Volume 1 of 5

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2021–June 30, 2022

Main Report

Quality Population Health Management
California Department of Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Commonly Used Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

- **A&I**—Audits & Investigations Division
- **ADHD**—Attention-Deficit/Hyperactivity Disorder
- **AHRQ**—Agency for Healthcare Research and Quality
- **AIDS**—acquired immunodeficiency syndrome
- **APL**—All Plan Letter
- **BMI**—body mass index
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems[1]
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CANS**—Child and Adolescent Needs and Strengths
- **CAP**—corrective action plan
- **CATI**—Computer Assisted Telephone Interviewing
- **CA WIC**—California Welfare and Institutions Code
- **CCC**—Children with Chronic Conditions
- **CDPH**—California Department of Public Health
- **CFR**—Code of Federal Regulations
- **CHIP**—Children's Health Insurance Program
- **CMS**—Centers for Medicare & Medicaid Services
- **COVID-19**—coronavirus disease 2019
- **DBA**—doing business as
- **Dental MC**—Dental Managed Care
- **DHCS**—California Department of Health Care Services
- **EDAP**—encounter data administrative profile
- **EDV**—encounter data validation
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FCC**—Family-Centered Care
- **FFS**—fee-for-service
- **HbA1c**—hemoglobin A1c
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[2]
- **HHS**—U.S. Department of Health & Human Services

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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

- **HIPAA**—Health Insurance Portability and Accountability Act of 1996
- **HMO**—health maintenance organization
- **HSAG**—Health Services Advisory Group, Inc.
- **HPI®**—California Healthy Places Index[3]
- **ISCAT**—Information Systems Capabilities Assessment Tool
- **LARC**—Long-Acting Reversible Contraception
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCO**—managed care organization
- **MCP**—managed care health plan
- **MHP**—mental health plan
- **MLTSS**—Managed Long-Term Services and Supports
- **MLTSSP**—Managed Long-Term Services and Supports Plan
- **MRR**—medical record review
- **MRRV**—medical record review validation
- **MS**—Microsoft
- **NCPDP**—National Council for Prescription Drug Programs
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **OB/GYN**—obstetrician/gynecologist
- **O/E**—observed/expected
- **PAHP**—prepaid ambulatory health plan
- **PCCM**—primary care case management
- **PCP**—primary care provider
- **PDSA**—Plan-Do-Study-Act
- **PHM**—population health management
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project
- **PMV**—performance measure validation
- **PNA**—population needs assessment
- **PSP**—population-specific health plan
- **QAPI**—quality assessment and performance improvement
- **QIHD**—Quality Improvement Health Disparities
- **QIP**—quality improvement plan

[3] Healthy Places Index® is a registered trademark of the Public Health Alliance of Southern California.

- **QPHM**—Quality Population Health Management
- **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- **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
- **SWOT**—Strengths, Weaknesses, Opportunities, Threats

1. Executive Summary

Purpose

This *2021–22 Medi-Cal Managed Care External Quality Review Technical Report* is an annual, independent, technical report produced by Health Services Advisory Group, Inc. (HSAG), the external quality review organization (EQRO) for the California Department of Health Care Services' (DHCS') Medi-Cal Managed Care program (MCMC). The purpose of this report is to provide a summary of the external quality review (EQR) activities of DHCS' contracted Medi-Cal managed care health plans (MCPs), population-specific health plans (PSPs) and the specialty health plan (SHP). This report will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans." Note that DHCS does not exempt any MCMC plans from EQR.

In addition to summaries of EQR activity results, this report includes HSAG's assessment of the quality of, timeliness of, and access to care delivered to MCMC beneficiaries by MCMC plans and as applicable, recommendations as to how DHCS can use the EQR results in its assessment of and revisions to the DHCS Comprehensive Quality Strategy.[4] Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS Comprehensive Quality Strategy goals as well as whether DHCS needs to revise the Comprehensive Quality Strategy based on the results presented in the EQR technical report.

The review period for this report is July 1, 2021, through June 30, 2022. HSAG will report on activities that take place beyond this report's review period in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.

Note that DHCS contracts with three Dental Managed Care (Dental MC) plans. HSAG summarizes the Dental MC plan activities in a separate EQR technical report.

For more information, refer to Section 2 of this report ("**Introduction**").

Medi-Cal Managed Care Program by the Numbers

Statewide MCMC beneficiaries as of June 2022[5]: **More than 12.6 million**

[4] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jul 29, 2022.

[5] California Health & Human Services Agency. *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 Aug 2, 2022.

DHCS' contracted MCMC plans: **25 MCPs**, **three PSPs**,[6] **and one SHP**[7]

Counties served: **All 58 counties across California**

For more information, refer to the MCMC Overview heading in Section 2 of this report ("**Medi-Cal Managed Care Overview**").

External Quality Review Highlights

Based on HSAG's assessment of the EQR activities conducted during the review period, the following are notable highlights:

- DHCS submitted the *DHCS Comprehensive Quality Strategy 2022* to the Centers for Medicare & Medicaid Services (CMS) on February 4, 2022.[8] The Comprehensive Quality Strategy:
  - Outlines DHCS' process for developing and maintaining a broader quality strategy to assess the quality of care that all Medi-Cal beneficiaries receive, regardless of delivery system.
  - Defines measurable goals and tracks improvement while adhering to the regulatory federal managed care requirements.
  - Describes DHCS' 10-year vision for the Medi-Cal program, which is for those served by the program to have longer, healthier, and happier lives.
  - Describes a whole-system, person-centered, and population health approach to care in which health care services are only one of many elements needed to support improved health for Medi-Cal members.
  - Introduces the Bold Goals: 50x2025 initiative, which focuses on children's preventive care, behavioral health integration, and maternity care, with an emphasis on health equity. In partnership with stakeholders across the State, DHCS' Bold Goals: 50x2025 initiative aims to achieve significant improvement in Medi-Cal clinical and health equity outcomes by 2025.

[6] Note: DHCS' contract with one of the three PSPs, Rady Children's Hospital—San Diego, ended December 31, 2021; therefore, as applicable in this report, HSAG includes information about activities completed by Rady Children's Hospital—San Diego from July 1, 2021, through December 31, 2021.

[7] Note: DHCS informed HSAG that as of May 2022, the one SHP, Family Mosaic Project, would no longer be included in EQRO activities; therefore, as applicable in the report, HSAG includes information about activities completed by Family Mosaic Project from July 1, 2021, through May 31, 2022.

[8] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on Jul 18, 2022.

- DHCS' Audits & Investigations Division (A&I) conducted compliance reviews (i.e., Medical and State Supported Services Audits) for all MCMC plans within the previous three-year period, as required by the Code of Federal Regulations (CFR) at Title 42, Section (§) 438.358.
- DHCS made progress toward fully meeting CMS' compliance review requirements by developing a compliance scoring methodology that includes all federal standards required by CMS. DHCS aims to implement the compliance scoring methodology beginning with the July 1, 2022, through June 30, 2023, A&I Medical Audit cycle.
- All MCMC plans were able to fully engage in the performance measure audit process and produce valid performance measure rates for all required Managed Care Accountability Set (MCAS) measures.
  - DHCS' MCAS is comprehensive and includes measures that collectively assess the quality, accessibility, and timeliness of care MCMC plans provide to their members.
  - DHCS has well-established, ongoing processes to monitor MCMC plan performance and to support plans in identifying the causes for their performance falling below the DHCS-established minimum performance levels.
  - While opportunities for improvement exist, the MCMC weighted averages improved significantly for several performance measures from measurement year 2020 to measurement year 2021, with the Behavioral Health domain having the greatest percentage of MCMC weighted averages that improved significantly from measurement year 2020 to measurement year 2021. The quality improvement strategies MCMC plans implemented may have contributed to the performance improvement observed in measurement year 2021.
- HSAG's performance improvement project (PIP) validation findings show that all MCMC plans built a strong foundational framework, used quality improvement tools to define quality improvement activities that have the potential to impact the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim, established an intervention plan for each intervention to be tested for their PIPs, and progressed to intervention testing.
- DHCS continued to demonstrate a commitment to monitor and improve members' experiences through the administration of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. These surveys play an important role as a quality improvement tool for the MCMC plans.
- DHCS continued to demonstrate a commitment to using data to drive decision making and quality improvement approaches by contracting with HSAG to conduct various analytic activities, including validation of network adequacy, health disparities analyses, preventive services utilization analyses, focus studies, and encounter data validation (EDV).
- The technical assistance HSAG provided to DHCS and the MCMC plans supported DHCS and the MCMC plans in making progress toward accomplishing the DHCS Comprehensive

Quality Strategy goals and vision, improving the health care services provided to Medi-Cal members, and achieving health equity.[9]

More detailed aggregate information about each activity may be found in the applicable sections of this volume, and MCMC plan-specific information is included in *Volume 2 of 5* and *Volume 3 of 5* of this EQR technical report.

[9] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

2. Introduction

External Quality Review

Title 42 CFR §438.320 defines "EQR" as an EQRO's analysis and evaluation of aggregated information on the quality of, timeliness of, and access to health care services that a managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) or their contractors furnish to Medicaid beneficiaries. Each state must comply with §457.1250,[10] and as required by §438.350, each state that contracts with MCOs, PIHPs, PAHPs, or PCCM entities must ensure that:

- Except as provided in §438.362, a qualified EQRO performs an annual EQR for each such contracting MCO, PIHP, PAHP, or PCCM entity.
- The EQRO has sufficient information to perform the review.
- The information used to carry out the review must be obtained from the EQR-related activities described in §438.358 or, if applicable, from a Medicare or private accreditation review as described in §438.360.
- For each EQR-related activity, the information gathered for use in the EQR must include the elements described in §438.364(a)(2)(i) through (iv).
- The information provided to the EQRO in accordance with §438.350(b) is obtained through methods consistent with the protocols established by the U.S. Department of Health & Human Services (HHS) Secretary in accordance with §438.352.
- The results of the reviews are made available as specified in §438.364.

DHCS contracts with HSAG as the EQRO for MCMC. HSAG meets the qualifications of an EQRO as outlined in §438.354 and performs annual EQRs of DHCS' contracted MCOs, PIHPs, PAHPs, and PCCM entities to evaluate their quality of, timeliness of, and access to health care services to MCMC beneficiaries. In addition to providing its assessment of the quality of, timeliness of, and access to care delivered to MCMC beneficiaries by MCMC plans, HSAG makes recommendations, as applicable, as to how DHCS can use the EQR results in its assessment of and revisions to the DHCS Comprehensive Quality Strategy.[11] Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS Comprehensive Quality Strategy goals as well as

[10] Title 42 CFR §457.1250 may be found at: https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L/subject-group-ECFR9effb7c504b1d10/section-457.1250. Accessed on: Jul 29, 2022.

[11] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jul 29, 2022.

whether DHCS needs to revise the Comprehensive Quality Strategy based on the results presented in the EQR technical report.

The following activities related to EQR are described in §438.358:

- Mandatory activities:
  - Validation of PIPs required in accordance with §438.330(b)(1) that were underway during the preceding 12 months.
  - Validation of MCO, PIHP, or PAHP performance measures required in accordance with §438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months.
  - A review, conducted within the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Part 438 Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement (QAPI) requirements described in §438.330.
  - Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, §438.14(b)(1).
- Optional activities performed by using information derived during the preceding 12 months:
  - Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity.
  - Administration or validation of consumer or provider surveys of quality of care.
  - Calculation of performance measures in addition to those reported by an MCO, PIHP, PAHP, or PCCM entity and validated by an EQRO in accordance with §438.358(b)(1)(ii).
  - Conducting PIPs in addition to those conducted by an MCO, PIHP, PAHP, or PCCM entity and validated by an EQRO in accordance with §438.358 (b)(1)(i).
  - Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
  - Assisting with the quality rating of MCOs, PIHPs, and PAHPs consistent with §438.334.
- Technical assistance to groups of MCOs, PIHPs, PAHPs, or PCCM entities to assist them in conducting activities related to the mandatory and optional activities described in §438.358 that provide information for the EQR and the resulting EQR technical report.

Unless noted otherwise in this report, DHCS provided HSAG with sufficient information to perform the EQR for the July 1, 2021, through June 30, 2022, review period. Additionally:

- The information HSAG used to carry out the EQR was obtained from all mandatory and select optional EQR-related activities described in §438.358.
- As applicable, DHCS followed methods consistent with the protocols established by the HHS Secretary in accordance with §438.352 to provide information relevant to the EQR.

- For each EQR-related activity, information DHCS gathered for use in the EQR included the elements described in §438.364(a)(2)(i) through (iv).
- Consistent with §438.350(f), DHCS made the EQR results available as specified in §438.364.

Purpose of Report

As required by §438.364, DHCS contracts with HSAG to prepare an annual, independent, technical report that summarizes findings on the quality of, timeliness of, and access to health care services provided by MCMC plans, including opportunities for quality improvement.

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 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 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 effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Section 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. DHCS

designates three of its MCOs as PSPs. MCMC has one PIHP with a specialized population, which DHCS designates as an SHP. CMS designates the Dental MC plans as PAHPs.

This report provides a summary of MCP, PSP, and SHP EQR activities. HSAG summarizes Dental MC plan activities in the *2021–22 Medi-Cal Dental Managed Care External Quality Review Technical Report*. Except when citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable), and the PIHP with a specialized population as an SHP. This report will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans." Note that DHCS does not exempt any MCMC plans from EQR.

Quality, Access, and Timeliness

CMS requires that the EQR evaluate the performance of MCOs, PIHPs, PAHPs, and PCCM entities related to the quality of, timeliness of, and access to care they deliver. Section 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 of, timeliness of, and access to health care services furnished to MCMC plan members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. 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, accessibility, and timeliness of care delivered to MCMC plan members. 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 is divided into five volumes that include the following content:

Volume 1—Main Report

- An overview of MCMC.

- A description of the DHCS Comprehensive Quality Strategy report.
- An aggregate assessment of MCMC for the federally mandated and optional EQR activities conducted during the review period of July 1, 2021, through June 30, 2022, identifying the following for each EQR activity:
  - Objectives
  - Technical methodology used for data collection and analysis
  - Description of the data obtained
  - Conclusions based on the data analysis

Volume 2—Medi-Cal Managed Care Plan-Specific Information

- Appendix A—Comparative MCMC Plan-Specific Compliance Review Results
- Appendix B—PSP-Specific Performance Measure Results
- Appendix C—Comparative MCMC Plan-Specific Performance Improvement Project Information
- Appendix D—Comparative MCMC Plan-Specific Population Needs Assessment Information
- Appendix E—MCMC Plan-Specific EQR Assessments and Recommendations
  - MCMC Plans' Self-Reported Follow-Up on EQR Recommendations from the 2020–21 Review Period
  - HSAG's Assessment of MCMC plans' EQR Strengths, Weaknesses, and Recommendations from the 2021–22 Review Period

Volume 3—Measurement Year 2021 Managed Care Health Plan Performance Measure Comparison

- Comparative MCP-specific results for all DHCS-required measurement year 2021 performance measures

Volume 4—Alternative Access Standard Reporting

- Detailed methodology, results, conclusions, and recommendations related to the alternative access standards reporting analyses.

Volume 5—Skilled Nursing Facility (SNF)/Intermediate Care Facility (ICF) Experience and Distance Reporting

- Detailed methodology, results, conclusions, and recommendations related to the SNF/ICF experience and distance reporting analyses.

During the review period, DHCS allowed MCMC plans continued flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on coronavirus disease 2019 (COVID-19) response efforts. As applicable in this report, HSAG notes when DHCS allowed MCMC plans flexibility for a specific EQR activity due to the COVID-19 pandemic. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

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 12.6 million beneficiaries (as of June 2022)[12] in the State of California through a combination of contracted MCMC 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.

During the review period, DHCS contracted with 25 MCPs, three PSPs,[13] and one SHP to provide health care services in all 58 counties throughout California. DHCS operates MCMC through a health care delivery system that encompasses six models of managed care for its full-scope services as well as a model for PSPs and a model for SHPs. DHCS monitors MCMC plan performance across model types.

A description of each MCP managed care model type may be found at https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf. The MCMC county map, which depicts the location of each MCP model type, may be found at https://www.dhcs.ca.gov/services/Documents/MMCD-Cnty-Map.pdf.

Following is a description of the PSP and SHP model types.

Population-Specific Health Plan model. During the review period for this report, the PSP model operated in Los Angeles, Riverside, San Bernardino, and San Diego counties; however, as of January 1, 2022, this model no longer operates in San Diego County due to DHCS' contract with the PSP in this county (Rady Children's Hospital—San Diego) ending. DHCS

[12] California Health & Human Services Agency. *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 Aug 2, 2022.

[13] Note: DHCS' contract with one of the three PSPs, Rady Children's Hospital—San Diego, ended December 31, 2021; therefore, as applicable in this report, HSAG includes information about activities completed by Rady Children's Hospital—San Diego from July 1, 2021, through December 31, 2021.

designates the following two MCOs as a "Population-Specific Health Plan" model because of their specialized populations:

- AIDS Healthcare Foundation—provides services in Los Angeles County, primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).
- SCAN Health Plan provides services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties.

Specialty Health Plan model. SHPs provide health care services to specialized populations. During the review period, DHCS held a contract with one SHP, Family Mosaic Project. This SHP provides intensive case management and wraparound services in San Francisco County for MCMC children and adolescents at risk of out-of-home placement.

Table 2.1 shows MCMC plan names, model types, reporting units, and the reporting unit enrollment as of June 2022. 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. HSAG obtained the enrollment information from the *Medi-Cal Managed Care Enrollment Report*.[12]

Table 2.1—Medi-Cal Managed Care Health Plan Names, Model Types, Reporting Units, and Reporting Unit Enrollment as of June 2022

* Kaiser NorCal provides Medi-Cal services in Sacramento County as a Geographic Managed Care 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.

S = The number of members enrolled in the reporting unit was too small to report based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard.

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2022
Managed Care Health Plans			
Aetna Better Health of California	Geographic Managed Care	Sacramento County	19,946
		San Diego County	26,299

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2022
Alameda Alliance for Health	Two-Plan—Local Initiative	Alameda County	307,665
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Geographic Managed Care	Sacramento County	210,604
	Regional	Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)	71,386
		Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties)	112,588
	San Benito	San Benito County	10,691
	Two-Plan—Commercial Plan	Alameda County	75,622
		Contra Costa County	35,819
		Fresno County	137,062
		Kings County	23,312
		Madera County	26,168
		San Francisco County	22,500
		Santa Clara County	81,131
	Two-Plan—Local Initiative	Tulare County	119,040

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2022
Blue Shield of California Promise Health Plan	Geographic Managed Care	San Diego County	120,907
California Health & Wellness Plan	Imperial	Imperial County	71,815
	Regional	Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)	91,089
		Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties)	70,127
CalOptima	County Organized Health System	Orange County	897,783
CalViva Health	Two-Plan—Local Initiative	Fresno County	328,315
		Kings County	34,935
		Madera County	43,819
CenCal Health	County Organized Health System	San Luis Obispo County	65,377
		Santa Barbara County	154,143
Central California Alliance for Health	County Organized Health System	Merced County	145,546
		Monterey and Santa Cruz counties	258,484
Community Health Group Partnership Plan	Geographic Managed Care	San Diego County	319,290

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2022
Contra Costa Health Plan	Two-Plan—Local Initiative	Contra Costa County	229,506
Gold Coast Health Plan	County Organized Health System	Ventura County	238,183
Health Net Community Solutions, Inc.	Geographic Managed Care	Sacramento County	129,461
		San Diego County	85,763
	Two-Plan—Commercial Plan	Kern County	83,309
		Los Angeles County	1,049,277
		San Joaquin County	25,215
		Stanislaus County	65,531
		Tulare County	122,804
Health Plan of San Joaquin	Two-Plan—Local Initiative	San Joaquin County	251,014
		Stanislaus County	156,898
Health Plan of San Mateo	County Organized Health System	San Mateo County	133,464
Inland Empire Health Plan	Two-Plan—Local Initiative	Riverside and San Bernardino counties	1,514,755
Kaiser NorCal (KP Cal, LLC)*	Geographic Managed Care and Regional	KP North (Amador, El Dorado, Placer, and Sacramento counties)	128,534
Kaiser SoCal (KP Cal, LLC)	Geographic Managed Care	San Diego County	64,890

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2022
Kern Health Systems, DBA Kern Family Health Care	Two-Plan—Local Initiative	Kern County	333,440
L.A. Care Health Plan	Two-Plan—Local Initiative	Los Angeles County	2,441,529
Molina Healthcare of California	Geographic Managed Care	Sacramento County	56,841
		San Diego County	237,334
	Imperial	Imperial County	17,184
	Two-Plan—Commercial Plan	Riverside and San Bernardino counties	204,044
Partnership HealthPlan of California	County Organized Health System	Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity counties)	106,628
		Northwest (Del Norte and Humboldt counties)	72,236
		Southeast (Napa, Solano, and Yolo counties)	226,162
		Southwest (Lake, Marin, Mendocino, and Sonoma counties)	248,756
San Francisco Health Plan	Two-Plan—Local Initiative	San Francisco County	161,989
Santa Clara Family Health Plan	Two-Plan—Local Initiative	Santa Clara County	295,814

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2022
UnitedHealthcare Community Plan	Geographic Managed Care	San Diego County	29,980
Population-Specific Health Plans			
AIDS Healthcare Foundation	Population-Specific Health Plan	Los Angeles County	781
SCAN Health Plan	Population-Specific Health Plan	Los Angeles, Riverside, and San Bernardino counties	12,059
Specialty Health Plan			
Family Mosaic Project	Specialty Health Plan	San Francisco County	S

Table 2.2 indicates the number of beneficiaries served by each model type as of June 2022.

