Volume 1 of 6

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2022–June 30, 2023

Main Report

Quality and Population Health Management
California Department of Health Care Services

March 2024

HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Commonly Used Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

- **ADHD**—Attention-Deficit/Hyperactivity Disorder
- **AHRQ**—Agency for Healthcare Research and Quality
- **AIDS**—acquired immunodeficiency syndrome
- **APL**—All Plan Letter
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems[1]
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CAP**—corrective action plan
- **CA WIC**—California Welfare and Institutions Code
- **CCC**—Children with Chronic Conditions
- **CCI**—California's Coordinated Care Initiative
- **CCR**—California Code of Regulations
- **CDPH**—California Department of Public Health
- **CFR**—Code of Federal Regulations
- **CHES**—Certified Health Education Specialist
- **CHIP**—Children's Health Insurance Program
- **CMS**—Centers for Medicare & Medicaid Services
- **COVID-19**—coronavirus disease 2019
- **CPHQ**—Certified Professional in Healthcare Quality
- **DBA**—doing business as
- **Dental MC**—Dental Managed Care
- **DHCS**—California Department of Health Care Services
- **EDV**—encounter data validation
- **EHR**—electronic health record
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FCC**—Family-Centered Care
- **FFS**—fee-for-service
- **HbA1c**—hemoglobin A1c
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[2]

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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

- **HHS**—U.S. Department of Health & Human Services
- **HIE**—health information exchange
- **HMO**—health maintenance organization
- **HSAG**—Health Services Advisory Group, Inc.
- **HPI®**—California Healthy Places Index[3]
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCO**—managed care organization
- **MCP**—managed care health plan
- **MLTSS**—Managed Long-Term Services and Supports
- **MLTSSP**—Managed Long-Term Services and Supports Plan
- **MRRV**—medical record review validation
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **O/E**—observed/expected
- **PAHP**—prepaid ambulatory health plan
- **PCCM**—primary care case management
- **PCP**—primary care provider
- **PDSA**—Plan-Do-Study-Act
- **PHQ**—Patient Health Questionnaire
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project
- **PMV**—performance measure validation
- **PSP**—population-specific health plan
- **QAPI**—quality assessment and performance improvement
- **QPHM**—Quality and Population Health Management
- **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- **SFTP**—secure file transfer protocol
- **SHP**—specialty health plan
- **SMART**—Specific, Measurable, Achievable, Relevant, and Time-bound
- **SNF/ICF**—Skilled Nursing Facility/Intermediate Care Facility
- **SPD**—Seniors and Persons with Disabilities
- **SUD/SMH**—substance use disorder/specialty mental health
- **SWOT**—Strengths, Weaknesses, Opportunities, Threats

[3] Healthy Places Index® is a registered trademark of the Public Health Alliance of Southern California.

1. Introduction

External Quality Review

Title 42 Code of Federal Regulations (CFR) Section (§)438.320 defines "external quality review (EQR)" as an external quality review organization's (EQRO's) analysis and evaluation of aggregated information on the quality of, timeliness of, and access to health care services that a managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) or their contractors furnish to Medicaid beneficiaries. Each state must comply with §457.1250,[4] and as required by §438.350, each state that contracts with MCOs, PIHPs, PAHPs, or PCCM entities must ensure that:

- Except as provided in §438.362, a qualified EQRO performs an annual EQR for each such contracting MCO, PIHP, PAHP, or PCCM entity.
- The EQRO has sufficient information to perform the review.
- The information used to carry out the review must be obtained from the EQR-related activities described in §438.358 or, if applicable, from a Medicare or private accreditation review as described in §438.360.
- For each EQR-related activity, the information gathered for use in the EQR must include the elements described in §438.364(a)(2)(i) through (iv).
- The information provided to the EQRO in accordance with §438.350(b) is obtained through methods consistent with the protocols established by the U.S. Department of Health & Human Services (HHS) Secretary in accordance with §438.352.
- The results of the reviews are made available as specified in §438.364.

The California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), as the EQRO for DHCS' Medi-Cal Managed Care program (MCMC). HSAG meets the qualifications of an EQRO as outlined in §438.354 and performs annual EQRs of DHCS' contracted MCO and PAHP entities to evaluate their quality of, timeliness of, and access to health care services to MCMC members (DHCS does not designate any of its MCMC plans as PIHP or PCCM entities). In addition to providing its assessment of the quality of, timeliness of, and access to care delivered to MCMC members by MCMC plans, HSAG makes recommendations, as applicable, as to how DHCS can use the

[4] Title 42 CFR §457.1250 may be found at: https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L/subject-group-ECFR9effb7c504b1d10/section-457.1250. Accessed on: Jan 5, 2024.

EQR results in its assessment of and revisions to the DHCS Comprehensive Quality Strategy.[5] Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS Comprehensive Quality Strategy goals as well as whether DHCS needs to revise the Comprehensive Quality Strategy based on the results presented in the EQR technical report.

The following activities related to EQR are described in §438.358:

- Mandatory activities:
  - Validation of performance improvement projects (PIPs) required in accordance with §438.330(b)(1) that were underway during the preceding 12 months.
  - Validation of MCO, PIHP, or PAHP performance measures required in accordance with §438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the state during the preceding 12 months.
  - A review, conducted within the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Part 438 Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement (QAPI) requirements described in §438.330.
  - Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and, if the state enrolls Indians in the MCO, PIHP, or PAHP, §438.14(b)(1).
- Optional activities performed by using information derived during the preceding 12 months:
  - Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity.
  - Administration or validation of consumer or provider surveys of quality of care.
  - Calculation of performance measures in addition to those reported by an MCO, PIHP, PAHP, or PCCM entity and validated by an EQRO in accordance with §438.358(b)(1)(ii).
  - Conducting PIPs in addition to those conducted by an MCO, PIHP, PAHP, or PCCM entity and validated by an EQRO in accordance with §438.358 (b)(1)(i).
  - Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
  - Assisting with the quality rating of MCOs, PIHPs, and PAHPs consistent with §438.334.
- Technical assistance to groups of MCOs, PIHPs, PAHPs, or PCCM entities to assist them in conducting activities related to the mandatory and optional activities described in §438.358 that provide information for the EQR and the resulting EQR technical report.

