG concluded the 2017–18 Medi-Cal Health Disparities Analysis outside the review period for this EQR technical report, HSAG includes a summary of the study because the information was available at the time this report was produced. The *2017 Health Disparities Report* includes the detailed study methodology and findings. Following are summaries of the study methodology and findings.

### *Methodology for 2017–18 Medi-Cal Health Disparities Analysis*

For the 2017–18 Medi-Cal Health Disparities Analysis, HSAG evaluated a set of measures at the statewide level, comprised of the reporting year 2018 EAS measures; and two measures from the 2017–18 Tobacco Cessation Focused Study and the 2017–18 LARC Utilization Focused Study, both of which DHCS contracted with HSAG to conduct. For reporting year 2018, DHCS required MCPs to report 30 EAS measures as well as demographic information about their beneficiaries, including the demographic characteristics chosen for the 2017–18 Medi-Cal Health Disparities Analysis. HSAG did not include the two *Screening for Clinical Depression and Follow-Up Plan* measures in the health disparities analysis due to unreliable data and inconsistent reporting by MCPs. HSAG also used the beneficiary-level data from the two focused studies mentioned previously to analyze the *Tobacco Cessation Therapy Use* and *LARC Utilization* measures. HSAG aggregated results from 23 full-scope MCPs<sup>38</sup> and then stratified the statewide rates for the 30 measures by race/ethnicity, primary language, age, and gender.

Although HSAG stratified all study measures by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. HSAG used the race/ethnic stratification listed below, which was based on data collection guidance from the federal Office of Management and Budget as well as the US Department of Health and Human Services. Note that for the *Tobacco Cessation Therapy Use* measure and *LARC Utilization* measure, HSAG used the stratifications from the original reports.

- ◆ Hispanic or Latino
- ◆ White
- ◆ Black for African American
- ◆ Asian
- ◆ American Indian or Alaska Native
- ◆ Native Hawaiian or Other Pacific Islander (Note that some “Other Pacific Islanders” were erroneously included in the “Asian” group due to limitations of existing fields.)

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<sup>38</sup> Note that the *Tobacco Cessation Therapy Use* measure also includes results from one PSP and one SHP.

- ◆ Other
- ◆ Unknown/Missing

To ensure the methodology aligned with national standards, HSAG utilized CMS' *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.<sup>39</sup> The detailed study methodology, including cautions, limitations, and definition of "health disparity," can be found in the *2017 Health Disparities Report*.

### **Key Findings for 2017–18 Medi-Cal Health Disparities Analysis**

Health disparities were identified when measure rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's measure rate was similar to the White group, then no health disparity was identified. Figure 16.2 displays the percentage and number of measures (out of 28 possible measures) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

#### **Figure 16.2—2017–18 Overall Racial/Ethnic Health Disparities**

Note: The *Ambulatory Care* indicators were not included in the racial/ethnic health disparities analysis.

