Department of Health Care Services

Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services

March 2019

REPORT 2018-111

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March 14, 2019
2018-111

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report regarding the Department of Health Care Services' (DHCS) oversight of the delivery of preventive services to children in the California Medical Assistance Program (Medi-Cal). Medi-Cal makes medical services available for more than half of the State's children, and this report concludes that millions of children do not receive the preventive services to which they are entitled. In fact, California ranks 40th for all states in providing preventive health services to children. Furthermore, utilization rates for these services vary widely throughout the State depending on region, age, and other demographic indicators. You can find an interactive dashboard at www.auditor.ca.gov/reports/2018-111/supplementalgraphics.html that demonstrates these differences.

One key reason that children do not receive preventive services is that, in many parts of the State, access to providers who treat children in Medi-Cal is limited. Limited access is due, in part, to low reimbursement rates for Medi-Cal providers. California could address this problem through financial incentives, such as pay-for-performance programs, similar to those offered in states with higher utilization rates. Such programs would likely require additional funding, but they would lead to healthier children and reduced health care costs over time.

Another barrier to children receiving preventive health care services is DHCS' deficient oversight of the managed care plans (plans) through which 90 percent of the children in Medi-Cal enroll. DHCS delegates much of its responsibility to ensure access and use of children's preventive services to these plans, and this report recommends that DHCS improve its oversight by doing the following three things:

- Provide clearer communication with plans, providers, and families regarding the preventive services that plans must make available to eligible children.
- Ensure that plans regularly identify and address underutilization of children's preventive services.
- Expand performance measures to include all age groups for which plans must provide preventive services.

Overall, DHCS' improved oversight of plans could help increase children's use of Medi-Cal-provided preventive services and, thereby, improve the health of children and reduce long-term health care costs.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CMS	Centers for Medicare & Medicaid Services
EPSDT	Early and periodic screening, diagnostic, and treatment
EQRO	External quality review organization
GAO	U.S. Government Accountability Office
HEDIS	Healthcare Effectiveness Data and Information Set
PDSA	Plan-Do-Study-Act

Contents

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Summary

Results in Brief

Because of a variety of problems, including a lack of providers willing to accept patients covered by the California Medical Assistance Program (Medi-Cal), an annual average of 2.4 million children who were enrolled in Medi-Cal over the past five years have not received all of the preventive health services that the State has committed to provide them. Nearly half of California's children receive medical care through Medi-Cal, a program that provides a safety net of health care services—including vital preventive services—to eligible children. According to the Centers for Disease Control and Prevention, providing children with annual preventive health services saves thousands of lives and reduces future health care costs by thousands of dollars per child. Despite the importance of these services, the use—or *utilization rate*—of preventive services by California's children in Medi-Cal has been consistently below 50 percent and is ranked 40th in the country—nearly 10 percentage points below the national average. In addition, despite efforts by the Department of Health Care Services (DHCS)—the state agency tasked with overseeing Medi-Cal—the utilization rate in California has not improved since fiscal year 2013–14. Although it is clear that DHCS cannot control all of the factors that influence whether families use preventive services for their children, it is equally clear from our review that DHCS can carry out its oversight responsibilities more effectively and more proactively.

A major cause of California's low utilization rate is that many of the State's children do not have adequate access to Medi-Cal providers who can deliver the required pediatric preventive services. Nearly 90 percent of children in Medi-Cal receive services through managed care plans (plans) that receive a monthly premium from DHCS to deliver services to eligible beneficiaries. To ensure that Medi-Cal beneficiaries have access to participating providers that can deliver these services, the U.S. Centers for Medicare and Medicaid Services required the State to develop and enforce standards that specified the maximum time and distance beneficiaries should have to travel for care. However, when California began implementing these time and distance standards in 2018, plans submitted almost 80,000 requests to DHCS proposing exceptions to the State's new standards, which was significantly more than DHCS anticipated. That number also highlighted the fact that there are many parts of California where Medi-Cal beneficiaries do not have adequate access to the providers they need. Of the 10,000 alternative access standards DHCS approved, 85 percent were for plans that had utilization rates below 50 percent for children's preventive services. Beyond the sheer volume of these approvals, some of the alternative access standards

Audit Highlights . . .

Our audit regarding DHCS' oversight of the delivery of preventive services to children in Medi-Cal revealed the following:

- *An annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services.*
- *Many of the State's children do not have adequate access to Medi-Cal providers who can deliver the required pediatric preventive services.*
- *Limited provider access is due, in part, to low Medi-Cal reimbursement rates.*
- *States with higher utilization rates offer financial incentive programs that California could implement, but it would likely require additional funding.*
- *DHCS delegates responsibilities to ensure access and use of children's preventive services to managed care plans, but it does not provide effective guidance and oversight.*
  - *It does not provide adequate information to plans, providers, and beneficiaries about the services it expects children to receive.*
  - *It does not ensure that plans regularly identify and address underutilization of children's preventive services.*
  - *It has not followed up on plans' efforts to mitigate cultural disparities in the usage of preventive services.*

that DHCS approved do not appear to be reasonable. For example, in San Joaquin County, DHCS-approved access standards would require some families to travel more than six hours, or nearly 250 miles, to see an in-plan pediatric eye specialist instead of the 60 minutes or 30 miles permitted under the State's time and distance standards. In this and other extreme instances, DHCS could have exercised its option of requiring the plans to allow families to visit a closer out-of-plan provider. However, it did not do so partly because its criteria for evaluating whether alternatives are reasonable focuses primarily on the efforts of the plans to meet the State's standards and not on whether the resulting times and distances are reasonable for a Medi-Cal beneficiary to travel.

Even so, increasing the number of providers who participate in Medi-Cal to better meet the State's time and distance standards, and thereby increasing access to and use of children's preventive services, will be difficult because of California's low Medi-Cal reimbursement rates. According to a 2017 study by the Kaiser Family Foundation, California's rates were only 76 percent of the national average, and only two states had lower rates. In addition to advocating for an increase in the State's reimbursement rates, DHCS could adopt financial penalties for underperforming plans and explore financial incentives for plans that increase utilization rates for children's preventive services. Although these options may require additional funding and would take time to realize results, similar programs in states with higher utilization rates indicate these efforts may be effective.

These states have implemented some best practices—which we described in Chapter 3—that California may be able to adopt, including statewide incentive programs that encourage providers and families to make sure children receive preventive services. In contrast to the way several high-performing states monitor the costs and benefits of the financial incentive programs they operate, DHCS allows plans to operate financial incentive programs to improve providers' performance but it does not monitor the costs or benefits of these programs nor does it share information about successful programs among all plans. DHCS believes its approach gives plans the flexibility to institute programs that suit their populations and local differences. However, as evidenced by California's low utilization rates, this approach does not appear to be working.

In fact, we found a consistent pattern of DHCS delegating responsibilities to plans but not providing a commensurate level of oversight. For instance, DHCS requires plans to provide a particular schedule of preventive services for children but it has not clearly informed plans, providers, and beneficiaries about these services. Federal law requires state Medicaid agencies to provide children under 21 years of age with early and periodic screening, diagnostic,

and treatment (EPSDT) services in accordance with a schedule that specifies reasonable standards for care. To comply with this requirement, in 2014 DHCS adopted the American Academy of Pediatrics' Bright Futures recommended schedule of care (Bright Futures), a schedule of children's preventive services. However, DHCS' contracts with plans continue to contain confusing language regarding a previously required schedule. Further, DHCS does not ensure that plans clearly communicate the required Bright Futures services to their providers and beneficiaries. Other examples of DHCS' lack of adequate oversight of the plans include the following:

- A federal law requires DHCS to annually inform families of children who have not used EPSDT services of the benefits of preventive health care, and DHCS relies on the plans to do so. However, none of the plans we spoke with perform this outreach.
- DHCS requires plans to report on performance measures for only a portion of the services in Bright Futures. Utilization rates were higher in that portion of Bright Futures services that require reporting.
- DHCS conducts annual medical audits of its plans, but it does not consistently review the provision of preventive services for all children during this process.
- DHCS requires all plans to have a mechanism to detect both over- and underutilization of health care services. However, DHCS does not consistently review the plans' actions to ensure that they specifically address underutilization of children's preventive services.
- To reduce staff time spent reviewing the accuracy of plans' provider directories, DHCS uses the lowest confidence level its statistical tool allows and approves directories even if it finds them to be only 80 percent accurate.

In addition to the problem of a lack of providers, available data show that California's diverse cultures—represented by a broad spectrum of ethnicities and languages—have dramatically different utilization rates. Rather than regularly analyzing these differences and conducting outreach targeted to specific communities with lower utilization rates on its own, DHCS delegates certain responsibilities for mitigating health disparities among children of differing racial and ethnic backgrounds to the plans. Specifically, DHCS requires plans to produce a report once every five years to identify health disparities and the cultural and linguistic needs among their beneficiaries; however, DHCS does not consistently follow up on the findings of these reports to ensure that plans actually make an effort to mitigate identified needs. Further, DHCS has done little to ensure that families are aware of available language services so as to minimize the use of children as interpreters.

Although it is the largest, Medi-Cal is not the only program DHCS oversees; and children's preventive services is only one component of the vast and complex Medi-Cal program. Thus, DHCS has many other competing priorities. However, each year millions of children in Medi-Cal are not receiving the preventive services that have been proven to promote better health outcomes and to avoid future medical expenses. As described earlier, most if not all the innovative programs for increasing utilization rates that DHCS may propose will likely require some level of additional funding from the Legislature. However, DHCS should not continue to entrust all progress to the plans and provide very little proactive oversight. California needs DHCS, as the state agency in charge of Medi-Cal, to fundamentally change its approach to overseeing the delivery of children's preventive health services and to actively propose and administer new efforts that will increase utilization rates.

Summary of Recommendations

Legislature

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 determine whether the resulting times and distances are reasonable to expect a Medi-Cal beneficiary to travel.
- Require any plan unable to meet those criteria to allow affected members to obtain health services outside of the plan's network.
- Direct DHCS to require such plans to inform affected members that they may obtain those services outside of the plan's network.
- Require plans to assist members in locating a suitable out-of-network provider.

To improve the health of California's children, the Legislature should direct DHCS to implement a pay-for-performance program targeted specifically at ensuring 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.

DHCS

To increase access to preventive health services for children, DHCS should propose to the Legislature funding increases to recruit more providers in the areas where they are needed most.

To improve access and utilization rates, DHCS should establish performance measures for Bright Futures services 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 conduct audit procedures through its annual medical audits that address the delivery of EPSDT services to all eligible children for all plans.

To ensure that plans' provider directories are accurate, DHCS should improve its processes for validating the accuracy of the directories that Medi-Cal beneficiaries use to access services.

To ensure that plans are effectively mitigating child health disparities related to cultural and linguistic needs in their service areas, DHCS should require plans to take action to address the most significant findings cited in their required reports on this issue and to regularly follow up to ensure that the plans have addressed the findings.

To help increase utilization rates, DHCS should monitor and identify effective incentive programs at the plan level and share the results with all plans.

Agency Comments

DHCS agreed with most of our findings and recommendations and partially agreed with others because it believes it has already undertaken the activities associated with these particular recommendations. Finally, it disagreed with our recommendation that it should propose funding increases to recruit more providers to areas that lack physicians serving children in Medi-Cal, pointing to a loan-repayment program it recently implemented for newly practicing physicians that are willing to serve Medi-Cal patients in underserved areas.

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Introduction

Background

The federal Medicaid program provides funds to states to pay for the medical treatment of low-income individuals including families with children. The federal Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program by approving state plans, reviewing state-reported expenditures, measuring access to health care, and providing other assistance and oversight. California participates in the federal Medicaid program through its California Medical Assistance Program, known as Medi-Cal. The program, overseen by the Department of Health Care Services (DHCS), provides a safety net of health care services, including preventive services for eligible children. According to DHCS, as of December 2017 over 5.5 million children—more than half of all children in California—were covered by Medi-Cal.

The State provides Medi-Cal benefits through two delivery systems: fee-for-service and managed care. Under fee-for-service, health care providers bill DHCS directly for approved services they provide to eligible beneficiaries. In managed care, DHCS pays a managed care plan (plan) a monthly capitation payment (premium)—a set amount per person covered—and the plan contracts with providers to deliver services for eligible beneficiaries. From December 2013 through June 2018, the number of children who were enrolled in these plans in California increased by 733,000, or 18 percent, while the number of children in the fee-for-service model decreased by 226,000, or 29 percent. As Figure 1 on the following page shows, managed care currently covers 90 percent of children in Medi-Cal. According to the chief of DHCS' Managed Care Quality and Monitoring Division (monitoring chief), DHCS has transitioned away from fee-for-service for several reasons, including cost-effectiveness, accessibility, and direction from the Legislature.

A Selection of Services in the Bright Futures Periodicity Schedule

SERVICE CATEGORY	PREVENTIVE SERVICE
Measurements	• Height and weight • Head circumference • Body mass index • Blood pressure
Sensory screening	• Vision • Hearing
Developmental health	• Developmental screening • Autism screening • Behavioral assessment • Drug use assessment • Depression screening
Physical examination	
Procedures	• Tuberculosis testing • Immunization • Anemia screening • Lead risk assessment
Oral health	• Fluoride varnish • Fluoride supplementation

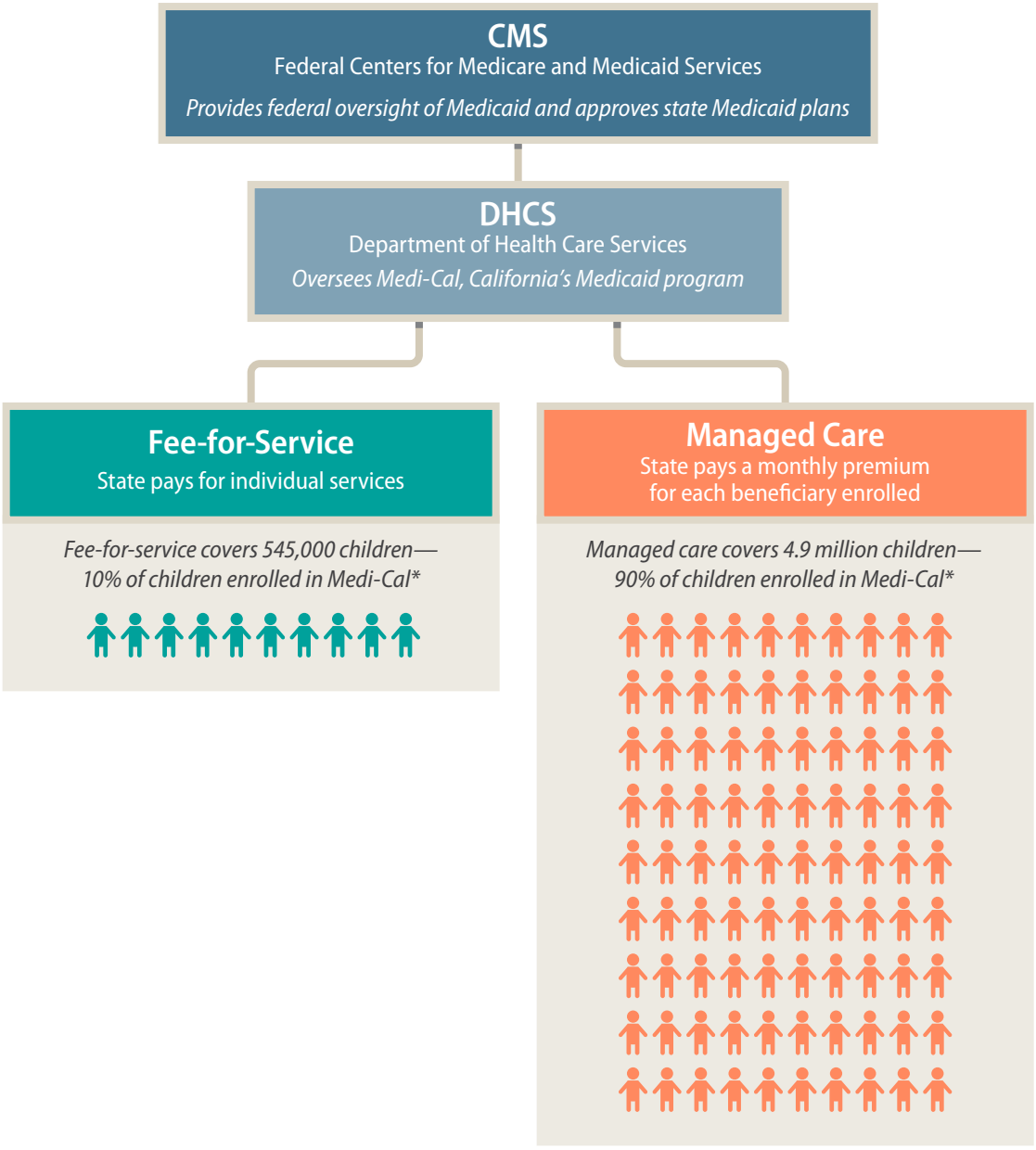
Source: Bright Futures Periodicity Schedule from the American Academy of Pediatrics.

Medi-Cal's Preventive Health Care for Children

Federal law requires state Medicaid agencies to provide early and periodic screening, diagnostic, and treatment (EPSDT) services to children under 21 years of age in accordance with a schedule that specifies reasonable standards for child health care. To comply with the requirement, DHCS adopted the American Academy of Pediatrics' Bright Futures recommended schedule of care (Bright Futures), which includes various health screenings, vision and hearing testing, and dental care, as further highlighted in the text box. EPSDT services are

designed to ensure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. For their children to receive preventive services, parents or guardians of eligible children must first enroll the children in Medi-Cal. Under managed care, they choose a plan and then select a primary care physician from the plan's network who will provide care and coordinate any needed referrals to specialists. Under fee-for-service, parents or guardians can select any Medi-Cal-approved provider.

Figure 1
DHCS Oversees Two Medi-Cal Delivery Systems for Providing Care



Source: DHCS' 2018 pediatric dashboard website.

* As of June 2018.

To assess the quality of care provided through Medi-Cal, DHCS requires plans to report on a set of performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS measures cover a wide range of services for both children and adults, including preventive services. Federal law also requires that each state develop and enforce network adequacy standards that require each Medicaid plan to have an adequate provider network that provides timely services. In addition, state law requires DHCS to implement and monitor time and distance standards to ensure that eligible children have reasonable access to care, including preventive services. State law that took effect in 2018 updated California's standards to meet the requirements of new federal rules, as shown in Table 1.

Table 1
To Meet the Requirements of New Federal Rules, State Law Specifies Network Adequacy Standards for Medi-Cal Managed Care Plans' Provider Networks

STANDARD TYPE*	STATE STANDARD FOR PROVIDER NETWORKS†	
Time and distance	**Primary Care**	
	All counties	10 miles or 30 minutes from beneficiary's address
	Specialty Care	
	Rural counties	60 miles or 90 minutes from beneficiary's address
	Small counties	45 miles or 75 minutes from beneficiary's address
	Medium counties	30 miles or 60 minutes from beneficiary's address
	Large counties	15 miles or 30 minutes from beneficiary's address
Timely access (not urgent)	**Primary Care**	
	All counties	Within 10 business days from request for an appointment
	Specialty Care	
	All counties	Within 15 business days from request for an appointment

Source: State law and DHCS' *Medicaid Managed Care Final Rule: Network Adequacy Standards* compliance report.

