Medi-Cal Managed Care Advisory Group Meeting

June 6, 2019

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Agenda

- Welcome and Introductions
- Provider Incentive Payment Updates
- Timely Access Survey: Results and Next Steps
- Managed Care Quality Update
- Data Discussion: Stoplight Reports
- Updates
  - Transitions and Implementations
  - Ombudsman Report
- APLs and DPLs Update
- Open Discussion
- Next Meeting – September 5, 2019

Welcome and Introductions

Update
Provider Incentive Payments

TIMELY ACCESS

Managed Care Quality and Monitoring Division
Department of Health Care Services

Timely Access Standards

- The Knox-Keene Health Care Service Plan Act of 1975 is the set of regulations passed by the State Legislature and administered by the Department of Managed Health Care (DMHC) to regulate health care plans within California.
- Per contractual requirements, Medi-Cal managed care health plans (MCPs) are held to the same standards.

Urgent Appointments	**Wait Time**
Services that do not require prior approval	48 hours
Services that require prior approval	96 hours
Non-Urgent Appointments	**Wait Time**
Primary care	10 business days
Specialty care	15 business days
Appointment with a mental health care provider	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days

DHCS Timely Access Process

Previous Process:

Audits & Investigations Validation Study	
Frequency	Annual
Appointment Type	First three available non-urgent appointments
Provider Categories	Primary care; Specialty care; and Prenatal care providers
Sample Size	Less than 40 providers
Population	Not reported

Current Process:

External Quality Review Organization (EQRO)	
Frequency	Annual study; quarterly results
Appointment Type	First three available urgent and non-urgent appointments
Provider Categories	Primary care; Specialty care; Prenatal care; Non-Physician Mental Health care; and Ancillary providers
Sample Size	Over 400 providers per reporting unit
Population	Adult and pediatric

EQRO Timely Access Survey

- DHCS' EQRO conducts an annual timely access survey of all MCPs to ensure compliance with provider availability and wait time standards for urgent and non-urgent appointments among network provider types.
- The survey consists of calling a randomized sample of network providers by each MCP's county/region-based reporting unit.
  - 411 providers per each reporting unit
  - Total of 28,000 providers contacted statewide
- Provider offices are called during standard operating hours (e.g., 9:00 am – 5:00 pm Pacific Time)

EQRO Timely Access Survey (cont'd)

- The survey captures the following:
  - The first three available times for urgent and non-urgent appointments;
  - The differences in appointment times between pediatric and adult;
  - Whether the provide is accepting new patients;
  - Whether the network provider is contracted with other MCPs in the same service area; and
  - The quality of the data that DHCS maintains for the network provider.
- Network provider categories include:
  - Primary care providers (PCP)
  - OB/GYN
  - DHCS core specialists
  - Non-physician mental health providers
  - Ancillary providers (physical therapy, MRI, and mammogram)

Timely Access Survey Process

EQRO

- Based on the MCPs' 274 file submission, selects sample providers
- Conducts telephone surveys to sample providers and call centers
- Calculates results by MCP and statewide
- Submits plan-specific and raw data to DHCS

DHCS

- Provides plan-specific results and raw data file to MCPs on a quarterly basis
- Analyzes MCP responses
- Communicates any areas of concern with the MCPs
- Provides technical assistance to MCPs

MCPs

- Identifies any corrections necessary to come into compliance
- Submits responses to survey findings including action plan and timeframes
- Depending on the area of concern, contracts with additional providers, corrects 274 file submission and/or conducts provider training as needed

Timely Access Focus Areas

Access

- Compliance with urgent and non-urgent wait time standards

Data Quality

- Incorrect/disconnected phone number
- Provider is not providing services at the office location
- Provider is not in an office that handles appointments (i.e., billing department, corporate office, etc.)

