DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

September 19, 2018

Ms. Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Ms. Cantwell:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved California's Access Assessment Design under the section 1115(a) demonstration entitled "Medi-Cal 2020" (11-W-00193/9), as submitted by the state and as modified through our discussions. The Access Assessment will include an investigation of the Managed Care Plans (MCP) network adequacy for managed care beneficiaries covered by the Knox-Keene Health Plan Service Act of 1975 (KKA) and existing Medi-Cal managed care contracts. As a one-time study, the Access Assessment will provide a broad, cross-sectional profile of both Medi-Cal and MCP provider networks as well as a comparison of network performance relative to established network standards and outcomes. A copy of the approved Access Assessment design is enclosed.

We look forward to continuing to work with you and your staff on the Medi-Cal 2020 Demonstration. If you have any questions, please contact your project officer, Mrs. Heather Ross, at either 410-786-3666, or by email at Heather.Ross@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosures

cc: Henrietta Sam-Louie, ARA Region IX

Table of Contents

1. Background **1**
Overview of California's Section 1115(a) Medicaid Waiver Renewal 1
Key Components of Access Assessment 2
Access Assessment Objectives 3

2. Assessment Framework **4**
Scope of the Access Assessment 4
Assessment Framework 5
Intersecting Dimensions of Access 7

3. Assessment Design **8**
Study Population 8
Data Collection and Sources 10
Administrative Data 10
Survey-Based Data 12
Preliminary Access Review 13
Analytic Methods 14
Network Capacity 14
Geographic Distribution 17
Availability of Services 20
Analysis of Access to Care Monitoring 25
Access Assessment Limitations 25

4. Reporting **26**
Access Assessment Reporting Layout 26
Public Comment 27
Access Assessment Deliverables Timeline 27

Appendix A. Medi-Cal Managed Care Health Plan Reporting Unit and Urbanicity **A-1**

1. Background

Overview of California's Section 1115(a) Medicaid Waiver Renewal

On December 30, 2015, California's Section 1115(a) Medicaid Waiver Renewal, entitled *California Medi-Cal 2020 Demonstration (Medi-Cal 2020),*[1] was approved by the Centers for Medicare & Medicaid Services (CMS). *Medi-Cal 2020* continues the State's commitment to improving California's health care delivery system and builds upon the successes of the previous 2010 Section 1115(a) *Bridge to Reform* waiver. Critical to the ongoing success and viability of Medi-Cal Managed Care (MCMC), the *Medi-Cal 2020* waiver serves to guide the California Department of Health Care Services (DHCS) through the next five years as DHCS works to transform the quality of care, access to care, and the efficiency of health care services for MCMC beneficiaries.

The Special Terms and Conditions (STCs)[2] set forth by CMS and DHCS established the conditions and limitations on the waivers and expenditure authorities. They describe in detail the nature, character, and extent of Federal involvement in the demonstration along with the State's obligations to CMS during the life of the demonstration. In accordance with the *Medi-Cal 2020* STCs, California is required to conduct a one-time assessment of MCMC beneficiaries' access based on current Medi-Cal managed care health plan (MCP) network adequacy requirements. The Access assessment will assess MCMC beneficiaries' access to primary, core specialty, and facility services, as well as compliance to MCP network adequacy and timely access requirements and standards.[3] Where possible, the Access assessment will also incorporate geographic, beneficiary, and provider characteristics into the review, including recommendations in response to any systemic network adequacy issues identified.

Following approval on July 25, 2016 (Senate Bill 815), DHCS amended its contract with Health Services Advisory Group, Inc. (HSAG), the current External Quality Review Organization (EQRO), to design and conduct the required Access assessment. Effective October 23, 2016, HSAG began working with DHCS to develop the overall Access assessment design, including facilitation of an advisory committee formed to provide input on the assessment structure. As required by the STCs, the following design outlines the proposed methods for addressing the STCs and assessing MCMC beneficiaries' access to health care services. Subject to CMS approval, the design will guide the data collection, calculation of access-related measures, and reporting of MCP and State compliance with existing network adequacy and timely access requirements.

[1] Medi-Cal 2020 Demonstration Approval. (2015, December 30). Retrieved March 11, 2017, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-demo-appvl-12816.pdf.

[2] California Medi-Cal 2020 Demonstration, Special Terms and Conditions. (2017, January 19). Retrieved March 11, 2017, from http://www.dhcs.ca.gov/provgovpart/Documents/MediCal2020STCTCjan192017.pdf.

[3] Network standards assessed in this Access assessment are based on requirements outlined in the Knox-Keene Health Plan Service Act of 1975 (KKA) and current MCMC contracts.

Key Components of Access Assessment

The requirements for the *Medi-Cal 2020* Access assessment include the following key components:

- **Establishment of the Access Assessment Advisory Committee (AAAC)**—Based on submitted applications, DHCS selected 18 committee members in 2016 to participate on an advisory committee tasked with providing feedback on the overall assessment design and the final report. The AAAC members were selected from a variety of backgrounds including consumer advocacy organizations, providers/provider associations, health plans/health plan associations, legislative staff, and MCMC beneficiaries. The mix of committee members ensures diverse and robust input on the development of the assessment methodology.

  Facilitated by HSAG, the AAAC members have met on three separate occasions[4] to review and offer suggestions on the continued development of the Access assessment design. In 2018, the AAAC will meet initially to review the assessment results and then meet a second time to review the final report and recommendations.

- **Preparation and Submission of an Access Assessment Design to CMS**—Working collaboratively with DHCS and the AAAC, HSAG will develop a detailed assessment design for submission, review, and approval by CMS. The Access assessment design will highlight the data sources, access measures, and assessment methods identified to support the review of the adequacy of Medi-Cal's beneficiaries' access to services. Upon approval from CMS, HSAG and DHCS will have ten months to execute the Access assessment design.

- **Preparation and Submission of Initial Draft and Final Access Assessment Reports**—Once the Access assessment results are compiled, HSAG will review the assessment findings with the AAAC and DHCS. HSAG will then produce an initial draft report and submit the report to the AAAC and DHCS. Upon receiving feedback, HSAG will modify the draft report as needed. DHCS will then publish the draft report for public comment, and include documentation of the AAAC's feedback. Following closure of the public comment period, HSAG will prepare a final report for submission to DHCS and CMS.

[4] The AAAC was convened on November 18, 2016, January 31, 2017, and March 28, 2017; meetings were open to the public.

Access Assessment Objectives

Based on the requirements outlined in the STCs and the goals of *Medi-Cal 2020*, the Access assessment will address the following objectives:

1. Assess MCP network adequacy and performance for managed care beneficiaries.
2. Assess MCP network compliance with established network standards and timely access requirements.[5]
3. Assess compliance with network adequacy requirements across MCPs and lines of business
4. Identify differences between the State's current network monitoring program and the requirements outlined in the Medicaid and Children's Health Insurance Program (CHIP) managed care final rule (42 Code of Federal Regulations [CFR] 438).

The Access assessment design, taking into account the four objectives outlined preceding, uses the access performance measures and analytic approach to address multiple dimensions of access (i.e., network capacity, geographic distribution, and availability of services), as described in Section 2—Assessment Framework.

[5] Network standards reported in this Access assessment are based on requirements outlined in the Knox-Keene Health Plan Service Act of 1975 (KKA) and MCMC contracts.

