SACRAMENTO COUNTY

SACRAMENTO COUNTY HEALTH AUTHORITY COMMISSION

MEETING 14:

OVERVIEW OF PUBLICLY AVAILABLE DATA

November 23, 2021

Agenda

1. Welcome/Opening Remarks
2. Agenda Review
3. Updates
4. Overview of Publicly Available Data
5. Public Comment
6. Closing Comments and Adjournment

Agenda Item 4:

Overview of Publicly Available Data

Overview - Background

- The Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) maintain the authorities in the state to monitor and oversee Medi-Cal Managed Care Plans (MCPs) in California.
  - DHCS is a purchaser of services and contracts with MCPs to cover services for Medi-Cal beneficiaries on a statewide basis.
    - There are 24 primary MCPs in California, five of which operate in Sacramento County.
  - DMHC is a regulator and assures compliance with the Knox-Keene Act of 1975.
- Both departments collect significant amounts and types of data from MCPs.
  - These data are together used for the purposes of monitoring and overseeing MCPs and ensuring quality care is provided to Medi-Cal beneficiaries across the state.
- Today's presentation will walk through some of the non-financial MCP data that are available today for purposes of monitoring and oversight.

Overview - Types of Data

KEY
Currently available at Sacramento-Plan level
Not provided at Sacramento-Plan level
Not public but may be requested

- **Medi-Cal Enrollment**
  - Demographic
- **Encounter Data**
  - Encounter Completeness Monitoring
  - Utilization
    - Emergency Room Visits per 1,000 Member Months
    - Emergency Room Visits with an Inpatient Admission per 1,000 Member Months
    - Inpatient Admissions per 1,000 Member Months
    - Outpatient Visits per 1,000 Member Months
    - Prescriptions per 1,000 Member Months
    - Mild to Moderate Mental Health Visits per 1,000 Member Months

Overview - Types of Data

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- **Beneficiary Satisfaction**
  - CAHPS
  - Grievances and Appeals
  - State Fair Hearings
  - Independent Medical Reviews (IMRs)
  - Ombudsman
  - Call Center
- **Quality**
  - Managed Care Accountability Set (MCAS)
  - Aggregated Quality Factor Score
  - Health Disparities Report
  - Performance Improvement Projects
  - Preventive Services Report

Overview - Types of Data

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- **Access to Care**
  - Network Adequacy
    - Provider Ratios
      - PCPs per 2,000 Members
      - Physicians per 1,200 Members
    - Time and Distance
    - Timely Access
    - Mandatory Provider Types
    - Facility Site Reviews and Medical Record Reviews
  - Interpreter Services

Medi-Cal Enrollment

- As of April 2021, Sacramento County had 583,155 Medi-Cal certified eligibles:

County	ACA Expansion Adult Age 19 to 64	Other	Parent/Caretaker Relative & Child	Undocumented	Total Eligibles
Sacramento	170,023	167,099	234,187	11,846	583,155

- Of the total eligibles, 479,522 were enrolled in an MCP representing 82% of the County's Medi-Cal population:

Medi-Cal Managed Care Plan (MCP)	Member Count
Aetna	14,188
Anthem Blue Cross	193,488
Health Net	118,533
Kaiser	100,817
Molina	52,496
Total	479,522

- **Medi-Cal Managed Care Enrollment Data:** Medi-Cal Managed Care Enrollment Report - Datasets - California Health and Human Services Open Data Portal

Medi-Cal Enrollment

- These data do tell us how many and what percent of members are enrolled in each MCP in Sacramento County.
- However, they do not break the data down by demographics.

Encounter Data

- **Encounter Data**
  - Encounter Completeness Monitoring
  - Utilization
    - Emergency Room Visits per 1,000 Member Months
    - Emergency Room Visits with an Inpatient Admission per 1,000 Member Months
    - Inpatient Admissions per 1,000 Member Months
    - Outpatient Visits per 1,000 Member Months
    - Prescriptions per 1,000 Member Months
    - Mild to Moderate Mental Health Visits per 1,000 Member Months

Encounter Data

- **Encounter Data**
  - Encounter Completeness Monitoring
    - DHCS monitors and publishes performance for MCPs on the completeness, accuracy, reasonability, and timeliness of encounter data.
  - Utilization
    - DHCS further uses encounter data that is submitted to monitor key utilization trends and identify areas for further investigation.
      - Emergency Room Visits per 1,000 Member Months
      - Emergency Room Visits with an Inpatient Admission per 1,000 Member Months
      - Inpatient Admissions per 1,000 Member Months
      - Outpatient Visits per 1,000 Member Months
      - Prescriptions per 1,000 Member Months
      - Mild to Moderate Mental Health Visits per 1,000 Member Months
    - These data are reported in DHCS' quarterly Managed Care Performance Dashboard.