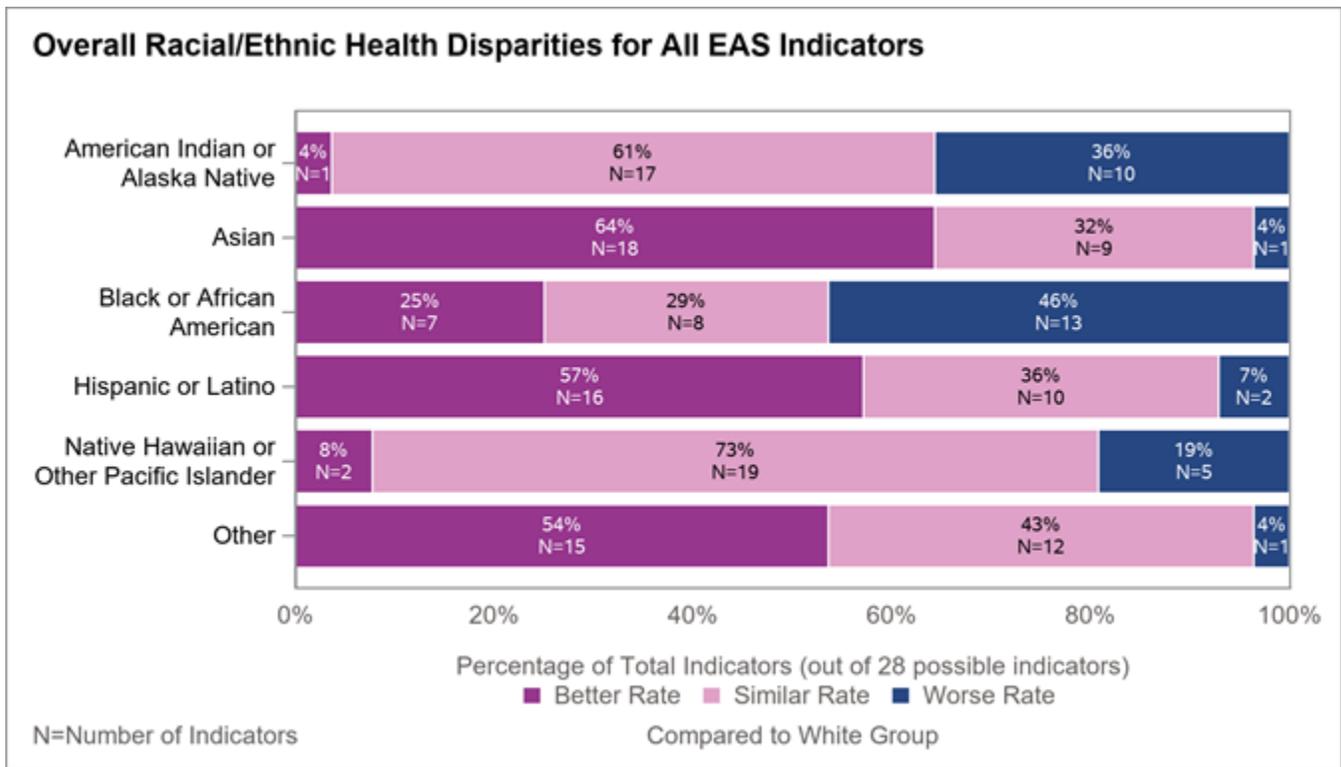
For the *LARC Utilization* indicator and the *Tobacco Cessation Therapy Use* indicator, the Asian racial/ethnic group also includes the Asian or Pacific Islander racial/ethnic group, and the Other racial/ethnic group also includes any Unknown racial/ethnic groups.

The *LARC Utilization* indicator and the *Tobacco Cessation Therapy Use* indicator were not stratified by the Native Hawaiian or Other Pacific Islander racial/ethnic group; therefore, this racial/ethnic group has a total of 26 indicators.

Due to rounding, the percentage of total indicators may not equal 100 percent for some racial/ethnic groups.

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<sup>39</sup> CMS Office of Minority Health and RAND Corporation. *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage*. Baltimore, MD. 2017.



The following are the overall conclusions for the 2017–18 Medi-Cal health disparities analysis:

- ◆ The rates for the Black or African American group were worse than those for the White group for approximately 46 percent of measures in the analyses.
  - All 13 indicators for which the Black or African American group rates were worse than those for the White group were related to health outcomes or access to care.
- ◆ The rates for the American Indian or Alaska Native group and Native Hawaiian or Other Pacific Islander group were worse than those for the White group for approximately 36 percent and 19 percent, respectively, of measures in the analyses.
- ◆ The rates for the Asian group and Hispanic or Latino group were better than the rates for the White group for approximately 64 percent and 57 percent, respectively, of measures in the analyses.

## 2018–19 Medi-Cal Health Disparities Analysis

DHCS contracted with HSAG to conduct a focused study on statewide health care disparities in the MCMC population using reporting year 2018 EAS measure rates reported by the 23 full-scope MCPs. During the review period for this EQR technical report, DHCS and HSAG had preliminary discussions about the demographic variables that will be included in the study; however, as of the end of the review period, HSAG had not yet begun the analyses. HSAG will include the results of the 2018–19 Medi-Cal Health Disparities Analysis in the 2019–20 EQR technical report.

## Opioid Focused Study

During contract year 2017–18, DHCS contracted with HSAG to conduct an evaluation of opioid use and medication assisted treatment within the State’s MCMC population to determine the need and capacity for addressing opioid overuse. Although HSAG began this focused study in contract year 2017–18, HSAG completed the study during the review period for this EQR technical report. The *2017–18 Opioid Focused Study Report* includes the detailed methodology, study results, and conclusions. Following is a summary of the 2017–18 Opioid Focused Study.