2. Assessment Framework

Scope of the Access Assessment

The scope of work of this Access assessment includes an investigation of MCP network adequacy for managed care beneficiaries covered by the Knox-Keene Health Plan Service Act of 1975 (KKA) and existing Medi-Cal managed care contracts. As a one-time study, the Access assessment will provide a broad, cross-sectional profile of both Medi-Cal and MCP provider networks as well as a comparison of network performance relative to established network standards[6] and outcomes. Specifically, the Access assessment will:

- Measure MCP compliance with existing network adequacy and with timely access requirements set forth in the KKA and Medi-Cal managed care contracts.[7]
- Expand the evaluation of provider networks beyond existing provider categories identified in existing regulations, and include additional primary and core specialty services and facilities. Additionally, the assessment will incorporate other non-traditional health care service modalities (e.g., telemedicine) based on the availability of data.
- Incorporate validated network data from a one-year period for the most recent time period available at the time of the analysis. Moreover, in order to capture multiple aspects of access, the assessment will synthesize information from multiple sources, including the most recent provider network data, beneficiary and encounter data inclusive of sub-capitated MCP data, State Fair Hearing (SFH) and Independent Medical Review (IMR) decisions, Ombudsman calls, previously collected appointment availability data, and grievances and appeals/complaints data.
- Review network compliance and performance of MCPs relative to overall, statewide provider networks available in the State of California (e.g., all licensed providers).
- Account for geographic differences (i.e., urban versus rural), previously approved alternative access standards (as applicable), and network status (i.e., in- or out-of-network).
- Present network adequacy and timely access findings at the State contractor MCP level as well as key beneficiary, provider, and geographic subpopulations as noted previously.

Focusing on the Medi-Cal-only managed care population, the Access assessment will be limited to evaluation of California's managed care service areas. Additionally, while HSAG will use some beneficiary demographics to assess network adequacy, HSAG will not disaggregate results by clinical or program-based subpopulations (e.g., disabled beneficiaries, foster care children).

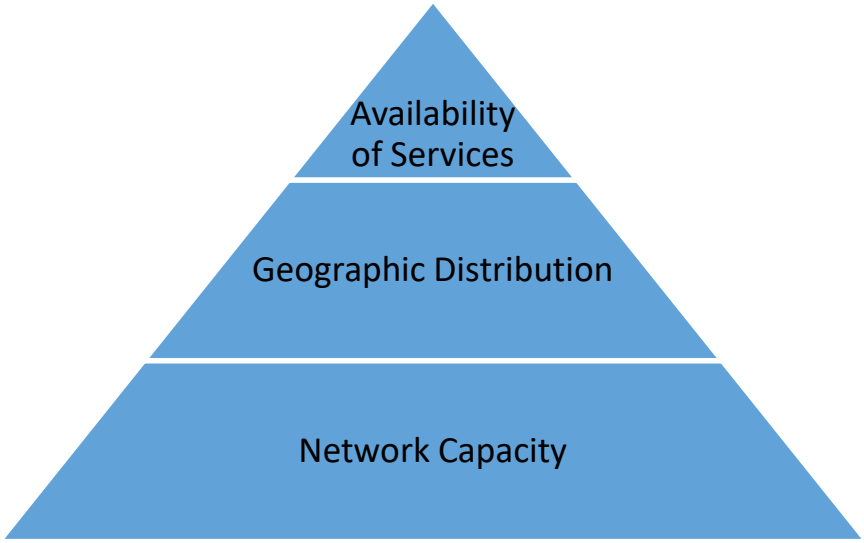
[6] Network standards assessed in this Access assessment are based on requirements outlined in the Knox-Keene Health Plan Service Act of 1975 (KKA) and MCMC contracts.

[7] Please note that while CMS has finalized the Medicaid Managed Care rule (42 CFR 438), the current Access assessment is limited to evaluation of existing standards in MCMC. As such, new network requirements will not be directly incorporated into this assessment.

Assessment Framework

As noted earlier, the purpose of the Access assessment is to document the accessibility of California's Medi-Cal managed care provider networks and to assess compliance with existing network standards and requirements. To fully understand and measure access and availability, HSAG will use a multi-dimensional framework to conduct the analysis. Access represents a complex construct concerned with understanding whether or not beneficiaries can obtain and use the health care resources necessary to maintain and/or improve their health. Figure 2.1 illustrates three key dimensions necessary to exploring and understanding beneficiary access to care (i.e., *Network Capacity*, *Geographic Distribution*, and *Availability of Services*).

Figure 2.1—Access Measurement Dimensions Model



The dimensions presented in Figure 2.1 are interrelated and each necessary to consider when developing a comprehensive view of access. *Network Capacity* addresses the underlying foundation of the provider network and refers to the supply of provider services available to beneficiaries. It addresses two key questions:

- Are health care services available?
- Is there an adequate supply of service providers available?

Using a variety of measures (e.g., provider-to-beneficiary ratios and provider counts), an assessment of the underlying capacity of a provider network can be obtained. If services are available and an adequate supply of providers and services are present, the opportunity to obtain health care exists, suggesting that beneficiaries *may* have access to services. Once capacity and infrastructure are established, it becomes important to understand the extent to which beneficiaries can *gain access* to reported services. However, gaining access to and utilization of services are dependent upon physical accessibility and acceptability of services, not simply on adequacy of supply. *Geographic Distribution* addresses whether or not the distribution of available services is adequate to facilitate access to all beneficiaries. Two key questions guiding assessments in this dimension include the following:

- Is the geographic distribution of providers relative to the beneficiary population reasonable?
- Does the geographic distribution of providers mirror the social, cultural, and clinical needs of the beneficiary population?

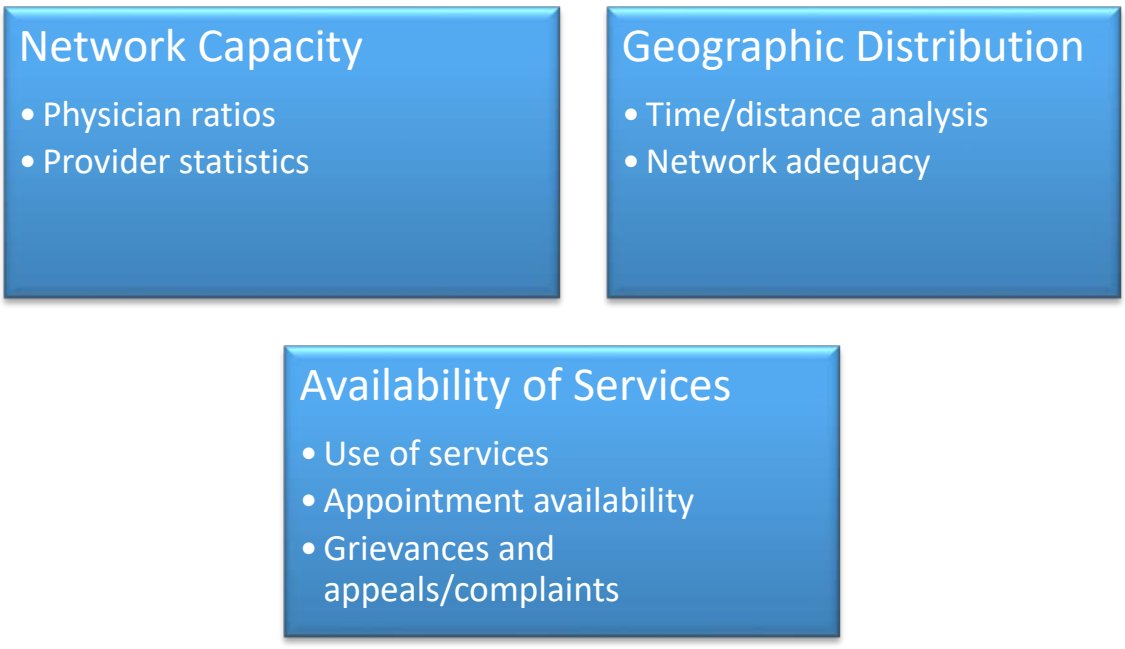
Key measures for assessing the geographic distribution of providers include time/distance analyses and compliance with network adequacy requirements. When combined with beneficiary and provider characteristics, these analyses will determine the extent to which the supply of providers is distributed appropriately relative to the beneficiary population. However, even with adequate capacity and appropriate distribution of services, assessing the *availability* of relevant services is critical in making sure beneficiaries have access. The third dimension of access, *Availability of Services*, is important for understanding the extent to which network services are relevant and effective in producing positive health outcomes. Key questions addressed by this dimension include the following:

- Are relevant services available for beneficiaries to achieve acceptable health outcomes?
- Is the availability of services timely?
- Does the use of services reflect appropriate management of health outcomes?

The availability of services can be assessed in terms of appointment availability, utilization, and/or outcomes of services. Taken together, the three dimensions offer a broad understanding of the factors impacting beneficiaries' access to care. The framework addresses the intersection of a network's underlying infrastructure (i.e., making services available), distribution (i.e., getting the services to beneficiaries), and availability (i.e., having the right kind of services available when needed).

Although described in detail in Section 3—Assessment Design, Figure 2.2 illustrates the key network performance measures that HSAG will use within each access dimension.

Figure 2.2—Network Performance Measures by Access Dimension



Intersecting Dimensions of Access

Taken individually, the dimensions of access described in Figure 2.2 are incomplete. Instead, evaluation of network adequacy should encompass all three dimensions in order to understand the impact of both network infrastructure and the implementation and actions of that infrastructure. While individual dimension results are important, the interaction of provider capacity and geographic distribution, along with appointment availability, provide a comprehensive picture of the adequacy of the Medi-Cal managed care provider networks.

To ensure that Medi-Cal beneficiaries have the potential to access the health care services that they need, HSAG will assess the existing capacity of MCPs' provider networks and those networks' abilities to afford access to health care services (i.e., *Network Capacity*). This component is key to establishing adequate access, although it is insufficient on its own to support the access and availability expectations of MCMC beneficiaries. Insufficient providers and the lack of specialists in a network have a direct impact on beneficiaries' access to care. HSAG will also examine the extent to which the distribution of Medi-Cal enrolled providers' practice locations mirror those of the beneficiary populations they serve (i.e., *Geographic Distribution*). Even with a large network of enrolled providers, if the providers are not distributed appropriately and proportionally relative to the beneficiaries, access to care will be adversely affected. Beneficiaries' access to local care is critical to ensuring that beneficiaries receive the health care services they need.

In addition to understanding the underlying provider network infrastructure, HSAG will also assess how well the network addresses the needs (clinical and cultural) of the beneficiaries (i.e., *Availability of Services*). For example, while a sufficient number of providers may be enrolled in a network and distributed proportionally relative to the enrolled beneficiary population, the providers must be active and willing to accept Medi-Cal patients. While individual dimension results are important, the interaction of provider capacity and geographic distribution, along with availability of services, is critical to developing a comprehensive picture of the adequacy of California's Medi-Cal managed care network provider networks.

3. Assessment Design

The primary objective of the Access assessment is to explore and assess Medi-Cal managed care beneficiaries' access to primary, core specialty, and facility services. As outlined in Section 2, HSAG will employ a multi-dimensional analytic approach to investigate existing levels of access as well as compliance with the managed care network adequacy requirements set forth in the KKA and current MCMC contracts. HSAG will assess access to care using a combination of network performance measures including descriptive statistics, point-in-time estimates and trend analyses, and utilization metrics. Synthesizing the results across each measure will provide a comprehensive profile of the capacity, distribution, and availability of health care services available to MCMC beneficiaries.

Although HSAG will present results at the statewide and managed care contractor levels, the Access assessment will include a series of comparative analyses that target the impact of key beneficiary, provider, and geographic (i.e., urban versus rural) characteristics on MCMC beneficiaries' access to care. These subgroup comparisons will allow DHCS to understand how access to services is affected by both geographic setting and beneficiaries' characteristics, as well as by differences in managed care provider networks. The following section outlines the population, data sources, and analytic methods that HSAG will use to conduct the Access assessment.

Study Population

The network analysis results will be based on HSAG's comparative evaluations of both MCMC beneficiaries and the providers who serve them. Additionally, HSAG will define comparison groups or subpopulations of beneficiaries and select providers to evaluate network performance across key demographics and MCPs.

Specifically, the primary study population will include MCMC beneficiaries enrolled in an MCP as of September 1, 2017, and residing within the State of California. For measures evaluated over time, HSAG will evaluate MCMC beneficiary enrollment based on the first day of each month between January 2017 and September 2017. See Appendix A for a complete listing of MCPs included in the Access assessment.

The study population will also include individual and facility-based providers who are active and enrolled with an MCP as of September 1, 2017. Table 3.1 shows the specific provider categories that HSAG will use to calculate provider-based measures in the Access assessment, including primary care physicians, core specialists, and facilities. Beneficiary and provider enrollment anchor dates are subject to change based on final approval from CMS on the Access Assessment Design and on the availability of beneficiary enrollment data.

Table 3.1—Provider Categories Included in the Access Assessment

Provider Category	Provider Specialty/Type[A]	
Primary Care Physician	♦ Family Practice ♦ General Practice ♦ Geriatrics ♦ Internal Medicine	♦ Obstetrics/Gynecology[B] ♦ Pediatrics ♦ Preventive
Non-Physician Medical Practitioner[8]	♦ Physician Assistant ♦ Nurse Practitioner	♦ Certified Nurse Midwife[B]
Core Specialty Care	♦ Cardiovascular Disease/ Interventional Cardiology ♦ Dermatology ♦ Endocrinology ♦ Gastroenterology ♦ General Surgery ♦ Hematology/Oncology ♦ Infectious Diseases ♦ Mental Health Outpatient Services[C]	♦ Nephrology ♦ Neurology ♦ Obstetrics/Gynecology[B] ♦ Ophthalmology ♦ Ophthalmology, Otolaryngology, Rhinology (ENT) ♦ Orthopedic Surgery ♦ Pediatric Mental Health Specialists ♦ Pediatric Physical Health Specialists ♦ Physical Medicine and Rehabilitation ♦ Psychiatry ♦ Pulmonary Disease
Facility-based and Special Providers	♦ Community Based Adult Services (CBAS) ♦ Federally Qualified Health Center (FQHC) ♦ Home Health ♦ Hospital, Inpatient ♦ Hospital, Outpatient ♦ Intermediate Care Facility (ICF) ♦ Rural Health Clinics (RHC) ♦ Skilled Nursing Facility (SNF)	

[A] Provider specialties are subject to change based on the final network adequacy standards defined by DHCS.

[B] Obstetricians/Gynecologists and Certified Nurse Midwives will be evaluated both within the primary care physician category, when identified as primary care physician, and independently.

[C] This category will include providers who deliver mental health services in outpatient settings including, but not limited to, licensed clinical social workers; marriage, family, and child counselors; substance use counselors; Qualified Autism Services Practitioners (QASPs); paraprofessional behavior technicians; and psychologists.