- Managed Care Performance Dashboard

Beneficiary Satisfaction

- **Beneficiary Satisfaction**
  - CAHPS
  - Grievances and Appeals
  - State Fair Hearings
  - Independent Medical Reviews (IMRs)
  - Ombudsman
  - Call Center

Beneficiary Satisfaction

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey.

- DHCS surveys MCP members every two-years.
- The goal of the CAHPS Health Plan Survey is to gather information from members that represent the true beneficiary experience. This is one of the only places where the member's voice is directly heard.
- Response rates have historically been low in comparison to national averages.
- Small denominators can be problematic (applicable to Sacramento).

Global Ratings	Composite Measures
Rating of Health Plan	Getting Needed Care
Rating of All Health Care	Getting Care Quickly
Rating of Personal Doctor	How Well Doctors Communicate
Rating of Specialist Seen Most Often	Customer Service
	Shared Decision Making

- CAHPS: 2019 CAHPS Medicaid Managed Care Survey

Beneficiary Satisfaction

- **Grievances and Appeals**
  - DHCS collects grievance and appeals data at the member level from MCPs on a quarterly basis.
    - These data are further stratified at the plan/operating area level by race/ethnicity, gender, age, population, and grievance type.
  - These data also provide indicators for where further investigation is needed.
  - These data are reported in aggregate in the quarterly Medi-Cal Managed Care Performance Dashboard.

- **Medi-Cal Managed Care Performance Dashboard:** Tabular January 9, 2020 Release (ca.gov)

Beneficiary Satisfaction

- **State Fair Hearings** – MCP members may file a State Fair Hearing after exhausting their MCP grievance and appeal process.
  - These data can highlight an area for further exploration to determine if MCPs are in compliance with requirements.
  - Data related to State Fair Hearings is reported in aggregate in the quarterly Medi-Cal Managed Care Performance Dashboard. MCPs are also provided specific reports to MCPs quarterly by DHCS.
    - Hearing outcomes have been grouped into three outcomes types: Denied or Dismissed, Granted, and Withdrawal or Non-Appearance.

- **Medi-Cal Managed Care Performance Dashboard:** Tabular January 9, 2020 Release (ca.gov)

Beneficiary Satisfaction

- **Independent Medical Reviews** – MCP members may file an Independent Medical Review (IMR) with the DMHC. IMRs consist of an independent clinical review of an appeal for services.
  - These data can highlight an area for further exploration to determine if MCPs are in compliance with requirements.
  - Data related to IMRs are provided to MCPs at the MCP level quarterly by DHCS.

- **IMRs:** Independent Medical Review and Complaint Reports

Beneficiary Satisfaction

- **Call Center -** Thirty days after the end of every quarter, MCPs must submit a completed Call Center Report.
  - DHCS measures the percentage of calls answered within 30 seconds in addition to the following:
    - Number of calls received
    - Number of calls abandoned
    - Number of calls answered
    - Average wait time
    - Average talk time
    - Abandonment rate
    - Service level
    - Member only calls
    - Medi-Cal only calls
  - These data are not reported publicly today.
- **Call Center:** ALL PLAN LETTER 14-012 (ca.gov)

Beneficiary Satisfaction

- **Ombudsman –** An Ombudsman is a person in a government agency to whom people can go to for assistance with navigating the programs or policies of the agency. The Medi-Cal Managed Care and Mental Health Office of the Ombudsman help resolve problems from a neutral standpoint to ensure that our members receive all medically necessary covered services and information for which plans are contractually responsible.
  - Aggregated data from calls to the Ombudsman are reported quarterly to the DHCS Managed Care Advisory Group, data are broken out by MCP.

- **Ombudsman:** Managed Care Advisory Group
- **DHCS Ombudsman:** Ombudsman (ca.gov)

Beneficiary Satisfaction

- These data as a collective provide an understanding of beneficiary satisfaction.
- Provide opportunities to identify areas in need of further investigation and possible corrective action for health plans.
- Are limited in terms of what they can tell you to the questions that are asked and response rates.

