Improving Quality Data Alignment Across California's Public Health Systems and Medi-Cal Managed Care Plans

Findings and Roadmap

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Prepared by the California Health Care Safety Net Institute (SNI)

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Executive Summary

California's public health care systems ("systems") and Medi-Cal managed care plans ("plans") share a common mission: to deliver high-quality, equitable care for the communities they serve. With more than 90% of Medi-Cal beneficiaries now enrolled in managed care, closer collaboration between systems and plans has become increasingly essential to improving care.

This collaboration is further reinforced by the California Department of Health Care Services (DHCS), which has more closely aligned its performance programs for systems and plans. The Quality Incentive Pool (QIP) holds systems accountable for meeting quality goals, while the Medi-Cal Accountability Set (MCAS) establishes quality standards for plans. To help meet MCAS performance targets, many plans have developed local pay-for-performance (P4P) programs that also financially incentivize systems to improve measure performance.

> "Increasingly, the plans and the public health care systems, or any providers, are tied together financially. So, our actions when we collaborate will lead to shared success, and when we don't collaborate will lead to shared loss."
>
> — **Giovanna Giuliani**
> **Executive Director**
> **California Health Care Safety Net Institute**

> "The stakes are higher both because the populations we're serving are becoming more similar and more members are in managed care. This gives plans and systems the opportunity to align incentives and align programs."
>
> — **Linnea Koopmans**
> **CEO**
> **Local Health Plans of California**

As DHCS gradually moves to holding plans responsible for reporting on QIP and other State value-based care programs, closer collaboration between systems and plans around the data needed for accurate reporting has become imperative.

Specifically, this shift from system-reported to plan-reported rates requires more timely and enhanced data exchange between both organizations. At the same time, overlap between QIP and MCAS quality measures has increased, along with shared quality goals—making strong coordination even more critical.

The data alignment challenge

Data alignment is foundational to successful collaboration. However, systems and plans often rely on differing patient-level data, which results in inconsistencies in reported performance and limits their ability to fully understand patients' needs. Only when data is aligned can organizations jointly identify care gaps and implement effective strategies to improve quality.

However, aligning this data is a resource-intensive endeavor. The work is technically complex and time-consuming, requiring dedicated staff time, specialized expertise, and relationship building across systems and plans.

To understand how organizations are navigating these challenges, the California Health Care Safety Net Institute (SNI) engaged data consultant Intrepid Ascent to conduct a six-month assessment (July-December 2024) of four regional collaborations between systems and plans in Alameda, San Francisco,[1] Ventura, and Riverside. These collaborations had made measurable progress in improving the alignment of quality rates.

This report and roadmap synthesize their experiences to share key lessons and recommendations for other systems and plans beginning to engage in this work. Their efforts highlight the importance of leadership commitment, collaborative governance structures, and well-defined processes for exchanging and validating data.

Regional collaborations featured in this report:

- **Alameda County.** Alameda Health System (AHS) and Alameda Alliance for Health (AAH)

- **San Francisco County:** San Francisco Health Network (SFHN) and San Francisco Health Plan (SFHP)

- **Ventura County:** Ventura County Health Care Agency (VCHCA) and Gold Coast Health Plan (GCHP)

- **Riverside County:** Riverside University Health System (RUHS) and Inland Empire Health Plan (IEHP)

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[1]   For the San Francisco region, Intrepid Ascent interviewed only the system, as the plan did not have the capacity to participate.

Key findings and roadmap

The key findings from these four regional collaborations are organized around the following themes:

- **Establish leadership commitment and joint governance structures**

  Successful data alignment efforts required leadership support to dedicate resources and protect staff time. Joint quality leadership committees and joint quality data working groups—composed of cross-functional staff from both organizations that met regularly—were critical to consistent communication, building trust, and collaboratively solving problems and making progress.

- **Monitor performance and share data**

  Systems' regular access to plans' performance reports supported more effective monitoring of quality measures and faster identification of care gaps. When plans enhanced the content and frequency of these reports, systems were better able to identify discrepancies and collaborate with plans to resolve them.

- **Clarify differences in quality measure specifications**

  Differences between QIP and MCAS/HEDIS measure specifications contributed to conflicting performance rates. When systems and plans worked together to clarify these specifications before reviewing patient-level data, they were better able to reduce confusion and avoid delays in the alignment process.

- **Close data gaps with supplemental files**

  Systems and plans created supplemental data files based on EHR data and exchanged them to address gaps in claims. While systems often initiated the creation of these files, early collaboration on file format, structure, and content requirements improved efficiency and reduced rework during the final validation and submission steps.

- **Advancing beyond supplemental data to integrated exchange**

  While supplemental file sharing has helped close data gaps, some systems and plans began exploring more integrated methods, such as Health Information Exchanges (HIE), to reduce manual effort and improve efficiency. These developments reflect ongoing work to streamline processes and strengthen long-term data alignment.

Roadmap

To support other systems and plans pursuing similar goals, this report includes a five-phase data alignment roadmap. Drawing on lessons learned from regional collaborations, the roadmap outlines practical steps to help systems and plans initiate collaboration, identify data gaps, and exchange information effectively. Ultimately, these joint efforts help them to deliver higher-quality, more coordinated care for their shared patients.

