External Quality Review (EQR) Technical Reports
FY 2021-2022 Medi-Cal Managed Care
Executive Summary: Final Report

Background

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.[1]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*.

Medi-Cal Managed Care Program by the Numbers
Statewide MCMC beneficiaries as of June 2022[2]: **More than 12.6 million**
DHCS' contracted MCMC plans: **25 MCPs**, **three PSPs**,[3] **and one SHP**[4]
Counties served: **All 58 counties across California**

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[1] *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.

[2] 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.

[3] 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.

[4] 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

Summary of Findings (include Recommendations)

1. Access

Number of Alternative Access Requests, Approvals, and Denials:
There were 7,375 requests submitted to DHCS, and 7,014 distinct combinations of request characteristics appeared in the data supplied by DHCS. Of these combinations, 5,523 (78.7 percent) were approved by DHCS.

- Denial Reasons
  - The MCP's alternative access standard request is incomplete. The MCP is to revise the request that follows APL 21-006[9] Attachment C instructions and resubmit.
  - DHCS located a closer out-of-network provider than the in-network provider and out-of-network provider that the MCP identified on the alternative access standard request. The MCP is to revise the request for miles/minutes or provide a justification and resubmit.
  - DHCS located an in-network provider within the time or distance standards that the MCP did not identify on the alternative access standard request. The MCP is to submit an updated accessibility analysis that shows the MCP is already meeting the time or distance standard.
  - The MCP's justification as to why the MCP was unable to contract with the closer out-of-network provider is insufficient. The MCP is to revise the justification and resubmit.

Distance and Driving Time Between Nearest Network Provider and Farthest Beneficiary:
The shortest median distance was 13 miles for Molina and ZIP Code 95610, while the longest median distance was 260 miles for IEHP and ZIP Code 92363. The shortest median drive time was 20 minutes for two combinations of MCPs and ZIP Codes, while the longest median drive time was 262 minutes for IEHP and ZIP Code 92332. The smallest median number of impacted beneficiaries was zero individuals in 32 combinations of MCPs and ZIP Codes, while the largest median number of impacted beneficiaries was 25,444 individuals for IEHP and ZIP Code 92201.

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

In ANC year 2021, the median number of days to approval or denial across all requests from all MCPs was 47 days for requests submitted during the initial request and decision phase between April 28, 2021, and August 12, 2021, and 47 days for requests submitted during the corrective action plan (CAP) request and decision phase between August 20, 2021, and March 10, 2022. In ANC year 2022, the median number of days to approval or denial across all requests from all MCPs was 35 days for requests submitted during the MMCE CalAIM request and decision phase between September 17, 2021, and November 24, 2021.

Consumer Complaints:
HSAG reviewed DHCS' quarterly grievance reports from State Fiscal Year (SFY) 2020–21 Quarter 3 through SFY 2021–22 Quarter 2 (January 2021 through December 2021) for beneficiaries' complaints related to access to providers. The DHCS grievance data included a county-level identifier and were stratified according to MCP and county. The grievance data identified counts of beneficiaries, noting "Timely Access," "Geographic Access," and "Out of Network" issues. On average, there were 587.2 grievance calls for each MCP and county. The lowest number of grievances for any MCP and county wherein any grievances were received was 1, and the highest number of grievances was 24,934.

Contracting Efforts:
In the data provided for the 2021–22 analyses, the contracting efforts that MCPs reported to DHCS included the following:

- Planning future provider outreach.
- Verifying provider location and contact information and seeking additional information when incorrect/out-of-date information was encountered.
- Contacting the provider via telephone, mail, or email.
- The provider was affiliated with a closed network.
- The provider declined to contract with the MCP.
- The provider was located outside the MCP's licensed service area.
- The provider was currently in contracting negotiations with the MCP.
- Provider information was incorrect/out-of-date, and contact was not possible.