Quality

- **Quality**
  - Managed Care Accountability Set (MCAS)
  - Aggregated Quality Factor Score
  - Health Disparities Report
  - Performance Improvement Projects
  - Preventive Services

Quality

- The Managed Care Accountability Sets (MCAS), previously known as the External Accountability Set (EAS), is a set of performances measures that DHCS selects for annual reporting by MCPs.
  - DHCS aligned its required measures to be reported by MCPs with the CMS Core Measures set.
    - Consists of approximately 60 measures in total.
    - The number of measures included in the MCAS was decreased from 60 to approximately 35 because MCPs do not have access to data to report performance rates on the measures.
      - Example – pharmaceutical measures will be eliminated on January 1, 2022 given Medi-Cal RX, the pharmacy carve-out.

Quality

- Managed Care Accountability Set (MCAS)
  - These data tell us how MCPs are performing on each of the MCAS measures in each of the geographic areas in which they operate.
  - Results related to MCP performance on MCAS can be found in the External Quality Review Technical Reports with Plan-Specific Evaluation Reports.
  - For Reporting Year 22, MCPs are held to a minimum performance level for 15 measures and are measured on an additional 21 measures.
    - Measures are either administrative (data only) or hybrid (data and medical record)
      - Example – Childhood Immunization Status: Combination 10 (CIS-10) (hybrid)
    - The Minimum Performance Level (MPL) is 50% of the national average of Medicaid health plan performance.
      - Not all measures are held to an MPL.
        - Reasons for no MPL may include no benchmark is available, the measure is a new measure, or denominators are too small.
- **MCAS:** Mgd Care Qual Perf EAS
- **EQRO Technical Report and PSERs:** Mgd Care Qual Perf EQRTR

Quality

- MCAS Domains
  - Acute & Chronic Disease Management
    1. Adult BMI Assessment—Total
    2. Ambulatory Care—ED Visits per 1,000 Member Months—Total*
    3. Asthma Medication Ratio—Total
    4. Comprehensive Diabetes Care--HbA1c Poor Control (>9.0 Percent) (inverse)
    5. Comprehensive Diabetes Care--Hemoglobin Alc (HbA1c) Testing
    6. Concurrent Use of Opioids and Benzodiazepines— Ages 18–64 Years (inverse)
    7. Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years (inverse)
    8. Controlling High Blood Pressure
    9. HIV Viral Load Suppression—Ages 18–64 Years
    10. HIV Viral Load Suppression—Ages 65+ Years
    11. Plan All-Cause Readmissions—Expected Readmissions—Total
    12. Plan All-Cause Readmissions—O/E Ratio—Total **
    13. Plan All-Cause Readmissions—Observed Readmissions—Total
    14. Use of Opioids at High Dosage in Persons Without Cancer— Ages 18–64 Years (inverse)
    15. Use of Opioids at High Dosage in Persons Without Cancer— Ages 65+ Years (inverse)

  - Behavioral Health
    1. Antidepressant Medication Management— Effective Acute Phase Treatment—Total
    2. Antidepressant Medication Management— Effective Continuation Phase Treatment—Total
    3. Follow-Up Care for Children Prescribed ADHD Medication— Continuation and Maintenance Phase
    4. Follow-Up Care for Children Prescribed ADHD Medication— Initiation Phase
    5. Screening for Depression and Follow-Up Plan— Ages 12–17 Years
    6. Screening for Depression and Follow-Up Plan— Ages 18–64 Years
    7. Screening for Depression and Follow-Up Plan— Ages 65+ Years

- **MCAS:** Mgd Care Qual Perf EAS
- **EQRO Technical Report and PSERs:** Mgd Care Qual Perf EQRTR

Quality

- MCAS Domains
  - Children's Health
    1. Adolescent Well-Care Visits
    2. Childhood Immunization Status—Combination 10
    3. Children and Adolescents' Access to Primary Care Practitioners—12–19 Years
    4. Children and Adolescents' Access to Primary Care Practitioners—12–24 Months
    5. Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years
    6. Children and Adolescents' Access to Primary Care Practitioners—7–11 Years
    7. Developmental Screening in the First Three Years of Life—Total
    8. Immunizations for Adolescents—Combination 2
    9. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total
    10. Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits
    11. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