Provider Training

- Caller reaches a voicemail during business hours
- Caller is put on hold for more than 5 minutes
- Refusal to participate in the survey

Appointment Times Collected

	ALL PROVIDER TYPES (PCPs, Specialists, Ancillary, OB/GYN, & Non-Physician MH Provider)		
	Overall % of all providers meeting 1st appointment time	Overall % of all providers meeting 1st appointment time	
		Non-Urgent	Urgent^
Statewide %	**85.8%**	**88.4%**	**81.7%**
Aetna	78.7%	85.6%	67.0%
Alameda	92.9%	93.6%	91.7%
Anthem	81.0%	85.7%	74.3%
CA Health & Wellness	70.4%	72.4%	66.9%
Cal Optima	90.5%	92.4%	87.7%
Calvae Health	81.6%	82.2%	80.8%
Care1st Partner Plan	80.4%	84.7%	73.7%
CenCal Health	77.1%	82.9%	67.3%
Central California Alliance	74.5%	77.3%	70.3%
Community Health Group	79.5%	81.7%	75.9%
Contra Costa Health Plan	98.0%	98.0%	98.1%
Gold Coast Health Plan	87.4%	92.1%	80.2%
Health Net	78.2%	81.8%	73.5%
Health Plan of San Joaquin	88.9%	89.9%	87.0%
Health Plan of San Mateo	85.8%	89.5%	78.2%
Inland Empire Health Plan	94.9%	96.8%	92.0%
Kaiser Nor Cal (KP Cal, LLC)	98.8%	100.0%	96.6%
Kaiser SoCal (KP Cal, LLC)	97.2%	97.7%	96.4%
Kern Family Health Care	90.3%	91.6%	88.2%
L.A. Care Health Plan	91.6%	92.6%	89.8%
Molina Healthcare	78.4%	84.3%	69.3%
Partnership Health Plan	87.3%	87.5%	86.9%
San Francisco Health Plan	92.3%	94.6%	88.0%
Santa Clara Family Health Plan	89.9%	90.9%	88.1%
United Healthcare	79.1%	84.1%	69.9%

^ Ancillary providers and OB/GYN providers not included

Unsuccessful Call Attempts

	ALL PROVIDER TYPES (PCPs, Specialists, Ancillary, OB/GYN, & Non-Physician MH Provider)		
	*Overall % of providers removed from sample due to data quality***	*Overall % of providers with appointment not collected due to training concerns***	*Overall % of all providers with appointment times collected
Statewide %	**45.8%**	**29.2%**	**25.1%**
Aetna	49.8%	33.3%	16.9%
Alameda	30.8%	33.1%	36.1%
Anthem	51.1%	39.2%	9.7%
CA Health & Wellness	55.2%	27.8%	16.9%
Cal Optima	39.6%	21.5%	38.9%
Calvae Health	61.2%	25.1%	13.7%
Care1st Partner Plan	42.6%	24.3%	33.1%
CenCal Health	41.0%	31.3%	27.7%
Central California Alliance	46.3%	29.2%	24.6%
Community Health Group	37.4%	28.4%	34.2%
Contra Costa Health Plan	17.4%	30.7%	52.0%
Gold Coast Health Plan	29.1%	32.3%	38.5%
Health Net	62.3%	25.3%	12.4%
Health Plan of San Joaquin	30.3%	29.9%	39.8%
Health Plan of San Mateo	53.8%	21.7%	24.5%
Inland Empire Health Plan	20.9%	26.9%	52.1%
Kaiser Nor Cal (KP Cal, LLC)	24.1%	8.2%	67.7%
Kaiser SoCal (KP Cal, LLC)	20.9%	5.2%	73.8%
Kern Family Health Care	27.3%	26.9%	45.8%
L.A. Care Health Plan	41.3%	28.4%	30.3%
Molina Healthcare	49.1%	27.8%	23.1%
Partnership Health Plan	42.8%	26.1%	31.1%
San Francisco Health Plan	30.1%	35.7%	34.2%
Santa Clara Family Health Plan	60.2%	14.4%	25.4%
United Healthcare	46.6%	36.6%	16.8%

New Quarter 3 Measures

Language Preference

- Providers who are aware that beneficiaries are entitled to receive interpretation services
- Language spoken at the provider site matches the 274 provider data file

Call Center

- Calls meeting wait time standard of 10 minutes
- Call center is aware that beneficiaries are entitled to receive interpretation services

Ongoing Monitoring

- DHCS monitors specific areas of performance among MCPs on a quarterly basis to identify trends which may indicate areas of concern.
- Each quarter DHCS issues a Quarterly Monitoring Response Template (QMRT) to MCPs that have been identified as having potential performance deficiencies.
- MCP responses must describe the cause and analysis of the deficiencies and the MCP's action plan.