* State law includes additional standards not shown here. We list the standards that are most applicable to our audit of children's preventive services in Medi-Cal.

† County size is based on population density.

However, it can be difficult for children in Medi-Cal to get doctor's appointments. A 2017 survey conducted by three children's advocacy groups[1] looked at appointment availability for Medi-Cal pediatric primary care in managed care in Imperial and Nevada counties, which have 76,000 and 21,000 Medi-Cal beneficiaries, respectively. The survey found that only one-third of attempted calls for a pediatric well-child

[1] The three children's advocacy groups that conducted the 2017 survey were *Children Now*, *The Children's Partnership*, and *Children's Defense Fund-California*.

appointment resulted in an appointment within the State's timely access standards, and about 40 percent of call attempts did not result in an appointment at all. The survey stated that this was usually because there was not a provider from the plan's provider directory accepting new Medi-Cal patients. Missed primary care appointments may lead to costly urgent care or emergency room visits.

The importance of providing children with preventive health services is backed by several studies. According to the U.S. Centers for Disease Control and Prevention, preventive services significantly reduce the risk of illness, disability, early death, and expensive medical care while providing cost savings. In 2014 the American Academy of Pediatrics published a national report stating that the vaccination of 4.3 million children, a key preventive health service, would prevent approximately 42,000 deaths and 20 million cases of disease, with a net savings of nearly $14 billion in direct costs and $69 billion in total societal costs. A 2015 report published by the National Bureau of Economic Research on the long-term impact of Medicaid expansion analyzed increases in Medicaid spending caused by the expansions and the government's return on investment. The report found that the government recoups its investment in a child's preventive care by age 36 through additional tax payments, and preventive services result in the government earning a 550 percent return on investment by age 60.

A Selection of DHCS Oversight Activities Related to Children's Preventive Services

- **Annual Medical Audit**—Conducts annual audits of plans based on risk assessments but only reviews certain audit categories for each plan annually; requires plans to complete corrective action plans to address audit findings.
- **Performance Improvement Project (PIP) process**—Requires plans to conduct in-depth analyses on two relevant health topics over an 18-month cycle. One PIP must be from a focus area selected by DHCS, and the other must be on a health topic on which the plan has demonstrated a need for improvement.
- **External Quality Review Organization (EQRO) Technical Report**—Reviews health services provided by all plans and validates plans' data collection processes.
- **EQRO Encounter Data Validation Study**—DHCS' EQRO compares a sample of beneficiaries' medical records against corresponding records in DHCS' medical record database.
- **EQRO Health Disparity Report**—DHCS' EQRO reports certain performance measures for beneficiaries, including children, by age, race, ethnicity, gender, and primary language.
- **Fee-for-Service Audit**—Audits fee-for-service providers typically on an as-needed basis, such as when addressing whistleblower complaints.
- **HEDIS Corrective Action Plan process**—Places a plan on a plan-do-study-act cycle when it fails to meet improvement thresholds.
- **Plan-Do-Study-Act (PDSA) Cycle**—Requires a plan to report quarterly on improvement progress when a selected HEDIS measure falls below the minimum level.

Source: Analysis of DHCS' policies and procedures and other documentation.

DHCS' Oversight of Plans

DHCS requires plans to cover and ensure the provision of preventive services. It had contracts with 22 full-service plans during the entire period of fiscal years 2013–14 through 2017–18 that operated in one or more counties to make health care services available to Medi-Cal beneficiaries in each county in California. Some of the plans' responsibilities include implementing a program to detect underutilization of preventive services, informing eligible recipients of the health services and assistance available to them, and identifying and addressing the cultural and linguistic needs of its members.

To ensure that the plans are meeting these responsibilities, DHCS has various mechanisms in place as outlined in the text box. In addition to audits and corrective action plans, DHCS also

contracts with an external quality review organization (EQRO) to prepare an annual report that summarizes findings on accessibility and quality of care related to the health care services that plans provide as well as on each plan's HEDIS rates. To create a uniform standard for assessing plans on performance measures, DHCS established minimum performance levels for each HEDIS measure that the plans are required by contract to meet. Additionally, DHCS produces an annual written report with strategies for assessing and improving the quality of health services furnished by the plans. For reasons described in the remainder of this report, we have concerns with how DHCS conducts these and other oversight activities.

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Chapter 1

MILLIONS OF CHILDREN ARE NOT RECEIVING AND HAVE LIMITED ACCESS TO PREVENTIVE HEALTH SERVICES THEY ARE ENTITLED TO THROUGH MEDI-CAL

Chapter Summary

Millions of children in Medi-Cal each year are not receiving the preventive services to which they are entitled. California ranks 40th among all states in providing preventive services to children through Medicaid. This is partly due to children not having adequate access to health care providers who accept Medi-Cal. Many managed care plans that contract with DHCS to provide Medi-Cal services struggle to meet the time and distance standards established by state law which became effective in 2018. California's Medi-Cal payment rates for both fee-for-service and managed care are among the lowest Medicaid rates in the country. However, increased funding could be used to expand the number of doctors willing to serve children in Medi-Cal, and to allow DHCS to tie financial compensation to plans' performance in providing preventive health care to children in Medi-Cal.

California Has Been Unsuccessful at Ensuring That Children in Medi-Cal Receive Preventive Care

DHCS is not sufficiently ensuring that children in Medi-Cal receive the preventive services it has committed to providing them. An average of 2.4 million children in Medi-Cal per year did not receive all required preventive services during fiscal years 2013–14 through 2017–18. Preventive services provide early detection and care to either avert health problems or diagnose and treat them as early as possible. As we described in the Introduction, federal law requires DHCS to provide preventive services to children under 21 years of age in accordance with a schedule. To comply with this requirement, DHCS adopted the Bright Futures schedule, which includes various services such as examinations, immunizations, and developmental screenings. Most of these services are provided at well-child visits. DHCS has committed to ensuring that all children in Medi-Cal receive all Bright Futures services. However, DHCS has not been able to make demonstrable progress in the use of these preventive services over the last several years.

According to our analysis of DHCS' data, the utilization rate for preventive services for children enrolled in Medi-Cal has been below 50 percent for the past five fiscal years, as shown in Table 2 on the following page. Additionally, utilization rates are lower among

certain age groups and geographical areas. Specifically, as further discussed in Chapter 2, utilization rates drop from nearly 70 percent for children in their first year of life to 42 percent for 1-year-olds and then drop again to 25 percent for 2-year-olds, as Figure 2 shows. Figure 3 on page 16 shows that most of the lowest utilization rates are in 15 rural counties in the eastern part of California, with the lowest usage in Alpine, Plumas, Mariposa, and Sierra counties.

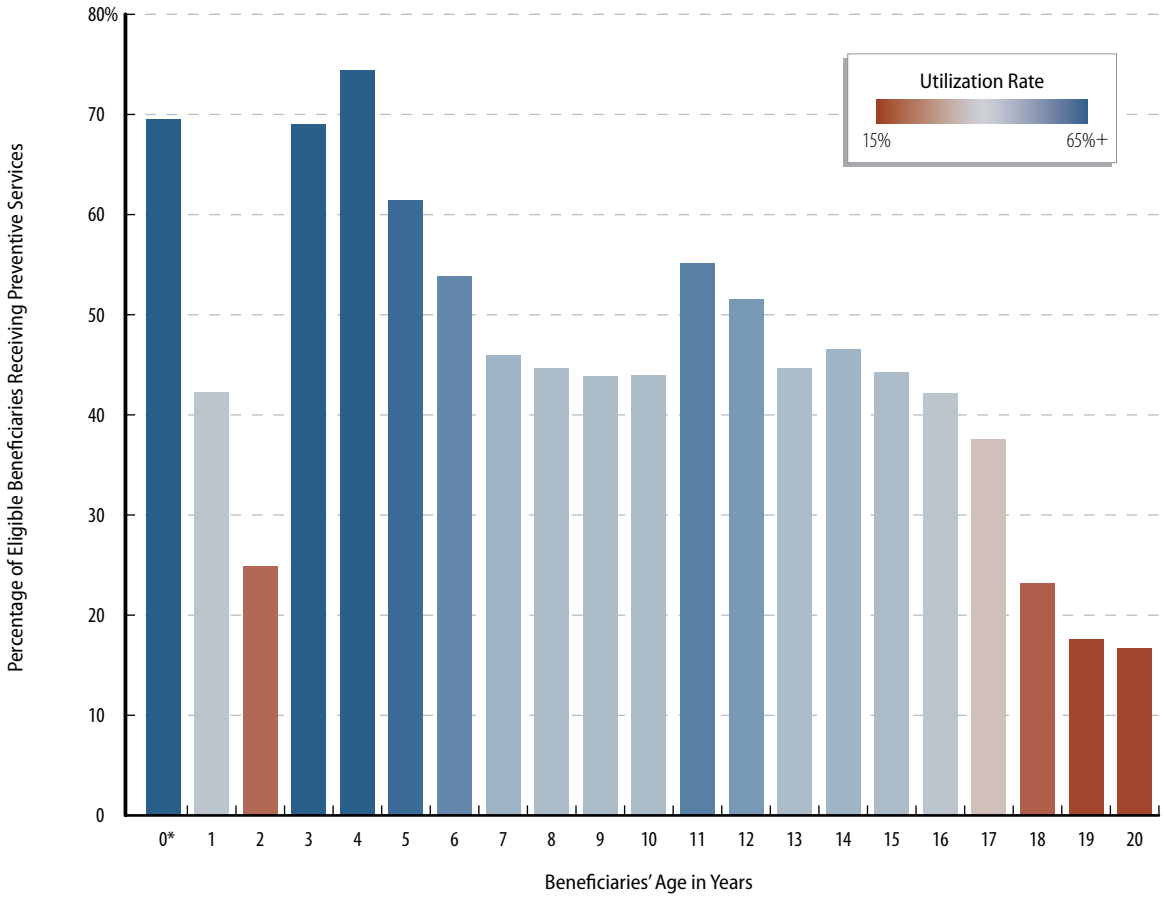
Table 2
Utilization Rates for Children in Medi-Cal Have Remained Below 50 Percent

FISCAL YEAR	UTILIZATION RATE
2013–14	49.5%
2014–15	47.0
2015–16	45.9
2016–17	47.8
2017–18*	45.2

Source: Analysis of DHCS' Management Information System/Decision Support System data.
* Fiscal year 2017–18 data may be incomplete because of a delay in DHCS receiving the data.

California also performs poorly in providing preventive care for children in Medicaid when compared to the rest of the country. As shown in Figure 4 on page 17, CMS data indicate that California's 49 percent utilization rate for preventive services for children in Medi-Cal is ranked 40th for all states. In fact, California's utilization rate has remained generally stagnant over the past five years. DHCS has been focusing on childhood immunization rates in Medi-Cal for the past five years but has not yet met its vaccination goal of 80 percent, with rates ranging instead from a high of 75 percent in 2013 to a low of 70 percent in 2017. California's low national ranking, and the fact that it has not met its goal, indicate that DHCS should do more to ensure the health of California's children.

Figure 2
Utilization Rates Were Low for Some of the Youngest Children in Medi-Cal
Fiscal Years 2013–14 Through 2017–18

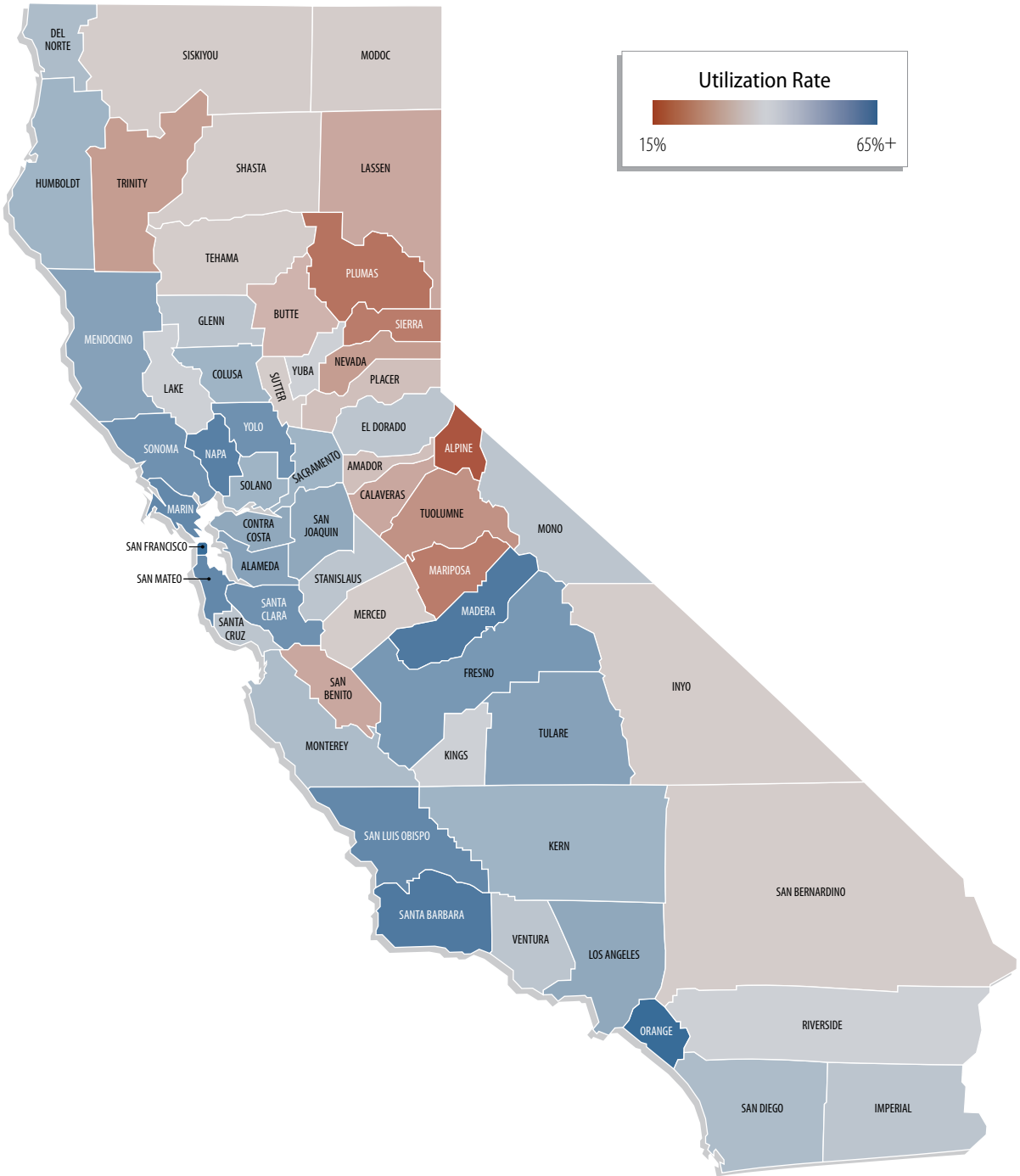


Source: Analysis of DHCS' Management Information System/Decision Support System data.

Note: Fiscal year 2017–18 data may be incomplete because of a delay in DHCS receiving data.

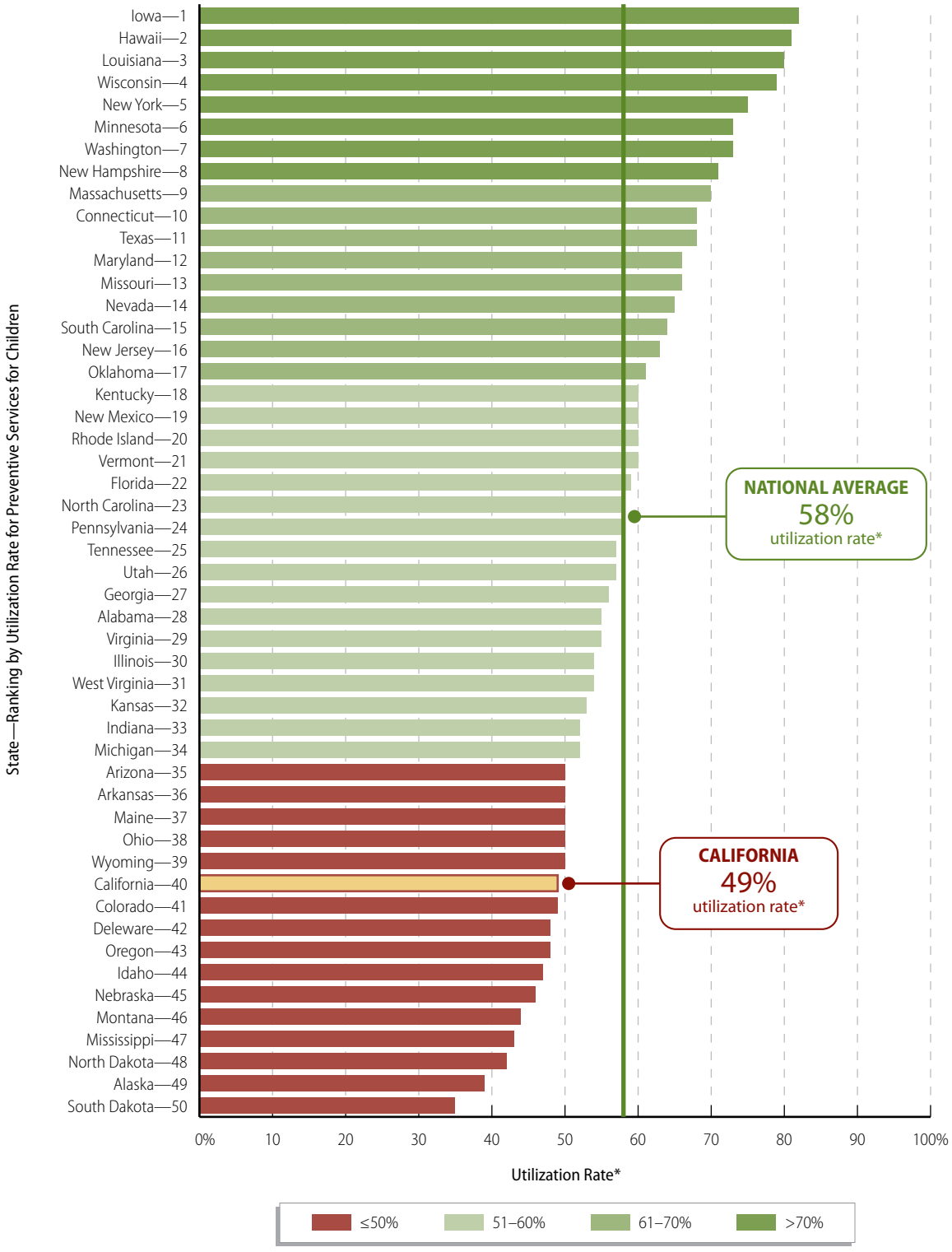
* In addition to the methodology we used to calculate the utilization rates outlined in the Scope and Methodology section of our report, DHCS states that increased parental attention to newborn health and pre-scheduling check-ups could be possible reasons for the higher utilization rates for children under age 1 year, but it has not conducted an analysis to verify this.