Acknowledgments

SNI is incredibly grateful to the systems and plans listed below for generously sharing their time, insights, and experiences during this project. Their thoughtful reflections on their joint data alignment efforts were essential to this report's development.

Name	Role	Organization
Tangerine Brigham	Chief Administrative Officer, Population Health *(former)*	Alameda Health System (AHS)
Jaime Martin	Manager, Value-Based Care	AHS
Tiffany Cheang	Chief Analytics Officer	Alameda Alliance for Health (AAH)
Julia Kim	Senior Manager, Analytics	AAH
Suzette Flores	Senior QI Data Analyst	Riverside University Health System (RUHS)
Corrine Matthews	Director, Incentive Payment Programs Director, Regulatory Compliance Department	RUHS
Vikram Kumar, MD	Chief Health Information Officer *(former)*	RUHS
Sacha Nakhoul	Director, Technology Solutions Delivery	Inland Empire Health Plan (IEHP)
Renata Ferreira	Director, Value-Based Care and Data Analytics	San Francisco Health Network (SFHN)
Rachel Stern, MD	Chief Medical Quality Officer, Ambulatory Care	Ventura County Health Care Agency (VCHCA)
Michelle Meissner	Director, Quality & Population Health	Gold Coast Health Plan (GCHP)
Shasta Gereau	Quality Program Manager	GCHP

Joint Governance and Staffing

Each system and plan attributed their success in aligning data to:

- Establishing strong leadership support that enabled them to prioritize this intense data reconciliation work.

- Implementing a two-tiered meeting framework—a leadership committee for strategic direction and oversight, alongside a technical working group for detailed data alignment—that fostered open and ongoing communication.

- Identifying and engaging staff with specialized expertise in quality measurement specifications and data analysis, as well as external resources with specific knowledge, when necessary.

Leadership support: critical to successful data alignment

Systems and plans reported varying degrees of initial leadership support for their data alignment work. Some organizations began with strong executive direction and backing, while others needed to demonstrate the value of this work to secure support, prioritization, resources, and protected staff time.

For example, to build the case for more resources, Alameda Health System's (AHS) Manager of Value-Based Care used a real-world example—the A1C HEDIS metric, a blood sugar control measure—to demonstrate the time-intensive and complex process of comparing metrics and reconciling data discrepancies between its QIP data and that of Alameda Alliance for Health (AAH). She also connected the strategic importance of aligning data to draw down pay-for-performance (P4P) funding.

These combined efforts—demonstrating the complexity of data reconciliation and its financial impact—secured leadership support to hire a consultant who conducted a short-term data comparison project across metrics.

The role of joint quality leadership committees

Most systems and plans reported having established joint quality committees with leadership representation from both organizations to oversee data alignment. These committees typically met monthly and included senior leadership, such as Chief Administrative Officers, Quality Directors, Chief Medical Quality Officers, Quality Program Managers, Directors of Quality and Population Health, Directors of Incentive Payment Programs, and Chief Health Information Officers.

These joint quality leadership committees:

- Provided strategic guidance and high-level oversight, allowing leaders from systems and plans to discuss shared goals, priorities, and resources.

- Fostered collaboration through open discussions about challenges, observations, and data-sharing initiatives.

- Facilitated clear communication and decision-making that drove data alignment and overall quality improvement efforts.

Systems and plans in Riverside and Ventura counties reported that regular meetings of their joint quality leadership committees strengthened their relationships. They credit these meetings for creating the foundation for successful quality improvement collaboration and performance improvement.

Other systems and plans reported similar results, noting that a regular forum for discussion was critical to making progress. However, one participant noted that not all system-plan partnerships across California have implemented similar leadership structures.

A need emerged for joint quality data working groups

Some systems and plans discovered that trying to analyze and align data at the patient level became too detailed for the joint quality leadership committees; they were not designed for the in-depth technical analysis and close collaboration needed to reconcile data discrepancies.

In response, systems and plans established separate joint quality data working groups, sometimes referred to as data huddles. They:

- Reviewed and examined patient-level data

- Investigated root causes of data discrepancies

- Adapted data-sharing processes to address gaps

- Verified patient-level data

These working groups maintained momentum by meeting weekly or biweekly and on an ad-hoc basis. They also spoke and communicated regularly between scheduled sessions to deepen understanding and resolve technical issues.

Specialized expertise for joint quality data working groups

Systems and plans staffed their joint quality data working groups from multiple departments: Quality, (Data) Analytics, Business Intelligence, Value-Based Care, Information Technology (IT), Informatics, Population Health, Provider Relations, Claims and/or Billing. Working group members reported needing specific technical expertise in quality measure specifications, Current Procedural Terminology (CPT) coding, and audit requirements. Both systems and plans emphasized including at least one member in the group who could define the specific data elements associated with each quality measure.

Each organization staffed the working groups differently, depending on their organizational structures, internal capabilities, and available resources. For example:

- One system's joint quality data working group benefited from an in-house report writing team that created internal QIP reports closely mirroring the population used for HEDIS measure calculations.