Ongoing Monitoring (cont'd)

- Through the Quarterly Monitoring process, DHCS releases each MCP its MCP-specific results and raw data.
- MCPs are required to analyze both data sets reflective of the current performance.
- DHCS provides technical assistance throughout the response process and works with MCPs to review their data and identify process improvements.

Next Steps

- Fall 2019
  - Establish a standard – obtain feedback
  - Timely Access Dashboard
- Year 3
  - Provider Directory validation
  - Review of current measures/methodology
  - Compliance threshold

Questions

Advancements in Monitoring Quality in Managed Care

Abbreviations

- AAP: American Academy of Pediatrics
- CAHPS: Consumer Assessment of Healthcare Providers and Systems
- CHIP: Children's Health Insurance Program
- CMS: Centers for Medicare and Medicaid Services
- CPSP: Comprehensive Perinatal Services Program
- DHCS: Department of Health Care Services
- EQRO: External Quality Review Organization
- FSR: Facility Site Review
- GNA: Group Needs Assessment
- HbA1c: Hemoglobin A1c (diabetes test)
- HEDIS: Healthcare Effectiveness Data and Information Set
- HIV: Human Immunodeficiency Virus
- MCAS: Managed Care Accountability Set
- MCP: Medi-Cal managed care health plan
- MPL: Minimum Performance Level
- MRR: Medical Record Review
- RY: Reporting Year
- USPSTF: United States Preventive Services Task Force

Quality Measures

Measure Set

Current	Future
External Accountability Set	***Managed Care Accountability Set***
• MCPs report yearly on a set of quality measures • Most measures are from HEDIS®	• MCPs will report yearly on a set of quality measures • Measures will be from CMS Child and Adult Core Sets as feasible

Benchmarks

Current	Future
Minimum Performance Level	*Minimum Performance Level*
• DHCS contracts require the MCPs to perform at least as well as the lowest 25% of Medicaid plans in the US	• DHCS will require MCPs to perform at least as well as 50% of Medicaid plans in the US where that information is available and services measured are delivered by MCPs • DHCS may establish alternative benchmarks for measures where that information is not available and for which the services measured are delivered by MCPs

Managed Care Accountability Set (RY 2020)

	Measure	Held to MPL
1	Plan All-Cause Readmissions	Yes
2	Adolescent Well-Care Visits	Yes
3	Adult Body Mass Index Assessment	Yes
4	Antidepressant Medication Management – Acute Phase Treatment	Yes
5	Antidepressant Medication Management – Continuation Phase Treatment	Yes
6	Asthma Medication Ratio**	Yes^
7	Breast Cancer Screening	Yes
8	Cervical Cancer Screening	Yes
9	Childhood Immunization Status – Combo 10	Yes
10	Chlamydia Screening in Women Ages 16 – 24**	Yes^
11	Comprehensive Diabetes Care HbA1c Testing	Yes
12	HbA1c Poor Control (>9.0%)	Yes
13	Controlling High Blood Pressure <140/90 mm Hg	Yes
14	Immunizations for Adolescents – Combo 2 (meningococcal, Tap, HPV)	Yes
15	Prenatal & Postpartum Care – Timeliness of Prenatal Care	Yes
16	Prenatal & Postpartum Care – Postpartum Care	Yes

17	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	Yes
18	Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits	Yes
19	Well-Child Visits in the 3rd 4th 5th & 6th Years of Life	Yes
20	Ambulatory Care: Emergency Department (ED) Visits	No
21	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	No
22	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	No
23	Children & Adolescents' Access to Primary Care Practitioners: 12-24 Months	No
24	Children & Adolescents' Access to Primary Care Practitioners: 25 Months – 6 Years	No
25	Children & Adolescents' Access to Primary Care Practitioners: 7-11 Years	No
26	Children & Adolescents' Access to Primary Care Practitioners: 12-19 Years	No
27	Contraceptive Care: All Women Ages 15-44**:	No
28	• Most or moderately effective contraception • Long Acting Reversible Contraception (LARC)	
29	Contraceptive Care: Postpartum Women Ages 15-44**:	No
30	• Most or moderately effective contraception – 3 days	
31	• Most or moderately effective contraception – 60 days	
32	• LARC – 3 days • LARC – 60 days	

33	Developmental Screening	No
34	HIV Viral Load Suppression	No
35	Annual Monitoring for Patients on Persistent Medications: ACE inhibitors or ARBs	No
36	Annual Monitoring for Patients on Persistent Medications: Diuretics	No
37	Concurrent Use of Opioids and Benzodiazepines	No
38	Use of Opioids at High Dosage in Persons Without Cancer	No
39	Screening for Depression and Follow-Up Plan: Age 12 and Older**	No

* Stratified by Seniors and Persons with Disabilities

** Measure is part of both the CMS Adult and Child Core Sets. Though MCPs will report the "Total" rate, data will be collected stratified by the child and adult age groups.

