Children's Preventive Services Audit

1) Major issues identified in the audit (page numbers are references to pages in the Audit):

    a. Utilization rates of preventive services – consistently below 50% over a 5-year window, an annual average of 2.4 million children had not received all of the preventive services they were entitled to. California ranks 40th out of 50 states in provision of preventive services and is nearly 10% below the national average (p. 13-17). Utilization rates have not improved since 2013-14, and utilization varied by language and ethnicity (p. 40-42). In addition, reliance on family for interpretation services, lack of interpreter services, and no active monitoring of provider groups to ensure interpreters are being used (p. 43). DHCS is not implementing EQRO recommendations on well-child visits for years 3 to 6 (p. 49).
    b. Problem of inadequate access to providers (p. 18-22) and beneficiary distance to travel and number of alternative access requests (10,000 out of 80,000 requests were granted, 85% of requests were for plans that had utilization rates below 50% for children's preventive services, state review doesn't take into account beneficiary travel). Example of San Joaquin patient needing to travel more than 6 hours or 250 miles to see a pediatric eye specialist.
    c. Medi-Cal Rates – California is 20 out of 29 states in per beneficiary spending ($3,800 per managed care beneficiary in 2016; p. 25). The audit cites a Kaiser Family Foundation study that rates (FFS) are only 76% of national average, and only two states had lower rates. The audit cites a federal MACPAC study that the most effective way to increase provider participation is through increasing rates (p. 24-26). (My comment: Plan rates paid to health care providers are proprietary. Anecdotally, FFS

rates are lower than commercial rates and Medicare rates, and rates are the biggest factor in determining access to care.)

d. Utilization rates are higher for ages for which DHCS has established performance measures (p. 31-32), and the audit recommends DHCS develop a pay-for-performance program that requires plans to meet performance targets (p. 27). Utilization rates improve when P4P is used, is higher in other states but DHCS does not track plans' results independently (p. 46-47). (Governor Newsom has proposed a Value-Based Payment Program for specific measures in his 2019-20 budget, DHCS has existing law authority to pay plans using P4P, and AB 537/Wood/Arambula has a P4P program.)
e. DHCS does not monitor costs or benefits of plans' financial incentive programs to improve provider performance, track results, or share best practices among plans (p. 46).
f. Federal EPSDT notification requirement (federal law requires DHCS to inform children and their families of the EPSDT benefits, the benefits of preventive care and how to obtain services) is delegated by DHCS to plans. The plans the Auditor reviewed did not perform this outreach, and DHCS did not follow up to ensure that plans conduct this outreach (p. 31).
g. DHCS' process for validating the status and location of plans provider directories had flaws – the method used was inconsistent and not statistically valid and DHCS could not demonstrate that it performed all of its reviews because it did not retain documentation (p. 38-39).

The California State Auditor report makes recommendations following each chapter, some which are for the Legislature, DHCS and others are unspecified "recommendations." The recommendations are listed below:

<u>Recommendations to Legislature</u>

To improve children's access to preventive health services, the Legislature should amend state law to do the following:

- Direct DHCS to modify its criteria for evaluating plans' alternative access standards requests to include not only whether plans' efforts were reasonable but also whether the resulting times and distances are reasonable to expect a Medi-Cal beneficiary to travel (this would be good to include in AB 1642 (Wood)/it is not included now).
- Require any plan unable to meet those criteria to allow its affected members to obtain services outside of the plan's network (AB 1642 does not require this; it instead requires the plans to try to find a closer out-of-network provider and then arrange for transportation is one is not available.)
- Direct DHCS to require such a plan to inform its affected members that they may obtain those services outside of the plan's network (AB 1642 requires this be in the plan's evidence of coverage or member handbook).
- Require the plan to assist members in locating a suitable out-of-network provider (this provision is in AB 1642).
- To improve the health of California's children, the Legislature should direct DHCS to implement financial incentives, such as a pay-for-performance program, designed to help ensure that plans are more consistently providing preventive services to children in Medi-Cal. To the extent DHCS can demonstrate that additional funding is necessary to operate such a program, the Legislature should increase funding specifically for that purpose (AB 537 (Wood) requires DHCS to develop a value-based incentive program to reward high-performing MCMC plans).

<u>Recommendations to DHCS</u>

To increase access to preventive health services for children in areas where they are needed most, DHCS should identify by September 2019

where more providers who see children are needed and propose to the Legislature funding increases to recruit more providers in these areas.

- To ensure that children in Medi-Cal have access to all of the preventive services for which they are eligible, DHCS should modify by May 2019 its contracts to make it clear to plans and providers that they are required to provide services according to Bright Futures.
- To ensure that eligible children and their families know about all the preventive services they are entitled to through Medi-Cal, DHCS should include by May 2019 clearer and more comprehensive. Although DHCS monitors utilization rates by language, it does not take steps to increase the availability of providers based on language needs.
- To ensure that eligible children and their families know about all the preventive services they are entitled to through Medi-Cal, DHCS should include by May 2019 clearer and more comprehensive information about those services in its written materials and by September 2019 ensure annual follow-up with any children and their families who have not used those services.
- To improve access and utilization rates, DHCS should establish by March 2020 performance measures that cover Bright Futures services through well-child visits for all age groups, and require plans to track and report the utilization rates on those measures.
- To ensure that health plans and providers are adequately delivering children's preventive services, DHCS should implement by September 2019 audit procedures through its annual medical audits that address the delivery of EPSDT services to all eligible children for all plans annually.
- To ensure that plans address underutilization of children's preventive services, DHCS should require plans by September 2019 to use their utilization management programs to identify barriers to usage specifically for these services and hold the plans accountable to address the barriers they identify.

- To better ensure the accuracy of its data and ensure that California receives all available federal Medicaid funding, DHCS should require its EQRO to perform its encounter data validation studies annually using the most recent set of data available, and it should implement recommendations from its EQRO studies.
- To ensure that plan provider directories are accurate, by September 2019 DHCS should begin using a 95% confidence level and not more than a 10% margin of error on its statistical sampling tool and should require at least 95% accuracy before approving a plan's provider directory. In addition, DHCS should ensure that its staff adhere to its policy to retain all documentation related to its review of provider directories for at least three years.
- To mitigate health disparities for children of differing ethnic backgrounds and language needs, DHCS should revise by September 2019 the methodology for its EQRO's health disparity study to enable it to better make demographic comparisons, and it should use the findings to drive targeted interventions within plan service areas. It should publish this study annually.
- To ensure that plans are effectively mitigating child health disparities in their service area, DHCS should implement by September 2019 a policy to require the plans to take action on the most significant findings cited in their group needs assessment reports, and to regularly follow up with the plans to ensure they have addressed the findings

<u>Recommendations</u>

- To help increase utilization rates, DHCS should begin by September 2019 to monitor and identify effective incentive programs at the plan level and share the results with all plans.
- To improve the usefulness of its PDSA process, DHCS should implement by September 2019 a process to share the results of

successful strategies with all plans and require plans to share these results with providers who could benefit from them.

- To improve its ability to ensure that children are receiving recommended preventive health services, DHCS should create by September 2019 an action plan to annually address the EQRO's recommendations relating to children's preventive services, including recommendations left unaddressed from the previous two years' reports.
- To maximize the benefits of the studies it commissions from its EQRO, DHCS should ensure that by September 2019 the EQRO's annual reports include an assessment of the actions plans have taken to address the EQRO's prior-year recommendations.