- One plan reported significant improvements in its rates after transitioning responsibility for EHR extracts from its IT representatives to Analytics team members. The Analytics participants, who worked with HEDIS data daily, were more familiar with the nuances of quality measurements.

Regardless of which departments were core to the group's in-depth work, Quality, Analytics, and IT teams consistently collaborated across systems and plans to resolve data discrepancies and improve data alignment.

Some of these joint working groups also found it valuable to engage external experts when they lacked internal technical expertise. In some cases, plans invited their HEDIS vendor to participate in the group's meetings. These vendors, with their specialized knowledge of algorithms and data intake processes, were especially helpful when the group conducted patient-level data analysis.

Examples of joint quality data working groups

Ventura

Ventura County Health Care Agency (VCHCA) and Gold Coast Health Plan (GCHP) established two collaborative structures: a Monthly Joint Quality Program Committee for leadership oversight and a Biweekly Joint Quality Operations Meeting focused on data alignment. The biweekly working group identified where data discrepancies existed, such as missing dates of service, CPT codes, or provider assignment issues; improved data quality; and validated patient-level information.

GCHP's IT and QI teams played crucial roles in the joint group's work. The IT team had a deep understanding of the elements the group needed to consider for numerator compliance, whether related to screening domains or preventive care. The plan's QI Analyst also worked closely with its HEDIS vendor data lead to conduct data validation.

Ventura's success: Meeting biweekly helped uncover hidden Well-Care Visits, closing rate alignment gap by 24.8%

During VCHCA and GCHP's Biweekly Joint Quality Operations Meetings, the group discovered that newborn visits were often billed to the mother since the baby did not yet have identification, creating significant gaps in rates reported by the system and plan for child and adolescent Well-Care Visits, particularly the W30 measure.

In response, GCHP developed internal mapping and logic to track these visits and included them in the W30 count, which successfully closed the gap in the W30 rate difference by 24.8%. These joint meetings also revealed a discrepancy in the reporting timeframe for Well-Care Visits—specifically the number of days reported between visits—even after controlling for differences in measure specifications.

San Francisco

San Francisco Health Network's (SFHN) Value-Based Care Data Analytics Director and San Francisco Health Plan's (SFHP) Quality Data Analytics Manager met weekly over the course of eight months to address discrepancies in their quality measure rates. The system also relied on a developer who wrote code to extract Epic data for supplemental data files that were sent to SFHP.

These weekly meetings enabled the system and plan to collaboratively address gaps in rates. Between meetings, SFHN and SFHP communicated frequently, conducted independent investigations, and followed up on items from the prior week's session. They reported that this regular meeting structure and consistent cadence were essential to their progress.

"Having that weekly touch base with SFHP was key to moving things forward and deciding on next steps and following up on the homework that we were supposed to do the week before."

– **Renata Ferreira**
Director of Value-Based Care and Data Analytics
San Francisco Health Network

Performance Monitoring and Reporting

Systems and plans are required to report to the California Department of Health Care Services on QIP and MCAS/HEDIS measures, respectively, based on a calendar year measurement period. However, they can choose how they monitor changes in performance throughout the year. This section discusses:

- How differences in system and plan internal monitoring methodologies affected alignment efforts.

- The role of performance tracking reports—gap-in-care reports and scorecards—in monitoring and comparing quality measure rates.

- How adding more data fields to these reports—or enhancing the details they contain - helped clarify patient-level compliance and support rate comparisons.

Different monitoring methods, challenges, and strategies

Each system and plan reported regularly monitoring QIP and MCAS rates, respectively, to identify any noteworthy shifts or trends. Specifically:

- Systems monitored performance on a rolling 12-month basis.[2] This approach provided a comprehensive view of trends over time and helped systems better predict year-end outcomes.

- Plans, however, typically monitored data on a year-to-date (YTD) basis.[3] This approach allowed for greater alignment with the current reporting period and more direct tracking of the impact of recent quality improvement initiatives.

These fundamental differences in monitoring methodologies often meant that systems and plans had to wait until mid-to-late in the year —when approximately a full year's worth of data became available —to effectively compare performance data. The timing mismatch created cascading effects on the quality improvement cycle, including:

- Delayed the start of detailed conversations between systems and plans about data alignment.

- Shortened the window for them to collaboratively identify data discrepancies, close gaps, and improve rates before reporting deadlines.

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2   A rolling 12-month period offers a continuously refreshed view of the past year's data by replacing the oldest month with the newest data each month.

3   YTD focuses on performance from the beginning of the current calendar year up to the present.

- Reduced the time available for proactive, targeted interventions and outreach to patients.

To address these challenges, some systems and plans adopted dual monitoring approaches. For example, Riverside University Health System (RUHS) continued its traditional rolling 12-month view and began tracking year-to-date metrics to align with Inland Empire Health Plan's (IEHP) monitoring approach.

> "We proactively run a rolling 12-months and YTD file for each measure to help understand gaps in care and bottlenecks in workflows. Then, based on these performance insights, we implement quality improvement initiatives which include PDSA cycles, engaging clinicians and care teams and enhancing our patient outreach and engagement activities."
>
> – **Corinne Matthews**
> **Director of Incentive Payment Programs**
> **Director of Regulatory Compliance Department**
> **Riverside University Health System**

Similarly, Gold Coast Health Plan (GCHP) implemented a more comprehensive monitoring approach. They tracked performance rates on a monthly basis, compared current rates to the prior month, and benchmarked against the prior measurement year's month-to-month performance. This allowed the plan to detect shifts and take action sooner to address performance issues.