[5] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

Unless noted otherwise in this report, DHCS provided HSAG with sufficient information to perform the EQR for the July 1, 2022, through June 30, 2023, review period. Additionally:

- The information HSAG used to carry out the EQR was obtained from all mandatory and select optional EQR-related activities described in §438.358.
- As applicable, DHCS followed methods consistent with the protocols established by the HHS Secretary in accordance with §438.352 to provide information relevant to the EQR.
- For each EQR-related activity, information DHCS gathered for use in the EQR included the elements described in §438.364(a)(2)(i) through (iv).
- Consistent with §438.350(f), DHCS made the EQR results available as specified in §438.364.

Purpose of Report

As required by §438.364, DHCS contracts with HSAG to prepare an annual, independent, technical report that summarizes findings on the quality of, timeliness of, and access to health care services provided by MCMC plans, including opportunities for quality improvement.

As described in the CFR, the independent report must summarize findings on access and quality of care for the Medicaid and Children's Health Insurance Program (CHIP) populations, including:

- A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to care furnished by the MCO, PIHP, PAHP, or PCCM entity.
- For each EQR-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the state can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.

- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.
- The names of the MCOs exempt from EQR by the state, including the beginning date of the current exemption period, or that no MCOs are exempt, as appropriate.

Section 438.2 defines an MCO, in part, as "an entity that has, or is seeking to qualify for, a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted Medi-Cal managed care health plans (MCPs) and population-specific health plans (PSPs) as MCOs. CMS designates the Dental Managed Care (Dental MC) plans as PAHPs.

This report provides a summary of MCP and PSP EQR activities. HSAG summarizes Dental MC plan activities in the *2022–23 Medi-Cal Dental Managed Care External Quality Review Technical Report*. Except when citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable). This report will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans." Note that DHCS does not exempt any MCMC plans from EQR.

Quality, Access, and Timeliness

CMS requires that the EQR evaluate the performance of MCOs, PIHPs, PAHPs, and PCCM entities related to the quality of, timeliness of, and access to care they deliver. Section 438.320 indicates that quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through:

- Its structural and operational characteristics.
- The provision of services consistent with current professional, evidence-based knowledge.
- Interventions for performance improvement.

Additionally, §438.320 indicates that access, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).

This report includes conclusions drawn by HSAG related to MCMC plans' strengths and weaknesses with respect to the quality of, timeliness of, and access to health care services furnished to MCMC plan members. In this report, the term "member" refers to a person entitled to receive benefits under MCMC as well as a person enrolled in an MCMC plan. While quality, access, and timeliness are distinct aspects of care, most MCMC plan activities and services cut across more than one area. Collectively, all MCMC plan activities and services affect the quality, accessibility, and timeliness of care delivered to MCMC plan members. In this report, when applicable, HSAG indicates instances in which MCMC plan performance affects one specific aspect of care more than another.

Description of Manner in Which MCMC Plan Data Were Aggregated and Analyzed and Conclusions Drawn Related to Quality, Access, and Timeliness

HSAG uses the following process to aggregate and analyze data from all applicable EQR activities it conducts to draw conclusions about the quality of, timeliness of, and access to care furnished by each MCMC plan. For each MCMC plan:

- HSAG analyzes the quantitative results obtained from each EQR activity to identify strengths and weaknesses related to the quality of, timeliness of, and access to care furnished by the plan and to identify any themes across all activities.
- From the aggregated information collected from all EQR activities, HSAG identifies strengths and weaknesses related to the quality of, timeliness of, and access to services furnished by the plan.
- HSAG draws conclusions based on the identified strengths and weaknesses, specifying whether the strengths and weaknesses affect one aspect of care more than another (i.e., quality of, timeliness of, or access to care).

In *Volume 2 of 6 (Appendix C)* of this EQR technical report, HSAG includes an assessment across all applicable EQR activities of each MCMC plan's strengths and weaknesses with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

Summary of Report Content

This report is divided into six volumes that include the following content:

Volume 1—Main Report

- An overview of MCMC.
- A description of the DHCS Comprehensive Quality Strategy report.

- An aggregate assessment of MCMC for the federally mandated and optional EQR activities conducted during the review period of July 1, 2022, through June 30, 2023, identifying the following for each EQR activity, as applicable:
  - Objectives
  - Technical methodology used for data collection and analysis
  - Description of the data obtained
  - Conclusions based on the data analysis

Volume 2—MCMC Plan-Specific Information

- Appendix A—PSP-Specific Performance Measure Results
- Appendix B—Comparative MCMC Plan-Specific Performance Improvement Project Information
- Appendix C—MCMC Plan-Specific EQR Assessments and Recommendations
  - MCMC Plans' Self-Reported Follow-Up on EQR Recommendations from the 2021–22 Review Period
  - HSAG's Assessment of MCMC plans' EQR Strengths, Weaknesses, and Recommendations from the 2022–23 Review Period

Volume 3—MCMC Plan Compliance Review Results Comparison

- Comparative MCMC plan-specific results for all compliance reviews DHCS conducted during the review period.

Volume 4—Managed Care Health Plan Performance Measure Comparison

- Comparative MCP-specific results for all DHCS-required performance measures.

Volume 5—Alternative Access Standard Reporting

- Detailed methodology, results, conclusions, and recommendations related to the alternative access standards reporting analyses.

Volume 6—Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

- Detailed methodology, results, conclusions, and recommendations related to the skilled nursing facility (SNF)/intermediate care facility (ICF) experience and distance reporting analyses.

Medi-Cal Managed Care Overview

In the State of California, DHCS administers the Medicaid program (Medi-Cal) through its fee-for-service (FFS) and managed care delivery systems. In California, the CHIP population is included in Medi-Cal.

MCMC provides managed health care services to more than 14.1 million members (as of June 2023)[6] in the State of California through a combination of contracted MCMC plans. DHCS is responsible for assessing the quality of care delivered to members through its MCMC plans, making improvements to care and services, and ensuring that MCMC plans comply with federal and State standards.

During the review period, DHCS contracted with 25 MCPs and two PSPs,[7] to provide health care services in all 58 counties throughout California. DHCS operates MCMC through a health care delivery system that encompasses six models of managed care for its full-scope services as well as a model for PSPs. DHCS monitors MCMC plan performance across model types.

A description of each MCP managed care model type may be found at MMCDModelFactSheet (ca.gov). The MCMC county map, which depicts the location of each MCP model type, may be found at https://www.dhcs.ca.gov/services/Documents/MMCD-Cnty-Map.pdf.

Note that beginning January 1, 2024, MCPs will operate under a restructured contract that requires high-quality, equitable, and comprehensive coverage. A list of MCPs by county and model type, including a comparison of the 2023 and 2024 differences, may be found at MCP County Table (ca.gov).

[6] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on Jul 12, 2023.