Table 2.2—Number of Beneficiaries Served by Model Type

S = The number of beneficiaries served was too small to report based on the HIPAA Privacy Rule's de-identification standard.

Medi-Cal Managed Care Plan Model Type	Number of Beneficiaries Served as of June 2022
County Organized Health System	2,546,762
Geographic Managed Care	1,414,573
Imperial	88,999
Population-Specific Health Plan	12,840
Regional	360,466
San Benito	10,691
Specialty Health Plan	S
Two-Plan	8,170,513

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

3. DHCS Comprehensive 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 meet CMS' requirements, DHCS produced a written quality strategy and submitted it to CMS on February 4, 2022.[14]

The *DHCS Comprehensive Quality Strategy 2022* outlines DHCS' process for developing and maintaining a broader quality strategy to assess the quality of care that all Medi-Cal beneficiaries receive, regardless of delivery system. The strategy also defines measurable goals and tracks improvement while adhering to the regulatory federal managed care requirements. The Comprehensive Quality Strategy:

- Provides an overview of all DHCS health care programs, including managed care, FFS, and others.
- Includes overarching quality and health equity goals, with program-specific objectives.
- Reinforces DHCS' commitment to health equity in all program activities.
- Provides a review and evaluation of the effectiveness of the *2018 Medi-Cal Managed Care Quality Strategy Report*, which provided the foundation for many of the changes and the revised approach described in the 2022 Comprehensive Quality Strategy.

In the "Quality and Health Equity Improvement Strategy" section of the Comprehensive Quality Strategy, DHCS includes details about its California Advancing and Innovating Medi-Cal (CalAIM) initiative, a five-year policy framework that encompasses a broader delivery system, program, and payment reforms across the Medi-Cal program.

Comprehensive Quality Strategy Development

DHCS' process for reviewing and updating its Comprehensive Quality Strategy included:

- Convening an interdisciplinary team to review all relevant materials and update the quality strategy.
- Reviewing all available documentation and previous public comments on the quality strategy.

[14] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jul 29, 2022.

- Posting the draft DHCS Comprehensive Quality Strategy for public review, presenting the draft document at stakeholder meetings, consulting with tribal organizations about the quality strategy, and incorporating stakeholder feedback into the final version.
- Reviewing the effectiveness of the *2018 Managed Care Quality Strategy*.
- Reviewing all recent EQRO reports, addressing EQRO recommendations, and incorporating overarching themes into the quality strategy.
- Posting the final *DHCS Comprehensive Quality Strategy 2022* on DHCS' Comprehensive Quality Strategy website.

Vision, Goals, and Guiding Principles

DHCS' Comprehensive Quality Strategy indicates that the 10-year vision for the Medi-Cal program is for those served by the program to have longer, healthier, and happier lives. The Comprehensive Quality Strategy describes a whole-system, person-centered, and population health approach to care in which health care services are only one of many elements needed to support improved health for Medi-Cal members.

The population health management (PHM) framework serves as the cornerstone of CalAIM and the foundation for the Comprehensive Quality Strategy goals and guiding principles, which reflect DHCS' commitment to health equity, member involvement, and DHCS' accountability.

Comprehensive Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and patient-centered chronic disease management
- Providing whole person care for high-risk populations, addressing drivers of health

Comprehensive Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability, and member involvement

In addition to outlining the implementation of PHM, the Comprehensive Quality Strategy identifies three clinical focus areas that will help to build a strong foundation of health:

- Children's preventive care
- Maternity care and birth equity
- Behavioral health integration

DHCS introduces the Bold Goals: 50x2025 initiative, which focuses on children's preventive care, behavioral health integration, and maternity care, with an emphasis on health equity. In partnership with stakeholders across the State, DHCS' Bold Goals: 50x2025 initiative aims to achieve significant improvement in Medi-Cal clinical and health equity outcomes by 2025.

To support the Comprehensive Quality Strategy vision and goals, DHCS has significantly changed its quality management structure and will rely on data to drive improvement. Additionally, to improve member representation in DHCS' stakeholder engagement efforts, DHCS and its partners will engage Medi-Cal members and community-based organizations to inform DHCS' work and will launch a consumer advisory committee composed of people from across the State who will advise and inform DHCS' policy and programs.

Managed Care Improved Access

As part of CalAIM, DHCS will seek to require additional populations to enroll in MCMC, including nearly all dual eligible beneficiaries in 2023, and further standardize benefits offered through MCMC across California's managed care delivery system. Standardization of benefits will ensure that members will have access to the same MCMC benefits regardless of their county of residence or the plan in which they are enrolled, leading to improved continuity of care.

Managed Care Performance Monitoring and Accountability

DHCS, MCMC plans, and stakeholders use information from a variety of dashboards to drive continuous quality improvement efforts. DHCS' new Quality and Population Health Management (QPHM) program will evaluate the efficacy of the existing public dashboards and work with stakeholders and individual programs to make changes so that the dashboards reflect the Comprehensive Quality Strategy goals and priority activities.

DHCS also selects performance measures for MCMC plans to report and use to inform continuous quality improvement strategies and interventions. As part of the new QPHM, DHCS leads a cross-division Quality Metric Workgroup that evaluates metrics for all program areas and makes recommendations about which metrics to include for monitoring and accountability. DHCS evaluates performance metrics based on the Comprehensive Quality Strategy guiding principles. Additionally, the metrics must be:

- Clinically meaningful.
- Have high population impact.
- Align with other national and State priority areas and initiatives as well as other public purchasers.
- Have an availability of standardized measures and data.
- Be evidence based.
- Promote health equity.

DHCS holds MCMC plans accountable to meet minimum performance levels for select performance measures that have existing national benchmarks. MCMC plans that do not meet the minimum performance levels are subject to corrective action plans (CAPs) and/or enforcement actions.

Starting with measurement year 2022, DHCS modified the MCAS to include key metrics in alignment with the Comprehensive Quality Strategy clinical focus areas as well as metrics that MCMC plans will be required to stratify by race and ethnicity. These stratified performance measure results will inform future health disparity reduction targets.

The most up-to-date information on the DHCS Comprehensive Quality Strategy is located at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx. Information regarding CalAIM is located at https://www.dhcs.ca.gov/calaim.

Recommendations—DHCS Comprehensive Quality Strategy

DHCS' Comprehensive Quality Strategy vision, goals, and guiding principles support improvement across all DHCS programs, including MCMC. The strategy provides a roadmap for bringing all relevant people into the continuous quality improvement processes that are outlined throughout the document. Based on the extensive details and planned activities described, HSAG has no recommendations for how DHCS can target the Comprehensive Quality Strategy vision, goals, and guiding principles to better support improvement to the quality, timeliness, and accessibility of care for MCMC beneficiaries.

4. Compliance Reviews

In accordance with 42 CFR §438.358, the state or its designee must 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.

In accordance with California Welfare and Institutions Code (CA WIC) §14456, DHCS directly conducts compliance reviews of MCMC plans, rather than contracting with the EQRO to conduct reviews on its behalf. Transparency and accountability are important aspects of the DHCS Comprehensive Quality Strategy, and conducting compliance reviews is one of the ways DHCS holds plans accountable to meet federal and State requirements that support the delivery of quality, accessible, and timely health care services to Medi-Cal members.[15]

Objectives

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

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

DHCS Compliance Review Methodology

To ensure that MCMC plans meet all federal requirements, DHCS incorporates into its contracts with these plans specific standards for elements outlined in the CFR.

DHCS' compliance review process includes, but is not limited to, a review of MCMC plans' 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 MCMC plans address all deficiencies identified in the compliance reviews conducted (i.e., Medical Audits and State Supported Services Audits for MCPs and PSPs and triennial oversight

[15] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jul 29, 2022.

reviews for the SHP) 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.

Compliance Reviews—Managed Care Health Plans and Population-Specific Health Plans

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

DHCS Audits & Investigations Division Medical Audits

To meet the requirements of CA WIC §14456, DHCS A&I annually conducts on-site medical audits of each MCP and PSP, 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 and PSP'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.

Compliance Reviews—Specialty Health Plan

DHCS A&I conducts triennial oversight reviews of specialty mental health services provided by each county mental health plan (MHP) to determine compliance with federal and State regulations as well as the terms of the MHP contract. Family Mosaic Project, an SHP, is part of the Children, Youth, & Families System of Care operated by the San Francisco Department of Public Health Community Behavioral Health Services; therefore, DHCS includes Family Mosaic Project in its triennial oversight reviews of the San Francisco County MHP. DHCS works closely with each MHP to ensure compliance and to identify opportunities for improvement. Using a collaborative and educational approach, DHCS provides guidance and technical assistance when it determines that the MHP is out of compliance. After the review, DHCS provides feedback related to areas of non-compliance. DHCS provides the MHP with a

written report of findings which includes a description of each finding and of any corrective actions needed. Within 60 days of receiving the final report of findings, MHPs are required to submit to DHCS a CAP for all items that DHCS determined to be out of compliance. If an urgent issue is identified, the issue is addressed immediately.

Evidence of Technical Methods of Data Collection and Analysis

DHCS applies the Generally Accepted Government Auditing Standards, also known as the Yellow Book. To show evidence of DHCS' assessment of the standards included in 42 CFR, DHCS provided HSAG with a crosswalk of the categories A&I reviews during the Medical Audits and the federal standards covered within each of the categories. Table 4.1 displays the A&I Medical Audit categories and the corresponding 42 CFR Subpart D and QAPI standards assessed during A&I's reviews.

Table 4.1—Subpart D and Quality Assessment and Performance Improvement Standards Reviewed within A&I Medical Audit Categories

A&I Medical Audit Categories	Subpart D and Quality Assessment and Performance Improvement Standard
Utilization Management	§438.114 Emergency and Poststabilization Services §438.210 Coverage and Authorization of Services §438.230 Subcontractual Relationships and Delegation §438.236 Practice Guidelines
Case Management and Coordination of Care	§438.114 Emergency and Poststabilization Services §438.208 Coordination and Continuity of Care §438.210 Coverage and Authorization of Services
Access and Availability of Care	§438.206 Availability of Services §438.207 Assurance of Adequate Capacity and Services §438.210 Coverage and Authorization of Services
Member's Rights	§438.100 Enrollee Rights §438.206 Availability of Services §438.208 Coordination and Continuity of Care §438.224 Confidentiality §438.228 Grievance and Appeal Systems
Quality Management	§438.214 Provider Selection §438.230 Subcontractual Relationships and Delegation §438.330 QAPI Program

While DHCS does not assess MCP and PSP compliance with 42 CFR §438.242: Health Information Systems as part of the Medical Audit process, DHCS includes references to these standards in its boilerplate managed care contracts and applicable All Plan Letters (APLs). Additionally, DHCS monitors MCP and PSP encounter data submissions. Note that DHCS indicates that it will include assessment of §438.56: Disenrollment: Requirements and limitations in the Medical Audits no later than 2023.

Scoring Methodology

To fully meet CMS' compliance review requirements, DHCS developed a compliance scoring methodology that includes all federal standards required by CMS. DHCS will implement the compliance scoring methodology beginning with the July 1, 2022, through June 30, 2023, A&I Medical Audit cycle. The scoring methodology will be reflected in the compliance review results included in the 2022–23 EQR technical report.

DHCS will assess MCMC plan compliance with the federal standards based on findings identified during the annual A&I Medical Audits and also from the results of other activities, such as EDV, annual network certification, and quality improvement oversight. DHCS will apply the following *Met*/*Not Met* scoring methodology based on identified findings:

- *Met* = 2 points
- *Not Met* = 0 points

The presence of a finding or identified noncompliance with a corresponding CFR element will result in DHCS scoring the CFR element as *Not Met* (score of 0 points). If DHCS identifies no findings or no evidence of noncompliance with a corresponding CFR element, DHCS will score the element as *Met* (score of 2 points). Scores will be individually shared with MCMC plans prior to DHCS submitting the results to the EQRO.

DHCS notified the MCMC plans of the new compliance scoring methodology on July 15, 2022. While this date is outside the review dates for this EQR technical report, HSAG includes the information since it was available prior to this report being finalized.

Timeliness of Compliance Reviews

As part of the EQR technical report production, DHCS submitted to HSAG all audit reports and CAP closeout letters for audits DHCS conducted within the previous three-year period and that HSAG had not already reported on in previous EQR technical reports.

HSAG determined, by assessing the dates of each plan's review, whether DHCS conducted compliance monitoring reviews for all MCMC plans at least once within the three-year period prior to the review dates for this report. Unless noted, HSAG excluded from its analysis information from compliance reviews conducted earlier than July 1, 2018, (i.e., three years prior to the start of the review period) and later than June 30, 2022, (i.e., the end of the review period).

HSAG reviewed all compliance-related information to assess the degree to which MCMC plans are meeting the standards that DHCS A&I 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 members.

Results

DHCS A&I continued its suspension of the in-person Medical and State Supported Services Audits of MCMC plans. The suspension began in April 2020 due to COVID-19 response efforts. A&I conducted all audits virtually during the review period and continued to require MCMC plans to comply with all CAP requirements imposed prior to the public health emergency.

To ensure DHCS' compliance with §438.358, HSAG reviewed the dates on which DHCS conducted its most recent compliance reviews of MCMC plans 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, 2021) and no later than the end of the review period for this report (June 30, 2022) for all MCMC plans.

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 2021–22 EQR technical report:

- DHCS provided evidence to HSAG of DHCS' ongoing follow-up with MCMC plans regarding findings that A&I identified during audits. DHCS provided documentation to HSAG of its follow-up with MCMC plans on CAPs as well as finding-related documentation from these MCMC plans. DHCS determined that the documentation from MCMC plans was detailed and reflected changes to policies and procedures to ensure compliance with areas A&I reviewed.
- HSAG identified no common areas for improvement since audit findings were specific to MCMC plans.

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.

Comparative MCMC plan-specific compliance review results are included in *Volume 2 of 5 (Appendix A)* of this EQR technical report.

Conclusions

Findings identified during the A&I audits reflected opportunities for improvement for MCMC plans in the areas of quality and timeliness of, and access to health care. Audit findings within the assessed areas were MCMC plan-specific; therefore, across all MCMC plans, HSAG identified no common 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.

During the review period, DHCS made progress toward fully meeting CMS' compliance review requirements by developing a compliance scoring methodology that includes all federal standards required by CMS. DHCS indicated that it will implement the compliance scoring methodology beginning with the July 1, 2022, through June 30, 2023, A&I Medical Audit cycle. The scoring methodology will be reflected in the compliance review results included in the 2022–23 EQR technical report.

In *Volume 2 of 5 (Appendix E)* of this EQR technical report, HSAG includes an assessment of each MCMC plan's strengths and weaknesses related to compliance reviews as well as HSAG's recommendations.

5. 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' QAPI 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.

To comply with §438.358, DHCS contracted with HSAG to conduct an independent audit in alignment with the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™[16] standards, policies, and procedures to assess the validity of the DHCS-selected performance measures calculated and submitted by MCMC plans. Additionally, DHCS contracted with HSAG to conduct an independent audit of the DHCS-selected performance measures calculated and submitted by MCPs that participate in California's Coordinated Care Initiative as Managed Long-Term Services and Supports Plans (MLTSSPs). During each audit, HSAG assesses the validity of each plan's data using CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[17] Following the audits, 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 their members.

Objectives

The purpose of HSAG's performance measure validation (PMV) is to ensure that each MCMC plan calculates and reports performance measures consistent with the established specifications and that the results can be compared to one another.

HSAG conducts HEDIS Compliance Audits and PMV, and analyzes performance measure results to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which each MCMC plan followed the established specifications for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

[16] HEDIS Compliance Audit™ is a trademark of NCQA.
[17] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jul 29, 2022.

Note: MCMC plans must calculate and report DHCS' required 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 Capabilities Assessment and an evaluation of compliance with performance measure specifications for a plan. All of HSAG's lead auditors are certified HEDIS compliance auditors.

Performance Measure Validation Activities

PMV involved three phases: audit validation, audit review, and follow-up and reporting. The following provides a summary of HSAG's activities with MCMC plans, as applicable, within each of the audit phases. Throughout all audit phases, HSAG actively engages with MCMC plans to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support these entities in understanding all audit requirements and in being able to report valid rates for all required performance measures.

Audit Validation Phase (October 2021 through May 2022)

- Forwarded HEDIS measurement year 2021 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Conducted the annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled virtual audit review dates.
- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS Compliance Audit and PMV processes, and ensure that MCMC plans were aware of important deadlines.
- Reviewed completed HEDIS Roadmaps and the Information Systems Capabilities Assessment Tool (ISCAT) to assess compliance with the audit standards, and provided the Information Systems standard tracking report which listed outstanding items and areas that required additional clarification.
- 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 (MRRV) to ensure the integrity of medical record review (MRR) processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Phase (January 2022 through April 2022)

- Conducted virtual audit reviews to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Follow-Up and Reporting Phase (May 2022 through July 2022)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final Information Systems 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 measurement year 2020 Audit Means and Percentiles. 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.

Description of Data Obtained

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

- HEDIS Roadmap and ISCAT.
- Source code, computer programming, and query language (if applicable) used to calculate the selected non-HEDIS performance measure rates.
- 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 interactions, discussions, and formal interviews with key MCMC plan 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 MCMC plan performance in providing accessible, timely, and quality health care services to their members. 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 MCPs' and PSPs' performance in comparison to high performance levels and minimum performance levels and for all MCMC plans, identified strengths, opportunities for improvement, and recommendations based on its assessment of MCMC plan performance.

Aggregate MCP, PSP, SHP, and MLTSSP performance measure results and conclusions are included in Section 6, Section 7, Section 8, and Section 9 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).

Note: Because DHCS' contract with Rady Children's Hospital—San Diego ended December 31, 2021, the PSP was not required to participate in the PMV process, which took place in 2022. HSAG therefore has no PMV or performance measure results to include in this EQR technical report for Rady Children's Hospital—San Diego.

Results

For measurement year 2021, HSAG conducted 28 PMVs, with 27 of those being NCQA HEDIS Compliance Audits. The exception was Family Mosaic Project, an SHP that reported non-HEDIS measures and underwent PMV consistent with CMS protocols. These 28 PMVs resulted in 59 separate data submissions for performance measure rates at the reporting unit level. HSAG also conducted PMV 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 PMV included preparation for the virtual audit review, Roadmap review, data systems review, supplemental data validation if applicable, source code review, a virtual audit review, MRRV when appropriate, primary source validation, query review, preliminary and final rate review, and initial and final audit reports production.

HSAG reviewed and approved the source code that Family Mosaic Project developed internally for calculation of the required non-HEDIS measures. In addition, HSAG reviewed and approved source code used to calculate the required non-HEDIS measures for all MCPs and PSPs.

Conclusions

The following contributed to all MCMC plans being able to fully engage in the audit process and produce valid performance measure rates for all required MCAS measures:

- DHCS permitting MCMC plans to choose the data collection methodology to use for measures with both hybrid and administrative options may have saved some MCMC plans the costs associated with using the hybrid methodology in instances wherein hybrid reporting did not improve their rates. Additionally, in instances wherein the MCMC plans were unable to report a measure rate using the hybrid methodology, DHCS' decision provided them the opportunity to report the rate administratively, which resulted in a *Reportable* (R) rate instead of a *Biased Rate* (BR).
- While HSAG identified instances of some MCPs being partially compliant with an information systems standard, HSAG auditors determined that the identified issues had a minimal impact on performance measure reporting. HSAG auditors determined that all PSPs were fully compliant with all information systems standards.
- With few exceptions, MCMC plans had integrated teams which included key staff members from both quality and information technology departments. HSAG observed that both areas worked closely together and had a sound understanding of the NCQA HEDIS Compliance Audit process. This multidisciplinary approach is crucial for reporting accurate and timely performance measure rates.
- MCMC plans used enrollment data as the primary data source for determining the eligible population for most measures. The routine data transfer and longstanding relationship between MCMC plans and DHCS continued to support implementation of best practices and stable processes for acquiring membership data. In addition to smooth and accurate processing by MCMC plans, the data included fewer issues compared to previous years and fewer retrospective enrollment concerns.
- The majority of MCPs and PSPs continued to increase use of supplemental data sources. These additional data sources offered MCPs and PSPs the opportunity to more accurately capture the services provided to their members. Moreover, reporting hybrid measures along with supplemental data reduced the amount of resources that MCPs and PSPs had to expend to abstract the clinical information, thus lessening their burden.
- MCPs and PSPs had rigorous editing processes in place to ensure accurate and complete pharmacy data.
- With few exceptions, MCPs and PSPs received most claims data electronically and had a very small percentage of claims that required manual data entry, minimizing the potential for errors.

It is important that MCPs and PSPs have comprehensive, ongoing oversight processes in place due to the continued increase in the number of supplemental data sources used for performance measure rate calculations. HSAG observed that MCPs and PSPs have opportunities to investigate methods to incorporate supplemental data sources earlier in the audit process to eliminate the review of data sources that are not applicable to the MCAS measures.

For some of the behavioral health measures, MCPs did not use all available data from DHCS that were needed to report an eligible population. During the audit process, HSAG stressed the importance of MCPs using all data made available to them by DHCS for behavioral health performance measure reporting.

HSAG auditors identified MCMC plan-specific challenges and opportunities for improvement and provided feedback to each MCMC plan, as applicable.