In addition to internal monitoring strategies like GCHP's, plans also provided systems with performance reports to support rate monitoring and comparison.

Performance tracking reports: gap-in-care reports and scorecards

Plans provided systems with two types of reports to track and monitor performance metrics related to QIP and P4P measures: gap-in-care reports and scorecards. These reports varied in their availability, frequency, and level of detail.

- **Gap-in-care reports** listed patients missing required care or services (i.e., not compliant with numerator criteria), enabling targeted outreach efforts by systems and plans.

- **Scorecards** provided metric-level performance data, allowing systems to assess their overall quality performance and identify areas for improvement.

Together, these reports allowed systems and plans to compare performance data and identify when they showed different results for the same measure. Such divergences often indicated potential data discrepancies that required closer examination.

While these reports helped systems and plans compare data, their usefulness was often affected by how and when they were delivered. Some plans shared gap-in-care reports and scorecards with their systems on a regular cadence—such as monthly—while others provided them sporadically or only upon request. This often made it difficult for systems to routinely track progress or engage in timely quality improvement efforts.

In addition, some systems reported inconsistencies in how time periods were defined in performance reports, which made analysis more difficult. For example, San Francisco Health Network (SFHN) reported that the time period for scorecards was often unspecified, making trend analysis challenging.

> "The way we started this process was by asking for a scorecard to compare the rates. We did some work to try to make that data gap smaller...but it was challenging without monthly tracking of data. This report is very sporadic—in 2022, we got one in January, and one in September. This made it impossible to track our progress with both the data reconciliation work, and with closing care gaps for patients. We don't know when or if members are compliant until end of the year."
>
> — **Renata Ferreira**
> **Director of Value-Based Care and Data Analytics**
> **San Francisco Health Network**

These issues—from irregular report delivery to unclear timeframes—limited how effectively systems could monitor trends or act on performance gaps throughout the year. To help address these challenges, Gold Coast Health Plan (GCHP) provided Ventura County Health Care Agency (VCHCA) with direct access to its HEDIS vendor platform (Inovalon), enabling more immediate and consistent visibility into performance data.

This access allowed VCHCA to view updated performance metrics without relying on report delivery from GCHP or submitting manual requests. It supplemented—rather than replaced—GCHP's ongoing monthly data sharing with the system. While the platform offered more timely and consistent information, engagement with it was low.

> "I think it's important that we track those trends over time and share the information with VCHCA each month, so they can use that data for their own internal processes, and then bring any issues that need to be discussed to our meetings."
>
> **– Shasta Gereau**
> **Quality Improvement Program Manager**
> **Gold Coast Health Plan**

Enhancing data fields in performance reports

Systems reported that the performance reports they reviewed often lacked key data elements, limiting their usefulness for comparing data and tracking trends. When plans included additional details, however, the reports became significantly more useful for effectively comparing performance metrics across systems and plans.

Specifically, the added data and details to gap-in-care reports and scorecards allowed systems to:

- Detect variations between overlapping QIP and MCAS/HEDIS measures.

- Recognize inconsistencies in patient compliance status.

- Identify areas that warranted further examination.

These enhancements were especially apparent when reports included specific data elements that made comparisons more precise. For example, when plans included specific data fields—such as dates of service, provider and facility information, numerator and denominator values, and exclusion criteria—systems could more effectively cross-reference this information with their QIP data. These additional fields enabled systems to verify patient compliance status and better understand why differences existed between their QIP data and plan-reported MCAS calculations.

In some cases, even when both the system and plan identified a patient as numerator compliant, the date of service still provided important context. It clarified which organization had the most current information. This timestamp was especially important for measures with multi-year lookback periods, such as cervical cancer screening, where recent data directly affects future compliance determination.

Patient-Level Data Alignment

While performance reports helped identify discrepancies at the aggregate level between system and plan performance rates, these organizations reported that resolving those differences required deeper, patient-level data analysis. This involved systems and plans reviewing individual patient records to identify data misalignment, investigating root causes, and implementing data exchange solutions, such as supplemental file sharing, to better align their quality data.

Reported data alignment process

The phases below reflect how systems and plans described their collaborative efforts to align quality data in practice.

- Systems identified discrepancies in quality rates by reviewing gap-in-care reports and/or scorecards provided by the plans.

- Systems compiled and sent a list of patient examples to plans to highlight patients where they believed clinical activity occurred but was not reflected in plans' data.

- Systems and plans met—often as joint quality data working groups—to investigate discrepancies together. At different stages, they analyzed individual patient records and discussed measure specification differences for QIP and MCAS/HEDIS. The latter helped them identify potential causes of misalignment they could reconcile.

- Based on root cause analysis, systems developed or enhanced supplemental data files (i.e., EHR extracts). These files were used to capture clinical activity not reflected in claims.