[7] Note: DHCS' contract with one of the 25 MCPs, UnitedHealthcare Community Plan, ended December 31, 2022; therefore, as applicable in this report, HSAG includes information about activities completed by UnitedHealthcare Community Plan during the review period.

Following is a description of the PSP model type.

Population-Specific Health Plan model. DHCS designates the following two MCOs as a "Population-Specific Health Plan" model because of their specialized populations:

- AIDS Healthcare Foundation—provides services in Los Angeles County, primarily to members living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).
- SCAN Health Plan provides services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, San Bernardino, and San Diego counties. Note that SCAN Health Plan began operating in San Diego County January 1, 2023.

Table 1.1 shows MCMC plan names, model types, reporting units, and the reporting unit enrollment as of June 2023. MCMC plans submit data for some EQR activities at the plan level and submit data for other activities at the reporting unit level. The bundling of counties into a single reporting unit allows a population size to support valid rates. HSAG obtained the enrollment information from the *Medi-Cal Managed Care Enrollment Report*.[6]

Table 1.1—Medi-Cal Managed Care Health Plan Names, Model Types, Reporting Units, and Reporting Unit Enrollment as of June 2023

* During the review period, Kaiser NorCal provided Medi-Cal services in Sacramento County as a Geographic Managed Care model type and in Amador, El Dorado, and Placer counties as a Regional model type; however, the MCP reports performance measure rates for all counties combined. DHCS' decision to have Kaiser NorCal report the combined rates ensures that the MCP has a sufficient sample size to compute accurate performance measure rates that represent the availability and quality of care provided for the population in the region and assists Kaiser NorCal with maximizing operational and financial efficiencies.

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2023
Managed Care Health Plans			
Aetna Better Health of California	Geographic Managed Care	Sacramento County	29,626
		San Diego County	39,723
Alameda Alliance for Health	Two-Plan—Local Initiative	Alameda County	356,532
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Geographic Managed Care	Sacramento County	242,100

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2023
	Regional	Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)	83,326
		Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties)	133,785
	San Benito	San Benito County	13,409
	Two-Plan—Commercial Plan	Alameda County	97,230
		Contra Costa County	40,787
		Fresno County	159,464
		Kings County	26,085
		Madera County	30,915
		San Francisco County	34,086
		Santa Clara County	96,345
	Two-Plan—Local Initiative	Tulare County	139,261
Blue Shield of California Promise Health Plan	Geographic Managed Care	San Diego County	152,366

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2023
California Health & Wellness Plan	Imperial	Imperial County	83,322
	Regional	Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)	106,357
		Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties)	83,329
CalOptima	County Organized Health System	Orange County	973,640
CalViva Health	Two-Plan—Local Initiative	Fresno County	357,098
		Kings County	39,665
		Madera County	48,323
CenCal Health	County Organized Health System	San Luis Obispo County	70,593
		Santa Barbara County	165,257
Central California Alliance for Health	County Organized Health System	Merced County	154,015
		Monterey and Santa Cruz counties	273,865
Community Health Group Partnership Plan	Geographic Managed Care	San Diego County	361,864
Contra Costa Health Plan	Two-Plan—Local Initiative	Contra Costa County	267,884

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2023
Gold Coast Health Plan	County Organized Health System	Ventura County	255,187
Health Net Community Solutions, Inc.	Geographic Managed Care	Sacramento County	148,176
		San Diego County	104,457
	Two-Plan—Commercial Plan	Kern County	97,173
		Los Angeles County	1,196,211
		San Joaquin County	32,878
		Stanislaus County	74,297
		Tulare County	133,357
Health Plan of San Joaquin	Two-Plan—Local Initiative	San Joaquin County	279,959
		Stanislaus County	178,378
Health Plan of San Mateo	County Organized Health System	San Mateo County	153,431
Inland Empire Health Plan	Two-Plan—Local Initiative	Riverside and San Bernardino counties	1,690,097
Kaiser NorCal (KP Cal, LLC)*	Geographic Managed Care and Regional	KP North (Amador, El Dorado, Placer, and Sacramento counties)	149,588
Kaiser SoCal (KP Cal, LLC)	Geographic Managed Care	San Diego County	73,346

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2023
Kern Health Systems, DBA Kern Family Health Care	Two-Plan—Local Initiative	Kern County	373,234
L.A. Care Health Plan	Two-Plan—Local Initiative	Los Angeles County	2,753,264
Molina Healthcare of California	Geographic Managed Care	Sacramento County	63,274
		San Diego County	265,701
	Imperial	Imperial County	21,477
	Two-Plan—Commercial Plan	Riverside and San Bernardino counties	232,670
Partnership HealthPlan of California	County Organized Health System	Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity counties)	113,167
		Northwest (Del Norte and Humboldt counties)	75,857
		Southeast (Napa, Solano, and Yolo counties)	242,903
		Southwest (Lake, Marin, Mendocino, and Sonoma counties)	267,129
San Francisco Health Plan	Two-Plan—Local Initiative	San Francisco County	195,633
Santa Clara Family Health Plan	Two-Plan—Local Initiative	Santa Clara County	336,518

Medi-Cal Managed Care Plan Name	Model Type	Reporting Unit	Reporting Unit Enrollment as of June 2023
UnitedHealthcare Community Plan	Geographic Managed Care	San Diego County	No enrollment due to DHCS' contract with the MCP ending 12/31/2022
Population-Specific Health Plans			
AIDS Healthcare Foundation	Population-Specific Health Plan	Los Angeles County	844
SCAN Health Plan	Population-Specific Health Plan	Los Angeles, Riverside, San Bernardino, and San Diego counties	17,999

Table 1.2 indicates the number of members served by each model type as of June 2023.

Table 1.2—Number of Members Served by Model Type

Medi-Cal Managed Care Plan Model Type	Number of Members Served as of June 2023
County Organized Health System	2,745,044
Geographic Managed Care	1,612,076
Imperial	104,799
Population-Specific Health Plan	18,843
Regional	424,942
San Benito	13,409
Two-Plan	9,267,344

During the review period, DHCS issued policy and health care service-related communications to the MCMC plans regarding DHCS' coronavirus disease 2019 (COVID-19) response efforts, including a detailed *Medi-Cal COVID-19 Public Health Emergency and Continuous Coverage*

Operational Unwinding Plan.[8] The unwinding plan includes details regarding the resumption of Medi-Cal redeterminations that went into effect April 1, 2023, as well as DHCS' approach for initiating and completing the redeterminations for Medi-Cal members according to the CMS requirements and within the 14-month CMS-required time frame. For details regarding all of DHCS' COVID-19-related communications, go to DHCS COVID-19 Response.