In *Volume 2 of 5 (Appendix E)* of this EQR technical report, HSAG includes an assessment of each MCMC plan's strengths and weaknesses related to PMV as well as HSAG's recommendations.

6. Managed Care Health Plan Performance Measures

Objective

The primary objective related to MCP performance measures is for HSAG to assess MCPs' performance in providing quality, accessible, and timely care and services to beneficiaries by organizing, aggregating, and analyzing the performance measure results.

Requirements

To comply with 42 CFR §438.330, DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. DHCS refers to this DHCS-required performance measure set as the MCAS. As outlined in the DHCS Comprehensive Quality Strategy, DHCS' QPHM program's Quality Metric Workgroup evaluates metrics for all program areas and makes recommendations about which measures should be required for monitoring and accountability. The workgroup also ensures that all required measures are aligned with the Comprehensive Quality Strategy and its key objectives.[18] The performance measure requirements support the advancement of DHCS' Comprehensive Quality Strategy goals as well as DHCS' *Medi-Cal's Strategy to Support Health and Opportunity for Children and Families*, which is a forward-looking policy agenda for children and families enrolled in Medi-Cal.[19]

DHCS consults with HSAG and reviews feedback from MCPs and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. MCPs must report county or regional rates unless otherwise approved by DHCS.

Medi-Cal Managed Care Accountability Set

DHCS' measurement year 2021[20] MCAS included select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also HEDIS measures. Several required measures include more than one indicator, bringing the total number of performance measure rates required for MCP reporting to 54. In this report, HSAG uses "performance measure" or "measure" (rather than indicator) to reference required MCAS

[18] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

[19] *Medi-Cal's Strategy to Support Health and Opportunity for Children and Families*. Available at: https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf. Accessed on: Aug 1, 2022.

[20] The measurement year is the calendar year for which MCPs report the rates. Measurement year 2021 represents data from January 1, 2021, through December 31, 2021.

measures. Collectively, performance measure results reflect the quality of, timeliness of, and access to care MCPs provide to their members.

Table 6.1 lists the measurement year 2021 MCAS measures by measure domain. HSAG organized the measures into measure domains based on the health care areas they affect. Organizing the measures by domain allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS. Additionally, Table 6.1 includes descriptions and indicates the data capture method(s) for each measurement year 2020 MCAS measure. For some MCAS performance measures, the specifications allow for both administrative and hybrid reporting methods; for these measures, DHCS allows MCPs to choose either methodology. Note that when reporting performance measure rates using the hybrid methodology, MCPs are required to procure medical record data.

Table 6.1—Measurement Year 2021 Managed Care 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 members 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.

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

* DHCS allows MCPs to choose the methodology for reporting the rate for this measure and expects that MCPs will report using the methodology that results in the higher rate.

Measure	Method of Data Capture
Children's Health Domain	
Child and Adolescent Well-Care Visits—Total The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.	Admin
Childhood Immunization Status—Combination 10 The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenza type B; three hepatitis B, one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday.	Admin or Hybrid*

Measure	Method of Data Capture
Developmental Screening in the First Three Years of Life—Total The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Admin
Immunizations for Adolescents—Combination 2 The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine, and have completed the human papillomavirus vaccine series by their 13th birthday.	Admin or Hybrid*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.	Admin or Hybrid*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.	Admin or Hybrid*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.	Admin or Hybrid*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits The percentage of members who turned 15 months old during the measurement year who had six or more well-child visits with a PCP during the last 15 months.	Admin
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits The percentage of members who turned 30 months old during the measurement year who had two or more well-child visits with a PCP during the last 15 months.	Admin

Measure	Method of Data Capture
Women's Health Domain	
Breast Cancer Screening—Total The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.	Admin
Cervical Cancer Screening The percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: ♦ Women 21 to 64 years of age who had cervical cytology performed within the last 3 years. ♦ Women 30 to 64 years of age who had cervical high-risk human papillomavirus testing performed within the last 5 years. ♦ Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus cotesting within the last 5 years.	Admin or Hybrid*
Chlamydia Screening in Women—Ages 16–20 Years The percentage of women 16 to 20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin
Chlamydia Screening in Women—Ages 21–24 Years The percentage of women 21 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin
Chlamydia Screening in Women—Total The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years Among women ages 15 to 20 at risk of unintended pregnancy, the percentage who were provided a LARC.	Admin
Contraceptive Care—All Women—LARC—Ages 21–44 Years Among women ages 21 to 44 at risk of unintended pregnancy, the percentage who were provided a LARC.	Admin

Measure	Method of Data Capture
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years Among women ages 15 to 20 at risk of unintended pregnancy, the percentage who were provided a most effective or moderately effective method of contraception.	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years Among women ages 21 to 44 at risk of unintended pregnancy, the percentage who were provided a most effective or moderately effective method of contraception.	Admin
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a LARC within 3 days of delivery.	Admin
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a LARC within 3 days of delivery.	Admin
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a LARC within 60 days of delivery.	Admin
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a LARC within 60 days of delivery.	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 3 days of delivery.	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 3 days of delivery.	Admin

Measure	Method of Data Capture
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years Among women ages 15 to 20 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 60 days of delivery.	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years Among women ages 21 to 44 who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 60 days of delivery.	Admin
Prenatal and Postpartum Care—Postpartum Care The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	Admin or Hybrid*
Prenatal and Postpartum Care—Timeliness of Prenatal Care The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	Admin or Hybrid*
Behavioral Health Domain	
Antidepressant Medication Management—Effective Acute Phase Treatment—Total The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).	Admin
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days (6 months).	Admin

Measure	Method of Data Capture
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Admin
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence, who had a follow-up visit for alcohol or other drug abuse or dependence within 7 days of the emergency department visit (8 total days).	Admin
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence, who had a follow-up visit for alcohol or other drug abuse or dependence within 30 days of the emergency department visit (31 total days).	Admin
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the emergency department visit (8 total days).	Admin
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the emergency department visit (31 total days).	Admin
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	Admin

Measure	Method of Data Capture
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the 30-day initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	Admin
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total The percentage of children and adolescents 1 to 17 years of age on two or more antipsychotic prescriptions who received blood glucose testing.	Admin
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total The percentage of children and adolescents 1 to 17 years of age on two or more antipsychotic prescriptions who received cholesterol testing.	Admin
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total The percentage of children and adolescents 1 to 17 years of age on two or more antipsychotic prescriptions who received blood glucose and cholesterol testing.	Admin
Screening for Depression and Follow-Up Plan—Ages 12–17 Years The percentage of members ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Admin
Screening for Depression and Follow-Up Plan—Ages 18–64 Years The percentage of members ages 18 to 64 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Admin
Screening for Depression and Follow-Up Plan—Ages 65+ Years The percentage of members ages 65 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Admin

Measure	Method of Data Capture
Acute and Chronic Disease Management Domain	
Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total This measure summarizes utilization of ambulatory care in the category of emergency department visits.	Admin
Asthma Medication Ratio—Total The percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Admin
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0 percent).	Admin or Hybrid*
Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years The percentage of members ages 18 to 64 with concurrent use of prescription opioids and benzodiazepines. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years The percentage of members ages 65 and older with concurrent use of prescription opioids and benzodiazepines. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin
Controlling High Blood Pressure—Total The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Admin or Hybrid*
Plan All-Cause Readmissions—Observed Readmissions—Total For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of observed 30-day readmissions.	Admin

Measure	Method of Data Capture
Plan All-Cause Readmissions—Expected Readmissions—Total For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of expected 30-day readmissions.	Admin
Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of observed 30-day readmissions divided by the count of expected 30-day readmissions.	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years The percentage of members ages 18 to 64 who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years The percentage of members ages 65 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Admin

Seniors and Persons with Disabilities Performance Measure Stratification

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2020, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

DHCS-Established Performance Levels

Each year, to create a uniform standard for assessing MCPs on performance measures, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. 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.

To establish the high performance levels and minimum performance levels for the measurement year 2021 MCAS HEDIS measures, DHCS used NCQA's Quality Compass®,[21] HEDIS 2021 Medicaid health maintenance organization (HMO) benchmarks. The Quality Compass HEDIS 2021 Medicaid HMO benchmarks reflect the previous year's benchmark percentiles (measurement year 2020). DHCS based the high performance levels for measurement year 2021 on NCQA's Quality Compass HEDIS 2021 Medicaid HMO 90th percentiles and the minimum performance levels for measurement year 2021 on the national Medicaid 50th percentiles.

According to DHCS' license agreement with NCQA, HSAG includes in Table 6.2 the benchmarks that DHCS used to establish the high performance levels and minimum performance levels for the measurement year 2021 HEDIS measures for which DHCS determined to hold MCPs accountable to meet the minimum performance levels.[22]

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

[22] The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the data") is Quality Compass® 2021 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® and HEDIS CAHPS® 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 6.2—High Performance Level and Minimum Performance Level Benchmark Values for Measurement Year 2021

Measurement year 2021 high performance level and minimum performance level benchmark values represent NCQA's Quality Compass HEDIS 2021 Medicaid HMO 90th and 50th percentiles, respectively, reflecting the measurement year from January 1, 2020, through December 31, 2020.

* A lower rate indicates better performance for this measure.

Measure	Measurement Year 2021 High Performance Level	Measurement Year 2021 Minimum Performance Level
Children's Health		
Child and Adolescent Well-Care Visits—Total	61.97%	45.31%
Childhood Immunization Status—Combination 10	53.66%	38.20%
Immunizations for Adolescents—Combination 2	50.61%	36.74%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total	87.18%	76.64%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	82.48%	70.11%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	79.32%	66.18%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	68.33%	54.92%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	82.82%	70.67%
Women's Health		
Breast Cancer Screening—Total	63.77%	53.93%
Cervical Cancer Screening	67.99%	59.12%
Chlamydia Screening in Women—Total	66.15%	54.91%
Prenatal and Postpartum Care—Postpartum Care	83.70%	76.40%

Measure	Measurement Year 2021 High Performance Level	Measurement Year 2021 Minimum Performance Level
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.21%	85.89%
Acute and Chronic Disease Management		
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total**	34.06%	43.19%
Controlling High Blood Pressure—Total	66.79%	55.35%

Measurement Year 2021 Quality Monitoring

For measurement year 2021, DHCS established accountability requirements based on quality improvement tiers. MCMC plans not meeting the minimum performance level for one or more measures within a performance measure domain will be placed in a quality monitoring tier. Following are the requirements for each tier:

- Green Tier—One performance measure rate below the minimum performance level in any domain.
  - Quality Improvement Requirement: Plan-Do-Study-Act (PDSA) cycles
- Orange Tier—Two or more performance measure rates below the minimum performance levels in any one domain.
  - Quality Improvement Requirement: PDSA cycles and SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis projects.
  - DHCS will require each MCMC plan to conduct no more than three quality improvement projects (i.e., PDSA cycles and/or SWOT analyses projects), not including PIPs. The MCMC plan-assigned DHCS nurse consultant, in collaboration with the MCMC plan, will determine the number and project type (i.e., PDSA cycles or SWOT analyses).
- Red Tier—Three or more performance measure rates below the minimum performance levels in two or more domains.
  - Implement a CAP.
  - Quality Improvement Requirement: Quality Improvement Assessment.
  - Attend executive leadership meetings every four months.
  - Attend a nurse consultant meeting prior to each executive leadership meeting.

DHCS will work with each MCMC plan to determine specific quality improvement requirements.

Enforcement Actions and Corrective Action Plans

CA WIC §14197.7 and the MCP contracts authorize DHCS to impose enforcement actions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Enforcement actions may include monetary and non-monetary sanctions. The level and type of enforcement action would depend on the number of deficiencies and the severity of the quality issues identified.

If an MCP continually fails to meet the established minimum performance levels or fails to submit the required information requested by DHCS during the CAP process, DHCS may:

- Impose additional monetary sanctions.
- Assign an MCP monitor or consultant.
- Terminate the MCP contract.

For measurement year 2021, DHCS will impose enforcement actions and CAPs on MCPs for MCAS performance measure rates that do not meet the minimum performance levels.

MCMC Weighted Average Calculation Methodologies

Measurement Year 2019

For all but two measures, HSAG calculated the measurement year 2019 MCMC weighted averages according to CMS' methodology.[23] To allow MCPs and their providers to focus on COVID-19 efforts, DHCS offered MCPs alternatives for reporting hybrid measure rates for measurement year 2019. Some MCPs used their MCP-level measurement year 2018 rates for all or some of their reporting unit rates; therefore, HSAG modified the measurement year 2019 MCMC weighted average calculations for the following measures:

- *Childhood Immunization Status—Combination 10*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*

[23] Centers for Medicare & Medicaid Services. Technical Assistance Brief: Calculating State-Level Rates Using Data from Multiple Reporting Units. March 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf. Accessed on: Aug 1, 2022.

The following is a summary of how HSAG modified the methodology for calculating the measurement year 2019 MCMC weighted averages for these two measures:

Childhood Immunization Status—Combination 10

For the reporting units for which Anthem Blue Cross and Molina used their respective measurement year 2018 *Childhood Immunization Status—Combination 3* measure MCP-level rates, HSAG used the eligible populations from the measurement year 2018 reporting unit rates for the *Childhood Immunization Status—Combination 3* measure when calculating the measurement year 2020 MCMC weighted average. Note that HSAG used the eligible population from the *Childhood Immunization Status—Combination 3* measure since it was the only *Childhood Immunization Status* measure DHCS required for measurement year 2018 and because it has the exact same eligible population as the *Childhood Immunization Status—Combination 10* measure.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total

Anthem Blue Cross used the measurement year 2018 MCP-level rate for all 12 reporting units for this measure; therefore, HSAG only used Anthem Blue Cross' MCP-level rate once to represent all 12 Anthem Blue Cross reporting units when calculating the measurement year 2019 MCMC weighted average for this measure.

Measurement Years 2020 and 2021

HSAG calculated the measurement years 2020 and 2021 MCMC weighted averages according to CMS' methodology.[24]

Results

HSAG presents the following statewide MCMC weighted average performance measure results grouped by measure domains in Table 6.3 through Table 6.10:

- As applicable, three-year trending for the MCMC weighted averages and a comparison of measurement year 2021 MCMC weighted averages both to the measurement year 2020 MCMC weighted averages and to the DHCS-established high performance levels and minimum performance levels.

[24] Centers for Medicare & Medicaid Services. Technical Assistance Brief: Calculating State-Level Rates Using Data from Multiple Reporting Units. March 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf. Accessed on: Aug 1, 2022.

  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[25] due to the COVID-19 public health emergency, DHCS decided not to compare measurement year 2019 performance measure results to benchmarks; therefore, HSAG does not display comparison of measurement year 2019 MCMC weighted averages to the high performance levels and minimum performance levels in these tables.
- The measurement years 2020 and 2021 MCMC weighted averages for each MCAS measure that HSAG compared to the corresponding national Medicaid average and whether the weighted averages were better or worse than the national Medicaid averages.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*,[26] due to the COVID-19 public health emergency, DHCS decided not to compare measurement year 2019 performance measure results to benchmarks; therefore, HSAG does not include measurement year 2019 MCMC weighted averages in these tables.

Please refer to Table 6.1 for descriptions of all MCAS measures included in Table 6.3 through Table 6.10, and Table 6.2 for the benchmarks HSAG used for high performance level and minimum performance level comparisons included in the applicable tables. The national Medicaid averages HSAG used for comparisons in the applicable tables represent the 2021 NCQA Quality Compass national Medicaid averages.

Please refer to *Volume 3 of 5* of this EQR technical report for comparative PMV information across all MCPs for all DHCS-required performance measures. The *Measurement Year 2021 Managed Care Health Plan Performance Measure Comparison* provides the following:

- Comparative performance measure results by domain.
- Comparisons to the high performance levels and minimum performance levels for applicable performance measures.
- Comparative SPD and non-SPD stratification results for applicable measures.

Children's Health Domain

Table 6.3 presents the MCMC weighted average performance measure results for measurement years 2019, 2020, and 2021 within the Children's Health domain.

[25] Health Services Advisory Group, Inc. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020*. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf. Accessed on: Aug 1, 2022.

[26] Ibid.

Note the following regarding Table 6.3:

- The following measures only have measurement years 2020 and 2021 MCMC weighted averages due to a break in trending from measurement year 2019 to measurement year 2020 or because they were new measures in measurement year 2020:
  - *Child and Adolescent Well-Care Visits—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- HSAG makes no comparison to the high performance level or minimum performance level for the *Developmental Screening in the First Three Years of Life—Total* measure because no national benchmarks existed for this measure.
- Based on DHCS performance measure requirements, HSAG compares the MCMC weighted averages to high performance levels and minimum performance levels for measurement year 2021 only for the following measures:
  - *Child and Adolescent Well-Care Visits—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- For measurement year 2019, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan (Anthem Blue Cross) and Molina Healthcare of California elected to use MCP-level rates instead of MCP reporting unit rates for the *Childhood Immunization Status—Combination 10* measure; therefore, caution should be exercised when comparing the measurement year 2020 MCMC weighted average to the measurement year 2019 MCMC weighted average for this measure.
- For measurement year 2019, Anthem Blue Cross elected to use an MCP-level rate instead of MCP reporting unit rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* measure, and for measurement year 2020, NCQA made specification changes to the measure; therefore, caution should be exercised when comparing the measurement year 2020 MCMC weighted average to the measurement year 2019 MCMC weighted average for this measure.

Table 6.3—Children's Health Domain Measurement Years 2019, 2020, and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Rate indicates performance at or better than the high performance level.

Bolded Rate = Rate indicates performance worse than the minimum performance level.

= Statistical testing result indicates that the measurement year 2021 rate is significantly better than the measurement year 2020 rate.

= Statistical testing result indicates that the measurement year 2021 rate is significantly worse than the measurement year 2020 rate.

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

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

^ For this measure, only the measurement year 2021 rate is compared to the high performance level and minimum performance level.

^^As indicated above in the notes regarding this table, caution should be exercised when comparing the measurement year 2020 MCMC weighted average to the measurement year 2019 MCMC weighted average for this measure.

— Indicates that the rate is not available.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
High Performance Levels and Minimum Performance Levels Comparisons				
*Child and Adolescent Well-Care Visits—Total^*	—	41.13%	47.51%	6.38
*Childhood Immunization Status—Combination 10^^*	38.32%	37.95%	**36.63%**	1.32
Immunizations for Adolescents—Combination 2	43.57%	43.05%	39.23%	-3.82
*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total^^*	86.71%	81.79%	85.02%	3.23
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	74.73%	80.65%	5.92

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	72.80%	78.99%	6.19
*Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits^*	—	37.70%	**40.23%**	2.53
*Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits^*	—	66.40%	**60.28%**	-6.12
No High Performance Levels or Minimum Performance Levels Comparisons				
Developmental Screening in the First Three Years of Life—Total	25.42%	23.11%	28.83%	5.72

Table 6.4 presents the measurement years 2020 and 2021 MCMC weighted averages for measures within the Children's Health domain that HSAG compared to the national Medicaid averages.

Table 6.4—Children's Health Domain Measurement Years 2020 and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

= Rate indicates performance at or better than the national Medicaid average.

Bolded Rate = Rate indicates performance worse than the national Medicaid average.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

* A comparison cannot be made because no national benchmarks existed for this measure in measurement year 2020.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate
Child and Adolescent Well-Care Visits—Total	41.13%*	47.51%
Childhood Immunization Status—Combination 10	**37.95%**	36.63%
Immunizations for Adolescents—Combination 2	43.05%	39.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total	81.79%	85.02%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	74.73%	80.65%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	72.80%	78.99%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	37.70%*	**40.23%**
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	66.40%*	**60.28%**

Women's Health Domain

Table 6.5 presents the MCMC weighted average performance measure results for measurement years 2019, 2020, and 2021 within the Women's Health domain. Note that HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:

- The *Chlamydia Screening in Women—Ages 16–20 Years* and *Ages 21–24 Years* measures
- All 12 *Contraceptive Care* measures

Table 6.5—Women's Health Domain—Measurement Years 2019, 2020, and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Rate indicates performance at or better than the high performance level.

Bolded Rate = Rate indicates performance worse than the minimum performance level.

= Statistical testing result indicates that the measurement year 2021 rate is significantly better than the measurement year 2020 rate.

= Statistical testing result indicates that the measurement year 2021 rate is significantly worse than the measurement year 2020 rate.

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

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 from measurement year 2019 to measurement year 2020 given the changes that NCQA made to the specification for this measure beginning with measurement year 2020.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
High Performance Levels and Minimum Performance Levels Comparisons				
Breast Cancer Screening—Total	62.19%	**57.04%**	53.99%	-3.05
*Cervical Cancer Screening^*	64.67%	**59.90%**	**58.18%**	-1.72
Chlamydia Screening in Women—Total	64.83%	61.63%	63.61%	1.98
*Prenatal and Postpartum Care—Postpartum Care^*	77.55%	78.87%	81.39%	2.52
*Prenatal and Postpartum Care—Timeliness of Prenatal Care^*	90.86%	**87.88%**	87.57%	-0.31
No High Performance Levels or Minimum Performance Levels Comparisons				
Chlamydia Screening in Women—Ages 16–20 Years	60.49%	57.94%	59.23%	1.29
Chlamydia Screening in Women—Ages 21–24 Years	69.52%	65.48%	67.91%	2.43

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 15–20 Years	2.58%	2.24%	2.04%	-0.20
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.82%	4.35%	4.37%	0.02
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.74%	14.70%	13.89%	-0.81
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.43%	23.58%	23.21%	-0.37
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	1.66%	2.82%	2.90%	0.08
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.31%	2.54%	2.50%	-0.04
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	13.36%	14.33%	14.06%	-0.27
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.85%	11.34%	11.02%	-0.32

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.73%	5.01%	4.86%	-0.15
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.24%	10.42%	10.04%	-0.38
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.99%	37.34%	35.88%	-1.46
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	34.68%	36.67%	35.18%	-1.49

Table 6.6 presents the measurement years 2020 and 2021 MCMC weighted averages for measures within the Women's Health domain that HSAG compared to the national Medicaid averages.