[8] Except in instances where non-physician practitioners are being evaluated for compliance with existing network standards, categorization of non-physician medical practitioners will be based on defined specialties. To eliminate inflation of network performance measures, HSAG will exclude non-physician medical practitioners with no designated specialty.

Data Collection and Sources

To complete the Access assessment, HSAG will collect and manage multiple data sources to assess access across three key dimensions (i.e., network capacity, geographic distribution, and availability of services). The data collected will include both administrative and survey-based data (i.e., post-audit timely access verification study). Administrative data sources include information extracted from DHCS's Medicaid Management Information System (MMIS) and maintained in DHCS's data warehouse, including beneficiary, provider, and encounter data, as well as other MCMC data (i.e., SFH decisions, IMR decisions, grievances, appeals, and complaints). The MMIS databases are the main repositories of the data that HSAG will use to conduct the assessment.

Administrative Data

Administrative data represent information collected, processed, and stored in electronic information systems, often as part of an agency's or organization's health care operations. As such, this information is readily available and frequently monitored to ensure its completeness and accuracy. Following are descriptions of the relevant administrative data sources that HSAG will use in conducting the Access assessment.

Data Warehouse—Beneficiary Data

HSAG will use beneficiary data to identify the population required to calculate all network performance measures as well as to classify MCMC beneficiaries by key characteristics (i.e., age, gender, race/ethnicity, and language). More specifically, HSAG will first combine the beneficiary demographic data with eligibility and enrollment data to determine the Access assessment population (i.e., active beneficiaries enrolled in an MCP), and then segment the population to conduct subpopulation analyses (e.g., compliance with time/distance standards by geography). HSAG will use these data to calculate provider-to-enrollee ratios, population counts and trends, subpopulation comparisons, and geographic-based distribution statistics.

Demographic, eligibility, and enrollment data will be extracted from the DHCS data warehouse for the following time period: December1, 2015, through September 30, 2017, to account for all network performance measure time periods.

Data Warehouse—Provider Data

Provider data represent another key data source for defining the Access assessment population. Provider databases include critical information on provider demographics and practice characteristics (i.e., location, specialty, and network status). HSAG will use these data to calculate provider-to-enrollee ratios, provider counts and network trends, subpopulation comparisons, and geographic-based distribution statistics.

Since SFY 2014–15, DHCS has implemented a new information management system (i.e., the Post Adjudicated Claims and Encounters System, or PACES), and is currently transitioning all MCPs to reporting managed care provider data according to the Healthcare Provider Information Transaction Set

(274). All MCPs are expected to be in production by May 2017 and to include monthly provider data from January 1, 2017, through the present. After MCPs have fully implemented 274 reporting, DHCS will validate and make the data available to HSAG for analysis.

Note that due to the frequency of changes in provider practices (e.g., acceptance of new patients, network status, and office location), provider data are accurate as of the time of submission. Additionally, certain fields related to practice characteristics may be incomplete or require additional reconciliation due to differences in the data collection and classification processes at individual MCPs.

Provider data will be extracted from the DHCS data warehouse for the following time period: January 1, 2017, through September 30, 2017.

Data Warehouse—Encounter Data

HSAG will use managed care encounter data from PACES to calculate a series of utilization measures in order to assess the availability of services. Electronic Data Interchange (EDI) 837 Health Care Claim transaction sets for inpatient, outpatient, and professional services will be extracted by DHCS and used by HSAG to evaluate key service utilization rates across different health care settings. Results from this analysis will provide insight into beneficiary patterns of service utilization and access. HSAG will also link managed care encounter data to beneficiary and provider data to standardize the calculation of rates and draw comparative analyses across key characteristics.

Due to expected submission lags associated with Medi-Cal's encounter data, HSAG will work with DHCS to extract inpatient, outpatient, and professional encounters for the following time period: January 1, 2014, through December 31, 2016—to account for all network performance measure time periods.

Health Care Consumer Data

Health care consumer data represent supplemental health care information collected and managed by DHCS and the California Department of Managed Health Care (DMHC), which are the entities responsible for the oversight and management of MCMC. Specifically, HSAG will use data related to denial of services (i.e., beneficiary complaints, grievances, and appeals; SFH decisions, Ombudsman calls, and IMR decisions). HSAG will use each of these data sources to categorize and examine the extent to which beneficiary complaints and grievances are related to access issues. HSAG will combine these data with beneficiary enrollment data to standardize rates and conduct comparative analyses across MCPs and by key demographic characteristics.

Although each data source becomes available on a differing schedule (e.g., monthly, quarterly), data from each source will be collected for the following time period: October 1, 2016, through September 30, 2017—with rates being reported monthly.

HEDIS IDSS and PLD Files

The Interactive Data Submission System (IDSS) data contains Healthcare Effectiveness Data and Information Set (HEDIS®)[9] data collected and reported by the Medi-Cal MCPs. This audited information is used to report each MCP's results for Medi-Cal's External Accountability Set (EAS), a set of performance measures selected annually by DHCS to monitor MCP performance. HSAG will use a subset of measures from this data source to report key HEDIS measures highlighting beneficiaries' access to care. Additionally, all MCPs are required to submit both NCQA-required Patient-Level Detail (PLD) files and CA-specific PLD files as part of the HEDIS audit process. The PLD files contain beneficiary-level results.

HEDIS IDSS and PLD files will be available in June 2017 for measurement period 2016. HEDIS measures reported in the Access assessment will cover dates of service during the following time period: November 6, 2015, through December 31, 2017.

Medical Licensing Data

In addition to using data maintained by DHCS and DMHC, HSAG will work with the Medical Board of California (Medical Board) to obtain provider information on all licensed physicians for the State of California. Information from the Medical Board will allow for high-level comparisons between the MCMC provider network and the potential provider network through the State of California, regardless of payer. HSAG will use these data to produce descriptive statistics and comparative analyses across key characteristics.

HSAG will request Medical Board licensure data for the following time period: January 1, 2017, through September 30, 2017.

Survey-Based Data

Survey-based data represent information collected directly from beneficiaries and providers and reflect patient and provider experiences. As noted in the STCs, HSAG will use data collected through DHCS's Audits & Investigations Division (A&I) to assess appointment availability and compliance with timely access standards outlined in the KKA and MCP contracts. Data collected through these surveys will identify appointment wait times associated with the first, second, and third available appointments. To assess timely access, the Access assessment will incorporate results from the audit, verification, and post-audit studies conducted by DHCS. Depending on the volume and quality of data collected, HSAG may produce descriptive statistics and conduct comparative analyses across key characteristics.

Survey data related to timely access will be procured for the following time period: January 1, 2017, through September 30, 2017.

[9] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 3.2 summarizes the data sources that HSAG will use for California's Access assessment.

Table 3.2—Data Source Summary

Data Source	Data Owner	Used in Monitoring	Time Period for Data[1]
Administrative Data Sources			
Beneficiary data	DHCS	Yes	12/01/15–09/30/17
274 Provider data	DHCS	Yes	01/01/17–09/30/17
Encounter data	DHCS	Yes	12/01/16–09/30/17
State Fair Hearing data	DHCS	Yes	10/01/16–09/30/17
Independent Medical Review	DHMC	Yes	10/01/16–09/30/17
Grievance and Appeals data	DHCS	Yes	10/01/16–09/30/17
Ombudsman Call data	DHCS	Yes	10/01/16–09/30/17
HEDIS IDSS and PLD data	DHCS	Yes	11/06/15–12/31/16
Medical Board Licensing data	Medical Board of CA	No	01/01/17–09/30/17
Survey-Based Data Sources			
Post-Audit Timely Access Verification Study data	DHCS	Yes	01/01/17–09/30/17
Corrective Action Plan Verification Study data	DHCS	Yes	01/01/17–09/30/17

[1] Differences in data source time periods are based on the availability of data. Additionally, beneficiary and provider data time periods are subject to change based on final approval of the Access assessment design by CMS.