Figure 3
Utilization Rates Were Typically Lower in the Eastern Half of the State
Fiscal Years 2013–14 Through 2017–18



Source: Analysis of DHCS' Management Information System/Decision Support System data.
Note: Fiscal year 2017–18 data may be incomplete because of a delay in DHCS receiving data.

Figure 4
California's Utilization Rate for Children's Preventive Services Ranked 40th in the Country
Federal Fiscal Year 2017



Source: CMS annual EPSDT data for all states, federal fiscal year 2017.

* CMS calculated the utilization rate by dividing the total number of eligible children receiving at least one initial or periodic screening by the total number of eligible children who should receive at least one initial or periodic screening.

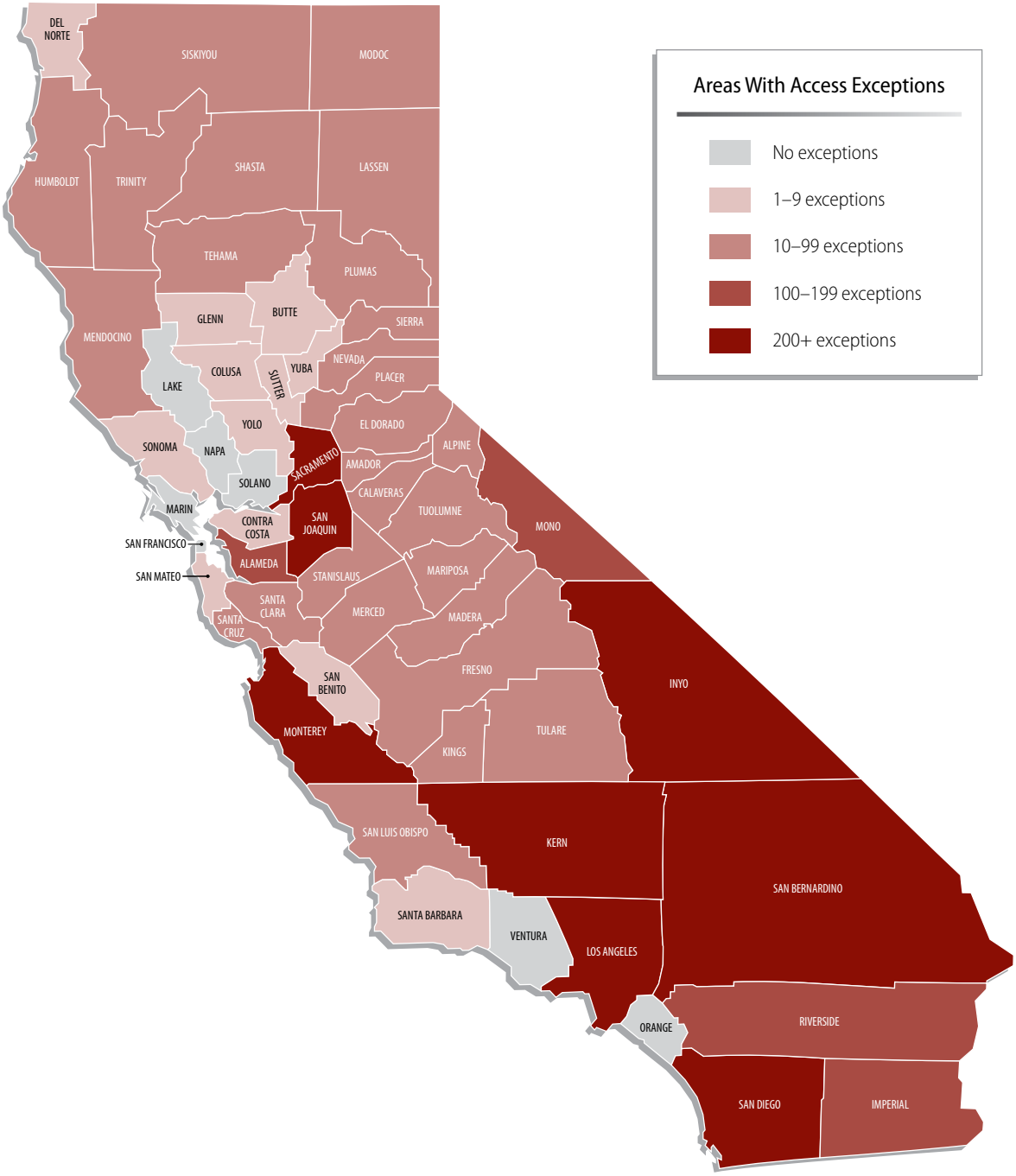
Many Families Do Not Have Adequate Access to Health Care Providers Who Serve Children in Medi-Cal

Our analysis of children's access to preventive care shows notable deficiencies with respect to both the number and location of providers who offer children's preventive services. California has had regulations in place intended to ensure that enrollees have access to needed health care services for many years; however, CMS's 2016 Managed Care Final Rule (final rule) required the State to develop and enforce new time and distance standards for access to providers. These standards limit how long, or how far, beneficiaries should have to travel to have access to primary care providers and specialists. State law effective January 1, 2018, established new time and distance standards based on each county's population density for managed care provider networks in each county as well as timely access standards that limit the number of days patients must wait to see a primary or specialist care provider. Another key component of the new standards requires the State to develop separate standards for adult and pediatric primary care and specialist providers.

DHCS' implementation of these new state and federal network adequacy requirements shows that children in many parts of the State have limited access to care. State law permits plans to request *alternative access standards*—exceptions to the network adequacy requirements—if the plans are unable to meet the new time and distance standards. According to state law, DHCS may allow alternative access standards for time and distance if the requesting plan has exhausted all other reasonable options to obtain providers to meet the applicable standard. After these laws became effective in 2018, plans submitted nearly 80,000 alternative access standards requests for exceptions to the State's time and distance standards—many times the number DHCS anticipated.[2] Of the almost 10,000 requests that DHCS approved, nearly 70 percent, or 6,800, were for providers who see children in specific zip codes. We show in Figure 5 a map of the State that depicts where there are the most notable problems with access to providers, based on the alternative access standards that DHCS approved during 2018.

[2] According to DHCS, there were a total of 182,000 possible requests that plans could have submitted, and some of the 80,000 requests plans actually submitted were duplicates.

Figure 5
Many Areas Struggled to Meet Access Standards in 2018, Especially in the Eastern Parts of the State



Source: Analysis of alternative access standards DHCS approved as of January 2019.

Health care plans have varying reasons for failing to meet access-to-care standards. Over the course of our audit, we conducted a focused review of three plans. Partnership HealthPlan of California (Partnership HealthPlan), one of the plans we reviewed, submitted alternative access requests for 10 of the 14 counties in which it operates. According to its senior director of provider relations, Partnership HealthPlan is willing to contract with any available provider, but it had to submit alternative access standards requests for areas where there are no available providers or where the only available providers were unwilling to serve Partnership HealthPlan's members. In another example, DHCS approved 151 alternative access requests for Alameda Alliance for Health (Alameda Alliance), another plan we reviewed. Alameda Alliance indicated that it found challenges meeting the standards for specialists who see children. DHCS also approved 140 alternative access standards for the third plan we reviewed, L.A. Care Health Plan (LA Care) in Los Angeles County. According to LA Care, it was unable to meet the new, more stringent time and distance standards because of a scarcity of providers in some areas and a decreasing number of providers willing to participate in its network. LA Care indicated that the challenges it identified also existed under the previous, less stringent standards, but they have become more acute because of the new standards.

Poor usage of children's preventive services is linked to poor access to care.

Poor usage of children's preventive services is linked to poor access to care. As we show in Table 3, DHCS approved the most alternative access standards for plans with lower utilization rates for children's preventive services. Of the 10,000 alternative access standards that DHCS approved, 8,400 or 85 percent were from plans with utilization rates for children's preventive services below 50 percent. For the five plans with the lowest utilization rates, DHCS approved an average of more than 500 alternative access standards, whereas for the five plans with the best utilization rates DHCS approved an average of fewer than 20 alternative access standards.

DHCS' analysis shows there is a lack of pediatricians in both rural and urban counties within the time and distance standards. As an example of the impact of these alternative access standards, some families in Mono County may have to travel almost nine hours, or 365 miles, to see a pediatric dermatologist instead of the 90 minutes and 60 miles permitted under the original access standards. In San Joaquin County, some families may have to travel up to six hours, or 245 miles, to see a pediatric ophthalmologist instead of the 60 minutes and 30 miles permitted under the original access standards. In San Bernardino County, some families may have to travel nearly two hours, or 70 miles, to see a pediatric primary care physician instead of the 30 minutes and 10 miles permitted under the original access standards. We show some of the most extreme alternative access standards DHCS approved in Table 4 on page 22.

Table 3
DHCS Approved More Alternative Access Standards for Plans With Lower Utilization Rates for Children's Preventive Services

MANAGED CARE PLAN*	UTILIZATION RATE†	APPROVED ALTERNATIVE ACCESS STANDARDS	NUMBER OF COUNTIES
California Health & Wellness Plan	39.9%	960	22
Care1st Partner Plan	41.1	411	1
Inland Empire Health Plan	41.4	438	2
Community Health Group Partnership Plan	42.4	262	1
Central California Alliance for Health	42.6	536	3
Molina Healthcare of California Premier Plan, Inc.	42.7	327	4
Gold Coast Health Plan	43.3	—	—
Anthem Blue Cross Partnership Plan	46.2	239	20
Health Plan of San Joaquin	47.3	3	1
Health Net Community Solutions, Inc.	47.4	4,671	7
Kern Family Health Care	47.5	95	1
Partnership HealthPlan of California	48.1	337	10
L.A. Care Health Plan	48.7	140	1
Contra Costa Health Plan	49.3	—	—
Kaiser SoCal‡	50.4	—	—
Alameda Alliance for Health	51.5	151	2
CalViva Health	51.9	110	3
Kaiser NorCal‡	52.5	—	—
Health Plan of San Mateo	53.7	1	1
Santa Clara Family Health Plan	55.0	25	1
CenCal Health	56.6	67	2
CalOptima	60.7	—	—
San Francisco Health Plan	64.2	—	—

Source: Analysis of DHCS' Management Information System/Decision Support System data and alternative access standards DHCS approved as of January 2019.

* DHCS also approved 1,142 alternative access standards for two plans that did not serve Medi-Cal beneficiaries during our entire audit period.

† Utilization rate is for fiscal years 2013–14 through 2017–18. However, fiscal year 2017–18 data may be incomplete because of a delay in DHCS receiving data.

‡ We list Kaiser NorCal and Kaiser SoCal separately because they report separate data to DHCS.

DHCS' procedure for reviewing alternative access standards requests includes determining whether the proposed alternative standard is reasonable. According to the monitoring chief, state law required DHCS to approve these alternative access standards for the plans that requested them because those plans had exhausted all other reasonable options to obtain providers to meet the applicable standard. However, state law says only that DHCS *may* allow the exceptions, not that it *must* allow them. Further, the monitoring chief added that in some of these cases, plans

might enter into temporary agreements with out-of-network providers rather than require beneficiaries to use the network providers covered by the alternative access standards. We question whether some of the approved alternative standards were reasonable. Instead of approving such extreme standards, DHCS could require plans to provide out-of-network access in such situations.

Table 4
DHCS Approved Extreme Alternative Access Standards for Driving Times and Distance for Children's Access to Some Pediatric Specialists in Some Parts of the State

PROVIDER TYPE	MAXIMUM APPROVED DRIVING TIME (IN MINUTES)	MAXIMUM APPROVED DISTANCE (IN MILES)	COUNTIES AFFECTED	NUMBER OF CHILDREN AFFECTED
Specialists				
Dermatology	520	365	Mono	34
Ophthalmology	375	245	San Joaquin	4,055
Nephrology	325	230	Inyo	0
Physical Medicine and Rehabilitation	315	327	Inyo	7
Hematology	270	200	Lassen, Modoc, Mono, Siskiyou	2,978
Neurology	260	300	Inyo	103
HIV/AIDS Specialists/Infectious Disease	235	324	Inyo, Kern	544
Oncology	230	299	Inyo, Kern	544
ENT/Otolaryngology	225	343	Inyo	9
Pulmonology	215	327	Inyo, Tulare	7
Endocrinology	205	313	Imperial, Inyo	297
Orthopedic Surgery	189	150	Inyo, Monterey	525
Psychiatry	180	327	Inyo	7
General Surgery	175	140	Kern, Tulare	552
Cardiology/Interventional Cardiology	175	239	Inyo, San Luis Obispo	222
Gastroenterology	165	150	Inyo	129
OB/GYN Specialty Care*	153	164	Inyo	12
Mental Health (nonpsychiatry) Outpatient Services*	150	83	Inyo	13
Primary Care				
OB/GYN Primary Care	250	230	Inyo	1
Primary Care Physician	115	85	Inyo, San Bernardino	8
Other Provider Types				
Hospital	140	120	Inyo, San Diego	241
Pharmacy	96	90	Inyo	7

Source: Analysis of alternative access standards DHCS approved as of January 2019, and DHCS' Management Information System/Decision Support System data.

Note: The counties we list and the children we total are those affected by the maximum time or distance standards for each provider type shown in the table.

* We include OB/GYN Specialty Care and Mental Health (nonpsychiatry) Outpatient Services with other specialists because they have the same time and distance standards.

The large number of exceptions to the access standards that DHCS granted highlights some of the deficiencies in Medi-Cal's managed care networks. In many cases, DHCS has approved alternative access time and distance standards for a plan in an area where Medi-Cal providers are present but not part of that plan's network. DHCS did so because it believed the plan's efforts to obtain additional providers were reasonable. In some cases, however, DHCS required plans to allow beneficiaries to obtain care from out-of-network providers. Even so, in these instances DHCS did not require the plans to inform their beneficiaries that they are eligible to obtain care in this fashion or to inform them of the process for obtaining out-of-network authorizations. As a result, many children may not be receiving necessary care because their families are unaware that they may be able to see a provider closer to where they live rather than only the providers their plan offers. In July 2018, members of a stakeholder advisory committee suggested that DHCS inform beneficiaries when they have the option to request an out-of-network provider; however, DHCS did not do so because it believed this information would be confusing to beneficiaries.

Many children may not be receiving necessary care because their families are unaware that, in some instances, they may be able to see a provider closer to where they live rather than only the providers their plan offers.

Although the State only recently adopted the time and distance standards required as a result of the final rule, DHCS needs to take additional steps to understand the scale and scope of the access problem in the State. Federal law requires that the State's network adequacy standards consider the number of providers not accepting new Medi-Cal patients as well as the ability of providers to communicate with beneficiaries in their preferred language. However, DHCS' procedure for reviewing alternative access standards requests does not require plans to identify in their requests which providers are, or are not, accepting Medi-Cal patients and what languages the providers speak.[3]

According to its monitoring chief, DHCS approves the alternative access standards requests based on the criteria specified in state law. Therefore, DHCS does not require plans to disclose whether their providers are accepting new Medi-Cal patients when the plans submit requests for alternative access standards. DHCS has not yet conducted an in-depth analysis of the alternative access standards requests to determine the areas of the State that are lacking doctors who are able to see children in Medi-Cal and to communicate with them in their preferred language because it has only just completed processing the requests for the first time. Furthermore, DHCS received additional data on Medi-Cal providers in late January 2019 when its EQRO provided it the final draft of a timely access study

[3] DHCS does obtain this information from plans' provider files during its annual review of plan provider networks, but it does not consider it when approving alternative access standards.

that DHCS commissioned in 2016. However, even with these data, the State will still have much work to do to understand its access problems before it can begin to target its improvement strategies.

Additional Funding Is Necessary to Improve California's Medi-Cal Provider Networks

Increasing the number of doctors who will provide preventive services to children in Medi-Cal will likely require additional funding. Our analysis shows that there are not enough doctors in California willing to treat children in Medi-Cal. This is, at least in part, because California's reimbursement rates are low compared to other states. In February 2019, the California Future Health Workforce Commission[4] issued a report describing problems caused by California's health provider shortages, including low usage of preventive services, geographic access issues, and limited cultural and language matches between providers and populations. Although the report covered more than just children in Medi-Cal, its findings match many of those described in this report. In fact, the report stated that Medi-Cal rates are not always sufficient to allow for the delivery of high-quality, timely services to health plan members. DHCS is working to attract more medical providers for children through recruitment incentives and by providing additional payments for certain services, but these methods are not targeted to specific areas of the State. A recent federal study found that the most effective way to increase provider participation is through increasing reimbursement rates.

There are not enough providers accepting Medi-Cal patients in many parts of the State.

Our analysis of the alternative access standards that DHCS approved shows that there are not enough providers accepting Medi-Cal patients in many parts of the State. Moreover, as we noted previously, DHCS' approval of alternative access standards shows that there is a lack of doctors who see children in both rural and urban areas throughout the State. California may need to increase its provider reimbursement rates to increase the number of providers willing to provide preventive care to children in Medi-Cal. California's Medi-Cal payment rates for both fee-for-service and managed care are among the lowest Medicaid rates in the country. A 2017 study of states' Medicaid fee-for-service rates by the Kaiser Family Foundation found that California's rates were only 76 percent of the national average, and that only two states—New Jersey and Rhode Island—had lower rates. Our analysis of data from a separate Kaiser Family Foundation report on states' 2016 Medicaid managed care spending

[4] The California Future Health Workforce Commission is composed of a statewide group of senior leaders across multiple sectors, including California's public university systems, health care organizations, advocacy groups, and state legislators.

per beneficiary shows that although its cost of living is high, California's spending per beneficiary is among the lowest—20th out of 29 states for which data are available. For example, in 2016, Florida spent about $4,500 per Medicaid managed care beneficiary, Texas spent an average of about $5,000, and New York spent $6,600. By comparison, California spent just $3,800 per managed care beneficiary in 2016.

To address the lack of providers, DHCS is implementing a recruitment incentive program which aims to recruit more new providers to Medi-Cal by paying for up to $300,000 of their medical school costs. Two of the three plans we reviewed also operate provider recruitment programs, but only LA Care's provider recruitment program targets underserved areas. As a result, it is uncertain whether the efforts these plans are taking will increase the number of providers who can provide preventive care for children in the areas of the State that need it the most.