- Systems internally validated supplemental files, checking for completeness, accuracy, and formatting. Some plans also reviewed files or provided feedback on files before formal submission.

- In addition to supplemental files, plans and systems exchanged various types of data, such as patient rosters, using methods ranging from shared portals to advanced integration.

- Systems submitted supplemental files to plans, which then forwarded them to their certified HEDIS vendor. In the final stage, these files were loaded into the HEDIS engine, which calculated and generated quality measure rates.

- In some cases, files were rejected due to formatting or coding issues.

- Systems and plans revised and resubmitted the files so they could be accepted by the HEDIS engine and the quality rate recalculated.

A critical first step: understanding specification differences

Several systems and plans reported that taking time at the outset of their data alignment work to clearly understand differences between QIP and MCAS/HEDIS measure specifications and methodologies would have made the process more efficient and effective. For example, one system said it needed to remind the plan of QIP requirements at the beginning of each meeting before investigations into data discrepancies could proceed.

At its core, the comparative analysis process involved identifying what was causing differences between rates calculated by systems for QIP and those calculated by plans for MCAS/HEDIS programs. This work revealed two types of differences:

1. Unavoidable differences caused by the variation in QIP and MCAS/HEDIS specifications, such as denominator criteria.

2. Actionable differences that presented opportunities to improve data completeness and quality for more accurate—and often improved—quality rates.

Data types and exchange methods

Resolving actionable differences required systems and plans to exchange a broad range of data using various methods and technologies. To support this work, plans are required to share a minimum data set with systems, as outlined in the Department of Health Care Services' (DHCS) [QIP Policy Letter](#) 22-005. The policy specifies what data must be exchanged to ensure systems can accurately calculate and report on QIP measures.

Building on this shared foundation, systems pulled together both data entered by clinical staff into their EHRs and external data received from plans. They then integrated this information into reporting data warehouses, where quality metrics were built and maintained.

Although systems ultimately shared a broader range of information, plans provided systems with:

- Eligibility data

- DHCS Plan Data Feed file

- Pharmacy data extracts

- Gap-in-care reports

- P4P scorecards/report cards

Systems, in turn, sent the following information to plans:

- Encounter data

- Admit, discharge, and transfer (ADT) data

- Lab results (when systems have on-site labs)

- Fee-for-Service (FFS) claims

- Supplemental data files (i.e., EHR extracts)

Alameda's comprehensive data exchange approach

Alameda Health System (AHS) and Alameda Alliance for Health (AAH) reported exchanging several types of data to support their joint quality alignment efforts.

AHS shared the following data with AAH:

- Encounter data through Epic

- Supplemental data files

- Lab results from Quest

AAH shared the following data with AHS:

- Pharmacy data

- Monthly scorecards

- Gap-in-care reports

AAH also received a monthly Plan Data Feed file from DHCS containing historical information for its members, including Medi-Cal Fee-For-Service services. The plan reported this historical data was valuable because some of its members recently transferred from other health plans. In these cases, the Plan Data Feed file included encounter data from those previous plans, creating a more complete care history.

AAH then filtered this data to include only members assigned to AHS and sent the filtered files to AHS monthly to support AHS's care coordination efforts. This multi-directional data flow enabled AHS and AAH to maintain more comprehensive patient records and conduct more accurate quality measure calculations.

Collaborative investigations of patient-level data

Systems and plans conducted patient-level comparisons to clarify why patients appeared as non-compliant in one organization's records but compliant in the others. They used several strategies to jointly investigate discrepancies and identify paths to alignment.

- **Selected quality measures strategically.** For example, San Francisco Health Network (SFHN) and San Francisco Health Plan (SFHP) decided to first address measures with the largest gaps, allowing them to focus their time and resources where improvements were most likely to have significant impact.

- **Conducted case-by-case analysis.** Teams from both organizations met—often in joint quality data working groups or ad-hoc sessions—to review individual patient records using screen-sharing and EHR access.

> "[The work] started out heavy on the analytics. Looking at patients together, I share my screen, and I pull up the patient from the gap-in-care report and I pull it in Epic, and I show SFHP how that patient is compliant and then the two of us think through why that patient is compliant and how we can get that data to SFHP."
>
> – **Renata Ferreira**
> **Director, Value-Based Care and Data Analytics**
> **San Francisco Health Network**

- **Uncovered root causes of misalignment.** Some systems and plans' collaborative reviews revealed issues such as missing encounters and miscoded CPT (Current Procedural Terminology). These discoveries directly informed supplemental file development and other data corrections.

Root cause analysis: How Riverside University Health System (RUHS) and Inland Empire Health Plan (IEHP) identified sources of data discrepancies

RUHS accessed patient rosters from IEHP's provider portal that showed the complete denominator and identified which members were numerator compliant or non-compliant. RUHS then compared this information against its QIP data to better understand the root causes of misalignment.

RUHS and IEHP's joint investigation revealed several common sources of data discrepancies:

- Claims from external providers were missed because CPT-2 codes did not transfer properly into the plan's data system, resulting in compliance not being captured.

- Some claims had not yet been adjudicated by the plan at the time of comparison, resulting in incomplete data.