Table 6.6—Women's Health Domain Measurement Years 2020 and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

= Rate indicates performance at or better than the national Medicaid average.

Bolded Rate = Rate indicates performance worse than the national Medicaid average.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate
Breast Cancer Screening—Total	**57.04%**	53.99%
Cervical Cancer Screening	**59.90%**	58.18%
Chlamydia Screening in Women—Ages 16–20 Years	57.94%	59.23%
Chlamydia Screening in Women—Ages 21–24 Years	65.48%	67.91%
Chlamydia Screening in Women—Total	61.63%	63.61%
Prenatal and Postpartum Care—Postpartum Care	78.87%	81.39%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.88%	87.57%

Behavioral Health Domain

Table 6.7 presents the MCMC weighted average performance measure results for measurement years 2019, 2020, and 2021 within the Behavioral Health domain.

Note the following regarding Table 6.7:

- The following measures were new beginning with measurement year 2020; therefore, no measurement year 2019 MCMC weighted averages are displayed:
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
- The following measures are new for measurement year 2021; therefore, no measurement years 2019 and 2020 MCMC weighted averages are displayed:
  - Both *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* measures
  - Both *Follow-Up After Emergency Department Visit for Mental Illness* measures
- For measurement year 2021, DHCS did not hold MCPs accountable to meet minimum performance levels for any measures within this domain; therefore, for all three measurement years included in Table 6.7, HSAG makes no comparisons to high performance levels or minimum performance levels for any measures.

Table 6.7—Behavioral Health Domain Measurement Years 2019, 2020, and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Statistical testing result indicates that the measurement year 2021 rate is significantly better than the measurement year 2020 rate.

= Statistical testing result indicates that the measurement year 2021 rate is significantly worse than the measurement year 2020 rate.

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

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 from measurement year 2019 to measurement year 2020 given the changes that NCQA made to the specification for this measure beginning with measurement year 2020.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2020–21 rate difference cannot be calculated because data are not available for both years.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
No High Performance Levels or Minimum Performance Levels Comparisons				
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.36%	60.05%	65.15%	5.10
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.12%	43.09%	48.52%	5.43
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	75.74%	79.89%	4.15

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	—	—	4.86%	Not Comparable
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	—	—	8.56%	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	—	—	23.25%	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	—	—	34.77%	Not Comparable
*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase^*	39.92%	43.91%	42.14%	-1.77
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase^*	47.21%	49.28%	49.35%	0.07
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	—	55.48%	62.61%	7.13

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	—	39.10%	45.33%	6.23
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	—	37.60%	43.98%	6.38
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	15.18%	18.25%	21.37%	3.12
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	9.72%	11.42%	13.00%	1.58
Screening for Depression and Follow-Up Plan—Ages 65+ Years	11.85%	13.15%	15.89%	2.74

Table 6.8 presents the measurement years 2020 and 2021 MCMC weighted averages for measures within the Behavioral Health domain that HSAG compared to the national Medicaid averages.

Table 6.8—Behavioral Health Domain Measurement Years 2020 and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance at or better than the national Medicaid average.

Bolded Rate = Rate indicates performance worse than the national Medicaid average.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

— Indicates that the rate is not available.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	60.05%	65.15%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.09%	48.52%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**75.74%**	79.89%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	—	**4.86%**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	—	**8.56%**
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	—	**23.25%**
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	—	**34.77%**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	43.91%	**42.14%**
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	**49.28%**	**49.35%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	**55.48%**	62.61%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	**39.10%**	45.33%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	**37.60%**	43.98%

Acute and Chronic Disease Management Domain

Table 6.9 presents the measurement years 2019, 2020, and 2021 MCMC weighted averages for measures within the Acute and Chronic Disease Management domain.

Note the following regarding Table 6.9:

- For the *Controlling High Blood Pressure—Total* measure:
  - HSAG only displays measurement years 2020 and 2021 MCMC weighted averages due to NCQA recommending a break in trending from measurement year 2019 to measurement year 2020.
  - Based on DHCS' performance measure requirements, HSAG compares the MCMC weighted average to the high performance level and minimum performance level for measurement year 2021 only.
- HSAG makes no comparisons to high performance levels or minimum performance levels for the following measures in this domain either because no national benchmarks existed for these measures or because DHCS did not hold MCPs accountable to meet minimum performance levels for the measures:
  - *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total*
  - *Asthma Medication Ratio—Total*
  - Both *Concurrent Use of Opioids and Benzodiazepines* measures
  - All three *Plan All-Cause Readmissions* measures
  - Both *Use of Opioids at High Dosage in Persons Without Cancer* measures

Table 6.9—Acute and Chronic Disease Management Domain—Measurement Years 2019, 2020, and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

= Rate indicates performance at or better than the high performance level.

Bolded Rate = Rate indicates performance worse than the minimum performance level.

= Statistical testing result indicates that the measurement year 2021 rate is significantly better than the measurement year 2020 rate.

= Statistical testing result indicates that the measurement year 2021 rate is significantly worse than the measurement year 2020 rate.

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

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.

** This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member

months are a member's "contribution" to the total yearly membership. DHCS establishes a high performance level and minimum performance level for this measure; however, as a higher or lower rate does not necessarily indicate better or worse performance, HSAG does not compare the rate to benchmarks.

^ For this measure, only the measurement year 2021 rate is compared to the high performance level and minimum performance level.

— Indicates that the rate is not available.

Not Tested = A measurement year 2020–21 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
High Performance Levels and Minimum Performance Levels Comparisons				
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total**	34.23%	41.50%	37.50%	-4.00
*Controlling High Blood Pressure—Total^*	—	58.41%	60.25%	1.84
No High Performance Levels or Minimum Performance Levels Comparisons				
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total***	44.82	31.96	33.67	Not Tested
Asthma Medication Ratio—Total	61.49%	64.26%	65.04%	0.78
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years**	13.60%	12.40%	11.12%	-1.28
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	11.00%	10.01%	9.09%	-0.92

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
*Plan All-Cause Readmissions—Observed Readmissions—Total**	8.91%	9.32%	9.19%	-0.13
Plan All-Cause Readmissions—Expected Readmissions—Total	9.58%	9.74%	9.54%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total**	0.93	0.96	0.96	Not Tested
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years**	5.25%	4.53%	4.94%	0.41
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	2.77%	2.49%	3.36%	0.87

Table 6.10 presents the measurement years 2020 and 2021 MCMC weighted averages for measures within the Acute and Chronic Disease Management domain that HSAG compared to the national Medicaid averages.

Table 6.10—Acute and Chronic Disease Management Domain Measurement Years 2020 and 2021 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance at or better than the national Medicaid average.

Bolded Rate = Rate indicates performance worse than the national Medicaid average.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

* A lower rate indicates better performance for this measure.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate
Asthma Medication Ratio—Total	64.26%	**65.04%**
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total**	**41.50%**	37.50%
Controlling High Blood Pressure—Total	**58.41%**	60.25%

Seniors and Persons with Disabilities

Table 6.11 presents the SPD and non-SPD MCMC weighted averages, a comparison of these averages, and the total MCMC weighted averages for the two measures MCPs stratified by SPD and non-SPD populations for measurement year 2021.

Table 6.11—Measurement Year 2021 Medi-Cal Managed Care Weighted Averages Comparison and Results for Measures Stratified by the SPD Population

= Statistical testing result indicates that the measurement year 2021 SPD rate is significantly better than the measurement year 2021 non-SPD rate.

= Statistical testing result indicates that the measurement year 2021 SPD rate is significantly worse than the measurement year 2021 non-SPD rate.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, 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 higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement 2021 SPD Rate	Measurement Year 2021 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2021 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total**	56.01	32.51	Not Tested	33.67

Measure	Measurement 2021 SPD Rate	Measurement Year 2021 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2021 Total Rate
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.84%	8.67%	Not Tested	9.19%

Comparison Across All Managed Care Health Plans

For measures for which HSAG compared rates to high performance levels, HSAG calculated the percentage of reported rates that were at or better than the high performance levels for measurement year 2021 across all performance measure domains at the MCP level. Table 6.12 lists each MCP, the number of rates at or better than the high performance levels, the total number of reported rates compared to high performance levels, and the percentage of reported rates that were at or better than the high performance levels in measurement year 2021, from highest to lowest percentage.

Table 6.12—Percentage of Measurement Year 2021 Rates At or Better Than the High Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Number of Rates At or Better Than the High Performance Levels	Total Number of Reported Rates Compared to High Performance Levels	Percentage of Rates At or Better Than the High Performance Levels
Kaiser SoCal	11	15	73%
Kaiser NorCal	8	15	53%
CalOptima	6	15	40%
Contra Costa Health Plan	6	15	40%
San Francisco Health Plan	6	15	40%
Health Plan of San Mateo	5	15	33%
CenCal Health	8	30	27%
Central California Alliance for Health	8	30	27%
L.A. Care Health Plan	4	15	27%
Alameda Alliance for Health	3	15	20%

Medi-Cal Managed Care Health Plan	Number of Rates At or Better Than the High Performance Levels	Total Number of Reported Rates Compared to High Performance Levels	Percentage of Rates At or Better Than the High Performance Levels
Community Health Group Partnership Plan	3	15	20%
UnitedHealthcare Community Plan	3	15	20%
CalViva Health	6	45	13%
Gold Coast Health Plan	2	15	13%
Santa Clara Family Health Plan	2	15	13%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	19	180	11%
Health Net Community Solutions, Inc.	9	105	9%
Aetna Better Health of California	2	30	7%
Blue Shield of California Promise Health Plan	1	15	7%
Inland Empire Health Plan	1	15	7%
Kern Health Systems, DBA Kern Family Health Care	1	15	7%
California Health & Wellness Plan	2	45	4%
Partnership HealthPlan of California	2	60	3%
Molina Healthcare of California	1	60	2%
Health Plan of San Joaquin	0	30	0%

For measures for which HSAG compared rates to minimum performance levels, HSAG calculated the percentage of reported rates that were worse than the minimum performance levels for measurement year 2021 across all performance measure domains at the MCP level. Table 6.13 lists each MCP, the number of rates worse than the minimum performance levels, the total number of reported rates compared to minimum performance levels, and the percentage of reported rates that were worse than the minimum performance levels in measurement year 2021, from highest to lowest percentage.

Table 6.13—Percentage of Measurement Year 2021 Rates Worse Than the Minimum Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Number of Rates Worse Than the Minimum Performance Levels	Total Number of Reported Rates Compared to Minimum Performance Levels	Percentage of Rates Worse Than the Minimum Performance Levels
Aetna Better Health of California	20	30	67%
Kern Health Systems, DBA Kern Family Health Care	10	15	67%
Molina Healthcare of California	34	60	57%
Health Net Community Solutions, Inc.	58	105	55%
California Health & Wellness Plan	24	45	53%
Health Plan of San Joaquin	14	30	47%
Partnership HealthPlan of California	28	60	47%
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	75	180	42%
Blue Shield of California Promise Health Plan	6	15	40%
Inland Empire Health Plan	6	15	40%
UnitedHealthcare Community Plan	6	15	40%
Gold Coast Health Plan	5	15	33%
Central California Alliance for Health	9	30	30%
Alameda Alliance for Health	3	15	20%
Health Plan of San Mateo	3	15	20%
L.A. Care Health Plan	3	15	20%
CalViva Health	8	45	18%
CalOptima	2	15	13%
Community Health Group Partnership Plan	2	15	13%
Contra Costa Health Plan	2	15	13%

Medi-Cal Managed Care Health Plan	Number of Rates Worse Than the Minimum Performance Levels	Total Number of Reported Rates Compared to Minimum Performance Levels	Percentage of Rates Worse Than the Minimum Performance Levels
San Francisco Health Plan	2	15	13%
Santa Clara Family Health Plan	2	15	13%
CenCal Health	3	30	10%
Kaiser NorCal	1	15	7%
Kaiser SoCal	1	15	7%

HSAG includes MCP-specific performance measure results for all required MCAS measures in *Volume 3 of 5* of this EQR technical report.

Summary of Measurement Year 2020 Quality Monitoring and Corrective Action Plans

Due to widespread COVID-19 impacts on utilization of medical services throughout much of 2020, DHCS did not impose CAPs on MCPs based on measurement year 2020 MCAS performance measure results. Following measurement year 2020 performance measure reporting, DHCS required the following for all MCPs and PSPs to support ongoing quality improvement efforts:

- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes three strategies related to the MCAS measure domains, one of which must address the Behavioral Health domain. MCPs and PSPs were required to submit an initial COVID-19 QIP on September 30, 2021, and a six-month progress update on March 31, 2022.
- For MCAS measure domains with two or more performance measure rates worse than the minimum performance levels in measurement year 2020, conduct a quality improvement project (PDSA cycles or SWOT analysis) for that domain. DHCS limited the number of quality improvement projects to a maximum of three per MCP/PSP, excluding the ongoing PIPs.

DHCS provided HSAG with a summary of MCPs' and PSPs' COVID-19 QIPs and quality improvement projects for inclusion in the EQR technical report. Following is an aggregate summary of the MCP COVID-19 QIPs and quality improvement projects. Note that while MCPs submitted their final PDSA cycle information outside the review period for this report, HSAG includes the information because it was available at the time this report was produced. HSAG

includes a summary of PSPs' COVID-19 QIP and quality improvement projects in Section 7 of this report ("**Population-Specific Health Plan Performance Measures**").

COVID-19 Quality Improvement Plan Summary

All 25 MCPs submitted a COVID-19 QIP as required. Each MCP's COVID-19 QIP consisted of three strategies, with one strategy designed to improve performance in the Behavioral Health domain. Across all MCPs, the number of strategies targeting the other performance measure domains were as follows:

- Acute and Chronic Disease Management—19
- Children's Health—18
- Women's Health—13

Almost all MCP strategies targeted all races/ethnicities, and most strategies were member-focused, including outreach, education, and incentives. To improve member access to services, MCPs also implemented strategies related to care coordination, appointment scheduling assistance, and appointment reminders. Provider-focused strategies primarily focused on education/training, incentives, and gaps-in-care reports.

In their six-month progress updates, MCPs reported the following:

- Strategy implementation status
  - Began implementing—outcomes available and showing improvement (64 strategies)
  - Began implementing—no outcomes available at this time (seven strategies)
  - Could not implement the strategy as planned (three strategies)
  - Still in the planning phase (one strategy)
- Next steps regarding strategy implementation
  - Continue implementing with no modifications (49 strategies)
  - Continue implementing with modifications (14 strategies)
  - Discontinue implementing (eight strategies)
  - Begin implementing in the foreseeable future (four strategies)

Plan-Do-Study-Act Cycles Summary

DHCS required 17 MCPs to conduct PDSA cycles to improve performance on measures for which these MCPs performed below the minimum performance levels in measurement year 2020. Across the 17 MCPs, 12 conducted two sets of PDSA cycles and five conducted one set of PDSA cycles. Of the 29 sets of PDSA cycles, 13 targeted measures within the Women's Health domain, 10 targeted measures within the Acute and Chronic Disease Management domain, and six targeted measures within the Children's Health domain.

The 17 MCPs conducted a total of 59 PDSA cycles to test interventions. Most interventions the MCPs tested were member-focused, including outreach, education, and incentives. To improve member access to services, MCPs also tested interventions related to appointment scheduling assistance, care coordination, and appointment reminders. Member outreach interventions were tested by more MCPs than any other member-focused intervention type. Provider-focused interventions that MCPs tested primarily included gaps-in-care reports and provider education/training.

Of the 59 PDSA cycles, four were unable to be implemented as planned. The PDSA cycle results from 42 tested interventions resulted in improvement, while 13 tested interventions did not lead to improvement.

MCPs reported plans to:

- Adopt 23 tested interventions.
- Adapt 22 tested interventions.
- Abandon 14 tested interventions.

Strengths, Weaknesses, Opportunities, Threats Analyses Summary

DHCS required 10 MCPs to conduct SWOT analyses to improve performance on measures for which these MCPs performed below the minimum performance levels in measurement year 2020. The 10 MCPs conducted a total of 34 strategies targeting the Children's Health and Women's Health domains. The MCPs identified 104 action items in total to help improve their performance.

Most action items were provider-focused, including education/training, incentives, gaps-in-care reports, and provider process changes. Forty-two action items included a provider education/training component. Member-focused action items primarily focused on outreach and education. Other action items supported members with scheduling appointments and accessing needed care, development of external partnerships, and provider and MCP process changes.

MCPs reported the following related to the status of the action items:

- 53 action items were in progress.
- 46 action items were completed.
- Five action items were discontinued.

Conclusions

DHCS' MCAS is comprehensive and includes measures that collectively assess the quality, accessibility, and timeliness of care MCPs provide to their members. Required performance measures assess screening, prevention, health care, and utilization services. DHCS requires all MCPs to conduct two PIPs, participate in quarterly regional collaborative discussions, and actively collaborate across delivery systems to support improvement across all required performance measures.

The percentage of MCMC weighted averages that improved significantly from measurement year 2020 to measurement year 2021 was greatest in the Behavioral Health domain, with nine of the 11 MCMC weighted averages that HSAG compared (82 percent) improving significantly from measurement year 2020 to measurement year 2021. The COVID-19 QIP strategies that MCPs implemented which targeted the Behavioral Health domain may have contributed to the performance improvement within this domain. Additionally, the interventions MCPs tested through PDSA cycles, action items implemented through SWOT analyses, and COVID-19 QIP strategies targeting other domains may have contributed to the performance improvement in the Children's Health, Women's Health, and Acute and Chronic Disease Management domains.

The MCMC weighted averages for four of the 15 measure weighted averages that HSAG compared to benchmarks (27 percent) were below the minimum performance levels in measurement year 2021:

- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 10*
- Both *Well-Child Visits in the First 30 Months of Life* measures

While the MCMC weighted averages were below the minimum performance levels for only four measures, MCMC weighted average comparisons between measurement years 2021 and 2020 show additional opportunities for improvement in all four domains based on 16 of 47 MCMC weighted averages declining significantly from measurement year 2020 to measurement year 2021 (34 percent).The Women's Health domain had the greatest percentage of MCMC weighted averages that declined significantly from measurement year 2020 to measurement year 2021 (53 percent [10 of 19 MCMC weighted averages]). Note that while the MCMC weighted averages for the *Breast Cancer Screening—Total* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures declined significantly from measurement year 2020 to measurement year 2021, the MCMC weighted averages for both measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021.

It is likely that a combination of factors, including the continued effects of COVID-19, affected MCPs' performance in measurement year 2021.

Throughout the review period (July 1, 2021, through June 30, 2022), DHCS provided extensive support to MCPs for addressing the continued effects of COVID-19 on their provision of health

care services to MCMC members. The technical assistance and resources that DHCS provided supported MCPs' efforts to provide quality, accessible, and timely health care to their members, including:

- Allowed MCPs continued flexibility in response to the challenges associated with COVID-19 and provided ongoing guidance to MCPs regarding the provision of services in the midst of the public health emergency.
- Assisted MCPs with prioritizing areas in need of improvement and identifying performance measures for MCPs to use as focus areas for quality improvement activities.
- Conducted technical assistance calls for MCPs as needed to discuss ongoing quality improvement efforts and support these MCPs in continuing to improve performance.
- Provided opportunities through quarterly collaborative discussions for DHCS and other State agencies (e.g., the 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 postcards highlighting MCP promising practices, educational information, and resources related to:
  - Improving blood lead screening, including resources that providers may use when outreaching and engaging with members on the importance of blood lead screening and resources related to addressing disparities in blood lead screening.
  - Gender Affirming Care: Cultural Competence, including trainings and resources for providers to better engage with members, establish relationships, and use evidence-based approaches to provide culturally competent techniques for delivering health care to LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual plus) members.
  - Controlling high blood pressure, including data stratifications for prevalence of hypertension, resources to help improve health disparities, and community resources to improve hypertension services.
- Provided updated COVID-19 resources for MCPs to use as part of their quality improvement efforts to improve preventive care access for members during the COVID-19 public health emergency.
- Continued updating and promoting the 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.

In *Volume 2 of 5 (Appendix E)* of this EQR technical report, HSAG includes an assessment of each MCP's strengths and weaknesses related to performance measure results as well as HSAG's recommendations. Additionally, in *Volume 3 of 5* of this EQR technical report, HSAG includes MCP-specific performance measure results for all required MCAS measures.

7. Population-Specific Health Plan Performance Measures

Objective

The primary objective related to PSP performance measures is for HSAG to assess PSPs' performance in providing quality, accessible, and timely care and services to beneficiaries by organizing and analyzing the performance measure results.