To supplement California's Medi-Cal reimbursement rates, in 2018 DHCS began using money from the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to pay providers additional money for specific services, including well-child visits. However, these supplemental payments are tied to annual funding allocations that are dependent on the level of tobacco tax revenue, which can vary from year to year, and on DHCS' decisions on how best to apply these funds. As a result, the Proposition 56 funds may not represent a stable or consistent source of funds that DHCS can use to attract and retain doctors who participate in Medi-Cal. Furthermore, according to DHCS and the plans we spoke with, different regions in California have different physician needs. For example, in some regions with limited access, there are providers but they do not accept Medi-Cal patients, whereas in other regions there are no providers at all. Therefore, any program to increase Medi-Cal provider reimbursement rates should be flexible enough to accommodate the differing needs of California's different regions. For example, in higher-cost areas where there are currently established providers, the State could choose to focus directly on increasing provider payment rates to attract more providers to Medi-Cal. In other areas, the State could focus on incentives, such as paying for provider education and relocation costs, and start-up subsidies to attract new providers to those regions. Regardless of the number and specifics of the incentives, without a steady, long-term source of funding to increase or augment California's Medi-Cal provider reimbursement rates, California will not be able to solve its health care access problem.

Without a steady, long-term source of funding to increase or augment California's Medi-Cal provider reimbursement rates, California will not be able to solve its health care access problem.

According to a January 2019 study released by the Medicaid and CHIP Payment and Access Commission[5], the federal legislative agency that makes recommendations to Congress and the states on Medicaid access issues, the only policy tool associated with an increase in providers accepting Medicaid beneficiaries is Medicaid payment rates.[6] Specifically, the study identified that in states with the lowest Medicaid rates, such as California, only 65 percent of physicians accepting new patients were willing to accept new Medicaid patients, compared to 81 percent of physicians willing to accept new Medicaid patients in states with higher Medicaid rates. Further, the study indicated that as state Medicaid rates increased, the percentage of physicians accepting Medicaid patients increased. The study also found that the use of managed care, the population in Medicaid, and physician demographics were not factors in these results, and that payment rates were the only significant factor that had an impact on provider willingness to accept new Medicaid patients.

DHCS Could Improve Access and Usage by Imposing Financial Sanctions, if Necessary, and by Paying Plans Based on Their Performance

Although DHCS' policies allow it to impose financial sanctions or penalties when plans do not meet established performance levels, these actions can take so long that plans rarely face such penalties. DHCS' policies allow it to impose financial sanctions on a plan if it fails to meet minimum performance levels after implementing a corrective action plan, but in many cases, DHCS does not require plans to implement a corrective action plan until it has failed to meet the same minimum performance levels for three consecutive years.[7] Because most quality-related corrective action plans run for five years, a plan's performance could improve but still remain below the minimum performance levels for eight consecutive years before DHCS would impose a financial sanction. As a result, plans have seldom faced financial repercussions if they fail to meet minimum performance levels. According to the monitoring chief, DHCS never financially sanctioned any plan for uncorrected deficiencies related to access and utilization during our audit period, and it only recently imposed such sanctions in late 2018 after our audit began.

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5 The Children's Health Insurance Program (CHIP) provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

6 The study looked at Medicaid fee-for-service rates and did not distinguish between base rates and supplemental payments or incentives such as those described earlier.

7 DHCS' policies also allow it to impose a corrective action plan if a plan underperforms on more than half of the performance measures in one year or if DHCS identifies a serious quality trend or issue the plan needs to correct.

The Legislature could direct DHCS to develop a pay-for-performance program to hold plans financially accountable for providing the children's preventive services the State requires. A pay-for-performance program would require that plans meet specified performance targets in order to receive portions of their Medi-Cal funding. Several states have implemented pay-for-performance programs, including Connecticut and Tennessee, which have utilization rates higher than California by 19 and 8 percentage points, respectively. According to CMS, its focus on improving the quality of health care delivery includes using incentives to improve care and tying payment to value through new payment models. The Governor's January 2019 budget proposal includes funding for some pay-for-performance measures for Medi-Cal, but the proposal does not specify whether the measures pertain to children's preventive services.

The Legislature could direct DHCS to develop a pay-for-performance program to hold plans financially accountable for providing the children's preventive services the State requires.

According to DHCS, a pay-for-performance program would likely be feasible and effective. The monitoring chief said a pay-for-performance program for children's preventive care would lead the plans to focus more efforts on providing those services and would likely improve their performance, although it could lead to declining performance on other services offered through Medi-Cal. Therefore, DHCS would prefer to develop a broader scope pay-for-performance program that looks at more services in Medi-Cal. However, given the combination of low utilization rates for children's preventive services that we observed, strong evidence that preventive services lead to future cost savings, and the fact that children make up nearly half of the Medi-Cal managed care population, any pay-for-performance program in Medi-Cal should have a strong focus on children's preventive services.

DHCS currently pays plans rates that it annually calculates, based on the plans' costs and other factors, and that CMS approves. As part of the rates development process, DHCS submits to CMS a range of appropriate rates that meet federal requirements that it could pay plans. However, because of the State's budget limitations and historical practice, California typically pays plans the lowest base rates. As a result of this practice, and because federal law limits under what conditions states can withhold funding from plans, DHCS' ability to hold underperforming plans financially accountable for providing all the children's preventive services the State requires is restricted.

Therefore, implementing a pay-per-performance program—through either financial incentives or penalties—will first require the State to raise the amount it pays plans above the minimum rates allowed by CMS. Furthermore, a pay-for-performance program will be subject to federal approval; and, as a result, the Legislature will need to consider federal Medicaid policy when it assesses whether

to authorize a pay-for-performance program. However, preventive care is vital to the health and well-being of millions of California's children, and providing that care is cost-effective in the long term.

Recommendations

Legislature

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.
- Require any plan unable to meet those criteria to allow its affected members to obtain services outside of the plan's network.
- Direct DHCS to require such a plan to inform its affected members that they may obtain those services outside of the plan's network.
- Require the plan to assist members in locating a suitable out-of-network provider.

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.

DHCS

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.

Chapter 2

DHCS DELEGATES MUCH OF ITS RESPONSIBILITIES FOR SERVING CHILDREN IN MEDI-CAL TO MANAGED CARE PLANS, BUT IT DOES NOT PROVIDE EFFECTIVE GUIDANCE AND OVERSIGHT

Chapter Summary

DHCS has not provided sufficient oversight of the plans to which it has delegated much of the responsibility of ensuring children in Medi-Cal receive preventive services and has not met its obligations to inform plans, providers, and beneficiaries about the preventive services it expects children to receive. For instance, it delegates to the plans its responsibility to reach out to the families of children who are not using preventive services, but it does not ensure that plans actually do so. Further, DHCS holds plans accountable for only a portion of the preventive services it requires them to provide children, and utilization rates are higher for those services. Finally, DHCS does not use its utilization management and annual audit processes effectively, nor does it proactively address cultural disparities that exist in the usage of preventive health services.

DHCS Does Not Provide Adequate Information to Plans, Providers, and Beneficiaries About the Services It Expects Children to Receive

DHCS has not made it clear to plans and providers that they are required to adhere to the Bright Futures schedule. California's Medicaid State Plan, which describes the nature and scope of its Medicaid program, requires the State to provide preventive health services to children according to Bright Futures. However, DHCS' contracts with plans do not make this requirement clear and frequently reference outdated requirements that are not in line with Bright Futures. For example, the contracts still direct plans to provide health assessments and ensure that children have received the preventive services in the Child Health and Disability Prevention program, which are former requirements, in addition to the health assessments and more frequent screenings that Bright Futures requires. This unclear and inconsistent contract language has led to confusion about the preventive health services the State expects plans to provide to children. One of the plans we reviewed, Alameda Alliance, even stated that it believes that DHCS only recommends—rather than requires— that plans follow the Bright Futures schedule. According to DHCS' deputy director of Health Care Delivery Systems, DHCS does require plans to follow the Bright Futures schedule and it intends to revise the contracts to eliminate the unclear language.

Moreover, DHCS' communications of updates related to EPSDT services do not rectify the contract's wording problems. DHCS uses letters sent jointly to all plans (all-plan letters) to clarify the contractual obligations and to provide instructions for how to implement changes in state or federal requirements. However, these letters are not always clear or direct. For example, DHCS sent an all-plan letter stating that federal requirements mandate the use of Bright Futures and that children's EPSDT services are broader than the Medi-Cal services that plans must provide to adults. However, the letter did not make it clear what services are required by Bright Futures or that plans must cover health services necessary to maintain or improve a child's health. In addition, other states, including New York, include Bright Futures in their provider handbooks but DHCS does not. Without such notification, many providers may be unaware of the requirements to provide all children in Medi-Cal with preventive services according to Bright Futures. When DHCS provides confusing and unclear instructions to plans, it increases the likelihood that providers will not deliver the appropriate level of preventive services.

Furthermore, DHCS provides limited and unclear information to the families of children in Medi-Cal about the services they can and should receive. To ensure that all eligible children and their families know how to access and use these services, federal law requires DHCS to inform the children and their families both verbally and in writing about services and benefits specific to preventive health care. This includes notice of the screening and diagnostic services available under the EPSDT program, that these services are free of charge to eligible individuals, and that transportation and scheduling assistance are also available. Further, federal law requires DHCS to provide EPSDT screenings upon request and without prior authorization. However, the written materials DHCS provides to Medi-Cal beneficiaries include confusing, inaccurate, or incomplete information about these services. Of particular concern is the fact that DHCS' beneficiary handbook does not discuss the benefits of preventive health care and does not make it clear that these services are free to eligible individuals and are available upon request. The handbook also fails to explain the comprehensive nature of the EPSDT benefits, does not communicate that children in Medi-Cal qualify for additional care such as vision and dental services, and does not include check-ups or immunizations in describing available preventive services. In July 2018, DHCS provided us a draft version of an updated beneficiary handbook; however, it did not address the issues we identified and, as of February 2019, has not been finalized.

The written materials DHCS provides to Medi-Cal beneficiaries include confusing, inaccurate, or incomplete information about preventive services.

DHCS contends that plans are responsible for informing their beneficiaries of the preventive services available to them but does little to hold plans accountable for sufficiently informing

their members. Our review of the three plans indicated that plans need to improve their communication with members. For example, nearly half of Alameda Alliance's members stated in a 2016 survey that the plan did not provide them with adequate information about taking care of children's health concerns, and one-third said the plan did not provide them with adequate information about vaccines and child development. Additionally, only 29 percent of its members stated that it was very easy to understand the letters and information the plan sent them. Yet the staff we spoke to at the three plans indicated that it would be up to providers to distribute this type of health information to parents.

This pattern of delegation specifically affects children who are not receiving preventive services. Federal law requires DHCS to perform annual outreach to children and their families who have not used EPSDT preventive services to inform them of the benefits of preventive health care and how to obtain services under the EPSDT program. DHCS states that it relies on the plans to perform any additional outreach and to follow up with families of children who have not used EPSDT services. None of the plans we visited, however, perform this annual outreach and DHCS does not follow up to ensure that plans conduct this outreach.

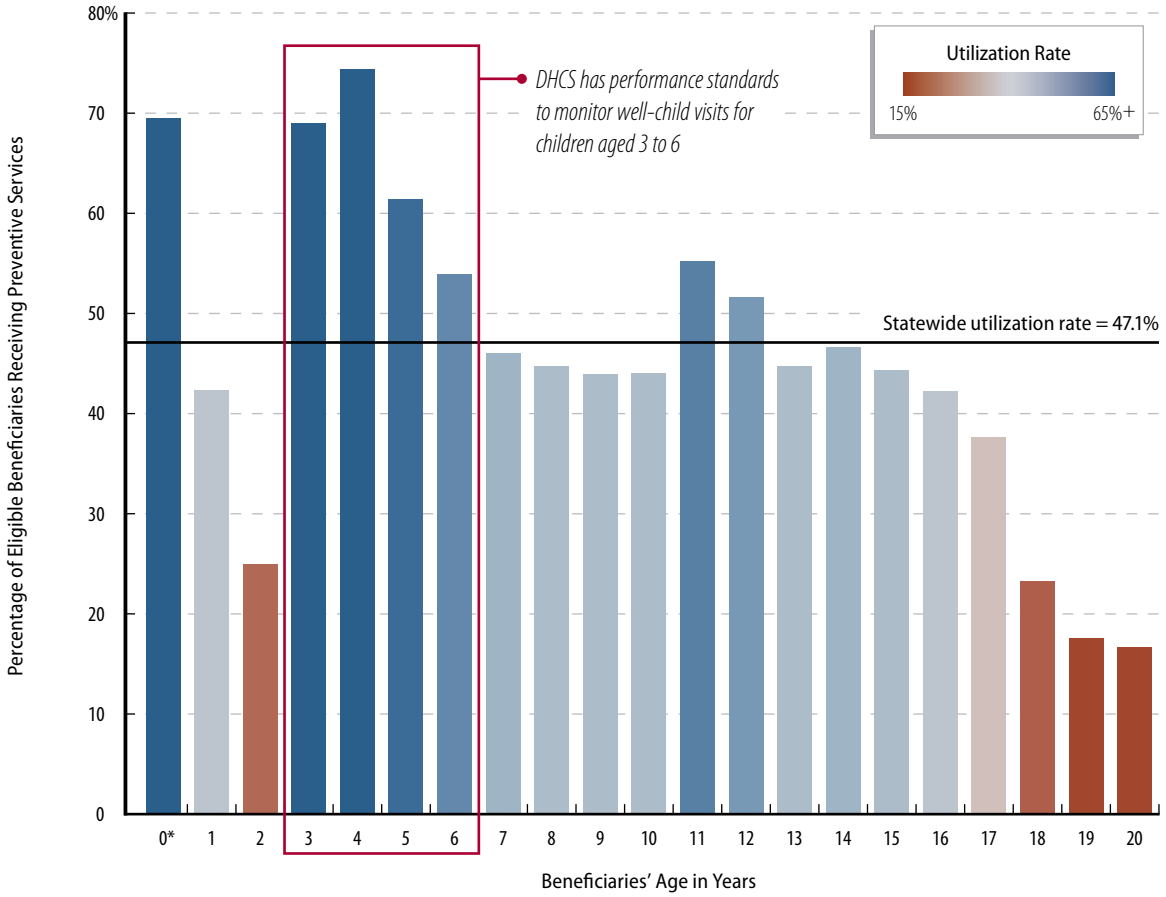
DHCS relies on plans to perform outreach to families of children who have not used preventive services, but it does not follow up with the plans to ensure they do so.

Utilization Rates Are Higher for Children When DHCS Has Performance Measures for Services

For the services for which DHCS has established performance measures and reporting requirements, utilization rates are higher. Some of the highest utilization rates occur within the 3- to 6-year-old group, as we show in Figure 6 on the following page. DHCS requires plans to meet minimum performance levels each calendar year for children in those age groups, which the plans have exceeded since at least 2014. It also requires health plans to report their performance annually in meeting those goals.

In contrast, utilization rates are much lower for 1- and 2-year-olds—ages for which DHCS has not set performance measures or reporting requirements for children's preventive care. It is critically important that young children receive preventive services to ensure their healthy development. Specifically, Bright Futures indicates that 1- and 2-year olds should receive at least three well-child exams in each year and vaccinations that include polio, measles, and hepatitis B. Of the 26 states currently monitoring use of services for this age group, 22 are demonstrating higher utilization rates than California. As an example, Connecticut demonstrated immediate improvements in the number of developmental screenings for children up to age 3 years once it began to track and monitor the provision of these services.

Figure 6
Utilization Rates Were Higher for Ages for Which DHCS Has Established Performance Measures
Fiscal Years 2013–14 Through 2017–18



Source: Analysis of DHCS' Management Information System/Decision Support System data.

Note: Fiscal year 2017–18 data may be incomplete because of a delay in DHCS receiving data.

* In addition to the methodology we used to calculate the utilization rates outlined in the Scope and Methodology section of our report, DHCS states that increased parental attention to newborn health and pre-scheduling check-ups could be possible reasons for the higher utilization rates for children under age 1 year, but it has not conducted an analysis to verify this.

DHCS also has performance measures for access to primary care visits for age 12 months to 19 years. However, the measures do not monitor whether a beneficiary receives Bright Futures preventive services during that visit; instead, they only monitor whether the child had a visit with a primary care practitioner once during the measurement year. According to DHCS' monitoring chief, DHCS adopted these measures nonetheless because they provide some information about children's access to primary care and DHCS cannot adopt performance measures to encompass all well-child visits for all ages because of resource constraints. However, as indicated in Figure 6, ages 2 and 18 through 20 have the lowest

utilization rates compared to all other ages, and DHCS does not have well-child performance measures for well-child visits for these ages.

According to DHCS, plans may be more aggressive about assisting providers with increasing utilization rates for certain age groups when it sets performance standards that the plans are required to meet. Currently, it only requires plans to report on the few children's preventive services through HEDIS measures that we indicate in Table 5 on the following page. According to DHCS, it uses HEDIS measures because they provide national benchmarks for comparison and are easier for the plans to report on. However, we believe DHCS should expand its performance measure set to include age groups with significantly lower utilization rates. For instance, adding the HEDIS measure for adolescent well-care visits would allow DHCS to monitor use of preventive care for adolescents and young adults from ages 12 to 20, likely fostering improved health outcomes. Further, according to a Pew-MacArthur[8] 2018 study, benchmarks can be a motivator for improved performance by establishing clear expectations and goals. Moreover, the plans we visited depend on the performance measures they report to DHCS to monitor and improve performance and also as one of the methods they use to identify and detect potential underutilization issues. Thus, if DHCS were to set performance measurements and reporting requirements for all well-child visits for age zero through 20 years, utilization rates would likely improve.

DHCS Does Not Use Its Utilization Management or Annual Audit Processes Related to Children's Preventive Services Effectively

DHCS has not performed sufficient oversight over plans' utilization management processes. DHCS requires all plans to maintain a utilization management program that includes a mechanism to detect both over- and underutilization of health care services. Despite this requirement, one of the plans we reviewed, Alameda Alliance, has not identified and addressed underutilization of children's preventive services in their utilization management programs. Although DHCS conducts annual medical audits to review whether plans have a utilization management program, it does not review the plans' actions to ensure that they specifically address underutilization of children's preventive services. DHCS' Audits and Investigations Branch stated that DHCS' contract with the plans was not specific enough to hold plans accountable for underutilization of pediatric services. However, the contract specifically requires plans

[8] The Pew-MacArthur Results First Initiative works with states to implement an innovative evidence-based policymaking approach that helps them invest in policies and programs that are proven to work.

to have mechanisms to detect over- and underutilization of health care services, which would include children's preventive services. By failing to determine whether plans are addressing underutilization of children's preventive services, DHCS is missing an opportunity to increase the provision of these services.

Table 5
DHCS' Performance Measures Capture Only a Few of the Bright Futures Services

BRIGHT FUTURES SERVICE*	0–5 MONTHS	6–11 MONTHS	12–24 MONTHS	25–35 MONTHS	3–6 YEARS†	7-10 YEARS	11–13 YEARS	14–17 YEARS	18–20 YEARS
History	X	X	X	X	✓	X	X	X	X
Measurements	X	X	X	X	✓	X	X	X	X
Body mass index	‡	‡	‡	X	✓	✓	✓	✓	X
Sensory screening	X	X	X	X	✓	X	X	X	X
Developmental/ behavioral health	X	X	X	X	✓	X	X	X	X
Physical exam	X	X	X	X	✓	X	X	X	X
Procedures	X	X	X	X	✓	X	X	X	X
Immunization	✓	✓	✓	X	✓	X	✓	X	X
Oral health	‡	X	X	X	✓	X	X	X	‡
Anticipatory guidance	X	X	X	X	✓	X	X	X	X

Source: Analysis of Bright Futures and the EQRO's definition of HEDIS measurements.