  - Women's Health
    1. Breast Cancer Screening
    2. Cervical Cancer Screening
    3. Chlamydia Screening in Women—Ages 16–20 Years
    4. Chlamydia Screening in Women—Ages 21–24 Years
    5. Chlamydia Screening in Women—Total
    6. Contraceptive Care—All Women—LARC—Ages 15–20 Years
    7. Contraceptive Care—All Women—LARC—Ages 21–44 Years
    8. Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years
    9. Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years
    10. Contraceptive Care—Postpartum Women—LARC—3 Days— Ages 15–20 Years
    11. Contraceptive Care—Postpartum Women—LARC—3 Days— Ages 21–44 Years
    12. Contraceptive Care—Postpartum Women—LARC—60 Days— Ages 15–20 Years
    13. Contraceptive Care—Postpartum Women—LARC—60 Days— Ages 21–44 Years
    14. Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years
    15. Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years
    16. Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years
    17. Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years
    18. Prenatal and Postpartum Care—Postpartum Care
    19. Prenatal and Postpartum Care—Timeliness of Prenatal Care

- **MCAS:** Mgd Care Qual Perf EAS
- **EQRO Technical Report and PSERs:** Mgd Care Qual Perf EQRTR

Quality

- Aggregated Quality Factor Score
  - The HEDIS® AQFS is a single score that accounts for MCP performance on all DHCS selected HEDIS® indicators. It is a composite rate calculated as percent of the National High Performance Level (HPL). The High Performance Level is 100%. The Minimum Performance Level is 40%. The State Population Weighted Average is calculated annually. A HEDIS® reporting unit is a combination of one MCP in a county or region.

- **Medi-Cal Managed Care Performance Dashboard:** Tabular January 9, 2020 Release (ca.gov)

Quality

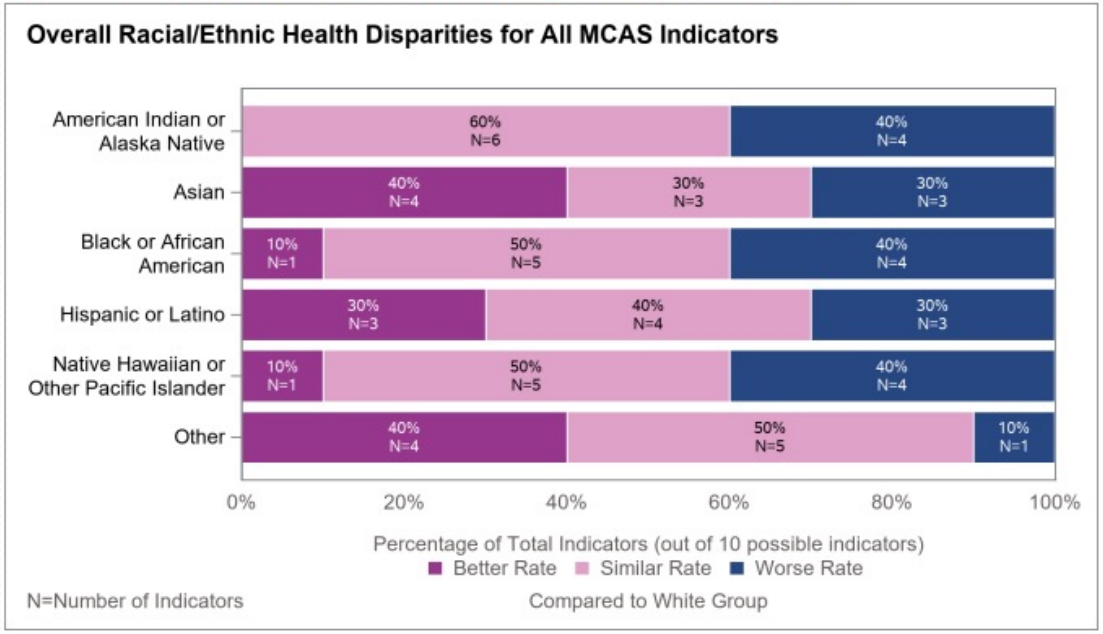
- Health Disparities Report
  - DHCS further stratifies certain MCAS measures by MCP/operating area and race/ethnicity, gender, age, language, and geographic area.
  - These data can be used to better understand if there is a distinct disparity within a subset of the Medi-Cal population.
    - For example, African-American/Black women have been found to have significantly lower post-partum service rates.
  - These data are currently reported at the MCP aggregate level.