### *Methodology for Opioid Focused Study*

HSAG collaborated with DHCS to identify appropriate Medi-Cal beneficiary claims associated with opioids. To identify the need and capacity for addressing opioid overuse in the Medi-Cal population, 15 measures were developed; however, due to data limitations, only 13 were reported. HSAG used measure-specific enrollment data for all MCMC beneficiaries meeting study eligibility criteria during the study period of July 1, 2016, through June 30, 2017, to create MCMC weighted averages based on MCP enrollment during the study period. HSAG also produced MCP- and county-level measure rates so that each MCP’s and county’s measure rates could be compared with MCMC weighted averages.

### *Conclusions for Opioid Focused Study*

Based on HSAG’s calculation of measures related to the need and capacity for treatment of opioid abuse covering the period of July 1, 2016, through June 30, 2017, HSAG identified the following notable highlights:

- ◆ The low rates observed for the Out-of-Network Buprenorphine Providers measure suggest that the MCPs have included most waived buprenorphine providers in their networks’ geographic regions.
- ◆ For treatment need measures, eight MCPs had rates at least 10 percent greater than the statewide weighted averages for three or more measures and therefore may have a greater proportion of their populations at increased risk of opioid abuse than other MCPs.
- ◆ Twenty counties had rates for treatment need measures at least 10 percent greater than the statewide weighted averages for four or more measures, suggesting a larger proportion of the population was at increased risk of opioid abuse than in other counties.
- ◆ For treatment capacity measures, only two MCPs had rates at least 20 percent less than the statewide weighted averages on three or more measures (excluding the Out-of-Network Buprenorphine Providers measure). These results suggest that additional research may be necessary.

## Recommendations across All Focused Studies

As part of the EQR technical report production process, HSAG identified no recommendations for DHCS in the area of focused studies.

## 17. Technical Assistance

At the State's direction, the EQRO may provide technical assistance to groups of MCOs, PIHPs, PAHPs, or PCCM entities as described at 42 CFR §438.358(d).

### Background

In addition to the technical assistance provided to MCMC plans as part of the PIP process, DHCS contracted with HSAG to provide supplemental technical assistance to help improve overall statewide performance. DHCS selected two technical assistance activity sets for HSAG to conduct during the July 1, 2018, through June 30, 2019, review period.

### Technical Assistance Activity for Performance Measures

#### Objective

Under the Technical Assistance Activity for Performance Measures, HSAG provides technical assistance to DHCS, as requested, to:

- ◆ Help build the DHCS quality improvement team's capacity to work directly with MCPs, PSPs, and SHPs to improve performance on EAS measures.
- ◆ Assist DHCS in identifying priority performance measures. Specifically, assist DHCS in developing and monitoring a strategy to raise performance on each of the priority focus areas identified in DHCS' annual *Medi-Cal Managed Care Quality Strategy Report*.
- ◆ Provide input and feedback to DHCS regarding DHCS' development and monitoring of CAPs and IPs for MCPs, PSPs, and SHPs with persistent substandard performance on one or more measures.
- ◆ Provide guidance to DHCS on improving monitoring activities and make recommendations, as appropriate, for improving DHCS' processes for holding MCPs, PSPs, and SHPs accountable for meeting contractual requirements.
- ◆ Review and provide feedback to DHCS on an array of documents related to quality improvement activities.
- ◆ Respond to requests from DHCS for input on a variety of quality improvement-related issues and topics via telephone and email.

Under the Technical Assistance Activity for Performance Measures, HSAG also provides technical assistance to MCPs, PSPs, and SHPs requiring additional guidance with IPs and CAPs, as identified by DHCS.

## Methodology

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each technical assistance session to ensure the most efficient provision of technical assistance with the greatest likelihood of resulting in enhanced skills and, ultimately, improved performance. To promote timely and flexible delivery, HSAG conducted technical assistance with DHCS, MCPs, PSPs, and SHPs by email, telephone, and Web conferences.

## Results—Technical Assistance Activity for Performance Measures

During the review period, HSAG provided technical assistance to DHCS on various topics related to improving statewide performance on EAS measures.