✓ = DHCS monitors usage of this preventive service through HEDIS measures.

X = DHCS does not monitor usage of this preventive service as Bright Futures recommends.

* Most of the above services include an array of preventive health care. For example, sensory screening includes vision and hearing screening.

† DHCS' performance metrics for children age 3–6 does not necessarily ensure that these children receive every service during each well-child visit.

‡ This service category is not recommended for this specific age range.

DHCS' annual medical audits provide only an intermittent and limited review of a plan's process for ensuring the effective delivery of children's preventive services. DHCS conducts an annual medical audit of each plan in which it evaluates plans' processes related to utilization management, access to care, and quality management. However, according to the acting chief of the Medical Review Branch, in an effort to reduce the burden on plans, DHCS only includes reviews of preventive services within these audits once

every three years unless it becomes aware of a deficiency. In the most recent audit review period, only 3 percent of DHCS audit findings were related to the delivery of preventive services and none of these findings were specific to children's preventive services. We would expect this small number of findings to be indicative of high performance, but instead, utilization rates for children's preventive services averaged less than 50 percent for each year during our audit period.

In addition, DHCS had not been conducting any audit procedures specific to EPSDT services for children until fall 2018. In practice, these new EPSDT audit procedures only include a review of some preventive services for a small number of children, and DHCS—based on its auditors' evaluation of risk—applies discretion in whether to conduct these reviews at all. By only reviewing a plan's process for overseeing a small number of children and conducting that review inconsistently, DHCS is not adequately holding plans accountable for resolving underutilization of children's preventive services. Thus, the steps DHCS has taken in its audits regarding children's preventive services have not contributed to demonstrable improvements to utilization rates.

Finally, DHCS' annual medical audits are also too limited to ensure that plans provide timely access to beneficiaries.[9] State law requires that all Medi-Cal beneficiaries have timely access to care within 10 days of a request for a nonurgent appointment with a primary care provider and within 15 days for a specialist. DHCS conducts telephone surveys of selected providers to confirm appointment wait times as part of its annual medical audits, but it does not follow a schedule to conduct the surveys, conducts them at its discretion, and contacts only 15 of the hundreds—and sometimes thousands—of providers participating in Medi-Cal plans. According to the acting chief of the Medical Review Branch, DHCS expects the plans to have policies to ensure timely access and only uses its audit procedures to validate a plan's process for overseeing wait-time standards. However, by conducting audit procedures on a discretionary basis and using a very small sample size, DHCS is limiting its ability to make an accurate determination of the effectiveness of a plan's policies.

DHCS Reduces the Effectiveness of Its Oversight by Not Ensuring That Plans Accurately Report the Services They Provide

While DHCS has taken steps to improve the accuracy of the plans' reports on the services they provide, it must expand these efforts or it risks the loss of some federal Medicaid funding. According to the

[9] In addition to medical audits, DHCS commissioned its EQRO in 2016 to conduct a timely access study to monitor beneficiaries' access to care. The EQRO provided a final draft to DHCS in January 2019; however, the results of this study and DHCS' plans regarding implementation of its recommendations were not available in time for our review.

U.S. Government Accountability Office (GAO), reliable *encounter data*—data on the services provided to beneficiaries—are central for CMS and the states to effectively oversee the Medicaid managed care program. For example, CMS and the states can use encounter data to help ensure that beneficiaries have access to covered services, that payment rates are set appropriately, and to identify inappropriate billing. Providers enter encounter data into a database to indicate what services they provided to beneficiaries. As we show in Figure 7, plans collect these data from providers, subcontractors, and other subcontracted plans and submit them to DHCS. Federal regulations require states to verify the accuracy of the encounter data that plans submit and forward these data to CMS. If states do not provide CMS with data that meet CMS standards, federal law requires CMS to withhold a portion of the federal share of Medicaid funding.

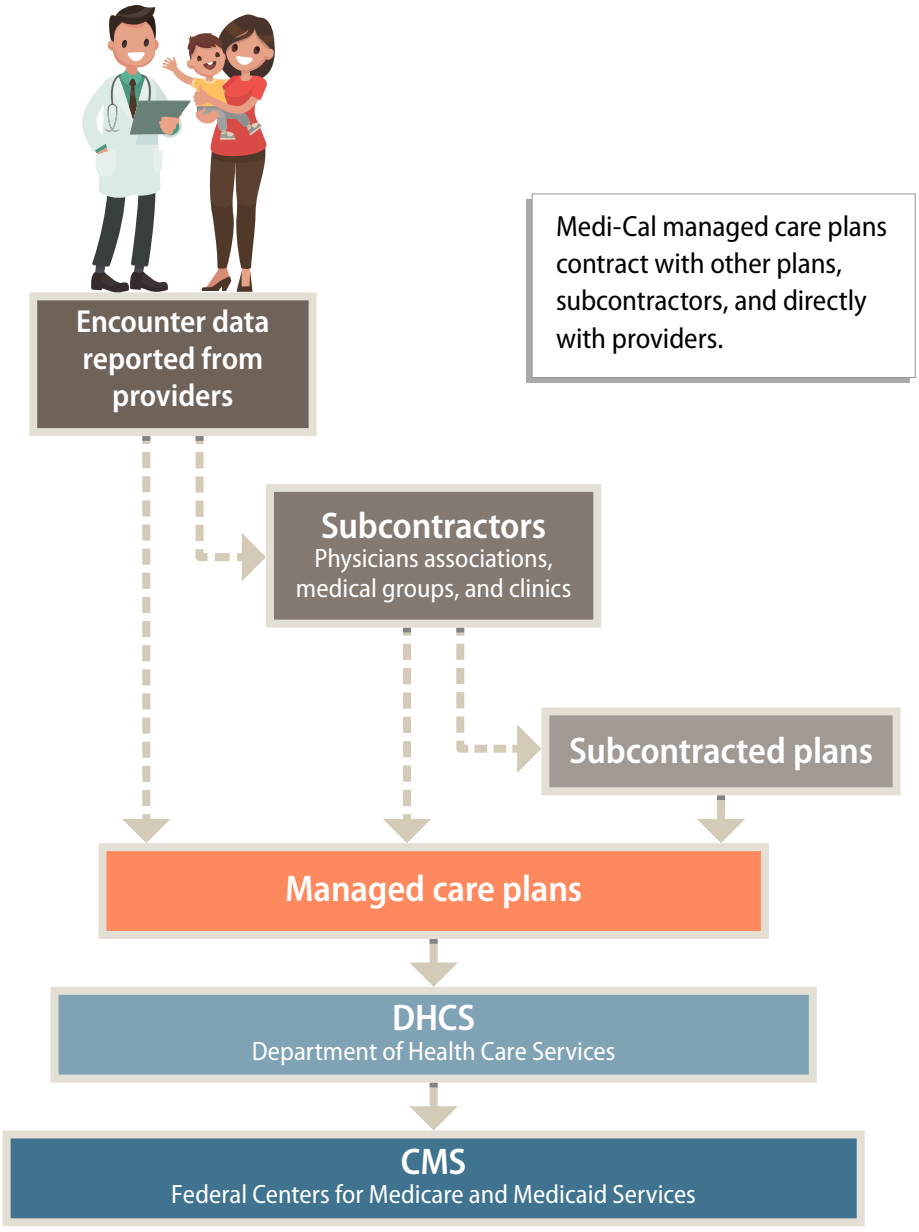
Federal regulations require states to verify the accuracy of the encounter data that plans submit and forward these data to CMS.

DHCS contracts with its EQRO to conduct periodic data validation studies to match the plans' self-reported encounter data to medical records, and these studies have shown that plans continue to struggle to report encounter data accurately and completely. Before a draft validation study completed in 2018, the EQRO issued its most recent report in 2015 and based it on encounter data from 2012. That report found pervasive data quality and completeness deficiencies, and it made several recommendations to improve data quality, which DHCS made some efforts to adopt. For example, DHCS transitioned to a new encounter data claims system and established an encounter data quality unit to address technical problems that affect accuracy. However, it did not implement all of the EQRO's recommendations from 2015, such as requiring plans to develop encounter data training programs and conduct audits of their providers.

In 2018 the EQRO began reviewing encounter data from 2016 and provided DHCS with a draft of its report in December 2018, which DHCS expects the EQRO will finalize in early 2019. While the draft report found that DHCS' encounter data from 2016 were more complete and accurate than the data from 2012, it also found that there were still considerable gaps in the data quality and that encounter data quality also varied widely by plan. For example, according to the draft report, most plans' encounter data for medical diagnosis codes and provider names still did not meet DHCS' completeness standards, while the accuracy rate of each plan's encounter data for all elements ranged from a low of 6 percent to a high of 54 percent. Notably, the EQRO repeated its recommendation that DHCS require plans to develop an encounter data education program and conduct audits of their providers. Each of the three plans we spoke with commented on the difficulty of ensuring that encounter data are accurate and highlighted their own struggles with ensuring the accuracy of data that providers submit. For example, LA Care indicated that before it recently

started including encounter data submissions as part of its pay-for-performance program, its managed care providers had little incentive to report encounter data accurately since the services they provide are not tied to the capitation payments they receive.

Figure 7
Encounter Data Reported From Providers to CMS Are Transferred and Modified Multiple Times, Potentially Creating Inaccuracies With the Data



Source: State law and Medicaid Managed Care Government Accountability Office October 2018 report.

As part of its recent changes to Medicaid rules, CMS placed a greater emphasis on accurate and complete reporting of encounter data. CMS also highlighted the importance of high-quality encounter data in an August 2018 letter to state health officials and reaffirmed this position—including its ability to withhold state Medicaid funding—in its October 2018 response to a GAO audit, which found that CMS needs to take additional action to help ensure encounter data reliability. Unless DHCS continues to improve the quality of its encounter data, the State risks losing federal funding if it is unable to meet CMS's criteria for the accuracy and completeness of managed care encounter data.

DHCS Relies on Provider Information That Could Be Inaccurate, Which Could Hinder Access to Care

DHCS' new process for validating the status and locations of plan providers also has flaws that could limit DHCS' ability to identify and target areas of low usage or reduced access to preventive care, and which could hinder beneficiaries' access to care. To verify that the provider data that plans submit are accurate, two separate divisions at DHCS use processes developed after our June 2015 report, *California Department of Health Care Services: Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care*, Report 2014-134. In that audit, we found that DHCS used inconsistent and not statistically valid methods when reviewing the provider data that plans were submitting for their provider directories. We also found that DHCS could not demonstrate that it performed all of its reviews of plans' provider directories because it did not retain the necessary documentation. Provider directories are one of the primary means by which beneficiaries can find health care providers. DHCS generally agreed with our findings from that audit and took steps to implement our recommendations. However, in spite of these steps, we found that problems remain, limiting the reliability of the information DHCS uses when it annually reviews provider networks and that beneficiaries receive about available providers.

DHCS' method for reviewing provider information does not provide sufficient assurance of the accuracy of the provider data that are made available to beneficiaries. DHCS uses a statistical survey tool to calculate how many providers from each plan it needs to verify when reviewing plans' provider directories for accuracy. This tool allows DHCS staff to select a margin of error, such as 5 percent or 10 percent, and a confidence level from 80 percent to 99 percent although guidance included with the tool recommends not using a confidence level below 90 percent. However, to limit the amount of staff time devoted to the provider information review process,

DHCS selected a 10 percent margin of error and an 80 percent confidence level—the lowest setting the tool allows. In contrast, CMS uses a confidence level of 95 percent in its consumer surveys, and a 90 percent confidence level for some activities related to payments. Because DHCS has chosen a lower confidence level, its sample size is much smaller, and it is likely that errors may go undetected in a significant portion of the provider directory reviews it conducts.

Further, the provider information itself can often be inaccurate. In our 2015 audit, which included our review of listings in the provider directories of three plans, we found that inaccurate listings for the providers we checked in those directories ranged from a low of 3 percent for one plan to as high as 23 percent for another plan. In spite of these concerns, DHCS continues to approve a plan's provider directory if it determines that information for 80 percent of the plan's providers that DHCS reviews is accurate. This means that although information for a significant portion of the providers in the directories may be inaccurate, DHCS would still approve them. For example, during its February 2018 review of Alameda Alliance's provider directory, DHCS found inaccurate or incomplete information for six of 39 providers sampled, or 15 percent, but still approved the directory as submitted. According to DHCS, some Medi-Cal beneficiaries rely exclusively on the provider directory to select their plan and provider. When the provider directory is inaccurate, families may have trouble finding a provider.

DHCS approves plans' provider directories if it determines that they are at least 80 percent accurate.

DHCS is also unable to show that it reviewed all the provider information it claims it reviewed. In response to our 2015 audit, DHCS adopted policies and procedures to retain all documentation related to its provider directory reviews for a minimum of three years. However, DHCS was not able to provide the review documentation we requested for this audit for two of four plans it said it reviewed because the contract manager for those plans was not able to locate the documents. Instead, DHCS provided the approval forms for those plans' provider directories, which a supervisor signs once DHCS has completed its review. However, the portion of the form listing review findings for one of the plans was blank, and the portion listing findings for the other plan said only "Approved." According to the chief of its Managed Care Internal Operations Branch, DHCS is revising its processes to ensure that the review tools are maintained for future reference. When DHCS staff do not maintain the supporting documentation from their directory reviews, DHCS is unable to demonstrate that it actually performed the necessary reviews to ensure that provider information in the directories is accurate.

DHCS Is Not Proactively Addressing Cultural Disparities That Exist in the Usage of Preventive Health Services

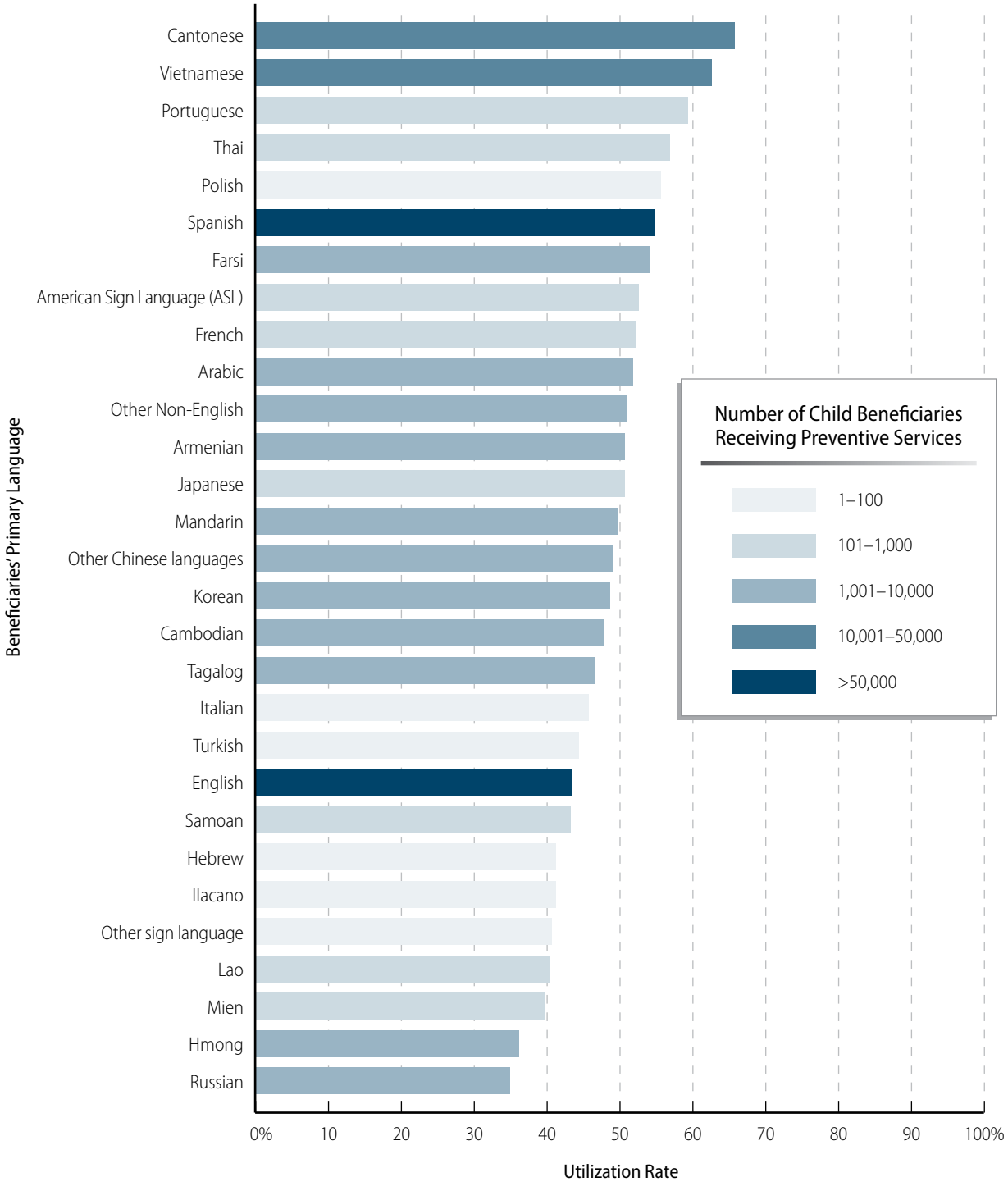
Cultural factors—ethnicity and language in particular—appear to impact utilization rates. As indicated in Figure 8, utilization rates for children's preventive services in fiscal year 2016–17 ranged from nearly 66 percent for Cantonese speakers to just under 35 percent for Russian speakers. In addition, Figure 9 on page 42 indicates that utilization rates by ethnicity during the same year were highest among Vietnamese populations at nearly 60 percent, while utilization rates for Guamanian and Samoan child beneficiaries were lowest at about 37 percent. Federal law requires each state to have a plan to identify, evaluate, and reduce—to the extent practicable—health disparities based on various characteristics including race, ethnicity, and primary language. According to the 2019 Health Workforce Commission Report, patients make greater use of preventive services and have higher levels of trust and satisfaction with providers of similar racial, linguistic, and social backgrounds. Although DHCS and the three plans we reviewed agreed that cultural factors impact utilization and access rates for children's preventive services, DHCS has not effectively mitigated the impact of cultural factors on utilization and access rates nor has it ensured that plans consistently mitigate those disparities on their own.