- Test results (e.g., A1Cs for blood sugar measurement) were submitted directly to IEHP by external partners. This information was not communicated back to RUHS and therefore not captured in its records.

- RUHS incorrectly identified patients as non-compliant because it was unaware that a claim had been processed with missing clinical values, resulting in incorrect quality reporting.

These findings from RUHS and IEHP illustrated specific circumstances that created data discrepancies between systems and plans.

Supplemental data files: key to aligning data

To resolve discrepancies like the above, systems developed and shared supplemental data files (i.e., EHR extracts). They contained clinical information not typically found in claims, such as developmental screenings or patient assessments, as well as essential data elements like patient IDs and dates of service.

These files were especially valuable for capturing care that did not generate billable codes—information that would otherwise be missing from performance metrics. Systems and plans consistently reported that exchanging these files was critical to filling data gaps, improving the accuracy of quality measure calculations, and aligning reported rates.

Early collaboration in supplemental file development

Systems reported that developing supplemental data files required significant resources. For example, RUHS sent files to IEHP approximately three times per year and described the preparation process as particularly labor-intensive.

Plans varied in their approach to file development:

- Some plans required systems to format supplemental files to their HEDIS vendor's Electronic Clinical Data Systems (ECDS) specifications. This allowed the files to pass directly through to the vendor with minimal modification, reducing rework and streamlining the process for both organizations.

- Other plans did not require systems to use specific file formatting initially. However, they proactively shared their vendor's ECDS specifications with systems early in the process. This enabled systems to align file content and structure before final file submission.

Not all plans followed either approach. Some systems built supplemental files without clear guidance or received specifications after submission. Consequently, this often led systems and plans to spend time reworking files and increased the risk of straining the relationship.

Expanding the scope of supplemental data files

As the number of MCAS measures held to Minimum Performance Levels (MPLs) increased each year, expectations for data completeness grew. Systems responded by broadening the scope of their supplemental data files to include more data. This caused the files to grow in both size and complexity over time. The expansion increased the workload for systems, which were ultimately responsible for enhancing the files and conducting extensive validation.

Despite these resource challenges, one system reported planning to further expand its supplemental data efforts by extending its data extraction lookback period to the inception of its EHR implementation. This would include MCAS/HEDIS measures not held to achievement rates under the plan's P4P program. This approach was intended to maximize the historical data available to support more complete data alignment.

Validation: a critical step in ensuring supplemental data accuracy

Developing and enhancing supplemental data files was only part of the process—rigorous validation was equally important. While both systems and plans conducted validation, systems often performed more detailed clinical reviews, whereas plans focused on ensuring file readiness and the quality of the data sources loaded into their HEDIS engines.

Systems' validation processes included multiple steps. For example, RUHS conducted validation checks upon initially receiving data, organizing and processing it. After standardizing the information, RUHS performed calculations and compared results against their EHR to verify accuracy.

Plans also conducted their own validation. AAH validated supplemental data files before loading them into its certified HEDIS engine software. And SFHP performed validation when receiving supplemental data files from SFHN.

> **Looking ahead:** Because systems conducted more detailed validation of the supplemental files for clinical accuracy and coding, one participant said that systems will still have an important role to play in data validation, even as DHCS shifts QIP reporting to plans.

San Francisco Health Network (SFHN) and San Francisco Health Plan's (SFHP) collaborative use of supplemental data files improved rate alignment

SFHN achieved a breakthrough when it discovered that SFHP could accept supplemental data files from its EHR system for use in the plan's MCAS/HEDIS reporting.

SFHN first conducted a patient-by-patient analysis to identify discrepancies between its clinical records and the quality rates reported by SFHP. Based on these findings, the two organizations launched a data alignment effort, meeting weekly over eight months.

They began by jointly reviewing the identified discrepancies to ensure records were accurately captured. As part of this work, SFHN shared patient-level data through targeted supplemental files. SFHN and SFHP also collaborated to define the structure and contents of these files—aligning on key data elements and formats to ensure the information could be accurately processed and incorporated into MCAS/HEDIS calculations.

SFHN reported that sending supplemental files was especially valuable for administrative measures, which rely solely on claims data and do not include medical record review. This made them more vulnerable to missing information.

In contrast, hybrid measures incorporate both claims and chart data, providing a more complete picture of care. Administrative measures such as Well-Child Visits, Developmental Screening, and Asthma Medication Ratio had shown significant discrepancies prior to this collaborative effort.

Supplemental files helped close these gaps by capturing clinical activities not associated with billing claims, even when CPT codes were not recorded during patient visits. This approach led to more accurate and aligned rates between SFHN and SFHP.

SFHN sent supplemental data files to SFHP for nine measures:

- Follow-Up After Emergency Department Visit for Substance Use (FUA)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Child and Adolescent Well-Care Visits (WCV)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Prenatal Depression Screening and Follow-Up (PND-E)
- Postpartum Depression Screening and Follow-Up (PDS-E)
- Asthma Medication Ratio (AMR)
- Developmental Screening in the First Three Years of Life (DEV)
- Colorectal Cancer Screening (COL)

SFHN noted that when given a choice, plans typically opted for hybrid reporting methods, as they provided a more complete view of patient care and supported stronger performance rate accuracy. This underscored the importance of supplemental files for administrative-only measures, where hybrid reporting was not available and claims alone frequently failed to capture the full scope of care delivered.