Preliminary Access Review

Following procurement of all beneficiary, provider, and service utilization data, HSAG will conduct a preliminary review of the data sources. This review will serve two key purposes:

1. To finalize the selected data sources and analytic datasets
2. To assess the distribution of providers and beneficiaries by select population characteristics

Using selected data sources, HSAG will clean, process, and categorize beneficiary and provider data to define the final beneficiary and provider populations for inclusion in the Access assessment as well as to define the final set of stratification variables. This process is critical for preparing the administrative data for analysis. HSAG will standardize and geo-code all Medi-Cal beneficiary and provider files using the

Quest Analytics software. During the geo-coding process, HSAG analysts will highlight and correct those addresses which include inaccurate zip codes, where possible, to maximize the number of providers and beneficiaries included in the assessment. HSAG will limit the final MCMC beneficiary population included in the Access assessment to beneficiaries residing within the State of California; however, HSAG will include all providers contracted by Medi-Cal MCPs in the assessment, regardless of office location.[10] Key activities of the preliminary file review will be confirming and evaluating the categorization of selected specialties and providers to ensure consistency across MCPs. HSAG will exclude from the analysis providers with no specialty identified or with a specialty not matching the listed categories within the provider crosswalk.

At a minimum, following the preliminary review HSAG will produce both demographic profiles and population counts by key stratification variables including the following:

- Beneficiary population counts by MCP, gender, age, race/ethnicity, and geography
- Provider distribution counts at the State contractor MCP level by core specialty and specialty category, MCP, and geography
- Provider distribution counts by key office/practice characteristics, as available (e.g., network status [in- and out-of-network], panel size, accepting new patients, panel restrictions, provider shortages due to geography), and level of activity[11]

Analytic Methods

As noted earlier, HSAG will evaluate three dimensions of provider access and timely access (i.e., network capacity, geographic distribution, and availability of services). Together, results from these three dimensions provide insight into the underlying network infrastructure as well its application and interaction with MCMC beneficiaries.

Network Capacity

Network Capacity addresses the underlying infrastructure of a provider network. Measures of network capacity assess whether or not health services are available to beneficiaries through a sufficient supply and variety of providers. Following are descriptions of the three measures that HSAG will use to assess the network capacity of MCMC provider networks.

[10] HSAG will individually evaluate outlier provider locations to ensure that no skewing or bias of provider-to-enrollee ratio or time/distance results occurs.

[11] *Level of activity* will be evaluated by linking provider network data to encounters and identifying the volume of services rendered by a given provider. This analysis assists in defining the difference between being listed in an MCP's provider network and rendering services. Differences noted in the analysis may indicate a gap in the provider network.

Beneficiary Count and Provider Supply

HSAG will calculate frequency distributions of both beneficiaries and physicians to provide a demographic profile of the MCMC beneficiary population and provider networks. In addition to presenting results by MCP and statewide, HSAG will stratify the provider network counts by physician specialty and category to allow comparative analyses across key characteristics (e.g., MCP and physician). HSAG will highlight in the results, by strata, differences in the classification and/or count of beneficiaries and providers. Table 3.3 describes key specifications for this measure.

Table 3.3—Measure Specifications: Beneficiary and Provider Counts

Measure Element	Description
Definition:	♦ The number of unique beneficiaries enrolled in an MCP as of the first of the month for the measurement period, by MCP ♦ The number of unique, active[i] providers, contracted with an MCP as of the first of the month for the measurement period, by provider specialty
Data Source(s):	DHCS data warehouse—beneficiary data, provider data, encounter data
Measurement Period:	♦ Point-in-time—September 1, 2017 ♦ Trend over time—monthly between January 2017 and September 2017
Stratification(s):	♦ For beneficiaries—age (i.e., adult/child), race/ethnicity, language, geography (i.e., urbanicity designation) ♦ For providers—provider specialty, network status, active status
Standard(s):	Not applicable

[i] *Active* providers will be defined using two methods: (1) designation as an active provider in DHCS's provider data, and (2) evidence (i.e., encounters) of rendering services to Medi-Cal members.

Medi-Cal Managed Care Provider Penetration Rate

Calculation of the MCMC provider penetration rate will allow HSAG to examine the extent to which licensed physicians in the State of California are contracted with MCMC and its MCPs. Drawing upon Medical Board data, HSAG will calculate by MCP and statewide the percentage of licensed physicians[12] contracted with one or more MCP(s). Results will include subpopulation analyses by physician specialty and category to allow comparative analyses across key characteristics (e.g., geography, MCP, and physician). HSAG will highlight in the results, by strata, differences in the classification and/or count of beneficiaries and physicians by strata. Table 3.4 describes key specifications for this measure.

[12] To the extent possible, the population of licensed physicians identified from the Medical Board data will exclude physicians not actively practicing or accepting Medi-Cal beneficiaries.

Table 3.4—Measure Specifications: Medi-Cal Managed Care Provider Penetration Rate

Measure Element	Description
Definition:	The percentage of unique physicians licensed in the State of California as of September 1, 2017, that are contracted with one or more MCP, by MCP
Data Source(s):	DHCS data warehouse—provider data Medical Board provider data
Stratification(s):	Provider specialty, network status, geography
Standard(s):	Not applicable

Provider-to-Beneficiary Ratio

Calculation of the provider-to-beneficiary ratio (provider ratio) will enable HSAG to assess the number of providers associated with an MCP's provider network relative to the number of assigned beneficiaries. This measure is a summary statistic that HSAG will use to highlight the overall capacity of an MCP's or program's provider network to deliver services to MCMC beneficiaries. Specifically, the provider ratio measures the number of providers by physician specialty relative to the number of beneficiaries. A lower provider ratio suggests the potential for greater network access because a larger pool of providers is available to render services to individuals. However, caution should be used when interpreting the results of this statistic as it does not account for key practice characteristics (e.g., panel status, acceptance of new patients, and practice restrictions). Instead, this analysis should be viewed as establishing a theoretical threshold for an acceptable minimum number of providers necessary to support a given volume of beneficiaries.

In order to account for differences in the availability of individual physicians due to enrollment with two or more MCPs, HSAG will adjust provider counts using an estimate of a full time equivalent (FTE). HSAG will make this adjustment using two methods:[13] (1) equal distribution, and (2) proportional distribution. The first method, equal distribution, distributes the FTE percentage equally based on the number of MCPs with which an individual physician is contracted. For example, if Provider X is contracted with four MCPs, that provider's FTE is equal to 0.25 FTEs for each MCP. Although this method accounts for impact on a provider's available panel size, it does not account for differences in proportional distribution of MCP populations. For example, in counties where the beneficiary population is distributed unequally across MCPs, large MCPs receive a disproportionately smaller percentage of the FTE relative to their beneficiary populations. As such, HSAG will apply a second adjustment wherein the FTE is distributed proportionally based on MCP beneficiary populations. While both methods make broad assumptions regarding the availability of physicians for beneficiaries, the adjusted rates provide

[13] HSAG will apply both provider ratio adjustments to primary care and core specialty physicians. However, if PACES provider data contain complete and accurate FTE percentages for primary care physicians, HSAG will use the FTE percentage directly from the data. Additionally, where data are available, the FTE distribution will account for providers' contracts with non-Medi-Cal health plans and any contracts with other Medi-Cal MCPs.

more robust estimates than do raw counts of physicians. Table 3.5 describes key specifications for this measure.