DHCS requires plans to produce a report once every five years to identify the cultural and linguistic needs of their beneficiaries; however, it has not ensured that plans have taken action to address the relevant disparity, access, or usage findings cited in those reports. DHCS' contracts with plans specify that these reports—called *group needs assessments*—must include a demographic profile of members and must assess related health risks and cultural factors of these populations. However, DHCS has not consistently followed up on plans' group needs assessment findings to ensure that each plan has made efforts to mitigate disparities identified in the report. For instance, Alameda Alliance has not yet established a health education program for its population of Hispanic children to combat high obesity, asthma, and hypertension rates even though it had explicitly outlined this as a goal in its 2016 group needs assessment report. DHCS could not provide evidence that it had followed up with Alameda Alliance on this particular disparity.

DHCS could not provide evidence that it has taken action to mitigate cultural health disparities for children's preventive services statewide.

In fact, DHCS could not provide evidence that it has taken action to mitigate cultural health disparities for children's preventive services statewide. Specifically, DHCS' EQRO published a health disparities study in July 2018 that reported some performance measures—including some for children's preventive services categorized by race, ethnicity, and primary language—to identify disparities among those groups. The report noted that immunization rates were lowest for African American/black children, that childhood and adolescent access

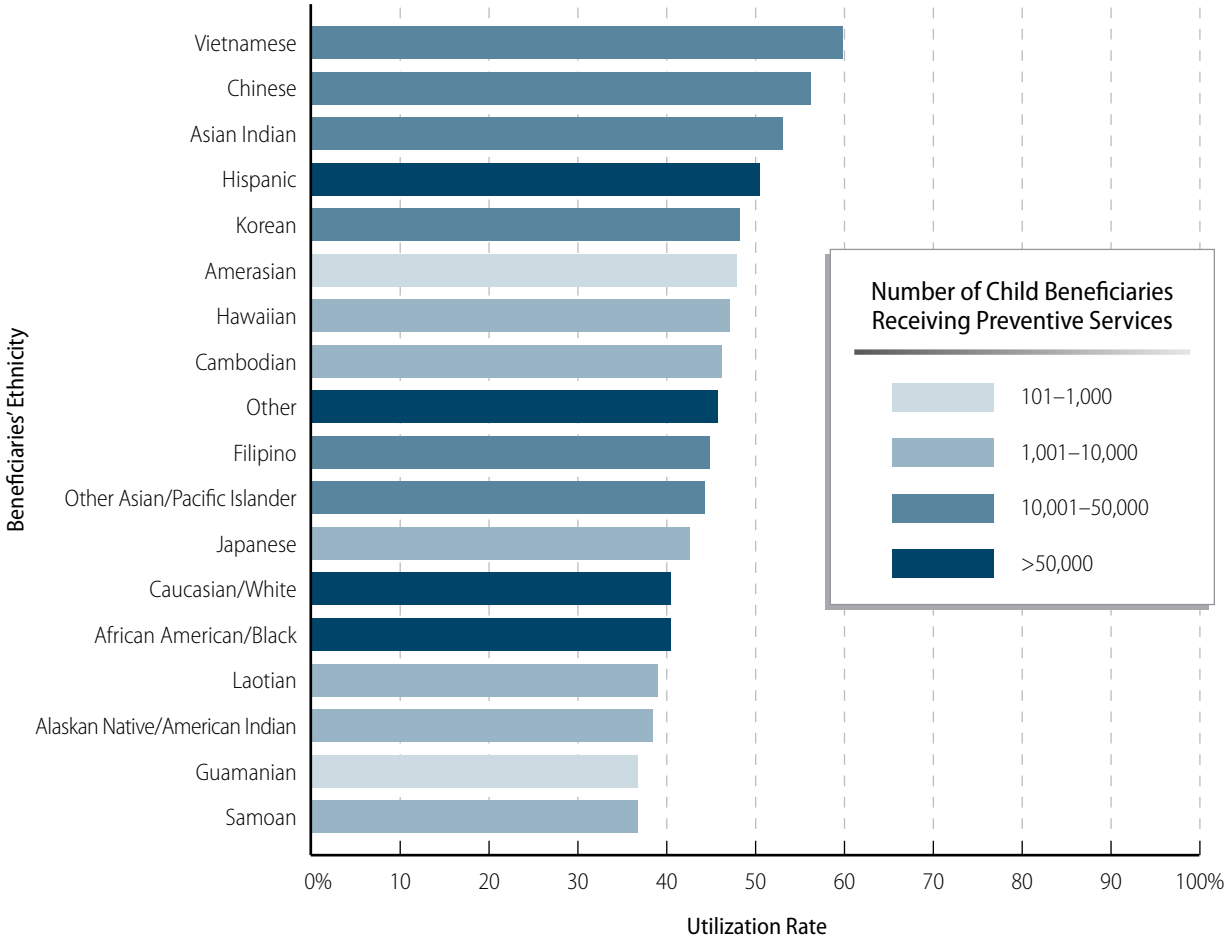
Figure 8
Utilization Rates Were Not Necessarily Higher for More Common Languages
Fiscal Year 2016–17



Source: Analysis of DHCS' Management Information System/Decision Support System data.

to primary care was lowest for certain European language speakers, and that the utilization rate for well-child visits for 3- through 6-year-olds was lowest for Caucasian/white children. However, DHCS stated that the methodology of the report did not allow it to specifically identify demographic disparities at the county or reporting unit level or to use the report for targeted interventions. Nevertheless, DHCS indicated that in future years it will incorporate a more expansive analysis within its EQRO's health disparity study, and it will include measures that enable it to better make demographic comparisons within the child Medi-Cal population. DHCS did not provide a conclusive timeline for this analysis, however.

Figure 9
Utilization Rates Were Not Necessarily Higher for More Common Ethnicities
Fiscal Year 2016–17



Source: Analysis of DHCS' Management Information System/Decision Support System data.

DHCS also does not take a proactive role in ensuring that children have access to health care in the language of both the child and the family. Although DHCS monitors utilization rates by language, it does not take steps to increase the availability of providers based on language needs. Instead, it relies on parents to request interpreters and on providers to provide the language services that families request. However, plans' surveys of their members reveal that some members are unaware that interpreters are available or they reported that their providers asked them to bring family members to act as an interpreter. The most recent group needs assessment surveys at the three plans we visited showed that 30 percent of Spanish-speaking beneficiaries at Partnership HealthPlan relied on friends or family members to interpret for them, 33 percent of Spanish-speaking beneficiaries at Alameda Alliance were not aware that medical interpreters were available, and fewer than one-third of LA Care members were able to get a professional interpreter when needed. Although DHCS verifies that plans provide interpreters through its audits, it does not actively monitor group needs assessment survey findings or require plans to take action on these survey findings. Thus, DHCS is failing to ensure that children have access to health care in the language of both the child and the family.

Although DHCS monitors utilization rates by language, it does not take steps to increase the availability of providers based on language needs.

Some plans have taken steps to conduct targeted outreach in order to address disparities in utilization rates without direction from DHCS. For example, Health Net identified a low immunization rate among the Russian community in Sacramento and then took steps to improve that rate through school interventions, outreach, and training for providers on Russian culture. Health Net noted a 10 percent improvement in its immunization rates over a three-year period as a result of its efforts. Although Health Net identified and addressed a child health disparity without assistance from DHCS, our analysis indicates that ethnic and linguistic child health disparities exist across all plans. Without taking a more active role in addressing these child health disparities, DHCS is missing an opportunity to improve access and utilization rates for millions of California children.

Recommendations

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

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 percent confidence level and not more than a 10 percent margin of error on its statistical sampling tool and should require at least 95 percent 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.

Chapter 3

DHCS IS MISSING OPPORTUNITIES TO HELP CALIFORNIA'S CHILDREN RECEIVE PREVENTIVE HEALTH SERVICES

Chapter Summary

DHCS could take several specific actions to help improve access and increase the usage of children's preventive services through Medi-Cal. For instance, DHCS could implement more effective incentive programs and other best practices to help increase access to—and usage of—preventive services for children. DHCS could also establish a formal process to share the results of its and its plans' strategies that have succeeded in increasing utilization rates for these services. Finally, although DHCS regularly commissions external studies related to children's preventive health services, it needs a better process to make sure it actually implements recommendations from these studies.

DHCS Can Do More to Operate Effective Incentive Programs and Implement Other Best Practices to Increase Access to—and Usage of—Preventive Services for Children

DHCS has begun implementing incentive programs, but it can do more to ensure that they are effective. Since 2005 DHCS has had a nonfinancial incentive program that rewards plans with a greater percentage of enrollments when they perform statistically better than other plans or do better than their own previous year's performances. This program focuses on eight performance measures, two of which relate to children's preventive services, including childhood immunization rates and well-child visits in the third through sixth years of life. DHCS scores plans based on how well they perform for each performance measure and then proportionally allocates the Medi-Cal beneficiaries who did not choose their own health plan into those plans based on the plans' performance scores—the higher the score, the more beneficiaries a plan is allocated.[10] However, since DHCS has not evaluated the impact of the program on usage of children's preventive services, it cannot demonstrate that this auto-assignment program leads to improved performance on the included performance measures. As we reference in Appendix C, DHCS has also initiated a program to incentivize preventive dental services in the Medi-Cal Dental program, which we audited in 2014.

[10] DHCS may also reduce the percentage of enrollments assigned to a plan because of inaccurate encounter data or an inadequate number of safety net providers—providers that treat patients regardless of their ability to pay.

Some health plans operate their own incentive programs to supplement low reimbursement rates and to improve performance related to children's preventive care. All three of the health plans we visited operate such incentive programs and demonstrated moderate increases in their utilization rates for children over the period we reviewed. For instance, Alameda Alliance rewards its providers per performance measure based on the percentage increase from the prior year's rate. Since the plan implemented its provider incentive program in 2015, utilization rates increased from 49 percent in fiscal year 2014–15 to 54 percent in fiscal year 2016–17. Partnership HealthPlan awards providers based on how well they perform on each selected measure compared to the national Medicaid performance measure rates as well as their relative improvement from previous years. Partnership HealthPlan's utilization rates increased from 48 percent in fiscal year 2013–14 to 50 percent in fiscal year 2016–17. Similarly, LA Care, which had an increase in utilization rates from fiscal years 2015–16 to 2016–17, awards its providers based on how well they perform compared to providers within the plan as well as on their relative improvement from the prior year in well-child visits and childhood and adolescent immunization rates. In fact, in 2017, LA Care began rewarding providers for high utilization rates in children's access to primary practitioners—a measure monitoring the percentage of children 12 to 19 years of age who had a visit with a primary care physician during the year—which can be an effective best practice for other plans' programs.

We identified practices in other states that California could consider adopting, including incentive programs, which could serve to supplement the State's reimbursement rates and improve performance.

As we show in Table 6, we identified practices in other states that California could consider adopting, including incentive programs, which could serve to supplement the State's reimbursement rates and improve performance. For example, Tennessee, which has a 57 percent utilization rate for children's preventive care, currently operates a statewide financial incentive program. It allows plans to select their own performance measures for improvement tied to incentives and requires plans to show a 5 percent improvement each year to be eligible for an incentive payment. Similarly, Connecticut, with utilization rates nearly 20 percent higher than in California, currently operates a statewide incentive program that awards providers who improve on utilization rates for developmental screening in the first three years of life. According to the Child Health and Development Institute of Connecticut, the number of children who received developmental screenings as a result of the program dramatically increased from nearly 15,000 in 2010 to 65,000 in 2017.

DHCS has not tracked the results of its own incentive program, nor has it tracked the results of programs that plans have developed independently. Thus, it cannot determine which programs are most effective or have the most potential to be expanded statewide.

Further, as discussed in the next section, DHCS does not facilitate plans' sharing of their programs' successes. As a result, DHCS is missing opportunities to increase access to and usage of critical children's preventive care services.

Table 6
California May Be Able to Benefit by Adopting Best Practices From Higher-Performing States

STATE	UTILIZATION RATE*	BEST PRACTICE
Iowa	82%	Incorporates well-care visits into sports physicals
Hawaii	81	
Wisconsin	79	Operates a statewide pay-for-performance program
New York	75	Includes Bright Futures schedule in its provider handbook
Connecticut	68	Monitors developmental screenings in the first three years of life
Texas	68	Provides diapers for check-ups
Rhode Island	60	Provides gifts for check-ups
North Carolina	58	Provides certification credit for quality improvement webinars
Utah	57	
Tennessee	57	Operates a statewide pay-for-performance program and incorporates well-care visits into sports physicals

Source: Analysis of various online publications and CMS annual EPSDT data for all states, federal fiscal year 2018.

* Utilization rate = total eligible children receiving at least one initial or periodic screening divided by total eligible children who should receive at least one initial or periodic screening.

DHCS Has Not Taken Sufficient Action to Meet its Immunization Goal, and It Does Not Share the Results of Successful Strategies Across All Plans

DHCS is not doing enough to improve the immunization rates for children in Medi-Cal. Federal law requires that DHCS develop and implement a quality strategy for assessing and improving services provided by its plans. Even though DHCS has been focusing on childhood immunization rates as part of its quality strategy for the past five years, it has not been able to meet its target of an 80 percent usage goal. In fact, because it has not taken sufficient action to address the causes of its low immunization rates, these rates decreased from calendar years 2014 through 2017. According to DHCS, two of the major reasons it has not been able to meet its target immunization rate of 80 percent are that not all providers have registered to use the California Immunization Registry, which supports patient reminders, and that providers do not always have the vaccines in stock. However, we found that DHCS has not

worked directly with providers to address these two issues. Instead, it stated that plans can work with the California Department of Public Health to increase provider usage of the California Immunization Registry and to monitor vaccine inventories, and DHCS expects the plans to educate providers about the importance and expectations of childhood immunizations.

DHCS is not maximizing the opportunities for improvement that its current processes provide.

Furthermore, DHCS is not maximizing the opportunities for improvement that its current processes provide. Specifically, if a plan performs below an established minimum performance level, DHCS requires the plan to conduct a PDSA cycle. A PDSA cycle is a performance improvement process in which a plan implements strategies to improve services at a particular provider and reports progress to DHCS quarterly. DHCS also expects a plan to adopt successful strategies as a best practice at its other provider sites wherever possible. In addition, DHCS conducts quarterly improvement calls open to all plans and invites plans to volunteer to share their successful strategies. According to DHCS' medical consultant, DHCS currently does not provide enough call time for all plans to share their successful strategies, and often plans are not available to present on potential best practices during these calls. Despite these and other informal efforts, we found that even if a PDSA cycle's results are successful, DHCS does not have policies and procedures in place to share this type of success with other plans. For instance, DHCS placed Partnership HealthPlan under a PDSA cycle from October 2016 to May 2017. As part of the PDSA cycle, Partnership HealthPlan conducted a workflow modification intervention based on its knowledge that providers generally spend only half of a well-child visit directly with the child. By replacing the provider with a nurse for the first half of every visit, providers performed more well-child visits and childhood immunization rates improved by 33 percent. DHCS considered Partnership HealthPlan's PDSA cycle to be successful but did not ensure that all other plans knew of the results.

DHCS also did not ensure that Partnership HealthPlan shared its successful strategy with its own providers across counties in the northeast and northwest portions of its service area even though Partnership HealthPlan had committed to doing so as part of its approved PDSA cycle. These counties may have benefited from the strategy because they had experienced continuously declining immunization rates. DHCS explained that it expects but does not require a plan to adopt successful strategies at all of the plan's providers because it considers the PDSA process an individualized improvement process and does not require plans to share promising practices with other plans. However, a DHCS' medical branch consultant agreed that it would make sense for DHCS to be responsible for ensuring that plans share successful practices.

By not encouraging plans to adopt known best practices or proactively sharing successful results itself, DHCS is limiting the usefulness of its PDSA process.

DHCS Has Not Implemented Some Recommendations From Its External Quality Review Organization for Improving Access and Quality of Care

DHCS did not implement many of its EQRO's recommendations related to children's preventive services. Federal law requires DHCS to ensure that an EQRO produces a technical report that summarizes findings on access and quality of care and includes recommendations for improving the quality, timeliness, and access to health care services. In 2017 the EQRO recommended that DHCS consider implementing strategies to improve well-child visits in the third through sixth years of life. The recommendation stemmed from the fact that plans' performance related to well-child visits in those age groups significantly declined from 2015 to 2016. DHCS chose not to implement the recommendation and explained that it may consider the EQRO's recommendation in 2019 since childhood immunization, rather than well-child visits, was the focus area at the time.

DHCS also failed to fully address a recommendation related to communicating the importance of preventive services. The EQRO's technical report included a focused study related to monitoring the plans' provision of developmental screening in the first three years of life. Although the EQRO report noted there was a consistent lack of education regarding the importance of children receiving developmental screenings—similar to the issues we identified earlier in this report—DHCS did not adopt it as a performance measure. DHCS explained that it commissions numerous studies annually to consider potential next steps, but it is not required to respond to such recommendations. However, our data indicate that average utilization rates for children aged 1 to 2 years are below the average utilization rates for all children and have remained below the fiscal year 2013–14 rates. By not adequately addressing the EQRO's annual recommendations relating to children's preventive services, DHCS is not maximizing its ability to ensure that children are receiving recommended preventive health services.

By not adequately addressing the EQRO's annual recommendations relating to children's preventive services, DHCS is not maximizing its ability to ensure that children are receiving recommended preventive health services.

Furthermore, federal law requires the State to ensure that the EQRO's annual report includes an assessment of the extent to which each plan has effectively addressed the EQRO's prior-year quality improvement recommendations. According to DHCS' monitoring chief, to assess plans' implementation of prior-year recommendations, the EQRO reviews each plan's self-reported actions and if the EQRO does not issue plan-specific recommendations related to these areas, DHCS considers the prior-year recommendations implemented.

However, this practice does not result in any definitive, written conclusions regarding whether plans have implemented prior-year recommendations. Thus, DHCS may not be meeting its obligation under federal law to have its EQRO include the assessment and is not maximizing its opportunities to increase plans' performance.

Recommendations

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.

We conducted this audit under the authority vested in the California State Auditor by Government Code 8543 et seq. and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

ELAINE M. HOWLE, CPA
California State Auditor

Date: March 14, 2019

Appendix A

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to examine the status of children in Medi-Cal focusing on DHCS' efforts to ensure access and usage of preventive health care services for Medi-Cal eligible children. Table A below lists the objectives that the Audit Committee approved and the methods we used to address them.