### Improvement Plans/Plan-Do-Study-Act Cycles and Corrective Action Plans

DHCS required MCPs to conduct PDSA cycles and submit PDSA Cycle Worksheets triannually for performance measures with rates that did not meet the minimum performance levels for the previous year. At DHCS' request, HSAG conducted secondary reviews of the PDSA Cycle Worksheets and provided suggestions to DHCS on the next steps for MCPs. As part of conducting secondary reviews, HSAG reviewed both PDSA Cycle Worksheets and DHCS' initial feedback on the PDSA Cycle Worksheets.

As part of the CAP process, DHCS also required MCPs under CAPs to conduct PDSA cycles and submit PDSA Cycle Worksheets triannually for performance measures with rates below the minimum performance levels for multiple years. HSAG conducted a secondary review of PDSA Cycle Worksheets submitted by MCPs under CAPs. For each PDSA Cycle Worksheet, HSAG focused on how the MCP carried out and evaluated the intervention testing. When indicated through HSAG's assessment of the PDSA cycles, HSAG conducted technical assistance during DHCS' CAP monitoring calls with MCPs. Additionally, HSAG validated PIPs submitted by MCPs under CAPs and, when needed, conducted individual technical assistance calls with MCPs to assist those MCPs with the rapid-cycle PIP approach.

HSAG includes information regarding MCP-specific technical assistance related to IPs and CAPs, as applicable, in appendices A through FF.

### Performance Measures and Audits

HSAG assisted DHCS with addressing various topics related to the *Depression Screening and Follow-Up for Adolescents and Adults* measures reporting. Notably, HSAG:

- ◆ Informed DHCS of several challenges that MCPs experienced in reporting the *Depression Screening and Follow-Up for Adolescents and Adults* measures for reporting year 2018.
- ◆ Confirmed that MCPs used different exclusion approaches in calculating the reporting year 2018 rates for the *Depression Screening and Follow-Up for Adolescents and Adults* measures.

- ◆ Participated in a meeting with DHCS and NCQA to discuss lessons learned from HEDIS 2018 and changes made to the HEDIS 2019 specifications for the *Depression Screening and Follow-Up for Adolescents and Adults* measures.
- ◆ Jointly hosted a webinar with DHCS and NCQA to provide MCPs with the most recent changes made by NCQA to HEDIS 2019 *Depression Screening and Follow-Up for Adolescents and Adults* measures and the ECDS reporting methodology.

For reporting year 2019 EAS measures, HSAG:

- ◆ Reviewed the reporting year 2019 EAS measure list and provided feedback to DHCS.
- ◆ Provided DHCS an analysis of how the *Plan All-Cause Readmissions* measure results from other states compare to the MCPs' *All-Cause Readmissions* measure results. HSAG also provided a summary of the similarities and differences between the *Plan All-Cause Readmissions* and *All-Cause Readmissions* methodologies to help guide DHCS' decision on replacing the *All-Cause Readmissions* measure with the *Plan All-Cause Readmissions* measure for reporting year 2019.

HSAG and DHCS began extensive discussions regarding reporting year 2020 MCAS measures. HSAG:

- ◆ Provided information for DHCS to consider as DHCS makes decisions regarding performance measure requirements for reporting year 2020.
- ◆ Reviewed the draft list of reporting year 2020 MCAS measures and provided feedback.
- ◆ Compiled NCQA's Medicaid HMO 50th percentile information for all HEDIS measures that DHCS will require MCPs to report in 2020. After receiving approval from DHCS, HSAG uploaded the information to HSAG's secure file transfer protocol (FTP) site for MCPs to retrieve.
- ◆ Provided suggestions to DHCS about which CMS Core Set measures would be appropriate for PSPs.

### Other Technical Assistance

HSAG provided DHCS with technical assistance on various topics, including:

- ◆ HEDIS measure and performance measure specifications and validation processes.
- ◆ Patient-level detail file layout and submission requirements.
- ◆ CAHPS survey administration and data submission processes.
- ◆ Rapid-cycle PIP methodology, validation criteria, and timeline.
- ◆ Examples of various network adequacy studies that HSAG has experience in conducting.
- ◆ Supplemental information that DHCS could provide to the State auditor to assist the California State Auditor's Office with conducting its audit of DHCS.
- ◆ Various EQRO activities for DHCS staff members to gain more comprehensive understanding of the mandatory and optional EQR activities.

Additionally, at DHCS' request, HSAG reviewed and provided feedback on numerous documents related to statewide performance quality improvement efforts.