- **Health Disparities Report:** Medi-Cal Managed Care Quality Improvement Reports

Quality

- Health Disparities Report - Example

Figure 1.1—Overall Racial/Ethnic Health Disparities for All Indicators



- **Health Disparities Report:** Medi-Cal Managed Care Quality Improvement Reports

Quality

- Performance Improvement Projects
  - MCPs are required to participate in a minimum of two Performance Improvement Projects (PIPs) annually.
  - PIPs generally focus on a specific issue and population. For example, lowering hbA1c for Latina women.
  - PIPs include a Plan, Do, Study, Act (PDSA) function.
  - MCPs must submit reports to DHCS specific to these PIPs and their performance on them.
  - PIPs are utilized to identify best practices and further spread those practices from them.
  - PIPs are also used for Corrective Action.

- **PIPs:** Mgd Care Qual Perf EQRTR

Quality

- **Preventive Services**
  - The 2020 Preventive Services Report reflects data collected during calendar year 2019. The report provides in-depth analyses of several existing DHCS measures as well as new administrative measures the EQRO developed to capture utilization of services by pediatric Medi-Cal managed care members.
  - These data are reported at the County specific level.

  - 2020 Preventive Services Report (ca.gov)
  - 2020 Preventive Services Report Addendum (ca.gov)

Quality

- Preventive Screening Report Measures:

Preventive Screening Report Measures
Chlamydia Screening in Women—16 to 20 Years (CHL–1620)
Developmental Screening in the First Three Years of Life—Total (DEV)
Screening for Depression and Follow-Up Plan (CDF)
Child and Adolescent Well-Care Visits (WCV)
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months— Six or More Well-Child Visits and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30)
Alcohol Use Screening (AUS)
Dental Fluoride Varnish (DFV)
Tobacco Use Screening (TUS)

- 2020 Preventive Services Report (ca.gov)

Quality

- Preventive Services Addendum:
  - DHCS issued an Addendum to its Preventive Services Report which included the following measures.

Preventive Screening Addendum Report Measures
Blood Lead Screening – 12 Months of Age
Blood Lead Screening – 24 Months of Age
Two Tests by 24 Months of Age
Catch-up Test by 6 Years of Age
Lead Screening in Children

- 2020 Preventive Services Report Addendum (ca.gov)

Access to Care

- DHCS MCP Monitoring and Oversight
- Corrective Action Plan (CAP)
  - DHCS annually reviews and certifies each MCPs network to the Centers for Medicare and Medicaid Services.
  - MCPs must submit granular data at the zip code level to determine if providers are available.
  - MCPs are scored on a range of four categories:
    - A **Pass** designation means the required standards were met.
    - An **AAS Pass** designation mean the required standard was not met but an AAS was approved for the MCP or a Delivery System Alternative Access Standard was granted.
    - A **Pass with Conditions** designation means the MCP did not fully meet the required standards, and DHCS imposed a temporary access compliance standard for the MCP to maintain until all ANC deficiencies are corrected.
    - A **Noncompliant** designation means the MCP did not fully meet the required standard and compliance will be determined through the quarterly monitoring process.

Access to Care

- Corrective Action Plan (CAP)
  - MCPs under the **Pass with Conditions** designation will have a CAP imposed. Under the CAP, DHCS establishes temporary access standards that each MCP must comply with, including, but not limited to, requiring authorization of out-of-network referrals and providing transportation.
- Financial Sanctions/Penalties
  - Should an MCP not come into compliance with the CAP, DHCS may impose financial sanctions and/or penalties on the MCP.

Access to Care

- **Network Adequacy**
- DHCS conducts an annual network certification of each MCP. Components of that certification include:
  - Provider Ratios
    - Primary Care Providers per 2,000 Members
    - Physicians per 1,200 Members
  - Time and Distance
  - Timely Access
  - Mandatory Provider Types
  - Facility Site Reviews and Medical Record Reviews
  - Interpreter Services

Network Certification: 2020 ANC Assurance of Compliance- FIRST PAGE.pdf

Access to Care

- Provider Ratios
  - Primary Care Providers per 2,000 Members
    - MCPs are contractually required to meet provider-to-member ratios for full-time equivalent (FTE) primary care physicians (PCPs) of one PCP to every 2,000 members.
  - Physicians per 1,200 Members
    - MCPs are contractually required to meet provider-to-member ratios for full-time equivalent (FTE) for total network physicians of one FTE physician to every 1,200 members.
  - These data are reported in DHCS' annual network certification and quarterly Managed Care Performance Dashboard.