^ MCPs held to the MPL on the total rate only.

Group Needs Assessment (GNA)

Purpose

- Conducted to identify:
  - Member health status, behaviors and needs
  - Available health education and cultural and linguistic programs and resources,
  - Health disparities and
  - Gaps in services
- Used to plan and implement culturally competent and linguistically appropriate services, health education, and continuous quality improvement programs
- **Goal: To improve health outcomes**

How is GNA Conducted

- Uses multiple data sources, techniques and tools
- Includes member input from survey and other methods
- Requires provider engagement
- Report conveys findings and how the MCP proposes to address the identified needs
  - Addresses special needs of groups such as
    - Seniors and persons with disabilities
    - Children with special health care needs
    - Members with Limited English Proficiency
    - Diverse cultural and ethnic backgrounds
- Prioritizes health education and cultural & linguistic services

Policy Improvements

- DHCS is in the process of evaluating the current GNA process and policy and identifying opportunities to improve
  - How to gather and use information in a meaningful way to impact identified member needs
- Identified issues in current GNA process:
  - GNA Report currently done every 5 years
  - Non-validated GNA Member Survey done very 5 years
  - GNA Report and Annual Work plans not well linked by data or objectives
- DHCS is not looking to change the purpose and goals of the GNA, but rather provide more guidance as to what should be considered in the assessment, what is needed with regards to the plan, and how that is communicated to and reviewed by DHCS.

Quality Reports

Quality Reports

Current	Future
EQRO Technical Report	EQRO Technical Report
• Plan Specific Evaluation reports	• Plan Specific Evaluation reports
• CAHPS® Survey Report • Health Disparities Report	• CAHPS® Survey Report • Health Disparities Report
	• **Preventive Services Utilization Report**

EQRO Technical Report

- Annual, independent assessment that summarize findings on access and quality of care

- The assessment in the Plan Specific Evaluation Reports will include information gathered from the MCP Group Needs Assessments

CAHPS Survey Report

- Summarizes results of member surveys that evaluate their experiences with their health care and health care providers

- The CAHPS Survey will now be done every
  2 years for Children and Adults
  - Previously done every 3 years
  - Will continue to be done annually for CHIP

- DHCS is in the process of evaluating the information gathered in the CAHPS Survey and how that information is used to identifying opportunities to increase the value and use of that data

Health Disparity Report

- 2016 Health Disparity Report
  - Selected EAS metrics stratified by age, gender, race/ethnicity, primary language
  - Available online
- 2017 Health Disparity Report
  - All metrics from the EAS stratified by age, gender, race/ethnicity, primary language
  - Expected to be available online soon
- **Future Reports will continue to expand with regards to metrics and stratifications based on available data sources**

Preventive Services Utilization Report

- New Annual Report
- **Goal**: Utilize encounter data to assess for appropriate utilization of preventive service in accordance with AAP Bright Futures and USPSTF Grade A and B recommendations
  - Other data sources may be identified and used as applicable

Monitoring Advancements

Facility Site Reviews (FSR)

- Assess and ensure the capacity of each primary care provider sites to provide safe and effective clinical services according to contractual requirements
- Primary Care sites receive a FSR when they enter managed care and every 3 years thereafter

Updates to FSRs

- Drafted an update to the FSR Tool & Guidelines and the MRR Tool & Guidelines
  - Followed federal and state regulations, AAP Bright Futures, USPSTF grade A and B recommendations, and CPSP requirements

- DHCS is evaluating the current policy and identifying opportunities to enhance the data collected during the FSR as well as how that data can be used for oversight of preventive services

Thank you for your comments on the draft. Comments are being reviewed at this time.