Requirements

To comply with 42 CFR §438.330, DHCS selects a set of performance measures to evaluate the quality of care PSPs delivered to their members. As stated previously, DHCS refers to the DHCS-required performance measure set as the MCAS. The measurement year 2021[27] MCAS included select CMS Adult and Child Core Set measures, some of which are also HEDIS measures. AIDS Healthcare Foundation and SCAN Health Plan provide services to specialized populations; therefore, DHCS' performance measure requirements for these PSPs are different than its requirements for MCPs or the SHP. Section 6 of this report ("**Managed Care Health Plan Performance Measures**") describes the role of DHCS' QPHM program in making recommendations for performance measure reporting. QPHM's role is further described in the DHCS Comprehensive Quality Strategy.[28] As with MCP performance measures, DHCS consults with HSAG and reviews feedback from PSPs and stakeholders to determine which CMS Core Set measures DHCS will require PSPs to report. PSPs must report county or regional rates unless otherwise approved by DHCS.

Table 7.1 and Table 7.2 list DHCS' performance measure requirements for AIDS Healthcare Foundation and SCAN Health Plan, respectively. Please refer to Table 6.1 for descriptions of all MCAS measures included in Table 7.1 and Table 7.2. For some MCAS performance measures, the specifications allow for both administrative and hybrid reporting methods; for these measures, DHCS allows PSPs to choose either methodology.

AIDS Healthcare Foundation

Table 7.1 lists AIDS Healthcare Foundation's measurement year 2021 MCAS measures by measure domain and indicates the data capture method(s) for each measure.

[27] The measurement year is the calendar year for which PSPs report the rates. Measurement year 2021 represents data from January 1, 2021, through December 31, 2021.

[28] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

Table 7.1—AIDS Healthcare Foundation Measurement Year 2021 Managed Care Accountability Set Measures

Admin = administrative method, which requires that the PSP identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, the PSP derives the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. The PSP may not use medical records to retrieve information. When using the administrative method, the PSP uses the entire eligible population as the denominator.

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

* DHCS allows the PSP to choose the methodology for reporting the rate for this measure and expects that the PSP will report using the methodology that results in the higher rate.

Measure	Method of Data Capture
Women's Health Domain	
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 21–44 Years	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	Admin
Behavioral Health Domain	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	Admin
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	Admin
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	Admin
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	Admin
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	Admin
Screening for Depression and Follow-Up Plan—Ages 65+ Years	Admin

Measure	Method of Data Capture
Acute and Chronic Disease Management Domain	
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total	Admin or Hybrid*
Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years	Admin
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years	Admin
Controlling High Blood Pressure—Total	Admin or Hybrid*
Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years	Admin
Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years	Admin

SCAN Health Plan

Table 7.2 lists SCAN Health Plan's measurement year 2021 MCAS measures by measure domain and indicates the data capture method(s) for each measure.

Table 7.2—SCAN Health Plan Measurement Year 2021 Managed Care Accountability Set Measures

Admin = administrative method, which requires that the PSP identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, the PSP derives the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. The PSP may not use medical records to retrieve information. When using the administrative method, the PSP uses the entire eligible population as the denominator.

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

* DHCS allows the PSP to choose the methodology for reporting the rate for this measure and expects that the PSP will report using the methodology that results in the higher rate.

Measure	Method of Data Capture
Women's Health Domain	
Breast Cancer Screening—Total	Admin
Behavioral Health Domain	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	Admin
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	Admin
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	Admin
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	Admin
Screening for Depression and Follow-Up Plan—Ages 65+ Years	Admin
Acute and Chronic Disease Management Domain	
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total	Admin or Hybrid*
Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years	Admin
Controlling High Blood Pressure—Total	Admin or Hybrid*
Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years	Admin

DHCS-Established Performance Levels

Like MCPs, PSPs 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 PSPs for outstanding performance. PSPs are subject to the same quality monitoring, enforcement action, and corrective action processes as MCPs. See the description of these processes in Section 6 of this report ("**Managed Care Health Plan Performance Measures**").

Results

Due to each PSP serving a specialized population, HSAG produces no aggregate information related to the PSP performance measures. Also, due to the PSPs serving separate, specialized populations, performance measure comparison across PSPs is not appropriate.

See *Volume 2 of 5 (Appendix B)* of this EQR technical report for measurement years 2019, 2020, and 2021 performance measure results for AIDS Healthcare Foundation and SCAN Health Plan.

COVID-19 Quality Improvement Plan Summary

AIDS Healthcare Foundation and SCAN Health Plan each submitted a COVID-19 QIP. Two of AIDS Healthcare Foundation's strategies targeted the Behavioral Health domain, and one strategy targeted the Acute and Chronic Disease Management domain. Two of SCAN Health Plan's strategies targeted the Acute and Chronic Disease Management domain, and one strategy targeted the Behavioral Health domain.

All but one strategy that the PSPs implemented targeted all races/ethnicities, and most strategies were member-focused, including outreach, education, and incentives. To improve member access to services, the PSPs also implemented strategies related to care coordination and appointment scheduling assistance. Provider-focused strategies primarily focused on gaps-in-care reports and incentives.

In their six-month progress updates, the PSPs reported the following:

- Strategy implementation status
  - Began implementing—outcomes available and showing improvement (five strategies)
  - Began implementing—outcomes available and showing no improvement (one strategy)
- Next steps regarding strategy implementation
  - Continue implementing with no modifications (two strategies)
  - Continue implementing with modifications (two strategies)
  - No next steps identified (two strategies)

Conclusions

As with the MCPs, DHCS has well-established, ongoing processes to monitor PSPs' performance and to support PSPs in identifying the causes for their performance falling below the minimum performance levels. DHCS' MCAS includes measures that collectively assess the extent to which each PSP is delivering quality, accessible, and timely health care. Required measures assess screening, prevention, health care, and utilization services. As with the MCPs, DHCS requires all PSPs to conduct two PIPs, participate in quarterly regional

collaborative discussions, and actively collaborate across delivery systems to support improvement across all required performance measures.

In *Volume 2 of 5 (Appendix E)* of this EQR technical report, HSAG includes an assessment of each PSP's strengths and weaknesses related to performance measure results as well as HSAG's recommendations.

8. Specialty Health Plan Performance Measures

Objective

The primary objective related to SHP performance measures is for HSAG to assess the SHP's performance in providing quality, accessible, and timely care and services to beneficiaries by analyzing the performance measure results.

Requirements

To comply with 42 CFR §438.330, DHCS selects performance measures to evaluate the quality of care delivered by the contracted SHPs to their members. Due to the specialized populations that SHPs serve, rather than requiring SHPs to report rates for the MCAS 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.

In measurement year 2021, DHCS held a contract with one SHP, Family Mosaic Project. Due to Family Mosaic Project's specialized population, DHCS determined that no HEDIS or CMS Core Set measures were appropriate for the SHP to report; therefore, DHCS required Family Mosaic Project to continue to report the following two measures the SHP designed in collaboration with DHCS and HSAG to evaluate performance elements specific to the SHP:

- *Promotion of Positive Pro-Social Activity*—Measures the number of Family Mosaic Project capitated members who are experiencing problems in the area of Recreational Impact on Functioning, as defined by a rating of "2" or "3" on the item "Recreational" on the initial Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment and who had demonstrated improvement on the "Recreational" item rating on the most recent CANS Comprehensive Assessment (i.e., mid-year, annual, or closing) during the measurement year.
- *School Attendance*—Measures the number of Family Mosaic Project capitated members who are experiencing problems related to school attendance, as defined by a rating of "2" or "3" on the item "School Attendance" on the initial CANS Comprehensive Assessment and who had demonstrated improvement on the "School Attendance" item rating on the most recent CANS Comprehensive Assessment (i.e., mid-year, annual, or closing) during the measurement year.

DHCS-Established Performance Levels

No national benchmarks exist for the SHP-developed measures; therefore, DHCS did not establish performance levels for Family Mosaic Project. Additionally, based on Family Mosaic Project's limited number of members and its work with a specialized population, DHCS did not require the SHP to conduct PDSA cycles or submit a COVID-19 QIP.

Results

Since measurement year 2017, Family Mosaic Project has had less than 30 beneficiaries for both performance measures, resulting in "NA" audit results (i.e., the SHP followed the measure specifications, but the denominators were too small to report valid rates).

Conclusions

Based on Family Mosaic Project's measurement year 2021 performance measure results, HSAG is unable to draw conclusions regarding the SHP's performance.

In *Volume 2 of 5 (Appendix E)* of this EQR technical report, HSAG includes an assessment of Family Mosaic Project's performance related to performance measures.

9. Managed Long-Term Services and Supports Plan Performance Measures

Objective

The primary objective related to MLTSSP performance measures is for HSAG to assess MLTSSPs' performance in providing quality, accessible, and timely care and services to beneficiaries by organizing, aggregating, and analyzing the performance measure results.

Requirements

As part of the Coordinated Care Initiative, DHCS holds contracts with 13 MLTSSPs to provide managed long-term services and supports (MLTSS) and Medicare wraparound benefits to dual-eligible beneficiaries who have opted out of or who are not eligible for Cal MediConnect.[29] While MLTSS services are not currently available statewide, the DHCS Comprehensive Quality Strategy indicates that by 2027, DHCS will transition to statewide MLTSS to advance its goals of whole-person care and aligned managed care delivery systems.[30] Table 9.1 lists MLTSSPs and the counties in which they operate.

Table 9.1—Managed Long-Term Services and Supports Plan Names and Counties

Managed Long-Term Services and Supports Plans	Counties
Aetna Better Health 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

[29] 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.

[30] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

Managed Long-Term Services and Supports Plans	Counties
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	Riverside, San Bernardino, and San Diego
Santa Clara Family Health Plan	Santa Clara
UnitedHealthcare Community Plan	San Diego

Table 9.2 lists the four MCAS performance measures that DHCS required MLTSSPs to report for measurement year 2021 and indicates the data capture method DHCS required MLTSSPs to use. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Table 9.2—Measurement Year 2021 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 members 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.

Measure	Method of Data Capture
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**	Admin
Plan All-Cause Readmissions—Observed Readmissions—Total	Admin
Plan All-Cause Readmissions—Expected Readmissions—Total	Admin
Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total	Admin

Results

Table 9.3 presents the MLTSSP weighted averages for each required performance measure for measurement years 2019, 2020, and 2021.

Table 9.3—Measurement Years 2019, 2020, and 2021 Statewide Weighted Average Performance Measure Results for Managed Long-Term Services and Supports Plans

= Statistical testing result indicates that the measurement year 2021 rate is significantly better than the measurement year 2020 rate.

= Statistical testing result indicates that the measurement year 2021 rate is significantly worse than the measurement year 2021 rate.

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

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

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

Not Tested = A measurement year 2020–21 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**	51.52	40.36	41.76	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.71%	10.21%	9.13%	-1.08

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Plan All-Cause Readmissions—Expected Readmissions—Total	10.32%	10.54%	9.78%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***	0.94	0.97	0.93	Not Tested

Table 9.4 presents comparative measurement year 2021 performance measure results across all MLTSSPs.

Table 9.4—Measurement Year 2021 Managed Long-Term Services and Supports Plan Reporting Unit Performance Measure Results Comparison

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

— Indicates that no rate is available because the MLTSSP had no members who met the MLTSS measure reporting criteria.

NA = The MLTSSP followed the specifications, but the denominator was too small (less than 150) to report a valid rate.

Managed Long-Term Services and Supports Plan Reporting Unit	*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**	*Plan All-Cause Readmissions—Observed Readmissions—Total***	*Plan All-Cause Readmissions—Expected Readmissions—Total*	*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***
Aetna Better Health of California—Sacramento County	NA	NA	NA	NA
Aetna Better Health of California—San Diego County	NA	NA	NA	NA

Managed Long-Term Services and Supports Plan Reporting Unit	*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**	*Plan All-Cause Readmissions—Observed Readmissions—Total***	*Plan All-Cause Readmissions—Expected Readmissions—Total*	*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan—Santa Clara County	61.26	NA	NA	NA
Blue Shield of California Promise Health Plan—San Diego County	132.40	NA	NA	NA
CalOptima—Orange County	48.53	15.17%	13.68%	1.11
Community Health Group Partnership Plan—San Diego County	37.92	7.49%	9.24%	0.81
Health Net Community Solutions, Inc.—Los Angeles County	61.07	12.66%	11.44%	1.11
Health Net Community Solutions, Inc.—San Diego County	64.74	NA	NA	NA
Health Plan of San Mateo—San Mateo County	60.78	10.26%	12.16%	0.84
Inland Empire Health Plan—Riverside/San Bernardino Counties	44.80	12.41%	10.94%	1.13
Kaiser SoCal (KP Cal, LLC)—San Diego County	32.42	8.90%	9.52%	0.93
L.A. Care Health Plan—Los Angeles County	40.87	12.42%	10.93%	1.14

Managed Long-Term Services and Supports Plan Reporting Unit	*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months**	*Plan All-Cause Readmissions—Observed Readmissions—Total***	*Plan All-Cause Readmissions—Expected Readmissions—Total*	*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total***
Molina Healthcare of California—Riverside/San Bernardino Counties	41.06	8.79%	9.39%	0.94
Molina Healthcare of California—San Diego County	42.99	8.76%	9.60%	0.91
Santa Clara Family Health Plan—Santa Clara County	45.66	10.30%	10.32%	1.00
UnitedHealthcare Community Plan—San Diego County	NA	NA	NA	NA

Conclusions

The MLTSS statewide weighted average for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure improved significantly from measurement year 2020 to measurement year 2021, reflecting a decrease in hospital readmissions for the MLTSS population.

10. Performance Improvement Projects

Validating PIPs is one of the mandatory EQR 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 both clinical and nonclinical areas that involve the following elements:

- Measuring performance using objective quality indicators
- Implementing interventions to achieve improvement in access to and quality of care
- Evaluating intervention effectiveness based on objective quality indicators
- Planning and initiating activities for increasing or sustaining improvement

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

To comply with the CMS requirements, since 2008 DHCS has contracted with HSAG to conduct an independent validation of PIPs submitted by MCMC plans. HSAG uses a two-pronged approach. First, HSAG provides training and technical assistance to MCMC 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 of, timeliness of, and access to care furnished by these plans.

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 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.

Requirements

DHCS requires that each MCMC plan conduct a minimum of two DHCS-approved PIPs. For the 2020–22 PIPs, DHCS required that one PIP be on the topic of Health Equity and the other PIP be related to Child and Adolescent Health.

DHCS required that MCMC plans' Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. DHCS strongly encouraged MCMC plans to select a health disparity related to an MCAS measure for which they are not performing well, with a particular focus on a disparity that may have been exacerbated by COVID-19. DHCS allowed MCMC plans that could not identify a health disparity based on population size to conduct their PIP on the entire population instead of a disparate subgroup.

For the Child and Adolescent Health PIPs, DHCS required MCMC plans to identify an area in need of improvement related to child and adolescent health. DHCS required PSPs that do not serve the child and adolescent populations to choose a PIP topic for any area in need of improvement, supported by plan-specific data. DHCS required the SHP to identify two PIP topics from a clinical or nonclinical area for which improvement would have a favorable impact on health outcomes or member satisfaction.

DHCS' Health Equity PIP requirement supports DHCS in accomplishing its Comprehensive Quality Strategy vision of eliminating health care disparities; and the Child and Adolescent Health PIP requirement supports the Comprehensive Quality Strategy's children's preventive care clinical focus area and DHCS' goals to improve child and adolescent preventive services.[31]

The SMART Aim end date for the 2020–22 PIPs is December 31, 2022.

Methodology

Rapid-Cycle Performance Improvement Project Overview

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 changes requires fewer resources and allows more flexibility for adjusting throughout the improvement process. By piloting changes on a smaller scale, MCMC plans have

[31] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

opportunities to determine the effectiveness of several changes prior to expanding the successful interventions.

The following modules guide MCMC plans through the rapid-cycle PIP approach:

- Module 1: PIP Initiation
- Module 2: Intervention Determination
- Module 3: Intervention Testing
- Module 4: PIP Conclusions

HSAG's rapid-cycle PIP process requires extensive, up-front preparation to allow for a structured, scientific approach to quality improvement, and it also provides sufficient time for MCMC plans to test interventions. Modules 1 through 3 create the basic infrastructure to help MCMC plans identify interventions to test. Once the plans achieve all validation criteria for modules 1 through 3, they test interventions using a series of PDSA cycles.

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 unsuccessful and should be stopped (abandon). MCMC plans complete Module 4 after testing all interventions and finalizing analyses of the PDSA cycles. Module 4 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.

Module Validation and Technical Assistance

Based on the agreed-upon timeline, MCMC plans submit each module 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. HSAG conducts PIP validation in accordance with the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[32] In *Volume 2 of 5 (Appendix C)* of this EQR technical report, HSAG includes a description of the validation criteria that HSAG uses for each module.

After validating each PIP module, HSAG provides written feedback to MCMC plans summarizing HSAG's findings and whether the plans achieved all validation criteria. Through an iterative process, plans have opportunities to revise modules 1 through 3 to achieve all validation criteria. Once MCMC plans achieve all validation criteria for modules 1 through 3, they test intervention(s) through the end of the SMART Aim end date. HSAG requests status

[32] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 1, 2022.

updates from MCMC plans throughout the PIP intervention testing phase and, when needed, provides technical assistance.

Once a PIP reaches completion, HSAG assesses the validity and reliability of the results to determine whether key stakeholders may have confidence in the reported PIP findings. HSAG assigns the following confidence levels for each PIP:

- High confidence
- Moderate confidence
- Low confidence
- No confidence

In *Volume 2 of 5 (Appendix C)* of this EQR technical report, HSAG includes the definition for each confidence level.

Results

Validations and Technical Assistance

During the review period, MCMC plans continued to conduct the 2020–22 PIPs. HSAG validated the following modules and notified MCMC plans and DHCS of the validation findings:

- Module 1—five resubmissions
- Module 2—13 initial submissions and 18 resubmissions
- Module 3—72 initial submissions and 51 resubmissions

All MCMC plans met all required validation criteria for modules 1 through 3 and progressed to the PIP intervention testing phase.

As needed, HSAG provided technical assistance via email, telephone, and Web conferences to help MCMC plans gain understanding of the PIP process and requirements. Some MCMC plans were unable to carry out the PIP interventions as originally planned due to ongoing challenges related to COVID-19. HSAG worked with individual MCMC plans to address their specific challenges so that they could move forward with the PIP process.

Beginning in February 2022, HSAG conducted PIP progress check-ins with MCMC plans. By the end of the review period, HSAG reviewed and provided feedback on PIP progress check-in documents for 44 PIPs. HSAG encouraged MCMC plans to incorporate this feedback when completing the final PDSA worksheets and Module 4.

Intervention Summary

During the review period, all MCMC plans began testing at least one intervention for each PIP. While each intervention was unique based on the individual key driver diagrams and failure modes and effects analysis of the MCMC plan's PIP, most of the interventions targeted members. Particularly, many of the interventions focused on outreaching to members, providing health education, and offering incentives to members for completing needed health care services. Other interventions focused on conducting provider education and training, as well as coordinating different modes of services to improve health care access (mobile mammography, home testing kits, etc.).

The MCMC plans will continue testing interventions through the PIP SMART Aim end date of December 31, 2022; therefore, HSAG includes no PIP intervention outcomes information in this MCMC EQR technical report. HSAG will include 2020–22 PIP outcomes in the 2022–23 MCMC EQR technical report.

In *Volume 2 of 5 (Appendix C)* of this EQR technical report, HSAG includes MCMC plan-specific PIP topics and module progression, as well as descriptions of interventions tested during the review period.

Conclusions

All MCMC plans met all validation criteria for modules 1 through 3 for both of their required PIPs by applying the feedback received during HSAG's rapid-cycle PIP validation and technical assistance processes. The validation findings show that all MCMC plans built a strong foundational framework, used quality improvement tools to define quality improvement activities that have the potential to impact the SMART Aim, established an intervention plan for each intervention to be tested for the PIPs, and progressed to testing the interventions through a series of PDSA cycles. The MCMC plans will continue testing interventions through the SMART Aim end date of December 31, 2022, to impact the PIP SMART Aim measure.

In *Volume 2 of 5 (Appendix E)* of this EQR technical report, HSAG includes an assessment of each MCP's strengths and weaknesses related to PIPs as well as HSAG's recommendations.

11. 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 this EQR technical report was produced.

To assist DHCS with assessing and monitoring network adequacy across contracted MCMC plans as described in the DHCS Comprehensive Quality Strategy,[33] DHCS contracted with HSAG to conduct the following network adequacy activities:

- Alternative Access Standards Reporting
- SNF/ICF Experience and Distance Reporting
- Timely Access Study

Objective

The objective for all network adequacy analyses is to provide results and conclusions for DHCS to use in monitoring MCMC plan adherence to the required federal and State network adequacy standards.

Alternative Access Standards Reporting

DHCS is responsible for the ongoing monitoring and oversight of its contracted MCPs and PSPs, including the assurance that MCPs' and PSPs' provider networks are adequate to deliver services to Medi-Cal members. If health care providers are unavailable or unwilling to serve Medi-Cal beneficiaries such that the MCP or PSP is unable to meet provider network standards, MCPs and PSPs may request that DHCS allow an alternative provider network access standard for specified provider scenarios (e.g., provider type, geographic area). The DHCS APL 21-006[34] provides DHCS' clarifying guidance regarding network certification requirements, including requests for alternative access standards. Additionally, CA WIC §14197.05[35] requires DHCS' annual EQR technical report to present information related to

[33] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

[34] All Plan Letter 21-006. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-006.pdf

[35] Cal. WIC §14197.05. Available at https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05.

MCPs' alternative access standard requests. As such, DHCS contracted with HSAG to process and report on data related to alternative access standards for provider networks.

The measurement period for the 2021–22 alternative access standards reporting analyses is from April 28, 2021, through March 10, 2022, reflective of the July 2021 Annual Network Certification and the Mandatory Managed Care Enrollment CalAIM initiative.[36,37]

HSAG includes the alternative access standards reporting methodology, results, and considerations in *Volume 4 of 5* of this EQR technical report.