The contracting efforts that MCPs reported in the alternative access standard requests in response to DHCS' analysis of their request included the following:

- The closest provider is already contracted with the plan.
- Out-of-network providers identified by DHCS are more distant than an in-network provider.
- The MCP plans to send the provider a contract.
- The MCP depends on contracted medical groups to contract with local providers.
- No non-contracted provider could be located.
- Members can access services from a non-contracted provider.
- The provider could not be found.

- The provider retired.
- The provider was deceased.
- The plan will reach out to an alternate provider for contracting.
- Providers cannot contract due to competing contracts.

Providers under Contract:

- Across all MCPs, the median percentage of contracted providers across counties and across provider types is 52.0 percent. This indicates that MCPs typically contract with at most just over half of the providers who are contracted with any MCP, across counties and provider types. That percentage is the upper limit of the number of providers contracted with each MCP located within a service area and serving that area as a percentage of all providers.
- The MCPs with the highest median percentage of contracted providers across counties and provider types are CenCal and Partnership (both at 100.0 percent). These MCPs typically contract with a higher proportion of providers located within the counties they serve than other MCPs.
- The MCP with the lowest median percentage of contracted providers across counties and provider types is Kaiser SoCal (9.3 percent). This MCP typically contracts with a lower proportion of providers located within the counties it serves than other MCPs.
- The provider type with the highest median percentage of contracted providers across counties and MCPs is Pediatric Nephrology (67.2 percent). MCPs typically contract with a higher proportion of providers of this type located within the counties they serve compared to other provider types.
- The provider type with the lowest median percentage of contracted providers across counties and MCPs is Adult Ear, Nose, and Throat (ENT)/Otolaryngology (9.1 percent). MCPs typically contract with a lower proportion of providers of this type located within the counties they serve compared to other provider types.

HSAG identified the following considerations for DHCS that may improve access and alternative access reporting:

- Incomplete and inaccurate information about provider locations and characteristics may be hindering MCPs' efforts to address gaps in their networks. One of the most frequent reasons for denial of an MCP's request is that DHCS located an out-of-network provider closer than the MCP's proposed in-network provider. Justifications for not contracting with the identified provider include that the out-of-network provider is affiliated with a closed network and will not contract with the MCP, or that the identified provider cannot be found at the specified location because the provider has moved, retired, or died. Furthermore, accurate estimation of reporting Element 5, "Percentage of providers in the plan service area by provider and specialty type that are under a contract with a Medi-Cal MCP," requires detailed information on all providers in a given area, and this information is not currently available from any source.

- Developing and maintaining a list of provider practice locations of identified Medi-Cal contracted providers will improve DHCS' ability to provide MCPs with more accurate and current information regarding eligible providers. Making this list comprehensive to include all provider practice locations for relevant provider types would improve DHCS' ability to inform MCPs about potential contracting opportunities and also make it possible to assess the percentage of all providers in a service area who are contracted with a given MCP.

2. Timeliness

Timely Access Study

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 11.1—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%

Provider Type	Percentage of First Available In-Person Appointment Meeting Wait Time Standards			
	Non-Urgent		Urgent	
	Adult	Pediatric	Adult	Pediatric
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

3. Quality

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.

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.

Performance Measure Results Analyses:

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.

Conclusion/Recommendations:
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.

4. Additional Network Adequacy Reporting

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[5] 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.

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

5. Beneficiary Perceptions of Care

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.[6,7] 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%**

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

[7] 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.

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.[8] 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.[9] *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.[10]

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:

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[8] 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.

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

[10] Ibid.

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

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.

6. Performance Improvement Projects

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.

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.

7. Information Systems: Encounter Data Validation Study

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.

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 15.3—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%

Key Data Elements	Medical Record Omission Rate	Encounter Data Omission Rate	Element Accuracy Rate
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.

Potential Concerns: Addressing Previous EQR Recommendations

External Quality Review 2020-2021 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 19.4—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

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
	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 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.	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.
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	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.

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
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.	

Recommendations

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.

There are several areas demonstrating opportunities of improvement, which DHCS will track HSAG's recommendations and work toward achievement.