Table 3.5—Measure Specifications: Provider-to-Beneficiary Ratio

Measure Element	Description
Definition:	The number of provider FTEs, as of the first of the month for the measurement period, relative to the number of MCMC beneficiaries by MCP
Data Source(s):	DHCS data warehouse—beneficiary, provider data
Measurement Period:	♦ Point-in-time—September 1, 2017 ♦ Trend over time—monthly between January 2017 and September 2017
Stratification(s):	Provider specialty, network status, geography
Standard(s):	Primary Care Physicians = 1: 2,000 Total Physicians = 1: 1,200 Nurse Practitioner = 1 PCP: 4 NPs Physician Assistant = 1 PCP: 4 PAs

Geographic Distribution

The second dimension of the Access assessment will evaluate the geographic distribution of providers relative to beneficiary populations. While the capacity analysis will identify whether or not the network infrastructure is sufficient in both number of providers and variety of specialties, the geographic network distribution analysis will determine whether or not provider locations are spread proportionally across the beneficiary population.

Provider Counts by Physician Specialty and Geography

Expanding on the frequency distributions calculated for beneficiaries and physicians for assessing network capacity, HSAG will use provider counts by geography, which is a descriptive measure, to map provider counts by physician specialty and geographic region. In addition to presenting results by MCP and statewide, HSAG will stratify the provider network counts by physician specialty and category to allow comparative analyses by category and by urbanicity[14] designation. HSAG will also create density maps to visually display the distribution of beneficiaries and providers. Table 3.6 describes key specifications for this measure.

[14] Urbanicity (i.e., rural versus urban) will be based on DHCS classification of counties. See Appendix A.

Table 3.6—Measure Specifications: Provider Counts by Geography

Measure Element	Description
Definition:	♦ The number of unique beneficiaries enrolled in an MCP as of the first of the month for the measurement period, by geography ♦ The number of unique, active providers contracted with an MCP as of September 1, 2017, by provider specialty and by geography
Data Source(s):	DHCS data warehouse—beneficiary, provider data
Measurement Period:	♦ Point-in-time—September 1, 2017 ♦ Trend over time—monthly between January 2017 and September 2017
Stratification(s):	♦ For beneficiaries—age (i.e., adult/child), geography (i.e., urbanicity designation) ♦ For providers—provider specialty, network status, geography
Standard(s):	Not applicable

Time/Distance Analyses—Compliance with Time/Distance Standards

To provide a comprehensive view of geographic distribution of providers relative to beneficiary populations, HSAG will calculate two spatially derived metrics: (1) percentage of beneficiaries within predefined access standards, and (2) the average distance and travel time[15] to the nearest provider. Both analyses use software from Quest Analytics to calculate the travel time or physical distance between addresses of beneficiaries and addresses of their nearest providers. HSAG will stratify all results by MCP and by physician specialty.

Table 3.7 describes the measure specifications for determining number and percentage of beneficiaries located within the predefined time/distance standards outlined in the KKA and MCMC contracts. This analysis will be limited to provider types where standards currently exist (i.e., primary care physicians[16] and hospitals).

[15] To the extent possible, drive time assumptions will be adjusted to account for varying traffic conditions and transportation options (e.g., public transportation).

[16] To the extent that data are available on whether or not PCPs are accepting new patients, time/distance results will be assessed for the entire provider network and for those PCPs accepting new patients.

Table 3.7—Measure Specifications: Compliance with Time/Distance Standards

Measure Element	Description
Definition:	The percentage of beneficiaries whose addresses fall within the time/distance standard established in the KKA or MCMC contracts for PCPs and hospitals, by MCP
Data Source(s):	DHCS data warehouse—beneficiary, provider data
Measurement Period:	Point-in-time—September 1, 2017
Stratification(s):	Network status
Standard(s):	For primary care physicians and hospitals—15 miles/30 minutes (KKA) or 10 miles/30 minutes (MCMC contract)

Average Time and Distance to Nearest Three Providers

HSAG will assess the average distance (in miles) and travel time (in minutes) between a beneficiary and the closest three providers[17] for all provider and facility types listed in Table 3.1. A smaller average distance or shorter travel time[18] indicates greater accessibility to providers because individuals must travel fewer miles or minutes to access care. In general, the smaller that the average distance is between beneficiaries and providers across specialties, the greater the alignment is in the geographic distribution of providers and beneficiaries. The average drive time and distance represent a standardized measure of the geographic distribution of providers relative to beneficiaries; the shorter the average drive time and distance, the greater the overlap in the distribution of providers relative to beneficiaries. Table 3.8 describes the specifications for this measure.

Table 3.8—Measure Specifications: Average Time and Distance to Nearest Three Providers

Measure Element	Description
Definition:	The average length of time and average distance to the nearest three providers for MCMC beneficiaries enrolled in an MCP as of September 1, 2017, by provider specialty and MCP
Data Source(s):	DHCS data warehouse—beneficiary, provider data
Measurement Period:	Point-in-time—September 1, 2017
Stratification(s):	Beneficiary age, geography, network status
Standard(s):	Not applicable

[17] To the extent that data are available on whether or not providers are accepting new patients, time/distance results will be assessed for the entire provider network and for those providers accepting new patients.

[18] Quest Analytics determines drive time based on the following parameters: 30 mph for urban, 45 mph for suburban, and 55 mph for rural. Estimates do not account for time of day, traffic, or traffic control devices (e.g., stop signs, stop lights); and may not mirror driver experience due to varying traffic conditions.

Availability of Services

While the first two assessment dimensions assess provider network infrastructure, the following measures assess the extent to which the network infrastructure translates into practice. Measures of services available assess whether or not network services are relevant and effective in producing positive health outcomes. HSAG will use two types of measures to assess availability of services in the MCMC provider networks.

Access-Related Complaints, Grievances, and Appeals

DHCS and DMHC monitor beneficiary experience through the collection and reporting of complaints, grievances, appeals, SFHs, and IMRs (all in the preceding list collectively referred to as grievances); this includes beneficiaries' access to health care services. HSAG will calculate grievance rates[19] to show the extent to which beneficiaries are denied access to services. Specifically, HSAG will calculate these measures as the number of access-related grievances per 1,000 member months. These measures are a summary statistic which HSAG will use to highlight the prevalence of access-related grievances for MCMC beneficiaries across MCPs. Table 3.9 describes specifications for these measures.

Table 3.9—Measure Specifications: Access-Related Complaints, Grievances, and Appeals

Measure Element	Description
Definition:	The number of access-related grievances during a rolling 12-month period per 1,000 member months, by month and MCP *Note: Separate rates will be calculated for each grievance source (i.e., complaints, grievances, appeals, Ombudsman calls, SFHs, and IMRs).*
Data Source(s):	DHCS Data Warehouse—beneficiary data MCMC data—complaints, grievances, appeals, Ombudsman calls, SFHs, IMRs
Measurement Period:	12-month rolling periods reported monthly between January 2017, through September 2017.
Stratification(s):	MCP, expedited status
Standard(s):	Not applicable

[19] Please note that HSAG will calculate five different but related access-related rates based on different data sources (i.e., beneficiary complaints, grievances, appeals, SFH requests, and IMRs).