- **Network Certification:** 2020 ANC Assurance of Compliance- FIRST PAGE.pdf
- **Medi-Cal Managed Care Performance Dashboard:** Tabular January 9, 2020 Release (ca.gov)

Access to Care

- Time and Distance
  - Standards are based on rural, small, medium and dense county categories.
    - Sacramento is considered dense because it has greater than 600 people per square mile.
      - Standards are comprised of the following provider types:
        - Pediatric and adult PCPs,
        - Pediatric and adult core specialists,
        - OB/GYN specialist,
        - Pediatric and adult mental health providers,
        - Hospitals, and
        - Pharmacies
        - Ancillary Services
        - Long Term Services and Supports

    - Time and Distance Example – for a primary care appointment, a provider must be available within 10 miles or thirty minutes of the member's residence.

- **Network Certification APL:** APL21-006AttA.pdf (ca.gov)
- **Network Standards:** APL21-006AttA.pdf (ca.gov)

Access to Care

- Timely Access
  - DHCS conducts an annual Timely Access Survey that measure provider compliance with appointment wait time standards and provides the results quarterly to each MCP.
  - The survey is performed by DHCS' contracted External Quality Review Organization (EQRO) and includes a statistically valid random sample of network providers to confirm the first three available times for urgent and non-urgent appointments for pediatric and adult members; the availability of interpreter services; and the languages spoken by the network providers and provider site locations.
  - These data are provided to MCPs on a quarterly basis for review and action.

- **Timely Access Report:** Timely Access Report_with Final Edits 02.23. CM.pdf (ca.gov)

Access to Care

- Mandatory Provider Types
  - The Social Security Act set forth that Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birth Center (FBC) services are mandatory Medicaid benefits. As such, these providers must be available in MCP networks.
  - MCPs must also contract with at least one certified nurse midwife (CNM) and one licensed midwife (LM) in their service areas, where available, per State and federal network adequacy requirements.
  - Indian Health Facilities (IHFs) are not required to contract with MCPs; however, MCPs are required to offer to contract with each IHF in the MCP's service area(s) and maintain documentation of all contracting efforts.

- **Network Certification:** 2020 ANC Assurance of Compliance-FIRST PAGE.pdf

Access to Care

- Facility Site Reviews and Medical Record Reviews
  - For all contracted PCP sites, MCPs are required to conduct initial and subsequent site reviews, consisting of an FSR and MRR, regardless of a PCP site's other accreditations and certifications. Each MCP must ensure that:
    - Each PCP site has passed an initial FSR prior to adding the provider(s) to the MCP's network and assigning MCP members to the provider(s).
    - Each PCP passes an initial MRR after the PCP is assigned members.
    - Each PCP site passes periodic subsequent site reviews, consisting of both an FSR and MRR, at least every three years after the initial FSR.
    - DHCS' most current FSR and MRR tools and standards are being utilized when conducting site reviews.
    - All PCP sites are held to the same standards.
    - The site review status of each contracted PCP site is properly tracked.
    - MCPs collaborate locally to determine how they will notify each other of site review statuses and results for shared providers.
  - These data are collected and reported to DHCS.

- **Facility Site Review APL 20-006:** DHCS Letterhead (ca.gov)

Access to Care

- **Interpreter Services**
  - MCPs are required by law, regulation, and contract to provide members with limited proficiency in English with a qualified interpreter or provider who speaks the member's primary language 24-hours per day.
  - MCP member medical records must indicate the member's primary language and if the member had refused interpretation services in the past.
  - Member informing materials must state that interpretation services are available. Call center staff must be able to access interpreter services.
  - MCPs provider directories must indicate which providers are competent in a language other than English.
- **Network Certification:** 2020 ANC Assurance of Compliance- FIRST PAGE.pdf

Annual Medical Audits/Surveys

- All of the aforementioned areas are encompassed into audits/surveys conducted regularly on MCPs.
- Though not thought of as traditional “data,” these audits/surveys provide significant information about overall MCP performance.

Annual Medical Audits/Surveys

- MCPs are audited annually by DHCS.
- Knox-Keene licensed MCPs are surveyed by the DMHC every three years.
- These audits/surveys function as the umbrella oversight of MCPs to determine if they are in compliance with their DHCS/MCP contract and/or Knox-Keene license, as applicable.
- Audits/surveys consist of document reviews, verification studies, and interviews with MCP representatives.
- Both departments maintain the authority to conduct additional audits and surveys should a concern be identified.