### ***Conclusions—Technical Assistance Activity for Performance Measures***

Due to the technical assistance that HSAG provided to DHCS, MCPs, PSPs, and SHPs during the review period:

- ◆ DHCS found HSAG's secondary review of PDSA cycles and CAPs helpful as it reinforced DHCS' findings and created synergy to provide optimal recommendations to MCPs.
- ◆ MCPs under CAPs became more proficient conducting the rapid-cycle PIP process.
- ◆ MCPs and DHCS gained most accurate and up-to-date information regarding the *Depression Screening and Follow-Up for Adolescents and Adults* measures.
- ◆ DHCS has a better understanding of performance measures, which will enable DHCS to make informed decisions regarding future performance measure requirements.
- ◆ DHCS has more in-depth understanding of the various performance measure validation and consumer survey activities.
- ◆ DHCS obtained descriptions of network adequacy work that HSAG has previously conducted, which will assist DHCS in making decisions regarding future network adequacy activities it may want HSAG to conduct.
- ◆ DHCS enhanced its understanding of EQRO activities.

### ***Recommendations—Technical Assistance Activity for Performance Measures***

HSAG has no recommendations for DHCS related to technical assistance activity for performance measures.

## **Technical Assistance Activity for Quality Improvement Collaboration**

### ***Objective***

Under the Technical Assistance Activity for Quality Improvement Collaboration, HSAG facilitates collaborative discussions with MCPs, PSPs, and SHPs for each focus area selected by DHCS. The objectives of the collaborative discussions are:

- ◆ To provide MCPs, PSPs, and SHPs the opportunity to share with each other about issues, barriers, promising practices, and solutions related to their quality improvement work in the focus areas.

- ◆ For MCPs, PSPs, and SHPs to benefit from HSAG’s insight and expertise, particularly related to the PIP process.
- ◆ For DHCS to share pertinent resources and insights, particularly around the possibility of collaboration with external partners.

## **Methodology**

Through joint planning meetings, HSAG and DHCS discussed potential topics for the collaborative discussions and the appropriate structure of the meetings based on those topics. DHCS and HSAG collaboratively determined the topic for each collaborative discussion based on:

- ◆ Feedback received from MCPs, PSPs, and SHPs about discussion topic preferences.
- ◆ MCPs’, PSPs’, and SHPs’ progression of the PIP process.
- ◆ Issues identified by HSAG through its validation of PIPs.
- ◆ Issues identified by HSAG during MCP-, PSP-, and SHP-specific technical assistance sessions.
- ◆ Issues identified by DHCS and HSAG through review of MCPs’ PDSA cycles.
- ◆ Issues identified by DHCS as part of its monitoring and oversight processes with MCPs, PSPs, and SHPs.

HSAG conducted the collaborative discussions through webinars and conference calls. Following each collaborative discussion, HSAG invited participants to complete the post-collaborative survey to anonymously provide feedback about the discussion and input for future discussions by setting it to launch immediately after participants exited Webex for the collaborative discussion. Additionally, following the collaborative discussions, HSAG emailed the online survey links to all MCP, PSP, and SHP staff members who had been invited to the collaborative discussions. Within 10 business days following each collaborative discussion, HSAG distributed a meeting summary by email to MCPs, PSPs, and SHPs and reminded collaborative discussion participants to complete the surveys.

## **Results—Technical Assistance Activity for Quality Improvement Collaboration**

During each quarter of the review period, HSAG and DHCS jointly facilitated three collaborative discussions on the following focus areas selected by DHCS:

- ◆ **Data**—A discussion focused on improving access to and collection of accurate laboratory, pharmacy, vendor, and supplemental data to help ensure better health outcomes and improve quality metric performance.
- ◆ **Health Disparities**—A discussion focused on ways to address health inequities at the MCP-, PSP-, and SHP-levels.

- ◆ Immunizations—A discussion focused on the quality improvement work of the numerous MCPs working on the *Childhood Immunizations* and *Immunizations for Adolescents* measures.

At the beginning of each collaborative discussion, DHCS provided an update on statewide efforts, partnerships, resources, and other pertinent information related to the collaborative discussion topic. Following DHCS' update, HSAG facilitated an open discussion that provided opportunity for MCPs, PSPs, and SHPs to share about successful quality improvement efforts as well as challenges and potential solutions related to the collaborative discussion focus area. Then, DHCS and HSAG invited topic-specific presenters to present followed by a question-and-answer session to provide the opportunity for MCPs, PSPs, and SHPs to ask the presenters questions.