For enrollment information about each county, go to https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report.

[8] California Department of Health Care Services. *Medi-Cal COVID-19 Public Health Emergency and Continuous Coverage Operational Unwinding Plan*. Available at: Medi-Cal-COVID-19-PHE-Unwinding-Plan.pdf. Accessed on: Jan 5, 2024.

2. DHCS Comprehensive Quality Strategy

In accordance with 42 CFR §438.340, each state contracting with an MCO, PIHP, or PAHP as defined in §438.2 or with a PCCM entity as described in §438.310(c) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity. Additionally, as indicated in §438.340(c)(2), states must review and update their quality strategy as needed, but no less than once every three years.

In *Volume 1 of 5* of the 2021–22 EQR technical report, HSAG indicated that DHCS submitted the *DHCS Comprehensive Quality Strategy 2022* to CMS on February 4, 2022.[9] In *Volume 1 of 5,* HSAG also summarized the following:

- DHCS' process for reviewing and updating the Comprehensive Quality Strategy
- The Comprehensive Quality Strategy vision, goals, and guiding principles.
- Notable aspects of the Comprehensive Quality Strategy related to improving access to comprehensive care and managed care performance monitoring and accountability.

During the review period for this EQR technical report, DHCS did not publicly post any formal updates to the Comprehensive Quality Strategy.

The most up-to-date information on the DHCS Comprehensive Quality Strategy is located at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx. Information regarding California Advancing and Innovating Medi-Cal (CalAIM) is located at https://www.dhcs.ca.gov/calaim.

Recommendations—DHCS Comprehensive Quality Strategy

Because DHCS did not publicly post any formal updates to its Comprehensive Quality Strategy during the review period for this EQR technical report, HSAG has no recommendations for DHCS. When DHCS produces an updated version of the Comprehensive Quality Strategy, HSAG will review the updated strategy to determine if it has recommendations on how DHCS can target the Comprehensive Quality Strategy vision, goals, and guiding principles to better support improvement to the quality, timeliness, and accessibility of care for MCMC members.

[9] *Volume 1 of 5 Medi-Cal Managed Care External Quality Review Technical Report—July 1, 2021–June 30, 2022*. Available at: Medi-Cal Managed Care Technical Report: July 1, 2021–June 30, 2022. Accessed on: Jan 5, 2024.

3. Compliance Reviews

In accordance with 42 CFR §438.358, the state or its designee must conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM entity's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

DHCS directly conducts compliance reviews of MCMC plans, rather than contracting with the EQRO to conduct reviews on its behalf. Transparency and accountability are important aspects of the DHCS Comprehensive Quality Strategy, and conducting compliance reviews is one of the ways DHCS holds plans accountable to meet federal and State requirements that support the delivery of quality, accessible, and timely health care services to Medi-Cal members.[10]

Objectives

DHCS' objective related to compliance reviews is to annually assess each MCMC plan's compliance with:

- The standards set forth in 42 CFR Part 438 Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the QAPI requirements described in §438.330.

HSAG's objectives related to compliance reviews are to assess:

- DHCS' compliance with conducting reviews of all MCMC plans within the three-year period prior to the review dates for this report.
- MCMC plans' compliance with the areas that DHCS reviewed as part of the compliance review process.

[10] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

Technical Methods of Data Collection and Analysis

DHCS collected the data for the MCMC plan compliance reviews through the annual DHCS Audits & Investigations Division Medical Audits and also from the results of other activities, including encounter data validation (EDV), annual network certification, and quality improvement oversight.

Scoring Methodology

Beginning with the July 1, 2022, through June 30, 2023, review period, DHCS implemented a scoring methodology that includes all federal standards required by CMS.

DHCS applied the following *Met*/*Not Met* scoring methodology based on identified findings from data collected through the data sources indicated above:

- *Met* = 2 points
- *Not Met* = 0 points

The presence of a finding or identified noncompliance with a corresponding CFR element resulted in DHCS scoring the CFR element as *Not Met* (score of 0 points). If DHCS identified no findings or no evidence of noncompliance with a corresponding CFR element, DHCS scored the element as *Met* (score of 2 points). Scores were individually shared with MCMC plans prior to DHCS submitting the results to HSAG.

DHCS notified the MCMC plans of the new compliance scoring methodology on July 15, 2022.

Timeliness of Compliance Reviews

HSAG determined, by assessing the dates DHCS conducted its compliance reviews, whether DHCS conducted the reviews for all MCMC plans at least once within the three-year period prior to the review dates for this report. Unless noted, HSAG excluded from its analysis information from compliance reviews conducted earlier than July 1, 2019, (i.e., three years prior to the start of the review period) and later than June 30, 2023, (i.e., the end of the review period).

Results

While DHCS conducted the compliance review scoring for all required CFR standards for most MCMC plans outside the review dates for this EQR technical report, HSAG includes the results because they were available prior to HSAG finalizing the report. DHCS indicated that it shared

the individual plan scores with each MCMC plan, and DHCS took the plans' feedback into consideration before finalizing the scores.

Compliance review scores across all plans show that the plans were fully compliant with most CFR standards, with most plans receiving scores of 100 percent for more than half of the 14 standards. All MCMC plans were fully compliant with the following two standards:

- §438.242—Health Information Systems
- §438.56—Disenrollment: Requirements and Limitations

The following three MCMC plans were fully compliant with all CFR standards:

- AIDS Healthcare Foundation
- Blue Shield of California Promise Health Plan
- Central California Alliance for Health

At least 50 percent of the MCMC plans had findings within the following CFR standards:

- §438.206—Availability of Services
- §438.208—Coordination and Continuity of Care
- §438.210—Coverage and Authorization of Services
- §438.228—Grievance and Appeal Systems

Based on having the lowest total CFR compliance scores when compared to all other MCMC plans (86 percent), the plans with the greatest opportunities for improvement are listed below:

- Kaiser NorCal
- Kaiser SoCal
- Kern Family Health Care

Across all MCMC plans, DHCS identified findings related to CFR standards that support quality, accessible, and timely care for Medi-Cal members.

Comparative MCMC plan-specific compliance review results are included in *Volume 3 of 6* of this EQR technical report.

Conclusions

To draw conclusions related to compliance reviews, HSAG reviewed the compliance review scoring results that DHCS submitted to HSAG. HSAG also assessed MCMC plan compliance with the standards and whether there were any common areas for improvement related to the quality, timeliness, and accessibility of care for MCMC members.