Impact of Changes

- Improves data collection and public reporting
- Advances MCP oversight and accountability
- Increases DHCS ability to share promising practices and lessons learned with all MCPs
- Informs DHCS in establishing state level priorities and strategies to improve care for all members

Questions

advisorygroup@dhcs.ca.gov

Encounter Data Discussion Stoplight Reports

Data Discussion

- Encounter Data Reporting
- Increase Emphasis on Encounter Completeness Monitoring
- Reporting and Monitoring Timeline
- Encounter Completeness Monitoring Metrics
- Encounter Completeness Monitoring Measurements
- Sample Reports
- Evaluation Processes

Encounter Data Reporting

- Federal regulation and the State's MCP contract require complete and accurate encounter data reporting.
- Federal Regulations require States to collect and submit complete and accurate encounter data to CMS under § 438.818.
- Furthermore States must validate for accuracy and completeness of encounter data from MCPs as required under § 438.242 prior to submission to CMS.

Increase Emphasis on Encounter Completeness Monitoring

- MCPs submit Rate Development Templates (RDTs) annually to provide cost and utilization experience for rate development.
- Reported utilization through encounter data and the RDT have routinely shown discrepancies.
- CMS continues to emphasize the use of encounter data in rate development.

Increase Emphasis on Encounter Completeness Monitoring Cont.

- Due to the discrepancies in reported utilization in the encounter data and the RDT, DHCS has implementing new encounter data completeness monitoring.

- The new monitoring compares encounter data utilization to RDT and other generated benchmarks used in rate development.

- The objective is to improve reported encounter data completeness as federally and contractually required.

Timeline
Reporting & Monitoring

Quarter	Events
Quarter 1 (January Release)	MCPs receive Q1 set of Stop Light Reports, Low performing MCPs may be placed under CAP, MCPs currently under CAP and still showing low performance may be Sanctioned.
Quarter 2 (April Release)	MCPs Receive Q2 set of Stop Light Reports.
Quarter 3 (July Release)	MCPs Receive Q3 set of Stop Light Reports, Low performing MCPs may be placed under CAP, MCPs currently under CAP and still showing low performance may be Sanctioned.
Quarter 4 (October Release)	MCPs receive Q4 set of Stop Light Reports.

Encounter Completeness Monitoring Metrics

Encounter monitoring reports will include metrics in the following categories:

- Plan Parent
- County/Rating Region
- 4 Category of Aid Groups
  - ACA OE, Adult, Child, SPD
- 4 Category of Service Groups
  - Inpatient Hospital, Outpatient & Emergency Room, Professional, Pharmacy

Encounter Completeness Monitoring Measurements

- RED - Major encounter completeness challenges
  - Encounter completeness percentage (ECP) is less than 70%
- YELLOW - Moderate encounter completeness or other reporting challenges
  - ECP is between 70% and 90% or above 110%
- GREEN - No clear encounter completeness challenges
  - ECP is between 90% and 110%

Evaluation Process

- Corrective Action Plan and sanction evaluation will occur twice a year, in Quarter 1 and Quarter 3
- MCPs that are identified with major encounter data completeness challenges in one or more of the service categories or populations may be placed under CAP
- MCPs that are under CAP must correct all encounter completeness challenges by the next CAP and sanction evaluation.
- MCPs that fail to come into compliance by next CAP and sanction evaluation may be sanctioned for incomplete encounter data submissions and the CAP will be extended.

Questions

Stoplight Reports and Encounter Data
MMCDEncounterData@dhcs.ca.gov.

Updates

- Transitions and Implementations
- Ombudsman Report

APLs and DPLs Update

MEDI-CAL MANAGED CARE HEALTH PLAN LETTERS ISSUED SINCE THE MARCH 2019 MANAGED CARE ADVISORY GROUP MEETING

ALL PLAN LETTERS (APLS)

ALL PLAN LETTERS (APLs)		
Letter Number	**Title and Description of Letter**	**Date of Issue**
APL 19-003	Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format Provides guidance to MCPs on the provision of the Provider Directory, Formulary, and Member Handbook in an electronic format to ensure the timely delivery of important information to members. MCPs have the option to send members a DHCS-approved notice in member welcome packets and/or annual informational mailings to inform members of how to obtain the Provider Directory, Formulary, and Member Handbook electronically. Seniors and Persons with Disabilities must still receive the paper form of the Provider Directory.	05/02/2019

Open Discussion

Next Meeting is scheduled on
September 5, 2019

For questions, comments or to request future agenda items please email advisorygroup@dhcs.ca.gov.