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

DHCS requires that MCPs provide coordination of care for their members requiring long-term care services, including services at SNFs/ICFs. The DHCS APL 17-017[38] 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 HSAG subsequently worked with DHCS to obtain the necessary data and to conduct the analyses annually.

HSAG includes the SNF/ICF experience and distance reporting analyses methodology, results, findings, items for consideration, and recommendations in *Volume 5 of 5* of this EQR technical report. HSAG also includes in *Volume 5* a summary of two pilot studies that HSAG conducted which informed the annual SNF/ICF study.

[36] July 2021 Annual Network Certification Report was submitted to CMS in November 2021 and is available at: https://www.dhcs.ca.gov/formsandpubs/Documents/2021-Annual-Network-Certification-Report.pdf. Accessed on: Aug 3, 2022.

[37] Information regarding CalAIM may be found at: https://www.dhcs.ca.gov/calaim. Accessed on: Dec 14, 2022.

[38] All Plan Letter 17-017. Available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-017.pdf. Accessed on: Aug 1, 2022.

Timely Access Study

Beginning in contract year 2016–17, DHCS contracted with HSAG to conduct an annual study to evaluate the extent to which MCMC plans are meeting the DHCS wait time standards. To ensure that MCMC plans and their providers could prioritize COVID-19 response efforts, DHCS canceled this study for calendar years 2020 and 2021. In July 2021, DHCS determined to resume the Timely Access Study activities beginning January 2022.

Methodology—Timely Access Study

HSAG conducts the study to evaluate the following three questions:

- To what extent are the MCMC plans meeting the wait time standards listed in Table 11.1?
- To what extent are the MCMC plans meeting the 10-minute wait time standard for their call centers?
- To what extent are the plans[39] meeting the 30-minute wait time standard for their nurse triage/advice lines?

Table 11.1—Timely Access Standards

The symbol "—" in the table denotes that the wait time standard is not applicable to an appointment type.

Note the following:

- The non-urgent follow-up appointments standard became effective on July 1, 2022; therefore, HSAG will conduct evaluation for this standard beginning in Quarter 3.
- Due to data issues:
  - HSAG will pause the evaluation of Alameda Alliance for Health's specialists for Quarter 3 and Quarter 4.
  - HSAG will begin the evaluation for Health Plan of San Mateo's dental providers in Quarter 3.

[39] While HSAG places calls to all MCMC plans' nurse triage/advice lines, the 30-minute wait time standard is only applicable to the plans that are not in the County Organized Health System model. Results from the County Organized Health System MCMC plans are for information only.

Appointment Type	Wait Time Standards			
	Non-Urgent Appointments	Urgent Appointments	Preventive Care Appointments	Non-Urgent Follow-up Appointments
Primary care appointment	10 business days	48 hours	—	—
Specialist appointment	15 business days	96 hours	—	—
Appointment with a mental health care provider (who is not a physician)	10 business days	96 hours	—	10 business days
Appointment with an ancillary provider	15 business days	—	—	—
Dental appointment for Health Plan of San Mateo's dental providers only	36 business days	72 hours	40 business days	—

HSAG collaborates with DHCS staff members to perform the following key quarterly activities primarily based on the most recent provider data submitted to DHCS by the MCMC plans:

- Submit data requirements document to DHCS for provider data extraction.
- Submit provider classification document to DHCS to define the study population (i.e., eligible providers for each appointment type).
- Review provider data extracted by DHCS and select sample providers.
- Conduct telephone surveys to sample providers, call centers, and nurse triage/advice lines.
- 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 MCMC plan reporting unit, with approximately 25 percent of the total sample being surveyed each quarter. If there are less than 411 providers in a provider category for a reporting unit, all providers will be selected. When more than one site exists, HSAG will randomly select one site from each sampled provider.

Quarterly, during standard operating hours (i.e., 9 a.m. to 5 p.m. Pacific Time), HSAG's trained callers make phone calls to all selected provider offices. During the calls, the callers follow tightly regulated scripts with designated response options to various questions that provider office personnel may ask. This allows data collection to be controlled and accurate. If a

provider is selected for more than one reporting unit, HSAG's methodology includes processes to minimize interruptions to provider offices. The calls are monitored consistently and on a regular schedule via audio and visual monitoring systems. At least 10 percent of all calls made are reviewed by a full-time monitoring staff member, and information collected during the phone calls is saved in an electronic tool for further analysis.

HSAG has a separate process for collecting appointment availability information from Kaiser NorCal and Kaiser SoCal providers due to these MCMC plans' automated appointment scheduling systems.

Calls to MCMC Plan Call Centers

HSAG makes 73 calls to each MCMC plan's call center annually. To minimize the interruption to the call centers, HSAG makes 19 calls per MCMC plan for the first quarter, then 18 calls per quarter for the remaining three quarters. For each quarter, 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.

Calls to MCMC Plan Nurse Triage/Advice Lines

HSAG makes 73 calls to each MCMC plan's nurse triage/advice line annually. To minimize the interruption to the nurse triage/advice lines, HSAG makes 19 calls per MCMC plan for the first quarter, then 18 calls per quarter for the remaining quarters. For each quarter, HSAG's trained callers make a call to each nurse triage/advice line 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 30 minutes. The hold time begins from the time the phone connects (or after pressing the correct option on the call tree) to the time when the callers reach a qualified health professional such as a medical doctor, physician's assistant, registered nurse, licensed clinical social worker, or licensed marriage and family therapist.

Submit Quarterly Deliverables to DHCS

To assess and report the calls to the providers, call centers, and nurse triage/advice lines, HSAG uses multiple study indicators. HSAG submits the following quarterly deliverables to DHCS to report the study indicator results and summarize the findings:

- Executive summary
- Statewide report and raw data files
- MCMC plan-specific report and raw data files

Based on the findings, HSAG provides in the quarterly reports specific and actionable considerations for DHCS and MCMC plans, as applicable.

Results—Timely Access Study

As indicated previously, DHCS resumed the Timely Access Study beginning January 2022 after cancelling the study for calendar years 2020 and 2021 to ensure that MCMC plans and their providers could prioritize COVID-19 response efforts. This section provides a summary of cumulative results from the first two quarters of calendar year 2022, which were completed during the review period for this report.

Calls to Providers

During the first two quarters of calendar year 2022, HSAG obtained at least one non-urgent in-person appointment time from 5,657 of 16,926 providers (i.e., a statewide weighted rate of 33.8 percent) and at least one urgent in-person appointment time from 4,684 of 14,462 applicable providers (i.e., a statewide weighted rate of 33.0 percent) included in the telephone survey and who met the study population criteria based on the survey calls.

Table 11.2 presents cumulative results from the first two quarters of calendar year 2022 for providers' compliance with non-urgent and urgent in-person appointment wait times, stratified by adult and pediatric member populations. Providers for which HSAG obtained at least one appointment have been included. 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.

Table 11.2—Cumulative First Two Quarters of Calendar Year 2022 Timely Access Study Statewide Provider Compliance for In-Person Appointment Wait Time Standards

Provider Type	Percentage of First Available In-Person Appointment Meeting Wait Time Standards			
	Non-Urgent		Urgent	
	Adult	Pediatric	Adult	Pediatric
PCP	78.9%	83.4%	46.2%	53.4%
Specialist	66.0%	65.0%	42.6%	44.5%
Non-Physician Mental Health Provider	77.9%	75.2%	63.8%	58.4%
Ancillary	83.9%		Not Applicable	
All Applicable Provider Types	**72.8%**		**46.8%**	

Calls to MCMC Plan Call Centers

During the first two quarters of calendar year 2022, HSAG made calls to each MCMC plan's call center. Of the 925 calls placed, 84.1 percent met the wait time standard of 10 minutes.

Calls to MCMC Plan Nurse Triage/Advice Lines

During the first two quarters of calendar year 2022, HSAG made calls to each MCMC plan's nurse triage/advice line. Of the 962 calls placed, 89.1 percent met the wait time standard of 30 minutes.

Quarterly Reports and Raw Data

Following completion of the calls each quarter, HSAG produced and submitted to DHCS reports and raw data files at the statewide aggregate and MCMC plan levels. Based on the findings, HSAG identified specific observations for each quarter and provided action items for DHCS' consideration. DHCS uses the quarterly reports and raw data to monitor the MCMC plans' compliance with appointment wait time standards. DHCS' process includes providing quarterly MCMC plan-level reports and raw data to each MCMC plan. DHCS requires the MCMC plans to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential issues with data quality, member services and/or provider training, or access to services provided; strategies to overcome any identified deficiencies; and a timeline for making needed corrections. DHCS reviews the responses, provides feedback to each MCMC plan, and determines whether the MCMC plan is required to take further action.

Conclusions—Timely Access Study

During the review period for this report, HSAG completed calls for only the first two quarters of calendar year 2022; therefore, HSAG makes no conclusions for the 2021–22 Timey Access Study. HSAG will include all calendar year 2022 results and conclusions for the 2021–22 Timely Access Study in the 2022–23 MCMC EQR technical report.

12. Health Disparities Studies

Objective

Health disparities reflect gaps in the quality of care between populations.[40] Within its Comprehensive Quality Strategy, DHCS identified the need to eliminate health care disparities through improved data collection and stratification, and disparity reduction efforts.[41] To address this need, DHCS contracts with HSAG to conduct health disparities studies using the MCAS measures reported by the MCPs.

The objective of the health disparities studies is to provide results and conclusions for DHCS to use to identify and address health care disparities affecting Medi-Cal beneficiaries. DHCS may use the results from these studies to inform strategies to contribute toward achieving the DHCS Comprehensive Quality Strategy vision of eliminating health care disparities as well as to inform the Comprehensive Quality Strategy Health Equity Roadmap.[42]

Antigen Disparities Pilot Study

Methodology—Antigen Disparities Pilot Study

To better understand the individual antigens driving MCP performance on the MCAS *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measures, and to support the launch of the Health Equity Measure Set in 2022 as cited in DHCS' Comprehensive Quality Strategy, DHCS contracted with HSAG to calculate and analyze the measurement year 2021 statewide and stratified antigen-specific immunization measure rates. For both immunization measures, MCPs used numerator and denominator criteria and minimum enrollment requirements defined by the HEDIS specifications for the Medicaid population. HSAG aggregated the results from the 25 full-scope MCPs and then stratified the statewide and MCP reporting unit rates for the measures by the following demographic and regional stratifications:

- Demographic
  - Race/ethnicity

[40] Kilbourne AM, Switzer G, Hyman K, et al. Advancing health disparities research within the health care system: A conceptual framework. *American Journal of Public Health.* 2006; 96:2113-2121. Available at: https://doi.org/10.2105/AJPH.2005.077628. Accessed on: Oct 28, 2022.

[41] *Department of Health Care Services Comprehensive Quality Strategy 2022.* Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Oct 28, 2022.

[42] Ibid.

  - Gender
  - SPD/non-SPD
- Regional
  - County
  - Population Density (i.e., rural/urban)
  - Delivery Type Model

Results—Antigen Disparities Pilot Study

For DHCS' internal use, HSAG produced statewide and MCP-specific Microsoft (MS) Excel spreadsheets that presented the stratified antigen-specific *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measure rates in pivot tables. Additionally, HSAG produced a patient-level detail file that included all members in the denominators for the two immunization measures, along with the following variables for each member:

- MCP reporting unit
- All demographic variables listed above
- ZIP Code
- A binary numerator flag for each antigen and the combination rates
- All variables from the California Healthy Places Index (HPI)

Conclusions—Antigen Disparities Pilot Study

Since the purpose of the pilot study was to calculate the statewide and stratified antigen-specific immunization measure rates for DHCS' internal use, HSAG drew no conclusions for the 2021–22 Antigen Disparities Pilot Study.

Health Disparities Trending Pilot Study

Methodology—Health Disparities Trending Pilot Study

To address the need identified by DHCS within its Comprehensive Quality Strategy to eliminate health care disparities through improved data collection and stratification, and disparity reduction efforts, DHCS contracted with HSAG to determine the best method for displaying trending results and selecting which key findings should be presented in the body of the 2021 annual health disparities report using the disparity identification methodology implemented for the *2020 Health Disparities Report*.

For the 2021–22 Health Disparities Trending Pilot Study, HSAG used seven MCAS indicators collected from the MCPs for measurement years 2019 and 2020. HSAG identified racial/ethnic health disparities for each indicator in alignment with the methodology used for the *2020*

Health Disparities Report (i.e., the rate for a racial/ethnic group was worse than the reference rate [i.e., the minimum performance level or median State performance rate] and the upper interval of the 95 percent confidence interval was below the minimum performance level/median State performance rate). HSAG developed trending display options and results from testing key finding criteria to determine which key findings should be presented in the annual *2021 Health Disparities Report*.

Results—Health Disparities Trending Pilot Study

For DHCS' internal use only, HSAG developed trending display options for the annual *2021 Health Disparities Report* at the statewide, domain, indicator, and regional levels. HSAG also provided descriptions of each display option, along with advantages and disadvantages of each option, and HSAG's recommendations.

Conclusions—Health Disparities Trending Pilot Study

DHCS agreed with HSAG's recommendations on which trending display options to use for the annual *2021 Health Disparities Report,* which HSAG will use to produce the report.

2021 Annual Health Disparities Study

The goal of the annual health disparities studies is to improve health care for Medi-Cal members by evaluating the health care disparities affecting members enrolled in Medi-Cal MCPs. HSAG does not include data for FFS beneficiaries in the analyses.

For the 2021 Annual Health Disparities Study, HSAG used measurement year 2021 performance measure data from the 25 MCPs. HSAG evaluated measure data collected for measurement year 2021 at the statewide level. HSAG aggregated results from 25 MCPs and then stratified the statewide rates for the MCAS measures by the following demographic stratifications:

- Race/ethnicity
- Primary language
- Age
- Gender
- SPD and non-SPD populations
- HPI quartile (for select measures)
- County

Although HSAG stratified all measures by the demographic stratifications listed above, HSAG only identified racial/ethnic health disparities. Additionally, HSAG presented comparisons to measurement year 2020 results, when applicable.

At the time this EQR technical report is being produced, HSAG is conducting the analyses for the 2021 Health Disparities Study. DHCS aims to publish the *2021 Health Disparities Report* in March 2023 and will post the report on the DHCS website at the following link: Medi-Cal Managed Care Quality Improvement Reports. The *2021 Health Disparities Report* will include the detailed study methodology, key results and findings, conclusions, and considerations.

13. Preventive Services Study

At the request of the Joint Legislative Audit Committee, the California State Auditor published an audit report in March 2019 regarding DHCS' oversight of the delivery of preventive services to children enrolled in MCMC. The audit report recommended that DHCS expand the performance measures it collects and reports on to ensure all age groups receive preventive services from MCPs.[43] In response to this recommendation, DHCS requested that HSAG produce an annual Preventive Services Report beginning in 2020. This report is published on the DHCS website annually.

The objective of the Preventive Services Study is to provide results and conclusions for DHCS to use to identify and monitor appropriate utilization of preventive services for MCMC children. Additionally, the results from this study support DHCS' renewed emphasis on prevention as described in the DHCS Comprehensive Quality Strategy.[44]

For the 2022 Preventive Services Study, HSAG continued to analyze child and adolescent performance measures that were calculated by HSAG and DHCS, and reported by the 25 full-scope MCPs from the MCAS. MCAS measures reflect clinical quality, timeliness, and accessibility of care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. DHCS can leverage the findings from the Preventive Services Study to address the clinical focus area of children's preventive care identified in its 2022 Comprehensive Quality Strategy[45] and monitor appropriate utilization of preventive services for MCMC children.

For 2022 study, HSAG evaluated measure data collected for HEDIS measurement year 2021, which consists of data collected during calendar year 2021. The indicator set for this analysis included 12 MCP-calculated indicators, four HSAG-calculated indicators (i.e., administrative indicators calculated by HSAG for DHCS), and five DHCS-calculated indicators. For each MCP-calculated indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the HEDIS specification for the Medicaid population or by the CMS Child Core Set. For the HSAG-calculated indicators, HSAG developed specifications for three indicators and used the CMS Child Core Set specifications for the remaining indicator. For the DHCS-calculated indicators, DHCS developed specifications for four of the indicators and used the HEDIS specification for the remaining indicator.

[43] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Aug 1, 2022.

[44] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

[45] Ibid.

At the time this EQR technical report is being produced, HSAG is conducting the analyses for the 2022 Preventive Services Study. DHCS aims to publish the *2022 Preventive Services Report* in April 2023 and will post the report on the DHCS website at the following link: Medi-Cal Managed Care Quality Improvement Reports. The *2022 Preventive Services Report* will include the detailed study methodology, key results and findings, conclusions, and considerations.

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).

The DHCS Comprehensive Quality Strategy includes the goal to engage members to be actively involved in their own health care and to provide input to DHCS about Medi-Cal policy.[46] DHCS also seeks to prioritize member experience in all quality improvement efforts. To help DHCS assess perceptions and experiences of beneficiaries as part of its evaluation of the quality of health care services provided by MCPs to their members, DHCS contracts with HSAG to administer and report the results of the CAHPS Health Plan Surveys for the CHIP and Medi-Cal populations.

HSAG administers the 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

During contract year 2021–22, HSAG administered the CAHPS survey to the CHIP population. HSAG includes a summary of the 2022 CHIP CAHPS survey results in this EQR technical report. HSAG also includes in this report a high-level summary of the 2021 Medicaid Managed Care survey since the results were not available at the time the 2020–21 EQR technical report was produced.

Objective

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

[46] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

2022 Children's Health Insurance Program Survey

The *2022 CHIP CAHPS Survey Summary Report* includes the survey's detailed methodology, results, conclusions, and recommendations. Following is a high-level summary of the survey.

Methodology—Children's Health Insurance Program Survey

During the review period, HSAG administered the standardized survey instrument CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS and Children with Chronic Conditions (CCC) measurement sets to a statewide sample of CHIP members enrolled in MCPs and FFS.

Table 14.1 lists the measures included in the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set.

Table 14.1—CAHPS Measures

Global Ratings	Composite Measures	CCC Composite Measures and Items
Rating of Health Plan	*Getting Needed Care*	*Access to Specialized Services*
Rating of All Health Care	*Getting Care Quickly*	*Family-Centered Care (FCC): Personal Doctor Who Knows Child*
Rating of Personal Doctor	*How Well Doctors Communicate*	*Coordination of Care for Children with Chronic Conditions*
Rating of Specialist Seen Most Often	*Customer Service*	*Access to Prescription Medicines*
		FCC: Getting Needed Information

Survey Sampling Procedures

The members eligible for sampling included those who were CHIP members at the time the sample was drawn and who were continuously enrolled in the same MCP for at least five of the six months of the measurement period (August 2021 through January 2022).
The members eligible for sampling included those who were 17 years of age or younger (as of January 31, 2022).

All CHIP members within the sample frame file were given a chronic condition prescreen status code of 1 or 2. A prescreen code of 1 indicated that the member had claims or encounters which did not suggest that the member had a greater probability of having a chronic condition. A prescreen code of 2 (also known as a positive prescreen status code)

indicated that the member had claims or encounters which suggested that the member had a greater probability of having a chronic condition. After selecting CHIP members for the general child sample (i.e., 3,065 child members), HSAG selected a CCC supplemental sample of 3,615 CHIP members with a prescreen code of 2 (i.e., the population of children who were more likely to have a chronic condition).[47] HSAG drew the supplemental sample to ensure an adequate number of responses from children with chronic conditions.

Survey Administration

The survey administration process allowed for three methods by which respondents could complete a survey in two phases. The first, or mail phase, consisted of a cover letter being mailed to the parents/caretakers of all sampled CHIP members that provided two options to complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope; or (2) complete the web-based survey through the survey website with a designated login. Members who were identified as Spanish speaking through administrative data were mailed a Spanish version of the survey. Members who were not identified as Spanish speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing parents/caretakers of members that they could call the toll-free number to request a Spanish version of the survey. The cover letter provided with the Spanish version of the survey had an English cover letter on the back side informing parents/caretakers of members that they could call the toll-free number to request an English version of the survey. All non-respondents 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 parents/caretakers of sampled members who had not mailed in a completed survey or completed the web-based survey. HSAG attempted up to three CATI calls to each non-respondent. The addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of the population.[48]

Survey Analysis

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS Measurement Year 2021, Volume 3: Specifications for Survey Measures*. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed the following analyses to comprehensively assess member experience:

- Response Rates
- Respondent Analysis

[47] The general child sample includes an oversample of 1,415 child members, and the CCC supplemental sample includes an oversample of 1,775 child members.

[48] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." Medical Care. 2002; 40(3): 190–200.

- Top-Box Scores[49]
- Comparative Analysis

Results—Children's Health Insurance Program Survey

Response Rates

HSAG mailed 6,680 child surveys to the sample of CHIP members selected for surveying. Of these, 1,277 child surveys were completed for the CHIP sample.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members in the sample. If the parent/caretaker of the CHIP member appropriately answered at least three of five NCQA-specified questions in the survey instrument, HSAG counted the survey as complete.

Table 14.2 presents the total number of CHIP members sampled, the number of ineligible and eligible members, the number of surveys completed, and the response rate for the CHIP population selected for surveying. The survey dispositions and response rates are based on the responses of parents/caretakers of children in the general child and CCC supplemental samples. The CHIP response rate of 19.31 percent was greater than the national child Medicaid response rate reported by NCQA for 2021, which was 16.7 percent.[50,51] In 2021, the CHIP response rate was 21.35 percent, which was 2.04 percentage points higher than the 2022 CHIP response rate. HSAG has observed a steady decline in CAHPS survey response rates over the past several years, so this small decline falls in line with national trends.