Annual Medical Audits/Surveys

Audits/Surveys generally review the following areas:

1. Utilization Management
    1. Utilization Management Review
    2. Prior Authorization Review
    3. Referral Tracking System
    4. Appeal Procedures
    5. Delegation of Utilization Management
2. Case Management and Coordination of Care
    1. Basic Case Management
    2. California Children's Services
    3. Early Intervention Services/Developmental Disability Services
    4. Initial Health Assessment
    5. Complex Case Management
3. Access and Availability
    1. Appointment Procedures and Monitoring Waiting Times
    2. Urgent Care/Emergency Care
    3. Telephone Procedures/After Hours Calls
    4. Specialist and Specialty Services
    5. Emergency Services and Family Planning Claims
    6. Access to Pharmaceutical Services
4. Member Rights
    1. Grievances and Appeals
    2. Cultural and Linguistic Services
    3. Confidentiality Rights (HIPAA)
5. Quality Improvement
    1. Quality Improvement System
    2. Provider Qualifications
    3. Delegation of Quality Improvement Activities
6. Administrative and Organizational Capacity
    1. Medical Director and Medical Decisions
    2. Health Education
    3. Fraud and Abuse

Annual Medical Audits/Surveys

Examples of Annual Medical Audit Findings:

- NEMT and NMT: The Plan is required to cover NEMT and NMT services and provide transportation for a parent or a guardian when the member is a minor. The Plan did not inform members that transportation costs are covered for parents or guardians of minors receiving NEMT and NMT services. (Access and Availability of Care)

- The Plan is required to administer a DHCS approved HRA survey within 45 days for SPD members deemed to be at a higher risk, and 105 days for those determined to be a lower risk. For the duration of the Covid-19 public health emergency, the HRA survey is to be administered within 135 days of enrollment, for high risk members, and within 195 days of enrollment, for low risk. The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020. (Case Management and Coordination of Care)

Annual Medical Audits/Surveys

Annual audit and survey information can be found here:

DHCS Medical Audits: Medical Review Audits and Corrective Action Plan

DMHC Medical Surveys: Health Plan Compliance/Medical Surveys

- Reported audits/surveys are only available by MCP and not by operating area.

Data Utilization

- DHCS and DMHC use these data to monitor and oversee MCPs and to drive quality improvement through incentives and/or sanctions/penalties.
  - Examples of incentives are:
    - Auto-Assignment Incentive Program
    - Rate Setting
  - Sanctions/Penalties

Auto-Assignment

- **Auto Assignment**
  - DHCS implemented the performance-based Auto Assignment Incentive Program in December 2005. The Auto Assignment rewards better performing plans in non-COHS counties with a greater percentage of assigned mandatory enrollees (those who do not choose a MCP) based on an assessment of comparative plan performance on eight performance measures.
- Auto Assignment Incentive Program (ca.gov)

Auto-Assignment

- HEDIS Measures Used in Auto-Assignment Incentive Program Year 15 (effective January 2020 to December 2020
  - Cervical Cancer Screening (CCS)
  - Childhood Immunization Status – Combination 3 (CIS-3)
  - Comprehensive Diabetes Care: HbA1c Testing (CDC-HT)
  - Controlling High Blood Pressure (CBP)
  - Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-Pre) Well-Child Visits in the 3rd, 4th, 5th , and 6th Years of Life (W34)
- Safety Net Measures
  - Percentage of hospital discharges from Disproportionate Share Hospital facilities (based on OSHPD hospital discharge data)
  - Percentage of members assigned to PCPs who are safety net providers (based on rates provided by the MCPs that have been validated by DHCS and validation of a sample of screen prints verifying PCP assignments)
- Encounter Data
  - High-performing = 6%
- Auto Assignment Incentive Program (ca.gov)

Sanctions/Penalties

- DHCS may impose administrative and financial sanctions on MCPs that violate standards, or the terms of their MCP contracts with DHCS (the authority to impose administrative and financial sanctions can be found in All Plan Letter 15-014).

- Administrative and Financial Sanctions (ca.gov)

Future Data

- DMHC Quality and Health Equity Measures
- DHCS Rate Development Measures
- DHCS Community Supports (ILOS) and Enhanced Care Management Incentive Measures (CalAIM)
- Population Needs Assessment (CalAIM)
- Ongoing Data Development and Evolution