To assess DHCS' compliance with §438.358, HSAG reviewed the dates on which DHCS conducted compliance reviews of MCMC plans and determined that DHCS conducted a compliance review no earlier than three years from the start of the review period for this report (July 1, 2022) for all MCMC plans.

DHCS' compliance review scores reflect that all MCMC plans were compliant with most CFR standard requirements. DHCS' identified findings are MCMC plan specific, and HSAG was unable to draw any conclusions related to common areas for improvement across all plans.

In *Volume 2 of 6 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each MCMC plan's strengths and weaknesses related to compliance reviews with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

4. Performance Measure Validation

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of those entities' QAPI programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(1)(ii) and (b)(2). The EQR technical report must include information on the validation of MCO, PIHP, PAHP, and PCCM entity performance measures (as required by the state) or MCO, PIHP, PAHP, and PCCM entity performance measures calculated by the state during the preceding 12 months.

To comply with §438.358, DHCS contracted with HSAG to conduct an independent audit in alignment with the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™,[11] standards, policies, and procedures to assess the validity of the DHCS-selected performance measures calculated and submitted by MCMC plans. Additionally, DHCS contracted with HSAG to conduct an independent audit of the DHCS-selected performance measures calculated and submitted by MCPs that participate in California's Coordinated Care Initiative (CCI) as Managed Long-Term Services and Supports Plans (MLTSSPs). During each audit, HSAG assesses the validity of each plan's data using CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[12] Following the audits, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about these plans' performance in providing quality, accessible, and timely care and services to their members.

Objectives

The purpose of HSAG's performance measure validation (PMV) is to ensure that each MCMC plan calculates and reports performance measures consistent with the established specifications and that the results can be compared to one another.

HSAG conducts HEDIS Compliance Audits, and analyzes performance measure results to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which each MCMC plan followed the established specifications for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

[11] HEDIS Compliance Audit™ is a trademark of NCQA.

[12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 5, 2024.

Note: MCMC plans must calculate and report DHCS' required performance measure rates annually for a measurement year (January through December) at the reporting unit level. DHCS defines a "reporting unit level" as a single county, a combined set of counties, or a region as determined and pre-approved by DHCS.

Technical Methods of Data Collection and Analysis

HSAG adheres to NCQA's *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information Systems Capabilities Assessment and an evaluation of compliance with performance measure specifications for a plan. All HSAG lead auditors are certified HEDIS compliance auditors.

Following is a description of how HSAG obtained the data for the PMV analyses, which it conducts via HEDIS Compliance Audits.

Performance Measure Validation Activities

The HEDIS Compliance Audit process involved three phases: audit validation, audit review, and follow-up and reporting. The following provides a summary of HSAG's activities with MCMC plans, as applicable, within each of the audit phases. Throughout all audit phases, HSAG actively engages with MCMC plans to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support these entities in understanding all audit requirements and in being able to report valid rates for all required performance measures. HSAG obtained information through interactions, discussions, and formal interviews with key MCMC plan staff members as well as through observations of system demonstrations and data processing.

Audit Validation Activities Phase (September 2022 through May 2023)

- Forwarded HEDIS measurement year 2022 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Forwarded an introductory packet that included the list of performance measures selected by DHCS for each population, the HEDIS measurement year 2022 Roadmap, a timeline for each of the required audit tasks, and guidance on the process requirements.
- Communicated frequently with MCMC plans throughout the audit season about important audit items, including reminders of upcoming deadlines, required processes, DHCS reporting requirements, performance measure clarifications, and NCQA updates.
- Scheduled virtual audit review dates.

- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS Compliance Audit processes, and ensure that MCMC plans were aware of important deadlines.
- Conducted survey sample frame validation for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys required by DHCS before the Certified Survey Vendor drew the final samples and administered the surveys.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards, and provided the Information Systems standard tracking report which listed outstanding items and areas that required additional clarification.
- Reviewed source code used for calculating the non-HEDIS performance measure rates to ensure compliance with the specifications required by the State.
- Verified that MCMC plans used NCQA-Certified measures for calculating the HEDIS performance measure rates either by using an NCQA-Certified vendor or contracting directly with NCQA to complete automated source code review.
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation (MRRV) to ensure the integrity of medical record review processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Meetings Phase (January 2023 through April 2023)

- Conducted virtual audit review meetings to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Follow-Up and Reporting Phase (May 2023 through July 2023)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final Information Systems standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS measurement year 2021 Audit Means and Percentiles. The report also included a comparison of the eligible populations for each measure to the prior year's eligible populations; and requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the

same from year to year. Additionally, auditors verified that MCMC plans used HEDIS Certified Measures[13] to generate the final rates.

- Compared the final rates to the patient-level detail files required by DHCS, ensuring that member-level data matched the final rate submission and met DHCS requirements.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

Description of Data Obtained

Through the methodology, HSAG obtained a number of different information sources to conduct the HEDIS Compliance Audits. These included:

- HEDIS Roadmap.
- Source code, computer programming, and query language (if applicable) used to calculate the selected non-HEDIS performance measure rates.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Re-abstraction of a sample of medical records selected by HSAG auditors.

Performance Measure Results Analyses

Using the validated performance measure rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about MCMC plan performance in providing accessible, timely, and quality health care services to their members. To aid in the analyses, HSAG produced spreadsheets with detailed comparative results. Additionally, HSAG submitted to DHCS the spreadsheets for DHCS to use in its assessment of these plans' performance across all performance measures.

HSAG assessed MCMC plans' performance in comparison to high performance levels and minimum performance levels and identified strengths, opportunities for improvement, and recommendations based on its assessment of MCMC plan performance.

Aggregate MCP, PSP, and MLTSSP performance measure results and conclusions are included in Section 5, Section 6, and Section 7 of this report ("**Managed Care Health Plan Performance Measures**," "**Population-Specific Health Plan Performance Measures**," and "**Managed Long-Term Services and Supports Plan Performance Measures**," respectively).

[13] HEDIS Certified Measures[SM] is a service mark of NCQA.

Results

For measurement year 2022, HSAG conducted 27 HEDIS Compliance Audits for 25 MCPs and two PSPs. The 27 audits resulted in 58 separate data submissions for performance measure rates at the reporting unit level. HSAG also conducted PMV with the 25 MCPs for a select set of measures that DHCS required MCPs to stratify by the Seniors and Persons with Disabilities (SPD) and non-SPD populations, and with 13 MLTSSPs for their MLTSS populations.