Table 14.2—Total Number of Respondents and Response Rate

Response rate is calculated as Number of Completed Surveys/Eligible Sample.

Population	Total Sample Size	Ineligible Sample	Eligible Sample	Completed Surveys	Response Rate
General Child Sample	3,065	34	3,031	537	17.72%
CCC Supplemental Sample	3,615	33	3,582	740	20.66%
CHIP	**6,680**	**67**	**6,613**	**1,277**	**19.31%**

[49] The percentage of survey respondents who chose the most positive score for a given item's response scale.

[50] National Committee for Quality Assurance. *HEDIS® Measurement Year 2021, Survey Vendor Update* Training. October 6, 2021.

[51] Please note, 2022 national response rate information was not available at the time this report was produced.

General Child Performance Highlights

Differences in scores should be evaluated from a clinical perspective. While the CHIP general child population results may be above or below the national 50th percentiles, differences in scores may not be important from a clinical point of view. HSAG observed the following:

- The gaps between the NCQA Medicaid national 50th and 90th percentiles were on average 4.1 percentage points for the general child population, indicating that the distributions of national performance were close together.
- The differences between the CHIP general child population scores and the NCQA Medicaid national 50th percentiles ranged from 0.3 to 9.8 percentage points below the NCQA Medicaid national 50th percentiles, with an average of 3.6 percentage points below the NCQA Medicaid national 50th percentiles for the general child population.

Top-Box Scores

The findings indicate opportunities for improvement in member experience for several areas of care, as all reportable measures scored below the NCQA Medicaid national 50th percentiles.

Comparative Analysis

The 2022 scores were not statistically significantly higher or lower than the 2021 scores for any measure.

Children with Chronic Conditions Performance Highlights

Differences in scores should be evaluated from a clinical perspective. While the CHIP CCC population results may be above or below the national 50th percentiles, differences in scores may not be important from a clinical point of view. HSAG observed the following:

- The gaps between the NCQA CCC Medicaid national 50th and 90th percentiles were on average 3.5 percentage points for the CCC population, indicating that the distributions of national performance were close together.
- The differences between the CHIP CCC population scores and the NCQA CCC Medicaid national 50th percentiles ranged from 0.5 to 12.3 percentage points below the NCQA CCC Medicaid national 50th percentiles, with an average of 6.2 percentage points below the NCQA CCC Medicaid national 50th percentiles for the CCC population.

Top-Box Scores

The findings indicate opportunities for improvement in member experience for several areas of care, as all reportable measures scored below the NCQA CCC Medicaid national 50th percentiles.

Comparative Analysis

The 2022 scores were not statistically significantly higher than the 2021 scores for any measure. The 2022 score was statistically significantly lower than the 2021 score for the *Rating of All Health Care* global rating.

Conclusions—Children's Health Insurance Program Survey

The following findings indicate opportunities for improvement in member experience for several areas of care:

- The general child population scored below the 2021 NCQA Medicaid national 50th percentiles for all reportable measures, which included:
  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
  - Composite Measures:
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Customer Service*
- The CCC population scored below the 2021 NCQA CCC Medicaid national 50th percentiles for all reportable measures, which included:
  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Specialist Seen Most Often*
  - Composite Measures:
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
  - CCC Composite Measures and Items:
    - *FCC: Personal Doctor Who Knows Child*
    - *FCC: Getting Needed Information*
    - *Access to Prescription Medicines*
- The 2022 score for the *Rating of All Health Care* global rating was statistically significantly lower than the 2021 score for the CCC population.

2021 Medicaid Managed Care Survey

Methodology—Medicaid Managed Care Survey

Sampling Procedures

Members eligible for sampling included those who were MCMC members at the time the sample was drawn and who were continuously enrolled in the MCP/PSP for at least five of the last six months of 2020 (July through December) with no more than a 45-day gap in enrollment. Adult members eligible for sampling included those who were 18 years of age or older (as of December 31, 2020). Child members eligible for sampling included those who were 17 years of age or younger (as of December 31, 2020).

For the adult and child Medicaid managed care populations, HSAG selected a systematic sample of Medicaid members from each of the MCPs for surveying. A minimum of 1,350 adult Medicaid members and 1,650 child Medicaid members were selected from each of the participating MCPs. Additionally, HSAG conducted a general oversample of the adult and child Medicaid populations, where appropriate. For the PSPs, HSAG selected all eligible adult and child Medicaid members. Based on these sampling approaches, HSAG administered the 2021 CAHPS surveys to 57,762 adult members and 58,770 parents or caretakers of child members.

Survey Administration

The survey administration process allowed adult members and parents or caretakers of child members 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 adult members and parents or caretakers of child members. All non-respondents 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 adult members and parents or caretakers of child members who had not mailed in a completed survey.

CAHPS Results

CAHPS experience measures are derived from individual questions that ask for a general rating, as well as groups of questions that form composite measures. Results presented in this report include four global ratings: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. Four composite measures are also reported: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. For the adult population only, three Effectiveness of Care measures are reported: *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

Results—Medicaid Managed Care Survey

Sample sizes for the 2021 CAHPS Survey were established with the goal of obtaining 411 completed surveys at the MCP level.[52] While the sample sizes were determined based on these goals, some measures at the MCP level had fewer than 100 responses. According to *NCQA HEDIS Specifications for Survey Measures*, if a measure has fewer than 100 responses, the measure is not reportable.[53] *NCQA HEDIS Specifications for Survey Measures* recommends targeting 411 completed surveys to meet the following statistical parameters: 1) confidence intervals with a margin of error under 5 percent at the 95 percent confidence level, and 2) statistical power of at least 80 percent in detecting differences of 10 percentage points.[54]

HSAG calculated State weighted scores for the adult and child Medicaid populations. Overall, the differences between the State weighted scores and the NCQA Medicaid national 50th percentiles ranged from -29.0 percentage points to 15.0 percentage points, with an average of -4.8 percentage points for the adult population and from -15.5 percentage points to 12.9 percentage points, with an average of -2.0 percentage points for the child population.

In addition, HSAG conducted State Comparisons analyses to facilitate comparisons of MCPs' performance to NCQA Medicaid national 50th percentiles. HSAG did not have access to the 95 percent confidence intervals of the national 50th percentiles; therefore, HSAG could only compare each MCP's 95 percent confidence interval to the national 50th percentile (and not the national 95 percent confidence interval). Caution should be taken when interpreting these results.

Kaiser SoCal showed the greatest level of performance by scoring significantly above the 2020 NCQA Medicaid national 50th percentiles for the following reportable measures:

- Adult and Child Populations
  - *Rating of Health Plan*
  - *Rating of All Health Care*
- Child Population
  - *Rating of Personal Doctor*
  - *Getting Needed Care*

[52] Based on the sample sizes, it would be expected that the PSPs would not have reached 411 completed surveys; therefore, caution should be taken when interpreting PSP-level results.

[53] National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2020.

[54] Ibid.

The following MCPs each scored significantly above the 2020 NCQA Medicaid national 50th percentile for one measure:

- Health Plan of San Mateo—*Rating of Specialist Seen Most Often* (adult population)
- Inland Empire Health Plan—*Customer Service* (adult population)
- CenCal Health—*Rating of Health Plan* (child population)

Aetna Better Health of California showed the greatest opportunity for improvement, with this MCP having the most reportable measures demonstrating significantly lower performance than the 2020 NCQA Medicaid national 50th percentiles. The measures with scores lower than the 50th percentiles are listed below:

- Adult and Child Populations
  - *Rating of Health Plan*
  - *Rating of Personal Doctor*
- Adult Population
  - *Rating of All Health Care*
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
  - *Advising Smokers and Tobacco Users to Quit*
  - *Discussing Cessation Medications*

Anthem Blue Cross Partnership Plan also showed an opportunity for improvement, as this MCP had the second most reportable measures with scores lower than the 50th percentiles. Anthem Blue Cross Partnership Plan received significantly lower scores than the 2020 NCQA Medicaid national 50th percentiles for the following reportable measures:

- Adult and Child Populations
  - *Rating of Health Plan*
  - *Rating of Personal Doctor*
- Adult Population
  - *Getting Needed Care*
  - *Advising Smokers and Tobacco Users to Quit*
  - *Discussing Cessation Medications*
  - *Discussing Cessation Strategies*
- Child Population
  - *How Well Doctors Communicate*

Conclusions—Medicaid Managed Care Survey

DHCS demonstrates a commitment to monitor and improve members' experiences through the administration of the CAHPS Survey. The CAHPS Survey plays an important role as a quality improvement tool for the MCPs and PSPs. The standardized data and results can be used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time.

Based on 2021 CAHPS performance, MCPs have opportunities to improve members' experience with care and services. MCPs have the greatest opportunities for improvement on the *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* measures. Low performance in these areas may point to issues with access to and timeliness and quality of care, as well as communication from providers to members.

The *2021 Medicaid Managed Care CAHPS Survey Summary Report* includes the surveys' detailed methodologies, results, conclusions, and recommendations. The report may be found at 2021 CA CAHPS Survey Summary Report.

15. Encounter Data Validation Studies

Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity is one of the optional EQR activities described at 42 CFR §438.358(c)(1).

Accurate and complete encounter data are critical to assessing health care quality, monitoring program integrity, and making financial decisions. Therefore, DHCS requires MCPs and PSPs 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.

DHCS contracts with HSAG to conduct EDV studies as an optional EQR activity. In addition to the procedures and quality assurance protocols DHCS maintains internally, according to 42 CFR §438.242, to ensure that enrollee encounter data submitted by MCPs and PSPs provide a complete and accurate representation of the services provided to Medi-Cal members under the MCPs' and PSPs' contracts with the State, the EDV studies conducted by HSAG are designed to meet the periodicity schedule required in 42 CFR §438.602(e) for an independent audit of the accuracy, truthfulness, and completeness of encounter data submitted by, or on behalf of, each MCP or PSP. Additionally, DHCS agreed to conduct the EDV study annually in response to findings and recommendations from the California State Auditor in an audit report published in March 2019.[55] Finally, the EDV study results support DHCS' efforts to improve data quality and reporting, which will help DHCS meet its Comprehensive Quality Strategy goal to improve the quality of care for Medi-Cal beneficiaries.[56]

Encounter Data Administrative Profile Study

To ensure that MCPs, PSPs, and their providers could continue to focus on COVID-19 response efforts and to not put individuals at risk by requiring travel for collection of medical record data, DHCS determined to have HSAG conduct an alternative EDV study that did not include MRR for the 2020–21 contract year. The Encounter Data Administrative Profile (EDAP) Study included an administrative analysis of historical encounter data in contrast to members' medical records received from service providers. At the time the 2020–21 EQR technical report was produced, the EDAP Study was still in process. Following is a summary of the study objectives, methodology, results, and conclusions. Note that although HSAG concluded the

[55] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Aug 1, 2022.

[56] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

2020–21 EDAP Study outside the review period for this EQR technical report, HSAG includes a high-level summary of the study because the information was available at the time this EQR technical report was produced.

Objectives—Encounter Data Administrative Profile Study

The objectives of the 2020–21 EDAP Study were for HSAG to:

1. Evaluate the completeness and accuracy of DHCS' 837 professional (837P), 837 institutional (837I), and National Council for Prescription Drug Programs (NCPDP) encounters with dates of service in calendar years 2018 and 2019.
2. Develop a methodology, based on the 2018 and 2019 encounter data, to monitor encounter data volumes at the category of service level for DHCS to use to monitor future encounter data quality.

Methodology—Encounter Data Administrative Profile Study

To successfully complete the 2020–21 EDAP Study, HSAG collaborated with DHCS to perform the following six activities:

- Activity 1: Duplicate encounters analysis—Assessment of duplicate encounters beyond what is captured in DHCS' current duplicate validations.
- Activity 2: Completeness and accuracy for key data elements—Assessment of the completeness and accuracy of key data elements.
- Activity 3: Member data referential integrity—Comparative analysis between managed care member information submitted in the encounter data and the information contained in the member eligibility data.
- Activity 4: Provider data referential integrity—Comparative analysis among managed care provider information submitted in the encounter data, and the monthly 274 provider data.
- Activity 5: Methodology for monitoring encounter data volumes—Development of a deployable methodology to monitor encounter data volumes at the category of service level.
- Activity 6: Follow-up with MCMC plans—Provide plan-specific results in comparison to the statewide results as appendices of the aggregate report. DHCS will determine how to share the information with plans as well as conduct any needed follow-up with the MCMC plans.

Results—Encounter Data Administrative Profile Study

HSAG conducted a series of analyses for the approved metrics for this study. HSAG calculated rates for each metric by plan and encounter type (i.e., 837P, 837I, and NCPDP); however, when the results indicated a data quality issue(s), HSAG investigated further to determine whether the issue was for a specific category of service (e.g., nursing facilities, hospice); provider type (e.g., vision vendor, nonemergency transportation vendor); or sub-

population. HSAG documented all analyses results and noteworthy findings in the *2020–21 Encounter Data Administrative Profile Study Report,* which HSAG developed for DHCS' internal use. To facilitate DHCS' follow-up with plans regarding any data issues identified from the study, HSAG provided plan-specific results in the report, which compare the plan-specific results to the statewide results. Additionally, HSAG produced and submitted an MS Excel workbook that DHCS can use in the future for monitoring encounter data volumes.

Conclusions—Encounter Data Administrative Profile Study

Overall, DHCS' encounter data should continue to support encounter data analyses such as HEDIS performance measure calculations. Data were largely complete and valid. While HSAG identified some gaps and data concerns, these factors should not preclude DHCS from conducting further analyses given adequate assessment of encounters prior to analysis.

Encounter Data Validation Medical Record Review Study

Objective—Encounter Data Validation Medical Record Review Study

The objective of the 2021–22 EDV Medical Record Review Study was to examine through a review of medical records the completeness and accuracy of the professional encounter data submitted to DHCS by the 25 MCPs and two PSPs included in the study.

Methodology—Encounter Data Validation Medical Record Review Study

Medical and clinical records are considered the "gold standard" for documenting access to and quality of health care services. During contract year 2021–22, HSAG evaluated MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2020, and December 31, 2020. 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?

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 indicators.

Results—Encounter Data Validation Medical Record Review Study

Table 15.1 displays the statewide results for each study indicator. Of note, for the medical record omission rate and encounter data omission rate, lower values indicate better performance.

Table 15.1—Statewide Results for Study Indicators

Rates shaded in gray and denoted with a cross (+) indicate having met the EDV study standards.

— indicates that the study indicator is not applicable for a data element.

* 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
EDV Study Standards	**Less than 10 percent**	**Less than 10 percent**	**More than 90 percent for each data element or 80 percent for all-element accuracy rate**
Date of Service	14.0%	3.6%+	—
Diagnosis Code	17.6%	2.4%+	99.2%+
Procedure Code	21.7%	8.6%+	98.2%+
Procedure Code Modifier	34.0%	6.9%+	99.7%+
Rendering Provider Name	12.8%	15.4%	64.9%
All-Element Accuracy with Rendering Provider Name	—	—	35.8%
All-Element Accuracy Excluding Rendering Provider Name*	—	—	63.4%

When comparing results from the most recent MRR activity (2018–19 EDV study), the number of statewide rates meeting the EDV standards decreased by one due to the lower medical record procurement rate in the current study.

The *2021–22 Encounter Data Validation Study Report* includes the detailed methodology, results, conclusions, and recommendations. The report is located at the following link: Medi-Cal Managed Care Quality Improvement Reports.

16. Focus 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 EQR activities described at 42 CFR §438.358(c)(5).

DHCS contracts with HSAG to conduct focus studies to gain better understanding of and identify opportunities for improving care provided to beneficiaries, which supports the DHCS Comprehensive Quality Strategy goals and vision.[57] HSAG conducted activities related to the one focus study during the review period—Quality Improvement Health Disparities (QIHD).

HSAG's Approach to Focus Studies

HSAG conducts each focus study in accordance with the CMS *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*. October 2019.[58]

Study Design

HSAG defines the scope of work and expected objectives for the focus 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 focus study may require the adaptation of standard health care quality measures for applicability to special populations; therefore, HSAG's analytic plan details the technical specifications for these measures to ensure methodological soundness and reliable calculability for the populations under study.

Data Collection

As much as possible, HSAG uses administrative data to conduct focus studies. While MRR may provide valuable insight into selected focus study topics, HSAG uses this approach sparingly in order to provide focus study results within a single contract year. After finalizing the methodology for each focus study, HSAG works with DHCS to develop a study-specific data submission file layout.

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[57] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

[58] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*. October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 1, 2022.

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 focus 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 focus 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.

Quality Improvement Health Disparities Focus Study

To help DHCS and MCPs prioritize health disparity areas on which to focus quality improvement efforts, DHCS contracted with HSAG in contract year 2020–21 to conduct the QIHD Focus Study. The goal of the QIHD Focus Study was to develop and test four methodologies for identifying three disparities from which each MCP reporting unit could choose for quality improvement efforts each year.

While the QIHD Focus Study began during the review period for the 2020–21 EQR technical report, the study concluded during the review period for this report; therefore, HSAG includes a summary of the study methodology, results, and conclusions in this EQR technical report.

Objective

The objective of the QIHD Focus Study was to provide results and conclusions regarding methodologies DHCS could use to identify three health disparities from which each MCP reporting unit could choose for quality improvement efforts each year.

Methodology

HSAG used 26 of the External Accountability Set HEDIS measures reported by the 25 full-scope MCPs for measurement years 2017 and 2018 (i.e., reporting years 2018 and 2019). HSAG developed and tested the following methodologies at the following levels to determine if three disparities for each MCP reporting unit could be determined at each level:

- Statewide health disparities

- Regional health disparities
- MCP reporting unit health disparities
- Combination (i.e., statewide, regional, and MCP reporting levels combined) health disparities

For measurement year 2017 data, HSAG tested the above methodologies using DHCS' historical methodology for identifying a health disparity (i.e., logistic regression and a 3 percentage point difference). For measurement year 2018 data, HSAG tested the above methodologies using the respective NCQA Quality Compass national Medicaid HMO 25th percentile as the reference rate for each indicator (i.e., all racial/ethnic group rates were compared to the national 25th percentile for each indicator).

Based on the findings from testing the four methodologies on measurement years 2017 and 2018 data, DHCS may choose one of the methodologies to be implemented for the MCPs to determine priority focus areas for quality improvement efforts each year.

Results

Following are summaries of the key findings of HSAG's testing of each of the four methodologies on measurement years 2017 and 2018 data.

Statewide

The statewide methodology identified priority focus areas (i.e., a combination of indicators and racial/ethnic disparities) at the statewide level based on the number of MCP reporting units sharing the disparity, size of the disparity, performance compared to national percentiles, and population size.

Key Findings

- For both measurement years 2017 and 2018, the Black or African American group accounted for a majority of the statewide focus areas.
- For both measurement years 2017 and 2018, a majority of the statewide focus areas were for hybrid measures. This impacted the number of MCP reporting units sharing the statewide focus areas because some racial/ethnic groups had small denominators for hybrid measures at the MCP reporting unit level.
- For measurement year 2017, disparities were identified by comparing the indicator rates for racial/ethnic groups to the rate for the White group to identify statistically significant differences that were also larger than 3 percentage points. Due to small denominators at the MCP reporting unit level, relatively few results were statistically significant, which resulted in fewer identified disparities. This resulted in only 23 of the 53 MCP reporting units (43.40 percent) sharing a disparity that matched with a statewide priority focus area.
- For measurement year 2018, while small denominators at the MCP reporting unit level still impacted results, the number of MCP reporting units sharing a disparity that matched with a statewide priority focus area increased to 46 out of 56 MCP reporting units (82.14 percent).

This is primarily due to the inclusion of the White group for measurement year 2018, which was a sufficiently large population within most MCP reporting units, even for hybrid measures.

Regional

The regional methodology identified priority focus areas (i.e., a combination of indicators and racial/ethnic disparities) at the regional level based on the number of MCP reporting units sharing the disparity within the region, size of the disparity, performance compared to national percentiles, and population size.

Key Findings

- For measurement year 2017, the Black or African American group accounted for a majority of regional focus areas, while the White group accounted for a plurality of regional focus areas for measurement year 2018.
- For both measurement years 2017 and 2018, nearly half of the regional focus areas were also identified as statewide focus areas.
- For measurement year 2017, nine of the 22 regional focus areas identified (40.91 percent) were shared by 25 percent or less of MCP reporting units within the respective region. However, for measurement year 2018, 18 of the 25 regional focus areas (72.00 percent) were shared by 50 percent or more of the MCP reporting units within the respective region.

MCP Reporting Unit

The MCP reporting unit methodology identified priority focus areas (i.e., a combination of indicators and racial/ethnic disparities) at the MCP reporting unit level based on the number of MCP reporting units sharing the disparity, size of the disparity, performance compared to national percentiles, and population size.

Key Findings

- For measurement year 2017, the Black or African American group had priority focus areas identified for a majority of MCP reporting units, while the White group had priority focus areas identified for a majority of MCP reporting units for measurement year 2018.
- For both measurement years 2017 and 2018, approximately 20 percent of the MCP reporting unit focus areas were also identified as statewide focus areas, and approximately 15 percent of the MCP reporting unit focus areas were also identified as one of the respective regional priority focus areas.
- For measurement year 2017,12 MCP reporting units did not have an identified priority focus area, and an additional five MCP reporting units only had one identified priority focus area. However, for measurement year 2018, two MCP reporting units did not have an identified priority focus area, and an additional two MCP reporting units only had one identified priority focus area.