Table A
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Identified and reviewed relevant federal and state laws, rules, and regulations related to timely access to care and utilization of preventive services for children.
2	Determine what efforts DHCS has made to do the following:	
	a. Ensure that eligible children are receiving preventive health care services.	• Interviewed key staff at DHCS. • Evaluated the efforts and processes DHCS uses to ensure eligible children receive preventive health care services. • Analyzed DHCS' data to evaluate the use of preventive care by children statewide and by age, language, ethnicity, health plan, and county. Our analysis included child Medi-Cal beneficiaries with full-scope benefits that were eligible for 11 or more months at a given age. For infants, our analysis included beneficiaries that were eligible for eight or more months prior to their first birthday. We calculated utilization rates using the Bright Futures recommended schedule of care, with the exception of infants. According to DHCS, infants may be tracked under their mother for three months. Therefore, we could only reasonably track the data for up to three of the seven infant services recommended by the Bright Futures schedule. As such, we considered infants that received three or more services prior to their first birthday to have received the recommended number of services. • Reviewed external review reports and evaluated DHCS' utilization of those reports to monitor and improve accessibility of preventive health care services for eligible children.
	b. Monitor and enforce standards for timely access, specifically for pediatric preventive care appointments.	• Interviewed key staff at DHCS. • Used plan and provider data to determine the extent of access and utilization of preventive services for children in California, including by region. • Determined whether efforts by DHCS to address timely access deficiencies identified by external review reports were sufficient and effective.
3	Determine whether DHCS is fully compliant with all federal Medicaid EPSDT policies and reporting requirements related to pediatric preventive care access and utilization.	• Identified and reviewed federal Medicaid laws and regulations related to EPSDT services. • Obtained and reviewed CMS policy manuals and guidance for states on EPSDT services. • Interviewed key staff at DHCS and obtained DHCS work products related to EPSDT services. • Interviewed key staff at CMS. • Evaluated DHCS' work products, policies, and procedures to determine whether they meet all federal requirements and CMS guidance.

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
4	Evaluate Medi-Cal contract language and departmental guidance to ensure that they make clear the following:	
	a. The requirements for timely access to care and delivery of preventive services for children.	Determined whether DHCS' contracting language and departmental guidance complied with, and made clear, all relevant criteria related to timely access to care and delivery of preventive services for children.
	b. The oversight and monitoring activities performed by DHCS.	• Evaluated all Medi-Cal contract language and departmental guidance to ensure it addressed and made clear all relevant oversight and monitoring activities of timely access to care and delivery of preventive services for Medi-Cal children. • Reviewed DHCS' most recent annual audits of health plans to ensure its audit procedures related to utilization management, access, and availability of care addressed all oversight requirements specified in DHCS' departmental guidance, contract language, and applicable law. • Evaluated whether DHCS' most recent audits of fee-for-service providers were adequate to ensure timely access to care and delivery of preventive services for Medi-Cal children. • Evaluated whether DHCS' oversight and guidance practices were adequate to ensure timely access to care and delivery of preventive services for Medi-Cal children. • Determined whether DHCS ensured that plans address audit findings.
5	Identify and evaluate incentive or quality improvement programs DHCS operates or has plans to implement to address deficiencies in pediatric care access and utilization.	• Interviewed key staff at DHCS. • Examined annual quality strategy reports and other relevant documents to identify incentives or quality improvement programs DHCS currently operates, and assessed their impacts on deficiencies in pediatric preventive care access and utilization. • Examined documents to assess the impacts of DHCS' financial sanctions on pediatric care access and utilization. • Evaluated the impact of DHCS' annual medical audit corrective action plans on pediatric care access and utilization. • Determined the amount of funds that are currently dedicated to quality improvement, and determined whether financial incentives have enhanced quality.
6	Identify and evaluate DHCS' policies and procedures to ensure that children receive timely care in the language of both the child and the family.	• Determined whether DHCS' policies and procedures related to language services comply with relevant criteria. • Identified and evaluated DHCS' methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State and in each health plan service area. • Evaluated efforts by DHCS to notify enrollees, potential enrollees, and their families about available language services. • Identified and evaluated DHCS' methods for monitoring and enforcing the provision of language services in health plan service areas. • Determined the extent to which DHCS and its health plans have made language and interpretation materials available for Medi-Cal enrollees, potential enrollees, and their families. • Analyzed DHCS' data to determine the preventive care utilization rates of children by language.
7	To the extent possible, identify and evaluate DHCS' policies and procedures for monitoring and mitigating disparities in preventive care access and utilization for children of differing racial and ethnic backgrounds.	• Determined whether DHCS' policies and procedures related to monitoring and mitigating disparities comply with relevant criteria and found no significant exceptions. • Analyzed DHCS' data to determine the preventive care utilization rates of children by ethnicity. • Identified and evaluated DHCS' processes for monitoring and mitigating disparities in preventive care access and utilization for children of differing racial and ethnic backgrounds.

	AUDIT OBJECTIVE	METHOD
8	Review DHCS' plan to prepare for, implement, and monitor upcoming changes to Medi-Cal rules related to pediatric care.	• Identified and reviewed recent state and federal laws and regulations effecting changes to Medi-Cal rules broadly related to pediatric care, including changes to Medi-Cal managed care. • Obtained and reviewed CMS policy manuals and guidance for states on recent and upcoming changes to Medicaid. • Interviewed key staff at DHCS and obtained DHCS work products related to recent and upcoming changes to Medi-Cal broadly related to pediatric care. • Interviewed key staff at CMS. • Reviewed and evaluated DHCS' work products, policies, procedures, and plans to implement and monitor recent and upcoming changes to Medi-Cal.
9	Review best practices for DHCS to consider to help ensure timely access to pediatric appointments and required children's preventive health services.	• Interviewed key staff at DHCS. • Evaluated well-performing Medi-Cal plans and identified best practices, including financial incentive programs that can be applicable to all plans. • Identified best practices at other states that ranked higher in utilization rates for children screening services, including financial incentive programs. • Reviewed online publications and other relevant documents to identify best practices for DHCS to consider to help ensure timely access and provision of care, including the *Medicaid Health Plans of America: Centers for Best Practices*.
10	Review and assess any other issues that are significant to the audit.	Reviewed the state budget and DHCS' Medi-Cal budget estimates to determine the State's Medi-Cal expenditures for various categories of service and health care delivery systems.

Source: Analysis of the Audit Committee's audit request number 2018-111, and information and documentation identified in the table column titled *Method*.

Assessment of Data Reliability

In performing this audit, we relied on electronic data obtained from DHCS' Management Information System/Decision Support System. The GAO, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of the computer-processed information that we use to support our findings, conclusions, or recommendations. To evaluate these data, we performed electronic testing of the data, reviewed existing information about the data, and interviewed agency officials knowledgeable about the data.

We also reviewed a report that revealed concerns with both the completeness and the accuracy of DHCS' medical encounter data from 2012. This report issued several recommendations to DHCS in an effort to improve data quality and DHCS took some steps to address these recommendations. Further, the draft EQRO report finalized in January 2019 found that DHCS' 2016 data were more complete and accurate than data from 2012, but it also found gaps in the quality of the data. However, we are unable to quantify the effect these issues had on the data we analyzed because source documentation was located at individual medical providers throughout the State, making testing of the data cost-prohibitive.

As a result, we found the data to be of undetermined reliability for the purpose of determining preventive care utilization rates of Medi-Cal beneficiaries under the age of 21 during fiscal years 2013–14 through 2017–18. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.

Appendix B

DHCS WILL NEED TO CONTINUE TO PREPARE TO IMPLEMENT RECENT AND UPCOMING CHANGES TO MEDI-CAL RULES RELATED TO PEDIATRIC CARE

Some of the most significant recent changes to Medi-Cal rules related to pediatric care stem from CMS' 2016 Managed Care Final Rule (final rule). The final rule changed many federal regulations related to Medicaid managed care. For example, the final rule creates a new requirement that the State and plans have a transition-of-care policy to ensure that beneficiaries can continue to access their health care services during their transition from fee-for-service to managed care or during a transition from one plan to another. DHCS updated California's transition-of-care policy, which includes additional provisions set forth in state law, to meet the requirements of the final rule and informed plans of these updates in an all-plan letter that DHCS published in July 2018.

One portion of the final rule that may have significant financial repercussions for Medi-Cal plans is the requirement that plans annually report to DHCS the percentage of their health care premium revenue that they spend paying claims, implementing quality improvement activities, and other specified expenditures. This portion is known as the *medical loss ratio* (MLR) and is governed by both state and federal law, which establishes new MLR standards that plans must meet starting in 2019. Specifically, plans must achieve a minimum MLR of at least 85 percent by allocating at least 85 percent of their adjusted premium revenues, as defined by federal law, to paying claims and other specific expenditures related to improving health care quality and fraud prevention. Further, if plans are unable to meet the new MLR standards by 2023, a new state law passed in response to federal regulations will require the plans to remit funds to DHCS, which will refund to CMS the federal portion of the affected Medicaid payments and transfer any remaining funds into an existing physician loan repayment program. As it begins to implement the new MLR requirements in 2019 and prepare for the remittance requirements that go into effect in 2023, DHCS will need to continue to work with plans to ensure that California maximizes the amount of federal funding available for Medi-Cal.

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Appendix C

DHCS HAS STRUGGLED TO RAISE THE MEDI-CAL DENTAL UTILIZATION RATE AND IT CONTINUES TO RISK MAKING IMPROPER PAYMENTS

The utilization rate for Medi-Cal Dental remained largely flat from 2013 through 2016, and although DHCS implemented most of the recommendations from our 2014 report, it has not updated its beneficiary eligibility system with sufficient death information to prevent multiple improper payments. In December 2014, the State Auditor issued a report titled *California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care*, Report 2013-125, and made 24 recommendations. These recommendations are related to increasing the utilization rate and provider participation for services available to children accessing the Medi-Cal Dental program, better monitoring DHCS' contract with its fiscal intermediary, and improving its data management to reduce improper payments. The term *utilization rate* refers to the percentage of Medi-Cal eligible children—persons aged zero to 20 years—who receive at least one dental service in a federal fiscal year. We focused our follow-up work on DHCS' implementation of those recommendations most likely to result in an increase in the utilization rate or in preventing improper payments.

DHCS Has Begun Changing Its Medi-Cal Dental Program, but It Has Struggled to Increase Its Utilization Rate

Of the 19 recommendations in our December 2014 report related to DHCS' utilization rate and its contract with its fiscal intermediary, DHCS has implemented or resolved the underlying issues for 15 of them. Table C.1 on the following page summarizes the 19 recommendations, the issues they relate to, and some of the key actions DHCS took to implement the recommendations. Nevertheless, according to data from CMS, California's utilization rate for children's dental services stagnated at 44 percent in federal fiscal years 2013 through 2016, and in federal fiscal year 2016 California ranked among the 10 states with the worst utilization rate nationwide.[11] In federal fiscal year 2016, 3.4 million children who participated in Medi-Cal did not receive any dental services, an increase of 500,000 children from 2013. DHCS is tasked with increasing the utilization rate, and in September 2016 the Legislature passed a bill setting the goal for the utilization rate at 60 percent or higher. DHCS set a preliminary timeline to reach that

[11] Data from the Centers for Medicare and Medicaid Services.

goal in calendar year 2024. Consequently, DHCS must show a gain in the utilization rate of 16 percentage points from its 2016 rate to meet its statutory goal.

Table C.1
DHCS Implemented Most of Our Recommendations Aimed at Increasing Its Utilization Rate and Strengthening Contract Management

CATEGORY	STATUS OF RECOMMENDATIONS	NUMBER OF RECOMMENDATIONS	ACTION
Beneficiary Utilization and Provider Participation	Fully Implemented	8	DHCS developed a statewide provider-to-beneficiary ratio, established guidelines to identify underperforming counties, developed processes to mitigate access issues in underperforming counties, removed inactive providers from the provider count, simplified the provider enrollment form, and published an annual reimbursement rate review that compares California to other states, among other actions.
	Not Fully Implemented	3	DHCS has not performed a trend analysis nor does it document steps to combat declining trends in its delivery system. DHCS did not document its implementation of supplemental payments for certain providers.
	Will Not Implement	1	DHCS will not include the provider-to-beneficiary ratio statewide as part of its reporting to the Legislature because it is not required to do so in law.
Strengthening Contract Management	Fully Implemented	7	DHCS entered into a new service provider contract that includes specific benchmarks, provided contract beneficiary data for outreach purposes, and required the contractor to submit outreach plans, among other actions.
	Total	**19**	

Source: Review of documentation provided by DHCS.

The overall number of children in the Medi-Cal Dental program has increased and DHCS points to other reasons for its low utilization rate. Between federal fiscal years 2013 and 2016, the number of eligible children increased by 900,000. Because DHCS' utilization rate has essentially remained unchanged during this time, the data indicate that it was able to absorb the enrollment growth but not increase the percentage of enrolled children it serves. According to DHCS, several factors contribute to the low utilization rate, including low provider participation, poor access to services in less populated areas of the State, low reimbursement rates for providers, a lack of education among enrollees of their benefits, and beneficiaries not prioritizing their oral health. Data show that seven counties did not have any Medi-Cal dental providers and six other counties had only one provider in calendar year 2016. In terms of reimbursement

rates, Medi-Cal Dental's fee-for-service rate was among the lowest in states using a fee-for-service model as of calendar year 2016. The American Dental Association reported that California reimbursed 38.7 percent of what dentists would have received from a private insurer whereas other states' Medicaid reimbursement varied from 36.4 percent to 98.4 percent. When comparing California's reimbursement rate against states with managed care programs, California still ranked near the bottom with reimbursement rates for other states ranging between 37.5 percent and 107.1 percent.

DHCS has entered into a contract it expects will improve its Medi-Cal dental utilization rate. Specifically, in its contract with an administrative services organization (ASO), the ASO must create a plan for outreach to beneficiaries, submit annual updates, and conduct monthly provider enrollment outreach workshops and weekly provider enrollment assistance events. The ASO must also meet benchmarks for increasing the utilization rate by 10 percentage points over three years. The transition to the new contract occurred in early 2018, and it is too soon for DHCS to know the efficacy of the changes it has made.

DHCS has also taken other steps to improve its dental utilization rate. In December 2015, CMS granted DHCS a five-year Medi-Cal waiver to implement the Dental Transformation Initiative (DTI), which included the goal of improving dental health for Medi-Cal eligible children by increasing usage of preventive dental services. The DTI funds four programs, termed *domains*. Domain 1 provides incentive payments for providers who meet or exceed preventive service benchmarks, Domain 2 incentivizes caries treatment plans aimed at preventing cavities, Domain 3 rewards providers for maintaining continuity of care, and Domain 4 supports the goals of domains 1 through 3 through pilot programs with broad-based provider and community support. DHCS has selected 15 projects initially for the DTI. The Medi-Cal waiver and its associated funding expire at the end of 2020.

DHCS was able to also provide supplemental payments to providers for fiscal year 2017–18 because of Proposition 56, which California voters approved in November 2016 to increase the excise tax rate on cigarettes and tobacco products. DHCS is allocated a portion of these funds for health care expenditures as a part of the annual state budget process. The Legislature authorized DHCS to extend the supplemental payments through June 2019. For fiscal year 2017–18 only, the Legislature allocated $140 million in Proposition 56 funds to reimburse dental providers for services.

Failure to Fully Implement Our Recommendations Could Lead to Continuing Improper Payments

In our December 2014 report, we made five data-related recommendations. DHCS has fully implemented two of them, as shown in Table C.2. DHCS has partially implemented the remaining three, including two recommendations we made to address reimbursements to providers for services purportedly rendered after a beneficiary's date of death. To address these questionable payments, we recommended that DHCS recover any funds it paid to providers inappropriately and obtain and use the Social Security Death Master File as a data source for updating its beneficiary eligibility system.

Table C.2
DHCS Performed Some Actions to Address Our Recommendations to Improve Data Management

CATEGORY	STATUS OF RECOMMENDATIONS	NUMBER OF RECOMMENDATIONS	ACTION
Improve Data Management	Fully Implemented	2	DHCS corrected erroneous data in its data warehouse and fixed issues with transferring data from its mainframe to its data warehouse, among other actions.
	Not Fully Implemented	3	DHCS has yet to update its monthly beneficiary eligibility system with accurate death information to ensure that payments are made only to eligible beneficiaries.
	Total	**5**	

Source: Review of documentation provided by DHCS.

Since 2014 DHCS has taken some action but needs to do more to reduce its risk of making improper payments. In 2016 DHCS began identifying claims made for services purportedly rendered after a beneficiary's date of death and has since recovered $58,000 in improper payments. However, DHCS has yet to access and use the Social Security Death Master File for date-of-death information to identify these claims; its current process relies on sources with incomplete death data. DHCS submitted an application in July 2018 requesting access to the Social Security Death Master File and the Social Security Administration is currently reviewing it. Until DHCS has complete death information in its beneficiary eligibility system, it risks making improper payments to providers by screening claims using incomplete information.

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

FEB 20 2019

Ms. Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides responses to the draft findings of the California State Auditor's (CSA) report entitled, *California Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventative Health Services.* The CSA conducted this audit and issued eight findings and 14 recommendations.

DHCS fully agrees with recommendations two, five, six, seven, nine through eleven, and fourteen. DHCS partially agrees with recommendations three, four, eight, twelve, and thirteen. DHCS does not agree with recommendation one.

DHCS has prepared corrective action plans for all eight findings. DHCS appreciates the work performed by CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Nicole Jacot, External Audit Manager, at (916) 713-8812

Sincerely,

Jennifer Kent
Director

Enclosure

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* California State Auditor's comments begin on page 75.

cc: Ms. Mari Cantwell
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The Department of Health Care Services' (DHCS) Response to The California State Auditor's (CSA) Draft Report Entitled, *California Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventative Health Services*
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Finding 1: California does not always ensure children in Medi-Cal receive preventive health services, and that plans provide adequate access to health care providers who serve children in Medi-Cal. DHCS does not require plans to implement a Corrective Action Plan (CAP) until the plan has failed to meet the same minimum performance. ①

Finding Agreement: Partially Agrees with Finding

Recommendation 1: 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.

Response: With respect to the finding, DHCS has three trigger types which may result in a Medi-Cal Managed Care Health Plan (MCP) having a CAP imposed on it, as opposed to only requiring a CAP after the plan has failed to meet the same minimum performance. These include not meeting the Minimum Performance Level (MPL) in three consecutive years for an External Accountability (EAS) measure; having 50 percent or more of EAS measures in a given operating area below the MPL in a given year; or at the discretion of DHCS. ②

DHCS does not agree with this recommendation. DHCS agrees that increasing the number of physicians that practice in California would be beneficial for all health care delivery systems and the Department has been actively involved in implementing a physician and dental provider loan repayment program using Proposition 56 funds as authorized and approved in the Budget Act of 2018. These loan repayments will be targeted specifically at newly-practicing providers that agree to see a specific percentage of Medi-Cal patients in their practice (at least 30 percent) and maintain that commitment for at least five years. These loans will be open to both pediatric and adult providers and additional criteria will include providers that are practicing in high-need specialty areas such as child psychiatry or practicing in a medically underserved area. ③

As required by federal and state laws and regulations, DHCS annually validates whether its MCPs have adequate networks based on a projection of future enrollment. Should a MCP demonstrate non-compliance with the certification, a CAP is

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④ imposed. Should the MCP not come into compliance with a CAP, sanctions are imposed.

⑤ Finally, DHCS has received its first year's analysis of the Timely Access Survey. This survey, which is completed quarterly by the External Quality Review Organization (EQRO), collects real time information about beneficiary experiences when scheduling pediatric and adult appointments. Information will be reported publicly. This data assists DHCS with monitoring beneficiary timely access to care.

Finding 2: DHCS does not provide adequate information to plans, providers, and beneficiaries about the services it expects children to receive. DHCS provides limited information to the families of children in Medi-Cal about the services they can and should receive.