Each HEDIS Compliance Audit included preparation for the virtual audit review, survey sample frame validation, Roadmap review, data systems review, supplemental data validation if applicable, source code review, a virtual audit review meeting, MRRV when appropriate, primary source verification, query review, preliminary and final rate review, and initial and final audit reports production.

Conclusions

To draw conclusions related to PMV, HSAG assessed the information gathered during the virtual audit review meetings, Roadmap documentation, email communications, and phone conversations with MCMC plans.

The following contributed to all MCMC plans being able to fully engage in the audit process and produce valid performance measure rates for all DHCS-required Managed Care Accountability Set (MCAS) measures:

- DHCS permitting MCMC plans to choose the data collection methodology to use for measures with both hybrid and administrative options may have saved some MCMC plans the costs associated with using the hybrid methodology in instances wherein hybrid reporting did not improve their rates. Additionally, in instances wherein the MCMC plans were unable to report a measure rate using the hybrid methodology, DHCS' decision provided them the opportunity to report the rate administratively, which resulted in a *Reportable* (R) rate instead of a *Biased Rate* (BR).
- HSAG auditors determined that all MCMC plans were fully compliant with all information systems standards.
- With few exceptions, MCMC plans had integrated teams which included key staff members from both quality and information technology departments. HSAG observed that both areas worked closely together and had a sound understanding of the NCQA HEDIS Compliance Audit process. This multidisciplinary approach is crucial for reporting accurate and timely performance measure rates.
- MCMC plans used enrollment data as the primary data source for determining the eligible population for most measures. The routine data transfer and longstanding relationship between MCMC plans and DHCS continued to support implementation of best practices and stable processes for acquiring membership data.

- The majority of MCMC plans continued to increase use of supplemental data sources. These additional data sources offered MCMC plans the opportunity to more accurately capture the services provided to their members. Moreover, reporting hybrid measures along with supplemental data reduced the amount of resources that MCMC plans had to expend to abstract the clinical information, thus lessening their burden.
- MCMC plans had rigorous editing processes in place to ensure accurate and complete pharmacy, laboratory, provider, and claims data.
- With few exceptions, MCMC plans received most claims data electronically and had a very small percentage of claims that required manual data entry, minimizing the potential for errors.

It is important that MCMC plans have comprehensive, ongoing oversight processes in place due to the continued increase in the number of supplemental data sources used for performance measure rate calculations. HSAG observed that MCMC plans continue to have opportunities to investigate methods to incorporate supplemental data sources earlier in the audit process to eliminate the review of data sources that are not applicable to the MCAS measures.

During the audit process, HSAG stressed the importance of MCMC plans using all data that DHCS made available to them for performance measure reporting.

HSAG auditors identified MCMC plan-specific challenges and opportunities for improvement and provided feedback to each MCMC plan, as applicable.

In *Volume 2 of 6 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each MCMC plan's strengths and weaknesses related to PMV with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

5. Managed Care Health Plan Performance Measures

Objective

The primary objective related to MCP performance measures is for HSAG to assess MCPs' performance in providing quality, accessible, and timely care and services to their members by organizing, aggregating, and analyzing the validated performance measure results.

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the analyses in this section from the MCPs during the PMV activities described in Section 4 of this report ("**Performance Measure Validation**") and from NCQA via NCQA's Quality Compass®.[14]

Description of Data Obtained

The data HSAG obtained for the analyses in this section were:

- Performance measure data submitted by the MCPs, which included numerators, denominators, and calculated rates.
- NCQA's HEDIS 2022 Medicaid health maintenance organization (HMO) benchmarks (50th percentiles, 90th percentiles, and national Medicaid averages).

Requirements

To comply with 42 CFR §438.330, DHCS selects a set of performance measures to evaluate the quality of care MCPs deliver to their members. DHCS refers to this DHCS-required performance measure set as the Managed Care Accountability Set (MCAS). As outlined in the DHCS Comprehensive Quality Strategy, DHCS' Quality and Population Health Management (QPHM) program's Quality Metric Workgroup evaluates metrics for all program areas and makes recommendations about which measures should be required for monitoring and accountability. The workgroup also ensures that all required measures are aligned with the

[14] Quality Compass® is a registered trademark of NCQA.

Comprehensive Quality Strategy and its key objectives.[15] The performance measure requirements support the advancement of DHCS' Comprehensive Quality Strategy goals as well as DHCS' *Medi-Cal's Strategy to Support Health and Opportunity for Children and Families*, which is a forward-looking policy agenda for children and families enrolled in Medi-Cal.[16]

DHCS consults with HSAG and reviews feedback from MCPs and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. MCPs must report county or regional rates unless otherwise approved by DHCS.

Medi-Cal Managed Care Accountability Set

DHCS' measurement year 2022[17] MCAS included select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also HEDIS measures. Several required measures include more than one indicator. In this report, HSAG uses "performance measure" or "measure" (rather than indicator) to reference required MCAS measures. Collectively, performance measure results reflect the quality of, timeliness of, and access to care MCPs provide to their members.

Beginning with measurement year 2022, NCQA required race and ethnicity stratifications for select HEDIS measures. DHCS also required MCPs to report the NCQA race and ethnicity stratifications for additional measures. The race stratifications are listed below:

- White
- Black or African American
- American Indian and Alaska Native
- Asian
- Native Hawaiian and Other Pacific Islander
- Some Other Race
- Two or More Races
- Asked but No Answer
- Unknown

[15] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

[16] *Medi-Cal's Strategy to Support Health and Opportunity for Children and Families*. March 2022. Available at: https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf. Accessed on: Jan 5, 2024.

[17] The measurement year is the calendar year for which MCPs report the rates. Measurement year 2022 represents data from January 1, 2022, through December 31, 2022.

The ethnicity stratifications are listed below:

- Hispanic/Latino
- Not Hispanic/Latino
- Asked but No Answer
- Unknown

Table 5.1 lists the measurement year 2022 MCAS measures by measure domain. DHCS organized the measures for which it holds MCPs accountable to meet minimum performance levels into measure domains based on the health care areas they affect. Organizing these measures by domain allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS. Additionally, Table 5.1 includes descriptions and indicates the data capture method(s) for each measurement year 2022 MCAS measure. For some MCAS performance measures, the specifications allow for both administrative and hybrid reporting methods; for these measures, DHCS allows MCPs to choose either methodology. Note that when reporting performance measure rates using the hybrid methodology, MCPs are required to procure medical record data.