- As a result, 38 of the 107 identified priority focus areas for measurement year 2017 (35.51 percent) were based on primary language or urbanicity, while five of the 156 identified priority focus areas for measurement year 2018 (3.21 percent) were based on primary language or urbanicity.

Combined

The combined methodology identified priority focus areas (i.e., a combination of indicators and racial/ethnic disparities) at the MCP reporting unit level based on the number of MCP reporting units sharing the disparity as well as if the disparity was also a statewide or regional priority focus area, size of the disparity, performance compared to national percentiles, and population size.

Key Findings

- For measurement year 2017, the Black or African American group had priority focus areas identified for a majority of MCP reporting units, while the White group had priority focus areas identified for nearly 90 percent of MCP reporting units for measurement year 2018.
- For measurement year 2017, approximately 27 percent of the MCP reporting unit focus areas were also identified as statewide focus areas, and approximately 14 percent of the MCP reporting unit focus areas were also identified as one of the respective regional priority focus areas. However, for measurement year 2018, approximately 54 percent of the MCP reporting unit focus areas were also identified as statewide focus areas, and approximately 19 percent of the MCP reporting unit focus areas were also identified as one of the respective regional priority focus areas.
- For measurement year 2017, 23 of the 53 MCP reporting units (43.40 percent) had a racial/ethnic priority focus area within the Appropriate Treatment and Utilization domain, while 42 of the 56 MCP reporting units (75.00 percent) had a racial/ethnic priority focus area within the Preventive Health and Women's Screening domain for measurement year 2018.

Conclusions

Based on the advantages and disadvantages of each tested methodology, HSAG presents the following conclusions for DHCS to consider when choosing a methodology to be implemented for MCPs to determine quality improvement priority focus areas each year:

- HSAG recommends that DHCS consider implementing the combined methodology for determining priority focus areas from which each MCP reporting unit may choose for quality improvement efforts each year. This methodology has been most effective for ensuring that most MCP reporting units focus on similar priority focus areas.

  - As part of the combined methodology, HSAG recommends splitting the Central and Southern Coast Region[59] into two separate regions, Southern Coast and Central Coast, to mitigate the substantial size and population characteristic differences.
- When identifying disparities to assign priority focus areas, DHCS should consider avoiding the historical method of identifying health disparities (i.e., using the White group as the reference group). Instead, DHCS should use the national Medicaid 25th or 50th percentile for each indicator to identify health disparities and assign priority focus areas. By having all MCP reporting units prioritize indicator rates below the national Medicaid 25th or 50th percentile, DHCS should see statewide indicator performance improve over time.
- For hybrid indicators with small denominators at the MCP reporting unit level, DHCS should consider removing or altering the current minimum denominator threshold (i.e., fewer than 30 members) to see if statewide disparities apply to more MCP reporting units. Because hybrid measures use a sample of cases, the eligible population sizes for these racial/ethnic groups are larger than 30, which would justify inclusion in the analysis.
- DHCS should consider determining priority focus areas at the indicator level rather than the indicator-demographic stratification level. While each MCP reporting unit may have a different racial/ethnic disparity for an indicator, DHCS may see the largest impact of future improvement efforts if all MCP reporting units focus on the same indicator, regardless of racial/ethnic group.
- DHCS could consider prioritizing focus areas from the same domain for all MCP reporting units when assigning priority focus areas. For example, if all MCP reporting units have an identified disparity within the Women's Health domain, DHCS may consider having MCP reporting units select priority focus areas from the identified disparities within that domain. This would maximize the impact of improvement efforts on statewide performance for indicators related to women's health.

[59] The Central and Southern Coast Region consists of Los Angeles, Monterey, Orange, San Diego, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura counties.

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). The technical assistance HSAG provides supports DHCS and the MCMC plans in making progress toward accomplishing the DHCS Comprehensive Quality Strategy goals and vision, improving the health care services provided to Medi-Cal members, and achieving health equity.[60]

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 three technical assistance categories for HSAG to support during the July 1, 2021, through June 30, 2022, review period.

Technical Assistance for Plans' Quality Improvement

Objective—Technical Assistance for Plans' Quality Improvement

The objective of Technical Assistance for Plans' Quality Improvement is for HSAG to assist MCMC plans in improving the quality of care they provide to members, which will help to improve their performance measure rates and, ultimately, improve overall statewide performance.

Under this technical assistance category, HSAG supports DHCS by providing technical assistance to each MCMC plan with performance measure rates worse than the minimum performance levels. Additionally, HSAG provides technical assistance to DHCS in various areas related to quality improvement.

Specifically, HSAG conducts the following activities as requested by DHCS:

- Provide performance measure expertise to DHCS in identifying and researching performance measures regarding updates to measure specifications and to the CMS Core Sets, trends, and best practices.
- Collaborate with DHCS to provide technical assistance to MCMC plans related to DHCS' Quality Monitoring and CAP Process.
- Provide technical assistance to MCMC plans requiring additional guidance with quality improvement activities being conducted as part of DHCS' Quality Monitoring and CAP Process.

[60] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

- Review and provide feedback to DHCS on an array of documents related to quality improvement activities, including providing subject matter expertise on quality performance measures to be included in or excluded from MCAS.
- Respond to requests from DHCS for input on a variety of quality improvement-related issues and topics.

Methodology—Technical Assistance for Plans' Quality Improvement

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each request 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 provided technical assistance to DHCS and MCMC plans via email, telephone, and Web conferences.

Results—Technical Assistance for Plans' Quality Improvement

Following is a high-level summary of the notable technical assistance HSAG provided to DHCS and MCMC plans during the review period to support quality improvement efforts.

Performance Measures and Audits

- Forwarded to DHCS, NCQA, and CMS updates to ensure DHCS is aware of NCQA and CMS requirements, knows of NCQA and CMS resources, and has the pertinent information needed to make performance measure requirement decisions.
- Responded to DHCS' questions and provided feedback to DHCS related to NCQA benchmarks, HEDIS Compliance Audit processes, HEDIS data, NCQA and CMS performance measure specifications, and historical and future performance measure requirements.
- Provided information to DHCS about other states' performance measure reporting processes and requirements.
- Provided guidance to MCMC plans about performance measure requirements and DHCS' expectations for MCMC plans' use of preventive services and health disparities data for quality improvement activities.

Consumer Assessment of Healthcare Providers and Systems

- Forwarded information to DHCS about NCQA's policy changes related to CAHPS survey sample frame validation.
- Provided DHCS with historical CAHPS survey information, guidance regarding including Medi-Cal FFS beneficiaries in the CAHPS survey population, and supplemental question options for CAHPS surveys.
- Responded to MCMC plans' requests for information and data related to the CAHPS survey HSAG administers on behalf of DHCS.

External Quality Review Technical Report

- Provided DHCS with considerations for changes to ensure meeting CMS' EQR technical report content requirements.
- Provided recommendations to DHCS about how to respond to CMS' feedback on previous years' EQR technical reports.

Other Technical Assistance

- Provided clarification to individual DHCS staff members about specific EQRO activities to help them gain a more comprehensive understanding of the various activities.
- Forwarded to DHCS announcements and updates from various organizations, such as CMS, to ensure DHCS is up to date on relevant information and requirements that may affect MCMC.
- Provided feedback and considerations to DHCS regarding various DHCS-proposed analyses.
- Provided feedback and recommendations to DHCS regarding its proposed approach for meeting the compliance review requirements as outlined in 42 CFR §438.358(b)(1)(iii).
- Produced an MS Excel workbook with all data from the 2020–21 Alternative Access Standards analyses to assist DHCS with responding to a request from the California State Auditor's Office.
- Upon request, provided MCMC plans with historical information to help with their quality improvement processes (i.e., PIP validation findings, collaborative discussion presentations, and quality conference presentations).

Conclusions—Technical Assistance for Plans' Quality Improvement

HSAG's technical assistance resulted in DHCS gaining information to assist in making informed decisions regarding various EQR activities and MCMC plan requirements. HSAG's additional technical assistance regarding compliance reviews helped DHCS to better understand how to ensure the Medical Audit process meets CMS' compliance review requirements as well as what information DHCS needs to provide to HSAG for inclusion in the annual EQR technical report. Additionally, HSAG's technical assistance to MCMC plans resulted in the plans receiving information needed for their internal quality improvement efforts.

Technical Assistance for Priority Quality Improvement Collaboration

Objective—Technical Assistance for Priority Quality Improvement Collaboration

Under the Technical Assistance for Priority Quality Improvement Collaboration, HSAG implements, facilitates, supports, and manages quarterly collaborative discussions for each DHCS-identified quality improvement priority area. The objectives of the collaborative discussions are:

- To provide MCMC plans the opportunity to share with each other about issues, barriers, promising practices, and solutions related to their quality improvement work in the priority areas or other quality performance measure areas.
- For MCMC plans to benefit from HSAG's insight and expertise.
- For DHCS to share pertinent resources, and its insights, particularly around potential collaboration with external partners.

Methodology—Technical Assistance for Priority Quality Improvement Collaboration

DHCS selected the following collaborative discussion focus areas that align with DHCS' MCAS domains:

- Child and Adolescent Health—Focusing on MCMC plans' quality improvement work for the *Child and Adolescent Health* PIPs and PDSA cycles related to child and adolescent health measures.
- Women's Health—Focusing on MCMC plans' quality improvement work on PIPs and PDSA cycles related to women's health, including maternal health.
- Disease Management and Behavioral Health—Focusing on MCMC plans' quality improvement work on PIPs and PDSA cycles related to acute and chronic disease management, as well as measures related to behavioral health.

Note that while there was no specific collaborative call related to health equity, DHCS and HSAG worked with the MCMC plans to weave a health equity focus into the collaborative call discussions frequently. Additionally, DHCS and HSAG also incorporated into the discussions the effects of COVID-19 on quality improvement efforts and how MCMC plans addressed the COVID-19 challenges.

Through joint planning meetings, HSAG and DHCS discussed potential topics for the collaborative discussions and the appropriate structure for the meetings based on the topics. DHCS and HSAG collaboratively determined the topic for each quarterly collaborative discussion based on:

- Feedback received from MCMC plans about what they would like discussed.
- Issues identified by DHCS and HSAG through EQR work with MCMC plans, including, but not limited to PIPs, MCAS performance measures and associated PDSA cycles, and MCMC plan-specific technical assistance sessions.

Additionally, HSAG:

- Served as the facilitator for each collaborative discussion planning meeting at intervals determined by DHCS.
- Collaborated with DHCS regarding the agenda and prepared agendas.
- Prepared and coordinated webinar presentations with DHCS and any MCMC plan or external partner presenters.
- Led discussions, kept track of participant attendance and roles, and compiled and disseminated notes to DHCS and the plans.

HSAG conducted the collaborative discussions through webinars and conference calls. Immediately following each collaborative discussion, HSAG invited participants to complete a post-collaborative discussion survey to provide anonymous feedback about the discussion and their input for future discussions. The survey link appeared immediately after participants exited the Webex, and HSAG also emailed the survey link to participants following each discussion. Within five State working days following each collaborative discussion, HSAG emailed the meeting notes to the MCMC plans and reminded collaborative discussion participants to complete the surveys. Once survey results became available, HSAG provided DHCS with a summary of the survey results.

Results—Technical Assistance for Priority Quality Improvement Collaboration

HSAG facilitated collaborative discussions in three of the quarters of the review period for this report. For all three quarters, DHCS determined COVID-19 vaccination strategies as the Disease Management and Behavioral Health collaborative discussion topic.

At the beginning of each collaborative discussion, DHCS provided an update on statewide efforts, external partnerships, resources, and other pertinent information related to the collaborative discussion topic. Following DHCS' update, representatives from one or more MCMC plans conducted presentations about their quality improvement efforts related to the collaborative discussion topic. During all three quarters, CDPH presented information to support MCMC plans in their COVID-19 vaccination strategies. Following the presentations, HSAG facilitated a question-and-answer session to provide the opportunity for MCMC plans to

ask the presenters questions. HSAG also encouraged the participants to engage in discussion around the presentation topic.

During the review period, HSAG and DHCS worked with the following entities to present information related to the collaborative discussion focus areas to support MCMC plans in their quality improvement efforts:

- Child and Adolescent Health
  - Anthem Blue Cross Partnership Plan
  - Blue Shield of California Promise Health Plan
  - Health Net Community Solutions, Inc.
  - L.A. Care Health Plan
  - Molina Healthcare of California
- COVID-19 Vaccines: Strategies and Promising Practices
  - CDPH
  - Central California Alliance for Health
  - Inland Empire Health Plan and L.A. Care Health Plan (Joint Presentation)
- Women's Health
  - CalOptima
  - CenCal Health
  - Kern Health Systems
  - San Francisco Health Plan
  - Santa Clara Family Health Plan

In all three quarters, most post-collaborative discussion survey respondents completed the surveys on the days of the calls. The survey respondents generally gave favorable ratings, and the survey results yielded no notable responses or feedback.

Conclusions—Technical Assistance for Priority Quality Improvement Collaboration

The collaborative discussions resulted in MCMC plans and DHCS sharing valuable information regarding quality improvement efforts for each priority topic. Additionally, CDPH provided comprehensive information about how to help members catch up on their needed immunizations as well as COVID-19 vaccination program updates, and shared about resources that MCMC plans may consider using to improve COVID-19 and other vaccination rates among members. MCMC plan participants actively engaged in discussions related to the presentations and exchanged ideas for improving performance. Additionally, the post-collaborative survey results revealed that MCMC plans found the presentations to be informative for creating partnerships and collaborations for quality improvement efforts.

Technical Assistance for Consultative Services

Objective—Technical Assistance for Consultative Services

The objective of Technical Assistance for Consultative Services is for HSAG to assist DHCS with additional activities undertaken as part of DHCS' QAPI strategy, or in response to newly enacted EQR-related federal- or state-directed activities.

Methodology—Technical Assistance for Consultative Services

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each request 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 provided technical assistance to DHCS and MCMC plans via email, telephone, and Web conferences.

Results—Technical Assistance for Consultative Services

During the review period of this report, DHCS requested HSAG's consultative services to help identify the winners for DHCS' 2021 CAHPS Quality Awards. Following the calculation methodology DHCS provided, HSAG used the most complete CAHPS Medicaid adult and child survey data, NCQA benchmarks, and member enrollment data to develop MS Excel spreadsheets to calculate entrants' scores. HSAG analyzed and ranked the MCPs to identify the categorial winners for the 2021 CAHPS Quality Awards.

Conclusions—Technical Assistance for Consultative Services

As a result of HSAG's consultative services, DHCS identified and awarded the winners of the 2021 CAHPS Quality Awards.

18. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of members. The PNA identifies member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues. MCP and PSP contractual requirements related to the PNA are based on Title 22 of the California Code of Regulations, sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), and Title 42 CFR §438.206(c)(2), §438.330(b)(4), and 438.242(b)(2).[61,62]

The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and must take action to address the opportunities for improvement. MCPs' and PSPs' PNA processes contribute toward helping DHCS to achieve its Comprehensive Quality Strategy goals and vision, including reducing health disparities and achieving health equity.[63]

Objectives

The objectives of the PNA are to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of all their members by:

- Identifying member health needs and health disparities.
- Evaluating health education, cultural and linguistic, and quality improvement activities and available resources to address identified concerns.
- Implementing targeted strategies for health education, cultural and linguistic, and quality improvement programs and services.

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[61] The California Code of Regulations is searchable and may be found at https://govt.westlaw.com/calregs/Search/Index. Accessed on: Aug 1, 2022.

[62] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. Title 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: Aug 1, 2022.

[63] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Aug 1, 2022.

Methodology

As part of the EQR technical report production, DHCS provided HSAG with a summary of the PNA report submission reviews.

Note that the PNA report submissions by MCPs and PSPs began during the review period for this EQR technical report; however, the submission, review and approval processes were completed outside the review period for this report. While the processes were completed outside the review period, HSAG includes a summary of the PNA report submissions because the information was available at the time this report was produced.

Results

During the PNA report submission and review process, 25 MCPs and two PSPs submitted reports to DHCS. Three MCPs requested extensions on their final submissions, and DHCS requested additional information regarding nine reports before providing PNA report approval. Upon review of all submissions and resubmissions, DHCS approved all PNA reports.

From the PNA reports, DHCS identified 132 objectives across all MCPs and PSPs. DHCS required MCPs and PSPs to include at least one objective focused on reducing a health disparity. Of the 132 objectives:

- Fifty-four (41 percent) were related to a health disparity.
- Forty-two (32 percent) were new objectives for 2022.
- Sixty-six (50 percent) were objectives continued from 2021.
- Twenty-four (18 percent) were objectives continued from 2021 but with changes (population, data source, etc.)
- Thirty-four (26 percent) targeted a specific race/ethnicity, with the top two being:
  - African American/Black—18 objectives.
  - Hispanic/Latinx—five objectives.
- Some included more than one targeted behavior or disease, with most objectives focusing on preventive services, member experience, and youth and child well visits.

2022 Action Plan Update

DHCS compared MCPs' and PSPs' 2021 objectives to 2022 progress data. MCPs and PSPs reported the following progress on objectives in 2022:

- Improvement for 68 objectives.
- Decline for 46 objectives, mostly due to COVID-19 influences between 2021 and 2022.
- No progress for six objectives.
- Unknown progress for 17 objectives due to data source issues.

In *Volume 2 of 5 (Appendix D)* of this EQR technical report, HSAG includes a list of MCMC plans' 2021 and 2022 PNA objectives, including the progress made on the 2021 objectives.

Conclusions

DHCS' PNA report review process included the opportunity for feedback and resubmission by MCPs and PSPs to ensure they met DHCS' expectations and requirements. DHCS provided HSAG with a summary of its assessment of the PNA reports that reflected DHCS' thorough review and assessment of the reports.

19. Follow-Up on Prior Year's Recommendations

External Quality Review Recommendations for DHCS

As part of the process for producing the *2021–22 Medi-Cal Managed Care External Quality Review Technical Report*, DHCS provided the following information on the actions that DHCS took to address recommendations that HSAG made in the *2020–21 Medi-Cal Managed Care External Quality Review Technical Report.* Table 19.1 provides EQR recommendations from the *2020–21 Medi-Cal Managed Care External Quality Review Technical Report*, along with DHCS' self-reported actions taken through June 30, 2022, that address the EQR recommendations. Please note that HSAG made minimal edits to Table 19.1 to preserve the accuracy of DHCS' self-reported actions.

Table 19.1—DHCS' Self-Reported Follow-Up on External Quality Review Recommendations from the 2020–21 Medi-Cal Managed Care Technical Report

2020–21 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. DHCS should ensure that A&I conducts a review of Family Mosaic Project every three years which includes assessment of the SHP's compliance with all required federal standards.	Family Mosaic Project is no longer funded with federal government dollars; therefore, DHCS is no longer required to conduct federally required audit and compliance functions for Family Mosaic Project. Please note the May 2022 Medi-Cal Local Assistance Estimate indicates that Family Mosaic Project is funded through the General Fund. Note that DHCS continues to monitor Family Mosaic Project's quality efforts through review of its annual quality improvement report.
2. The SNF Experience results showed that 19.54 percent of long-stay SNF residents had a hospital admission from their SNF during calendar year 2020. Given that many hospitalizations from SNFs are preventable/avoidable, further analysis is needed to understand why these hospitalizations are occurring. DHCS should consider analyzing these hospitalizations using Minimum Data Set discharge assessments, primary diagnoses	DHCS is exploring the feasibility of conducting the analysis and considering how it aligns with the implementation of CalAIM and other high-priority quality-based initiatives.

2020–21 External Quality Review Recommendations	Self-Reported Actions Taken by DHCS during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
codes on the claim/encounter for the hospital admission from the SNF, and the services received in the hospital. By leveraging additional data, DHCS can begin to understand the reasons why Medi-Cal members are admitted to hospitals from their SNFs and determine if the reason the member was admitted to the hospital could have been managed within the SNF.	
3. Approximately 25 percent of ICF stays were excluded from the ICF distance analysis due to the resident having the same place of residence as the ICF address on the date of admission and for months prior to admission. Consequently, DHCS should work with Medi-Cal MCPs to investigate potential data completeness issues, particularly in Ventura County, where residents with the same place of residence as the ICF address were most frequently identified.	Currently, the ICF benefit is not required to be covered in all counties. DHCS will consider this effort in the future once the ICF benefit is contractually required to be covered in all counties.

Assessment of DHCS' Self-Reported Actions

HSAG reviewed DHCS' self-reported actions in Table 19.1 and determined that DHCS adequately addressed HSAG's recommendations from the *2020–21 Medi-Cal Managed Care External Quality Review Technical Report*. DHCS documented that Family Mosaic Project is no longer federally funded and is therefore no longer subject to the federal compliance review requirements. Additionally, DHCS stated that it will take into consideration HSAG's recommendations related to hospitalizations from SNFs and potential data completeness issues related to ICF stays.

External Quality Review Recommendations for MCMC Plans

DHCS provided each MCMC plan an opportunity to summarize actions taken to address recommendations HSAG made in its 2020–21 MCMC plan-specific evaluation report. In *Volume 2 of 5 (Appendix E)* of this EQR technical report, HSAG includes each MCMC plan's self-reported follow-up on the 2020–21 EQR recommendations as well as HSAG's assessment of the self-reported actions.