Finding Agreement: Partially Agrees with Finding

Recommendation 2: To ensure children in Medi-Cal have access to all 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.

Response: DHCS partially agrees with the finding. DHCS has issued guidance to Medi-Cal MCPs pertaining to the services that it expects children to receive, including an All-Plan Letter (APL) in 2014 and again in 2018 by APL 18-007.

⑥

With respect to the recommendation, DHCS is in full agreement with the exception of the timeline for implementation. DHCS will update its Medi-Cal MCP Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) APL; and draft updated contract language pertaining to EPSDT. DHCS will further detail MCP responsibility to provide services according to Bright Futures in these documents. The mandate for MCPs to provide services according to Bright Futures is currently present in APL 18-007, but DHCS will make the requirement more prominent by adding an additional stand-alone section that focuses on Bright Futures solely. DHCS has authority to mandate contractual requirements through APLs, and as such will utilize the EPSDT APL to set forth a majority of the requirements. APLs take

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varying periods of time to issue based on their complexity and the need to incorporate stakeholder review. Given this, DHCS anticipates completing this recommendation by November 1, 2019. (6)

Recommendation 3: To ensure that all eligible children and their families know about all the preventative 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.

Response: DHCS partially agrees with the recommendation as it has already been engaged in many activities to date as described below relative to updating Medi-Cal informing materials about the EPSDT benefit. (7)

DHCS has updated its primary beneficiary publication, entitled "myMedi-Cal" and started a process to make changes in all of its written materials regarding the provision of EPSDT services for beneficiaries and providers. One of the first efforts undertaken was the update to its webpage on December 28, 2018, regarding the provision of EPSDT services. The DHCS EPSDT webpage changes, informed in part by stakeholder review and feedback, include an overview of information regarding the provision of these services for both beneficiaries and providers.

DHCS is also in the process of updating and removing older documents from the DHCS website that reference inaccurate information on EPSDT services and is reviewing and revising, as applicable, program reference materials to reflect the language presented on the EPSDT webpage. Given the enormity of this task, which will include the need to translate the affected documents into the 19 Medi-Cal threshold languages, this task will not be fully completed by September 2019. DHCS will provide an updated timeline of completing this task when it provides its six month update to this recommendation.

In terms of providers, DHCS has revised one section of the Medi-Cal Provider Manual and created a new Preventive Services section. The Preventive Services section, released in January 2019 and updated in February 2019, now specifies applicable billing codes for providers to use when providing preventive and other services listed in the Bright Futures' Periodicity Schedule.

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The new EPSDT services section will provide a variety of information including a requirement that providers communicate and inform beneficiaries of EPSDT services. This section is expected to publish in spring of 2019.

In addition to the changes above to the provider bulletin, the Department will be providing supplemental payments using Proposition 56 funds on specific preventive codes, many of which are directly applicable to children's' preventive services.

In addition to the provider bulletin, DHCS requires County Welfare Departments (CWDs) to send informing materials to all beneficiaries every year, which includes information on EPSDT. As referenced earlier, "myMedi-Cal" is an informational booklet provided to applicants and includes information regarding the Medi-Cal application process, how to access Medi-Cal benefits and services, including EPSDT services, and certain rights and responsibilities on being enrolled into the Medi-Cal program. DHCS worked extensively with stakeholders to improve the readability and clarity of the EPSDT information included in this document.

Additionally, the language in the myMedi-Cal document leverages the same wording and guidance as the updated DHCS EPSDT webpage. DHCS expects to publish and print copies of the revised document by May 31, 2019.

DHCS will include more comprehensive information about what a beneficiary is entitled to under the EPSDT benefit in its Medi-Cal MCP member materials, including the MCP Member Handbook/Evidence of Coverage (EOC). An updated version of the EOC will be issued to MCPs for translation and distribution by July 1, 2019.

Finally, DHCS will engage in a targeted outreach campaign to beneficiaries with full-scope Medi-Cal eligibility to inform them about the availability of EPSDT services under Medi-Cal and how to access preventive services. This will include an initial mail and call campaign to beneficiaries and their families which will occur by January 1, 2020. Stakeholders will be engaged as a part of developing these initial outreach materials. All outreach materials will be translated into the 19 threshold languages. DHCS will also contract with an independent entity to conduct surveys of beneficiaries, design outreach materials, and

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engage with stakeholders, in order to determine the best outreach processes moving forward. It is expected that the independent entity's work will be completed by December 31, 2020.

Finding 3: DHCS does not use its utilization management or annual audit processes related to children's preventative services in an effective manner. By failing to determine whether plans are addressing underutilization of children's preventive services, DHCS is missing an opportunity to increase the provisions of these services.

Finding Agreement: Fully Agrees with Finding

Recommendation 4: 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.

Response: DHCS partially agrees with this recommendation. The metrics for the Bright Futures schedule are led by national organizations such as the National Quality Forum, who in turn, create such metrics and maintain national data to do so including setting benchmarks. (8)

DHCS will add administrative measures from the Centers for Medicare and Medicaid Services (CMS) adult and child core set to the EAS Set, increase the MPL for Medi-Cal MCPs from 25 percent to 50 percent, increase Medi-Cal MCP sanctions (as appropriate), and add early childhood metrics to the Governor's Value Based Purchasing initiative.

DHCS will also work with its EQRO to develop alternative ways of assessing MCP performance for areas of Bright Futures that do not have an identified metric. For example, DHCS is in the process of working with its EQRO to develop its first Preventive Services Report. This report will utilize member and provider data to measure MCP compliance, provider performance, and member utilization of appropriate preventive services. Stakeholders will be engaged when developing this report. The report is expected to be issued in 2020. DHCS will require MCPs

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to develop plans of action to address findings based on the results of the report. Should an MCP not come into compliance, DHCS will impose additional penalties and/or sanctions.

Recommendation 5: 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 addresses the delivery of EPSDT services to all eligible children for all plans on an annual basis.

Response: DHCS fully agrees with the recommendation. DHCS will implement new audit procedures to address this recommendation by September 2019.

Recommendation 6: To ensure plans address underutilization of children's preventative services, DHCS should require plans by September 2019 to use their utilization management programs to identify barriers to utilization specifically for these services and hold plans accountable to address the barriers they identify.

Response: DHCS fully agrees with the recommendation. DHCS will work with its EQRO to develop a process to measure MCP utilization. DHCS is in the process of working with its EQRO to develop its first Preventive Services Report. This report will utilize member and provider data to measure MCP compliance, provider performance, and member utilization of appropriate preventive services. Stakeholders will be engaged when developing this report. The report is expected to be issued in 2020. DHCS will require MCPs to develop plans of action to address findings based on the results of the report. Should a MCP not come into compliance, DHCS will impose additional penalties and/or sanctions.

Finding 4: DHCS reduces the effectiveness of its oversight by not ensuring plans accurately report the services they provide. DHCS relies on provider information which could be inaccurate, and which could hinder access to care. DHCS is also unable to show that it reviewed all the provider information it claims, reviewed in response to the CSA 2015 audit, DHCS adopted policies and procedures to retain all documentation related to its provider directory reviews for a minimum of three years. However, DHCS was not able to provide the review documentation we requested for this audit for two to four plans because the contract manager

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for those plans were not able to locate the documents. Instead, DHCS provided the approval forms for those plans' provider directories which a supervisor signs once DHCS has completed its review; however, the portion of the plan was blank.

Finding Agreement: Fully Agrees with Finding

Recommendation 7: To ensure the accuracy of its data and ensure that California receives all available federal Medicaid funding, DHCS should require EQRO to perform its encounter data validation studies annually using the most recent set of data available, and implement recommendations for its EQRO studies.

Response: DHCS fully agrees with the recommendation. DHCS is compliant with the encounter data monitoring requirements prescribed in the Code of Federal Regulations (CFR) 438.818 and 438.242. Although these requirements became effective July 1, 2017, DHCS has been compliant with many of the requirements since new encounter data monitoring efforts were launched in January 2015.

As the CSA noted, DHCS expanded its monitoring efforts in the accuracy category through an Encounter Data Validation study. This study will be conducted on an annual basis and brings DHCS into full compliance with the new federal requirements. DHCS has already received the first version of this report. The second report will be completed by March 2020.

DHCS has also launched an additional encounter data monitoring effort that compares the amount of utilization reported through each MCP's Rate Development Template and the amount of encounter data submitted to DHCS. This effort will significantly strengthen DHCS's oversight of MCP encounter data.

CMS has developed a process and a set of metrics to measure state Medicaid agencies on the quality of their encounter data. To date, DHCS has not received any findings or been placed under a CAP by CMS for encounter data quality.

Recommendation 8: To ensure plan providers directories are accurate, by September 2019 DHCS should begin using a 95 percent confidence level and not more than a 10 percent margin of error on its statistical sampling tool and should require at least 95 percent accuracy

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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.

Response:

⑨ DHCS partially agrees with the recommendation. While DHCS cannot agree to change the confidence level to 95 percent, DHCS can review the current provider directory tool and determine the feasibility of changing the confidence level to a level higher than the current 80 percent.

DHCS is exploring other avenues to perform provider directory validation in a more systematic approach, including an increased statistically significant sample size. This effort would engage the Department's EQRO to conduct validation quarterly, significantly strengthening the process in its entirety. It is anticipated that this effort will be implemented by January 1, 2020.

DHCS will adhere to its policies to retain all documentation related to its review of provider directories for at least three years.

Finding 5: DHCS is not proactively addressing cultural disparities that exist in the usage of preventive health services. Federal law requires each state to have a plan to identify, evaluate, and reduce—to the extent practicable—health disparities based on various characteristics including race, ethnicity, and primary language. Although DHCS and the three plans reviewed agreed that cultural factors impact utilization and access rates for children's preventive services, DHCS has not effectively mitigated cultural factors' impact on utilization and access rates nor has it ensured that plans consistently mitigate those disparities on their own. DHCS also does not take a proactive role in ensuring that children have access to health care in language of child and the family. Although DHCS monitors utilization rates by language, it does not take proactive steps to increase the availability of providers based on language needs. Instead it relies on parents to request interpreters, and providers to provide the language services that families request.

Finding Agreement: Fully Agrees with Finding

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Recommendation 9: To mitigate health disparities for children of differing ethnic backgrounds and language needs, DHCS should revise by September 2019 the methodology for its health disparity study to enable it to better make demographic comparisons, and should use the findings to drive targeted interventions within plan service areas. It should publish this on an annual basis.

Response: DHCS fully agrees with the recommendation. DHCS published its first health disparities report in 2018. The second health disparities report has been revised to allow for additional metrics and demographic comparisons and will be released in Spring of 2019. The third iteration of this report will be expanded to include revised methodologies specific to demographic comparisons.

The EQRO will continue to produce this report on an annual basis and each iteration will continue to evolve as DHCS identifies opportunities to expand the metrics being analyzed. The health disparities report will be utilized to drive targeted interventions within Medi-Cal MCP service areas. This will occur between Spring of 2019 and the end of the calendar year.

Recommendation 10: To ensure plans are effectively mitigating child health disparities in their service area, DHCS should implement by September 2019 a policy to require plans to take action on the most significant findings cited in their Group Needs Assessment (GNA) reports and to regularly follow-up with plans to ensure the plans have addressed the findings.

Response: DHCS fully agrees with the recommendation. Plan Specific Evaluation Reports (PSERs) are individual Medi-Cal MCP reports which summarize performance and make recommendations pertaining to it. They are issued by the Department's EQRO. DHCS is in the process of incorporating the GNA which addresses plan health disparity approaches into the plan PSERs. The PSERs will be utilized to provide recommendations to plans pertaining to their GNAs. DHCS will follow-up with the plans to ensure they are engaging in efforts to address recommendations. These reports are issued to CMS in April annually. It is too late to incorporate this recommendation into this year's report. It will be incorporated into the next year's report.

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Finding 6:	DHCS can do more to ensure it operates effective incentive programs and implements other best practices to increase access to, and usage of, preventive services for children. DHCS has not evaluated the impact of the program on utilization of children's preventative services, it cannot demonstrate that the auto assignment program leads to improved performance in the included performance measures. DHCS has not tracked the results of its own incentive program nor has it tracked the results of programs that plans have developed independently. Thus it cannot determine which program are most effective or have the most potential to be expanded statewide. DHCS does not facilitate plans sharing of their programs successes.
Finding Agreement:	Fully Agrees with Finding
Recommendation 11:	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.
Response:	DHCS fully agrees with the recommendation. DHCS will implement a go forward practice to collect and share plan-identified effective incentive programs that are reported to DHCS as contractually required. DHCS will share the plan identified effective incentive programs with all Medi-Cal MCPs.

Finding 7:	DHCS has implemented an improvement process for its plans, but does not share the successful results across all plans. DHCS is not doing enough to improve the immunization rates for children in Medi-Cal. It has not been able to meet its target of 80 percent utilization goal because it has not taken sufficient action to address cause of its low immunization rates. DHCS is not maximizing the opportunities for improvement that its current processes provides. If a Plan-Do-Study-Act (PDSA) results in a successful intervention, DHCS does not have policies and procedures in place to share successful interventions with other plans. DHCS did not ensure to share its successful intervention with its own providers, it does not track nor have counties committed to doing so as part of its approved PDSA.
Finding Agreement:	Partially Agrees with Finding
Recommendation 12:	To improve the usefulness of its PDSA process, DHCS should implement by September 2019 a process to share the results of

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successful interventions with all plans, and require plans to share these results with providers who would benefit from them.

Response: DHCS partially agrees with the finding and fully agrees with the recommendation, per the below described activities taken to date pertaining to sharing of best practices amongst plans.

DHCS currently compiles information from Medi-Cal MCP PDSA, performance improvement projects, and CAP submissions to track the types of interventions that MCPs are exploring. DHCS shares promising practices as well as lessons learned based on this information with MCPs through individual MCP technical assistance, Quality Collaborative Teleconferences attended by all MCPs, Quality Improvement Highlights that are sent to all MCPs, and a variety of in person meetings, including the quarterly Medical Directors Meeting.

DHCS also has developed a Quality Improvement Toolkit that allows MCPs to access many applicable resources in one location through an external SharePoint site.

DHCS will engage further with MCPs to share best practices and issue a document summarizing them. DHCS will work with MCPs to identify appropriate best practices to be implemented in their respective geographic areas.

Finally, DHCS is including childhood immunizations as a measure under its Value Based Payment initiative that is being funded by Proposition 56 funds with the intent of driving improvement in reporting and utilization of this metric on a statewide basis.

Finding 8: DHCS has not implemented recommendations from its external quality review organizations for improving access to quality care. DHCS did not implement many of its EQRO's recommendations related to children's preventive services. DHCS chose not to implement the recommendation since childhood immunization, rather than well child visit was the focus area at the time. DHCS also failed to fully address a recommendation related to communicating the importance of preventive services. DHCS did not adopt the development screening in the first three years of life as a performance measure.

Finding Agreement: Partially Agrees with Finding

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Recommendation 13: To improve its ability to ensure 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 preventative services, including recommendations left unaddressed from the previous two years' report.

⑩ **Response:** DHCS partially agrees with the finding and recommendation as it is in compliance with federal CFR requirements pertaining to this issue.

DHCS will develop a process to evaluate recommendations relating to children's preventive services and determine those which the Medi-Cal MCP's should operationalize through an action plan. These findings will be incorporated into the EQRO's annual technical report which is submitted to the CMS in April of each year. DHCS will need approximately eight months to address prior year findings.

Recommendation 14: To maximize the benefits of the studies it commissions from its EQRO, DHCS should ensure that by September 2019 the EQRO's annual report includes an assessment of the actions plans have taken to address the EQRO's prior-year recommendations.

Response: DHCS fully agrees with the recommendation. DHCS will instruct the EQRO to incorporate an assessment of actions taken to address the prior year's recommendation. These reports are issued in April annually to CMS, thus, a new report including these findings will not be possible to complete until April 2020.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on DHCS' response to the audit. The numbers below correspond to the numbers we have placed in the margin of DHCS' response.

DHCS misstates our finding and misses the larger, more important point. As indicated on page 26 of this report, in many cases, DHCS does not require plans to implement a corrective action plan until it has failed to meet minimum performance levels for three years, and most corrective action plans run for five years. As a result, plans have only recently faced any financial penalties for failing to meet minimum performance levels. (1)

On page 26 of this report, and in the report draft we provided to DHCS, we acknowledged all three reasons DHCS could impose a corrective action plan if a plan underperforms. (2)

Given its vision to improve the overall health and well-being of all Californians, including children, it is unclear why DHCS disagrees with our recommendation. It acknowledges that more providers would be beneficial and goes on to describe a loan repayment program that we acknowledge on page 25 it is implementing. However, given the extent of the problems we identified, the impact of children not receiving preventive services, and its inability to improve utilization rates for these services above 50 percent for the past five years, DHCS should try multiple approaches to fixing these problems, not just one. (3)

As we state on page 27, DHCS had never financially sanctioned any plan for uncorrected deficiencies related to access and utilization until it imposed such sanctions in late 2018, after our audit was nearing completion. (4)

As we indicate in the footnote on page 35, the first year's results of DHCS' timely access study were not available in time for our review. Further, as we indicated on page 23, DHCS has not yet conducted an in-depth analysis of the alternative access standards requests it approved to determine the areas of the State that are lacking doctors who are able to see children in Medi-Cal because it has only just completed processing the requests for the first time. DHCS should use these new tools to implement our recommendation that it identify where more providers who see children are needed and propose to the Legislature funding increases to recruit more providers in these areas. (5)

⑥ As we state on page 29, DHCS' contracts reference outdated requirements that are not in line with Bright Futures, and as we state on page 30, its most recent all-plan letter for EPSDT services does not explicitly state what services are required by Bright Futures. Because of the importance of the issue, DHCS should make these changes expeditiously. We look forward to DHCS updating us on its progress in implementing the recommendation in its 60-day and six-month responses.

⑦ As we state on page 31, federal law requires DHCS to perform annual outreach to children and their families who have not used EPSDT preventive services to inform them of the benefits of preventive health care and how to obtain services under the EPSDT program, but DHCS' response does not address this requirement. We look forward to DHCS updating us on its progress in implementing the recommendation in its 60-day and six-month responses.

⑧ DHCS' response does not state whether it will establish performance measures that cover well-child visits for all age groups as we recommend. We understand that DHCS may not adopt all HEDIS measures relating to children's preventive services; however, as we state on page 31, utilization rates are higher for the services for which DHCS has established performance measures and reporting requirements. We look forward to DHCS updating us on its progress in implementing the recommendation in its 60-day and six-month responses.

⑨ We stand by our recommendation, and look forward to receiving DHCS' six-month, 60-day, and one-year responses in which we expect it will update us on its progress in strengthening its reviews of the accuracy of provider directories.

⑩ Our finding and recommendation focus on improving DHCS' ability to provide preventive services to children in Medi-Cal by addressing its EQRO's recommendations. We made no determination of DHCS' compliance with federal law with regard to its implementation of its EQRO's recommendations as its response implies.