During the review period, HSAG and DHCS worked with the following entities to present about their successful quality improvement efforts related to the collaborative discussion focus areas:

- ◆ Data
  - Alameda Alliance for Health
  - Central California Alliance for Health
  - Health Net Community Solutions, Inc.
  - Health Plan of San Joaquin
  - L.A. Care Health Plan
- ◆ Health Disparities
  - CDPH Office of Health Equity
  - Gold Coast Health Plan
  - Inland Empire Health Plan
  - Health Net Community Solutions, Inc.
  - Molina Healthcare of California Partner Plan, Inc.
  - Partnership HealthPlan of California
- ◆ Immunizations
  - CalOptima
  - Molina Healthcare of California Partner Plan, Inc.
  - Partnership HealthPlan of California

Post-collaborative discussion survey respondents gave favorable ratings to the following questions related to collaborative discussions held during the review period:

- ◆ How important to your quality improvement work was the topic that was presented during the collaborative discussion call?
- ◆ How easy was it for you to understand the information presented during the collaborative discussion call?

- ◆ How likely are you to apply the information that you heard during the collaborative discussion call to your current quality improvement efforts?
- ◆ How likely are you to apply the information that you heard during the collaborative discussion call to your future quality improvement efforts?
- ◆ How likely are you to share with a colleague the information that you heard during the collaborative discussion call?

The survey respondents gave neutral ratings to the question about the likelihood of considering presenting on future collaborative discussion calls; however, they provided valuable input on potential topics for future collaborative discussion calls.

### ***Conclusions—Technical Assistance Activity for Quality Improvement Collaboration***

MCPs, PSPs, and SHPs actively participated in the collaborative discussions by asking presenters questions and sharing about their own experiences, challenges, and lessons learned. The post-collaborative discussion surveys revealed that MCPs, PSPs, and SHPs found presentations to be helpful and applicable to their current and future quality improvement work.

### ***Recommendations—Technical Assistance Activity for Quality Improvement Collaboration***

HSAG has no recommendations for DHCS related to technical assistance activity for quality improvement collaboration.

## 18. Follow-Up on Prior Year’s Recommendations

As part of the process for producing the *2018–19 Medi-Cal Managed Care Technical Report*, DHCS provided the following information on the actions that DHCS took to address recommendations that HSAG made in the *2017–18 Medi-Cal Managed Care Technical Report*. Table 18.1 provides EQR recommendations from the *2017–18 Medi-Cal Managed Care Technical Report*, along with the DHCS’ self-reported actions taken through June 30, 2019, that address the EQR recommendations. Please note that HSAG made minimal edits to Table 18.1 to preserve the accuracy of DHCS’ self-reported actions.

**Table 18.1—DHCS’ Self-Reported Follow-Up on External Quality Review Recommendations from the 2017–18 Medi-Cal Managed Care Technical Report**

2017–18 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
<p>1. When DHCS evaluates whether or not to change the required measures for MLTSSPs, obtain input from MLTSSPs and other stakeholders through various methods such as questionnaires or focused studies regarding the feasibility and applicability of requiring MLTSSPs to report the newly created Long-Term Services and Supports HEDIS measures.</p>	<p>DHCS has reviewed the newly created Long-Term Services and Supports HEDIS measures from NCQA, including attending webinars hosted by NCQA on the new measures. While DHCS elected not to adopt the measures for reporting year 2020 in light of the other extensive quality performance changes for reporting year 2020, DHCS is considering the measures for future use. Prior to any changes to the MLTSS measures, DHCS will consult with the MLTSSPs and other stakeholders to seek their input.</p>

### Assessment of DHCS’ Self-Reported Actions

HSAG reviewed DHCS’ self-reported actions in Table 18.1 and determined that DHCS adequately responded to HSAG’s recommendation from the *2017–18 Medi-Cal Managed Care External Quality Review Technical Report*. DHCS provided a description of its actions related to consideration of adopting the NCQA Long-Term Services and Supports HEDIS measures, including DHCS’ rationale for not requiring MLTSSPs to report the new measures for reporting year 2020. DHCS also indicated commitment to obtaining MLTSSP and other stakeholder input prior to future DHCS changes to the MLTSSP performance measure reporting requirements.