Service Utilization

HSAG will calculate utilization rates for several places of service to identify where beneficiaries are receiving services and to determine whether or not utilization patterns reflect appropriate management of health outcomes. Specifically, HSAG will calculate, per 1,000 member months by MCP, rates of emergency department (ED), urgent care, inpatient admissions, and outpatient visits. HSAG will also assess the utilization of alternative modalities (e.g., telemedicine). In the absence of standards, utilization rates are informational and are used comparatively to understand differences in how beneficiaries access services. Table 3.10 describes specifications for this measure.

Table 3.10—Measure Specifications: Utilization Rates per 1,000 Member Months

Measure Element	Description
Definition:	The rate of services used by MCMC beneficiaries enrolled in an MCP, with an encounter between January 1, 2016, and December 31, 2016, for each of the following categories: ♦ ED visits ♦ Urgent care visits ♦ Inpatient admissions ♦ Outpatient visits ♦ Mental health outpatient visits ♦ Telemedicine ♦ Non-emergency non-medical transportation
Data Source(s):	DHCS data warehouse—beneficiary data, MCMC encounter data
Technical Specifications:	HEDIS 2017 Technical Specifications, Volume 2—*Ambulatory Care (AMB)* and *Inpatient Utilization—General Hospital/Acute Care (IPU)*
Measurement Period:	January 1, 2016, through December 31, 2016
Stratification(s):	Age, geography
Standard(s):	Not applicable

Additionally, using HEDIS IDSS and PLD files submitted by MCPs, HSAG will report a series of HEDIS measures designed to assess access to preventive, outpatient, and inpatient services. Table 3.11, Table 3.12, Table 3.13, and Table 3.14 describe the specifications for these measures.

Table 3.11—Measure Specifications: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Measure Element	Description
Definition:	The percentage of MCMC beneficiaries 3 through 6 years of age and enrolled in an MCP who had one or more well-child visits with a PCP during the measurement year.
Data Source(s):	DHCS—MCP IDSS and PLD files DHCS data warehouse—beneficiary data
Technical Specifications:	HEDIS 2017 Technical Specifications, Volume 2—*W34*
Measurement Period:	January 1, 2016–December 31, 2016
Stratification(s):	Age, geography
Standard(s):	For Measurement Year (MY) 2016: Minimum Performance Level (MPL) = 64.72 High Performance Level (HPL) = 82.97

Table 3.12—Measure Specifications: Ambulatory Care (AMB)

Measure Element	Description
Definition:	The rate of services used by MCMC beneficiaries enrolled in an MCP, with an encounter for ambulatory care between January 1, 2016, and December 31, 2016, for each of the following categories: ♦ ED visits ♦ Outpatient visits
Data Source(s):	DHCS—MCP IDSS and PLD files DHCS data warehouse—beneficiary data
Technical Specifications:	HEDIS 2017 Technical Specifications, Volume 2—*AMB*
Measurement Period:	January 1, 2016–December 31, 2016
Stratification(s):	Age, geography
Standard(s):	Not applicable

Table 3.13—Measure Specifications: Prenatal and Postpartum Care (PPC)

Measure Element	Description
Definition:	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following: ♦ *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal visit as an MCMC beneficiary enrolled in an MCP in the first trimester, on the enrollment start date, or within 42 days of enrollment in an MCP. ♦ *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Data Source(s):	DHCS—MCP IDSS and PLD files DHCS data warehouse—beneficiary data
Technical Specifications:	HEDIS 2017 Technical Specifications, Volume 2—*PPC*
Measurement Period:	January 1, 2016–December 31, 2016
Stratification(s):	Age, geography
Standard(s):	For Measurement Year (MY) 2016: *PPC-Prenatal*: MPL = 74.21 and HPL = 91.00 *PPC-Postpartum*: MPL = 55.47 and HPL = 73.61

Table 3.14—Measure Specifications: Children and Adolescents' Access to Primary Care Practitioners (CAP)

Measure Element	Description
Definition:	The percentage of MCMC beneficiaries 12 months through 19 years of age who had a visit with a PCP.
Data Source(s):	DHCS—MCP IDSS and PLD files DHCS data warehouse—beneficiary data
Technical Specifications:	HEDIS 2017 Technical Specifications, Volume 2—*CAP*
Measurement Period:	January 1, 2016–December 31, 2016
Stratification(s):	Age, geography
Standard(s):	Not applicable

Appointment Availability

To evaluate appointment availability, HSAG will synthesize results from DHCS's Post-Audit Timely Access Verification Study and Corrective Action Plan Verification Study to evaluate the average length of time it takes for an MCMC beneficiary to schedule an appointment. However, since the volume of data will vary by MCP, the results will be used for informational purposes only. Table 3.15 and

Table 3.16 describe two measures that examine the availability of appointments.

Table 3.15—Measure Specifications: Average Number of Days to Appointment

Measure Element	Description
Definition:	The average number of days to the soonest first, second, and third appointments by MCP
Data Source(s):	DHCS Post-Audit Timely Access Verification Study data DHCS Corrective Action Plan Verification Study
Measurement Period:	Based on available data
Stratification(s):	Based on available data
Standard(s):	Not applicable

Table 3.16—Measure Specifications: Percentage of Appointments Compliant with Timely Access Standards

Measure Element	Description
Definition:	The percentage of appointments that meet DHCS timely access standards by MCPs for the following appointment types: ♦ Non-urgent, primary care ♦ Urgent care ♦ Specialist ♦ First prenatal visit
Data Source(s):	DHCS Post-Audit Timely Access Verification Study data DHCS Corrective Action Plan Verification Study
Measurement Period:	Based on available data
Stratification(s):	Based on available data
Standard(s):	♦ For non-urgent, primary care—10 business days ♦ For urgent care—48 hours ♦ For a specialist—15 business days ♦ For first prenatal visit—two weeks (GMC model and Two-Plan Model) or 10 business days (COHS)

Analysis of Access to Care Monitoring

Although the Access assessment is limited to assessing network adequacy and timely access based on the standards defined in the KKA and MCMC contracts, HSAG will conduct a comparative desk review of California's existing network requirements, standards, and monitoring program relative to the Medicaid and CHIP revised final rule for Medicaid managed care (42 CFR 438). HSAG will conduct a comprehensive review of the KKA and MCMC contracts, the Medicaid and CHIP revised final rule for Medicaid managed care, and any documentation outlining DHCS's proposed approach to implementing CMS's final rule. HSAG will identify differences across the various documents and summarize if, and where, gaps exist. This qualitative approach will identify differences between the State's current network monitoring program and the requirements outlined in the CHIP managed care final rule (42 CFR 438).

Access Assessment Limitations

While conducting the Access assessment, HSAG will document all limitations that potentially affect the results. These Access assessment limitations will be presented in the draft and final reports.

4. Reporting

Following its assessment of the network adequacy of Medi-Cal's managed care provider networks and subsequent synthesis of the findings, HSAG will prepare initial draft and final reports that highlight key findings, compliance with existing standards and access requirements, and any systemic recommendations. HSAG will produce both the initial draft and final reports in alignment with the STCs and the deliverables schedule included in Table 4.1.