Note: DHCS included the *Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate* measure in the measurement year 2022 MCAS; however, because rates for this measure were not calculated, DHCS opted to not have HSAG present information related to this measure in this EQR technical report. DHCS will explore including this or a similar measure in future EQR technical reports to assess reduction of low-risk cesarean deliveries.

Table 5.1—Measurement Year 2022 Managed Care Accountability Set Measures

Admin = administrative method, which requires that MCPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MCPs derive the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. MCPs may not use medical records to retrieve information. When using the administrative method, MCPs use the entire eligible population as the denominator.

Hybrid = hybrid method, which requires that MCPs identify the eligible population using administrative data, then extract a systematic sample of members from the eligible population, which becomes the denominator. MCPs use administrative data to identify services provided to these members. When administrative data do not show evidence that MCPs provided the service, MCPs review medical records for those members to derive the numerator.

ECDS = Electronic Clinical Data Systems method, which expands the use of electronic data for quality measurement. Data sources that MCPs may use to identify the denominator and derive the numerator include, but are not limited to, member eligibility files, electronic health records (EHRs), clinical registries, health information exchanges (HIEs), administrative claims systems, electronic laboratory reports, electronic pharmacy systems, immunization information systems, and disease/case management registries.

* DHCS allows MCPs to choose the methodology for reporting the rate for this measure and expects that MCPs will report using the methodology that results in the higher rate.

^ NCQA requires race and ethnicity stratifications for this measure.

^^ DHCS requires race and ethnicity stratifications for this measure.

Measure	Method of Data Capture
Children's Health Domain (Measures held to minimum performance levels.)	
*Child and Adolescent Well-Care Visits—Total^* The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.	Admin
*Childhood Immunization Status—Combination 10^^* The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenza type B; three hepatitis B, one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday.	Admin or Hybrid*
*Immunizations for Adolescents—Combination 2^^* The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus vaccine series by their 13th birthday.	Admin or Hybrid*
Lead Screening in Children The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	Admin or Hybrid*
*Well-Child Visits in the First 30 Months of Life^^* Two rates are reported: ♦ *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*—The percentage of members who turned 15 months old during the measurement year who had six or more well-child visits with a PCP during the last 15 months. ♦ *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*—The percentage of members who turned 30 months old during the measurement year who had two or more well-child visits with a PCP during the last 15 months.	Admin
Reproductive Health Domain (Measures held to minimum performance levels.)	
Chlamydia Screening in Women—Total The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin

Measure	Method of Data Capture
*Prenatal and Postpartum Care^* Two rates are reported: ♦ *Postpartum Care*—The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. ♦ *Timeliness of Prenatal Care*—The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	Admin or Hybrid*
Cancer Prevention Domain (Measures held to minimum performance levels.)	
Breast Cancer Screening—Total The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.	Admin
Cervical Cancer Screening The percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: ♦ Women 21 to 64 years of age who had cervical cytology performed within the last 3 years. ♦ Women 30 to 64 years of age who had cervical high-risk human papillomavirus testing performed within the last 5 years. ♦ Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus within the last 5 years.	Admin or Hybrid*
Chronic Disease Management Domain (Measures held to minimum performance levels.)	
*Controlling High Blood Pressure—Total^* The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Admin or Hybrid*
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^* The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0 percent).	Admin or Hybrid*

Measure	Method of Data Capture
Behavioral Health Domain (Measures held to minimum performance levels.)	
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total^^ The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the emergency department visit (31 total days).	Admin
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total^^ The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of substance use disorder, or any diagnosis of drug overdose, who had a follow-up visit within 30 days of the emergency department visit (31 total days).	Admin
Report Only Measures (Measures not held to minimum performance levels.)	
Adults' Access to Preventive/Ambulatory Health Services—Total The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.	Admin
Ambulatory Care—Emergency Department (ED) Visits—Total This measure summarizes utilization of ambulatory care in the category of emergency department visits. The measure reports the number of visits per 1,000 member months. Member months are a member's "contribution" to the total yearly membership.	Admin
Antidepressant Medication Management The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported: ♦ *Effective Acute Phase Treatment—Total*—The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ♦ *Effective Continuation Phase Treatment—Total*—The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	Admin
Asthma Medication Ratio—Total The percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Admin

Measure	Method of Data Capture
Colorectal Cancer Screening^ The percentage of members 50 to 75 years of age who had appropriate screening for colorectal cancer.	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception Among women at risk of unintended pregnancy, the percentage who were provided a most effective or moderately effective method of contraception. Two rates are reported: ♦ *Ages 15–20 Years* ♦ *Ages 21–44 Years*	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days Among women who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 60 days of delivery. Two rates are reported: ♦ *Ages 15–20 Years* ♦ *Ages 21–44 Years*	Admin
Depression Remission or Response for Adolescents and Adults The percentage of members 12 years of age and older with a diagnosis of depression and an elevated Patient Health Questionnaire (PHQ-9) score, who had evidence of response or remission within 4 to 8 months of the elevated score. Three rates are reported: ♦ *Follow-Up PHQ-9*—The percentage of members who have a follow-up PHQ-9 score documented within 4 to 8 months after the initial elevated PHQ-9 Score. ♦ *Depression Remission*—The percentage of members who achieved remission within 4 to 8 months after the initial elevated PHQ-9 score. ♦ *Depression Response*—The percentage of members who showed response within 4 to 8 months after the initial elevated PHQ-9 score.	ECDS

Measure	Method of Data Capture
Depression Screening and Follow-Up for Adolescents and Adults^^ The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates are reported: ♦ *Depression Screening*—The percentage of members who were screened for clinical depression using a standardized instrument. ♦ *Follow-Up on Positive Screen*—The percentage of members who received follow-up care within 30 days of a positive depression screen finding.	ECDS
Developmental Screening in the First Three Years of Life—Total The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Admin
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Admin
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total^^ The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the emergency department visit (8 total days).	Admin
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total^^ The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of substance use disorder, or any diagnosis of drug overdose, who had a follow-up visit within 7 days of the emergency department visit (8 total days).	Admin