Data exchange: methods and data types

While SFHN and SFHP's success demonstrated the power of well-executed supplemental file sharing, some systems and plans pursued alternative approaches that reduced reliance on supplemental files in specific cases by enabling direct access to clinical data. However, these methods did not eliminate the need to formally submit supplemental data files for HEDIS reporting, particularly when standardized file formats were required for audit and validation.

Below are four key approaches implemented by systems and plans, presented in order of increasing technical sophistication and integration capabilities:

1. **Basic exchange: secure file transfer protocols (SFTP) for file sharing.** Each system and plan reported using SFTP for sending and receiving data, making it the most common method for file sharing. For example, Ventura County Health Care Agency (VCHCA) extracted data from Cerner, packaged it, and sent it to Gold Coast Health Plan (GCHP) through SFTP.

2. **Centralized access: provider portals and reporting platforms.** IEHP's provider portal allowed authorized users to download reports on quality measures. The reports on the portal were updated monthly and contained additional data not available via the HL7 (Health Level Seven)[4] message, which is sent directly to RUHS' Epic system. For example, RUHS was able to pull down rosters from IEHP's portal to determine compliancy. This allowed RUHS to cross-reference the plan's information against its internal QIP data to identify discrepancies. Similarly, GCHP offered systems access to its HEDIS vendor platform where they could also view their own rates.

3. **Direct integration: EHR system access.** Some systems and plans leveraged direct EHR access so plans could conduct medical record review. This approach proved effective for hybrid measures in MCAS/HEDIS reporting, which combined administrative claims data with clinical data extracted from medical records in the EHR.

4. **Advanced integration: HIE and real-time data exchange.** Each system and plan reported participating in an HIE, often to gain access to ADT feeds. RUHS and IEHP demonstrated a sophisticated approach, combining information accessed through the HIE with data shared directly between the system and plan. For example, when a patient was admitted to the emergency department, RUHS could send an ADT notification through the HIE to alert IEHP. In some cases, IEHP then responded with information about the patient's compliance status on select P4P measures. This real-time response populated into RUHS' Epic.

   Although this approach was more advanced, IEHP reported challenges in the quality and completeness of the data flowing through the HIE. The plan's Quality team reported being unable to load some of the data accessed via the HIE into the HEDIS engine because it did not meet the required format specifications or compliance standards.

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4   Health Level Seven (HL7) is a set of international standards for exchanging and integrating electronic health information between systems.

Submitting supplemental data files to HEDIS engines: the final step

While some data exchange approaches—such as direct EHR access or HIE integration—helped improve data sharing and real-time coordination, they did not replace the need to submit supplemental data files for formal HEDIS reporting. These files remained key to ensuring that clinical data not captured in claims was counted in official rate calculations.

After developing and validating supplemental data files, systems sent them to plans for final submission. Plans then submitted the files to their HEDIS vendors, who loaded them into specialized software engines to calculate quality performance rates.

Plans largely handled this final step in one of two ways:

- **Pass-through file approach.** When systems developed supplemental files using ECDS specifications from the outset, plans submitted them directly to their HEDIS vendors with minimal modification. As noted earlier, this streamlined approach worked best when plans shared vendor specifications early in the development process.

- **Additional processing required.** In other cases, plans and systems needed to perform additional formatting or validation before submission. Regardless of the submission method, plans were responsible for the final quality assurance of the file. Some plans described working closely with vendors—such as Inovalon or Cotiviti—during this step to ensure the files were properly structured and complete.

Rejection to resolution: how systems and plans fixed file issues

When supplemental files were rejected by a plan's HEDIS vendor during the submission process due to formatting or coding issues, systems and plans collaborated to troubleshoot the problems and revise the files for resubmission. These situations often required multiple rounds of rework and reinforced the importance of aligning early on file formatting and validation requirements.

From discrepancy to alignment: data integration benefits

When validated supplemental data successfully flowed into plans' HEDIS engines and were properly calculated, both systems and plans benefited from:

- Improved data completeness and accuracy

- More closely aligned quality performance rates

- Accurate and actionable data to inform targeted joint quality improvement efforts

These data alignment efforts demonstrated that successful collaboration between systems and plans requires more than data sharing alone. Collaboration depends on frequent communication, joint problem-solving at the patient level, dedicated resources, and a shared commitment to identifying and resolving data discrepancies.

Improving Data Alignment:

A Roadmap for California's Public Health Care Systems and Medi-Cal Managed Care Plans

June 2025

This roadmap is based on the experiences of four California public health care systems and four Medi-Cal managed care plans working in partnership to align their quality data. Their lessons learned informed the steps outlined below, helping other systems and plans approach this work more effectively from the start.

Although these steps are presented as sequential phases for clarity, systems and plans adapted them based on their specific circumstances and capabilities.