Access Assessment Reporting Layout

HSAG will ensure that the report adheres to Section 508 compliance standards that align with U.S. Department of Health and Human Services Section 508 Accessibility checklists and the United States Access Board Section 508 Standards. At minimum, the final report will include the following five sections: Executive Summary, Background, Access Assessment Design, Findings, and Conclusions and Recommendations. Specifically, the report will address the following:

1. The **Executive Summary** section will concisely state the Access assessment goals and the questions addressed in the report. In presenting the key findings, HSAG will describe analytic results in the context of policy-relevant implications and recommendations as defined in the STCs.
2. The **Background** section will focus on describing the context of the Access assessment, existing network monitoring activities, and future network monitoring plans. This section will also describe the legislative authority and scope of work that provided the requirements and structure for the Access assessment.
3. The **Access Assessment Design** section will contain a description of the overall assessment framework and analytic approach. Specifically, this section will contain a detailed description of the available data sources and network performance measures associated with each access dimension. Additionally, this section will include a discussion of any limitations affecting the results and subsequent interpretation of the findings.
4. The **Findings** section will contain a detailed presentation of the key findings and outcomes of each network performance measure. HSAG will present results in aggregate at the statewide and MCP levels, as well as by key beneficiary and provider demographics, as applicable. When available, HSAG will present trended results to highlight the changing network landscape.
5. The **Conclusions and Recommendations** section will summarize the overall quality of access for Medi-Cal managed care beneficiaries, along with providing recommendations for DHCS to address systemic deficiencies and future monitoring requirements.

Public Comment

After feedback from the AAAC has been received, processed, and incorporated into the initial draft report, and prior to HSAG producing the final report, DHCS will post the initial draft report on DHCS's website for a 30-day public comment period. This public comment period will take place no later than 10 months following CMS's approval of the Access assessment design.

Drawing on its extensive experience managing and analyzing public comments, HSAG will work collaboratively with DHCS to ensure that HSAG's process meets California requirements. HSAG will define and implement an appropriate platform for posting, receiving, and processing public comments. This process will include development of all communication materials including public notices, website updates, feedback instructions, response time frames, and public response templates. DHCS will review and approve all materials and documents to ensure that they meet State expectations and requirements.

Following DHCS's posting of the Access assessment initial draft report, HSAG staff will retrieve all public comments weekly in order to facilitate batch processing. Once processed, HSAG will review and summarize the individual comments and then categorize them using pre-defined categories developed in collaboration with DHCS. Categorization of the feedback will allow HSAG to not only provide an overall summary of the comments but also report on the number and type of comments received.

When managing data from public comment requests, proper data aggregation and meaningful data summarization techniques are critical. In order to efficiently manage the process of retrieving, classifying, and responding to public comments, HSAG has developed an internal application to process incoming comments, store the information, and automate summary report generation. This application streamlines the data collection and reporting processes while ensuring accuracy.

Following review and approval by DHCS, all appropriate comments and responses will be placed in an appendix of the final report. The State will submit the final Access assessment report to CMS no later than 90 days after the initial draft report is posted for public comment.

Access Assessment Deliverables Timeline

Both the initial draft and final reports will be produced in alignment with the STCs and the schedule of events and deliverables listed in Table 4.1.

Table 4.1—Schedule of Access Assessment Events and Deliverables

Event/Deliverable	Date
AAAC entrance meeting.	11/18/2016
HSAG submit Access assessment design outline to DHCS for review.	12/22/2016
DHCS submit CA Access assessment design to CMS.	**04/21/2017**
HSAG submit initial draft Access assessment report to DHCS for review.	02/27/2018
AAAC exit meeting.	March 2018
DHCS post Access assessment final report for public comment.	04/09/2018
DHCS submit Access assessment report to CMS.	**06/29/2018**

Appendix A. Medi-Cal Managed Care Health Plan Reporting Unit and Urbanicity

MCP Name	MCP Abbreviation	MCP County/ Reporting Unit	Model	Urbanicity[B]
Alameda Alliance for Health	AAH	Alameda	LI	Medium
Anthem Blue Cross Partnership Plan	Anthem	Alameda	CP	Medium
		Contra Costa	CP	Medium
		Fresno	CP	Medium
		Kings	CP	Rural to Small
		Madera	CP	Rural to Small
		Sacramento	GMC	Medium
		San Francisco	CP	Medium
		Santa Clara	CP	Medium
		Tulare	LI	Medium
		Region 1[A]	Regional	Medium
		Region 2[A]	Regional	Medium
		San Benito	San Benito	Rural to Small
California Health & Wellness Plan	CHW	Imperial	Imperial	Rural to Small
		Region 1[A]	Regional	Medium
		Region 2[A]	Regional	Medium
CalOptima	CalOptima	Orange	COHS	Medium
CalViva Health	CalViva	Fresno	LI	Medium
		Kings	LI	Rural to Small
		Madera	LI	Rural to Small
Care1st Partner Plan	Care1st	San Diego	GMC	Medium
CenCal Health	CenCal	Santa Barbara	COHS	Medium
		San Luis Obispo	COHS	Medium
Central California Alliance for Health	CCAH	Monterey/Santa Cruz	COHS	Medium
		Merced	COHS	Rural to Small
Community Health Group Partnership Plan	CHG	San Diego	GMC	Medium
Contra Costa Health Plan	CCHP	Contra Costa	LI	Medium
Gold Coast Health Plan	Gold Coast	Ventura	COHS	Medium
Health Net Community Solutions, Inc.	Health Net	Kern	CP	Medium
		Los Angeles	CP	Large
		Sacramento	GMC	Medium
		San Diego	GMC	Medium
		San Joaquin	CP	Medium
		Stanislaus	CP	Medium
		Tulare	CP	Medium
Health Plan of San Joaquin	HPSJ	San Joaquin	LI	Medium
		Stanislaus	LI	Medium
Health Plan of San Mateo	HPSM	San Mateo	COHS	Medium

MCP Name	MCP Abbreviation	MCP County/ Reporting Unit	Model	Urbanicity[B]
Inland Empire Health Plan	IEHP	Riverside/San Bernardino	LI	Large
Kaiser NorCal	Kaiser NorCal	KP North (Amador, El Dorado, Placer, and Sacramento counties)	GMC and Regional	Medium
Kaiser SoCal	Kaiser SoCal	San Diego	GMC	Medium
Kern Family Health Care	KFHC	Kern	LI	Medium
L.A. Care Health Plan	L.A. Care	Los Angeles	LI	Large
Molina Healthcare of California Partner Plan, Inc.	Molina	Riverside/San Bernardino	CP	Large
		Sacramento	GMC	Medium
		San Diego	GMC	Medium
		Imperial	Imperial	Rural to Small
Partnership HealthPlan of California	Partnership	Southwest (Marin, Mendocino, Sonoma, and Lake counties)	COHS	Medium
		Southeast (Napa, Solano, and Yolo counties)	COHS	Medium
		Northwest (Del Norte and Humboldt counties)	COHS	Rural to Small
		Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity counties)	COHS	Medium
San Francisco Health Plan	SFHP	San Francisco	LI	Medium
Santa Clara Family Health Plan	SCFHP	Santa Clara	LI	Medium

[A] Region 1 includes Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties; Region 2 includes Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties.

[B] Urbanicity is based on the criteria defined by DHCS's proposed Network Adequacy Policy proposal. The categories of counties are based on population count: Rural to Small = <55,000 to 199,999, Medium = 200,000 to 3,999,999, and Large = ≥ 4,000,000. Please note that these categories are subject to change based on the DHCS's final network adequacy policy.