The roadmap is organized into five phases for systems and plans to implement together:

Establish leadership support and governance structures

Share performance reports and select quality measures

Identify and analyze discrepancies

Assess data exchange approaches and identify additional data needs

Submit data, monitor results, and increase alignment

Establish leadership support and governance structures

1 | **System and plan secure executive leadership support**

- System and plan obtain leadership buy-in for data alignment work
- If lack buy-in, make the case internally (i.e., demonstrate improved performance rates via initial alignment work)
- Ensure leadership provides necessary resources and protected staff time

2 | **System and plan establish joint committees, working groups**

- Form a Joint Quality Leadership Committee with leadership from both organizations:
  - Focus on strategic direction and resource allocation
  - Schedule monthly meetings
- Form a Joint Quality Data Working Group with staff from both organizations:
  - Focus on investigating and resolving data discrepancies
  - Include Quality, Analytics, Informatics, and IT staff who understand measure specifications
  - Include external experts (e.g., the plan's HEDIS vendor) and technical consultants as needed
  - Schedule weekly or biweekly meetings with regular communication in between

Share performance reports and select quality measures

1 **System and plan align performance monitoring approaches**

- System adopts year-to-date monitoring of QIP rates, alongside its rolling 12-month approach
- Plan adopts rolling 12-month view of MCAS/HEDIS rates, alongside its year-to-date monitoring

2 **Plan enhances and shares performance reports**

- Plan adds key data elements (e.g., dates of service) to performance reports: scorecards and gap-in-care reports
- Plan provides system with direct access to reports through its provider portal or HEDIS vendor platform
- If direct access is not feasible, plan sends enhanced scorecards and gap-in-care reports to system on a monthly basis

3 **System reviews performance reports to identify rate differences**

- System reviews scorecards and gap-in-care reports
- System identifies notable differences between its QIP rates and the plan's MCAS/HEDIS rates
- System documents specific measures with rate variances and shares with plan

4 **Systems and plans jointly select initial quality measures for alignment**

- System and plan collaboratively identify measures that are most relevant to both organizations
- For example, they may prioritize measures where:
  - The plan risks not meeting Minimum Performance Levels (MPLs)
  - The system is not meeting QIP targets
  - There are significant rate discrepancies
- After reviewing these priorities and identifying any overlap, system and plan agree on an initial set of measures to align

Identify and analyze discrepancies

1 **System identifies and shares data on patient-level discrepancies**

- Based on gap-in-care reports, system creates a list of patients whose compliance status differs from the plan's data
- System sends this list of non-compliant patients to the plan

2 **System and plan jointly analyze patient-level data**

- Joint Quality Data Working Group or other individuals from system and plan's Quality, Analytics, and IT departments meet to review discrepancies together:
  - Include staff who can explain measure logic and data elements for QIP and MCAS/HEDIS specifications
  - Include plan's HEDIS vendors and technical consultants, as needed
- Ensure staff have a shared understanding of measure specification differences
- Compare and analyze specific patient records across both organizations
- Categorize differences as either unavoidable variations or actionable data gaps

3 **System and plan jointly identify and categorize root causes of discrepancies**

- System and plan identify specific root causes (e.g., unreported test results)
- Continue regular meetings (weekly or biweekly) with ongoing communication (e.g., MS Teams channel) between sessions focused on developing specific data exchange approaches for discrepancies

Assess data exchange approaches and identify additional data needs

1 — **System and plan assess data exchange approaches to address actionable discrepancies**

- Identify potential exchange strategies based on the specific root causes of discrepancies
- Options include configuring the EHR to auto-drop CPT-2 codes or enabling the plan with direct, read-only access to the EHR

2 — **System and plan identify additional data beyond EHR data that may help fill gaps**

- Determine what additional data could address specific discrepancies
- Examples include lab results from external labs and claims data from other providers

3 — **System and plan prepare for and begin supplemental file development**

- Plan shares its HEDIS vendor's Electronic Clinical Data Systems (ECDS) specifications with the system before file development begins
- System and plan agree on file structure and data fields
- System extracts clinical data not captured in claims from its EHR, focusing on administrative measures
- System builds files based on the previously agreed-upon structure and according to the HEDIS vendor's technical specifications

4 — **System maps custom EHR codes**

- System identifies any custom EHR codes not accepted by HEDIS and maps them to meet specification requirements
- System compiles this information into a brief narrative and mapping document and sends to the plan
- Plan uses this document to supplement claims data in a format that can pass audit

5 — **System validates and sends supplemental files to plan**

- System conducts internal validation of files for clinical accuracy, coding, and formatting
- Plan reviews file structure and completeness
- System finalizes and sends validated file to plan using the previously agreed-upon structure and specifications

Submit data, monitor results, and increase alignment

1 | **Plan and HEDIS vendor process supplemental data**

- Plan conducts final quality assurance of file
- Plan submits file to its HEDIS vendor
- Vendor validates file structure, codes, and compliance with MCAS/HEDIS specifications
- If acceptable, vendor loads the file into HEDIS engine for rate calculation
- If rejected, system and plan collaborate to troubleshoot issues and revise the file for resubmission

2 | **System and plan monitor results and increase collaborative alignment work**

- Continuously track rate changes following data exchange improvements and QI efforts; adjust strategies as needed
- Document successful approaches and lessons learned for future reference
- Identify additional measures for alignment and future collaboration

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For more information, please contact SNI's Amanda Clarke.