Measure	Method of Data Capture
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication Two rates are reported: ♦ *Initiation Phase*—The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. ♦ *Continuation and Maintenance Phase*— The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the 30-day initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	Admin
Metabolic Monitoring for Children and Adolescents on Antipsychotics The percentage of children and adolescents 1 to 17 years of age on two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: ♦ *Blood Glucose Testing—Total*—The percentage of children and adolescents on antipsychotics who received blood glucose testing. ♦ *Cholesterol Testing—Total*—The percentage of children and adolescents on antipsychotics who received cholesterol testing. ♦ *Blood Glucose and Cholesterol Testing—Total*—The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	Admin
Pharmacotherapy for Opioid Use Disorder The percentage of new opioid use disorder pharmacotherapy events with opioid use disorder pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of opioid use disorder.	Admin
Plan All-Cause Readmissions For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of observed 30-day readmissions. Three rates are reported: ♦ *Observed Readmissions—Total* ♦ *Expected Readmissions—Total* ♦ *Observed/Expected (O/E) Ratio—Total*	Admin

Measure	Method of Data Capture
Postpartum Depression Screening and Follow-Up The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported: ♦ *Depression Screening*—The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. ♦ *Follow-Up on Positive Screen*—The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	ECDS
Prenatal Depression Screening and Follow-Up The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported: ♦ *Depression Screening*—The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. ♦ *Follow-Up on Positive Screen*—The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	ECDS
Prenatal Immunization Status The percentage of deliveries in the measurement period in which women received influenza and Tdap vaccinations. Three rates are reported: ♦ *Influenza* ♦ *Tdap* ♦ *Combination*	ECDS
Topical Fluoride for Children The percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications. ♦ *Dental Services—Total* ♦ *Oral Health Services—Total* ♦ *Dental or Oral Health Services—Total*	Admin

Seniors and Persons with Disabilities Performance Measure Stratification

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2022, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits—Total*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

DHCS-Established Performance Levels

Each year, to create a uniform standard for assessing MCPs on performance measures, DHCS establishes high performance levels and minimum performance levels for a select number of MCAS HEDIS measures. DHCS uses the established high performance levels as performance goals and recognizes MCPs for outstanding performance. MCPs are contractually required to perform at or above DHCS-established minimum performance levels.

To establish the high performance levels and minimum performance levels for the measurement year 2022 MCAS HEDIS measures, DHCS used NCQA's Quality Compass HEDIS 2022 Medicaid HMO benchmarks. The Quality Compass HEDIS 2022 Medicaid HMO benchmarks reflect the previous year's benchmark percentiles (measurement year 2021). DHCS based the high performance levels for measurement year 2022 on NCQA's Quality Compass HEDIS 2022 Medicaid HMO 90th percentiles and the minimum performance levels for measurement year 2022 on the national Medicaid 50th percentiles.

According to DHCS' license agreement with NCQA, HSAG includes in Table 5.2 the benchmarks that DHCS used to establish the high performance levels and minimum performance levels for the measurement year 2022 HEDIS measures for which DHCS determined to hold MCPs accountable to meet the minimum performance levels.[18]

Table 5.2—High Performance Level and Minimum Performance Level Benchmark Values for Measurement Year 2022

Measurement year 2022 high performance level and minimum performance level benchmark values represent NCQA's Quality Compass HEDIS 2022 Medicaid HMO 90th and 50th percentiles, respectively, reflecting the measurement year from January 1, 2021, through December 31, 2021.

^ A lower rate indicates better performance for this measure.

Measure	Measurement Year 2022 High Performance Level	Measurement Year 2022 Minimum Performance Level
Children's Health Domain		
Child and Adolescent Well-Care Visits—Total	62.70%	48.93%
Childhood Immunization Status—Combination 10	49.76%	34.79%
Immunizations for Adolescents—Combination 2	48.42%	35.04%

[18] The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the data") is Quality Compass® 2022 and is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on the data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

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Measure	Measurement Year 2022 High Performance Level	Measurement Year 2022 Minimum Performance Level
Lead Screening in Children	79.57%	63.99%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	67.56%	55.72%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	78.07%	65.83%
Reproductive Health Domain		
Chlamydia Screening in Women—Total	67.84%	55.32%
Prenatal and Postpartum Care—Postpartum Care	84.18%	77.37%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.89%	85.40%
Cancer Prevention Domain		
Breast Cancer Screening—Total	61.27%	50.95%
Cervical Cancer Screening	66.88%	57.64%
Chronic Disease Management Domain		
Controlling High Blood Pressure—Total	69.19%	59.85%
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	30.90%	39.90%
Behavioral Health Domain		
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	72.01%	54.51%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	32.38%	21.24%

Measurement Year 2022 Quality Enforcement Actions

California Welfare and Institutions Code (CA WIC) §14197.7[19] and the MCP contracts authorize DHCS to impose enforcement actions on MCPs that fail to meet the required minimum performance levels for any of the applicable MCAS measures in any reporting unit. Enforcement actions may include corrective action plans (CAPs) and monetary and non-monetary sanctions. The level and type of enforcement action depend on the number of deficiencies and the severity of the quality issues identified.

Enforcement Tiers

For measurement year 2022, DHCS established accountability requirements based on enforcement tiers. MCPs not meeting the minimum performance level for one or more measures within a performance measure domain will be placed in an enforcement tier. Following are the criteria for each tier:

- Tier 1—One performance measure rate below the minimum performance level in any one domain.
- Tier 2—Two or more performance measure rates below the minimum performance levels in any one domain.
- Tier 3—Three or more performance measure rates below the minimum performance levels in two or more domains.

DHCS will determine the appropriate quality enforcement action based on each MCP's enforcement tier assignment, including both monetary and non-monetary penalties or sanctions. MCPs will not be subject to monetary sanctions for reporting units that do not trigger a tier rating or for reporting units assigned to Tier 1.

Monetary Sanctions

DHCS will determine monetary sanctions by taking into account the following factors:

- Severity—The percentage point difference between the MCP's performance measure rate and the minimum performance level.
- Trending—The difference between the MCP's measurement year 2022 performance measure rate and measurement year 2021 performance measure rate.
- Population Not Served—The number of affected members who did not receive the service based on the numerator and denominator data the MCP submitted during the MCAS PMV process.

[19] Cal. WIC §14197.7. Available at: Law section (ca.gov). Accessed on: Jan 5, 2024.

- Healthy Places Index (HPI)[20] Impact—DHCS will reduce the sanction amount for MCPs operating in underserved ZIP Codes.

Details regarding DHCS' measurement year 2022 quality enforcement actions, including the detailed methodology DHCS will use to determine monetary sanction amounts, may be found at All Plan Letter (APL) 23-012.[21]

MCMC Weighted Average Calculation Methodologies

HSAG calculated the measurement years 2020, 2021, and 2022 MCMC weighted averages according to CMS' methodology.[22]

Results

Please refer to Table 5.1 for descriptions of all MCAS measures displayed within this "Results" heading. Additionally, refer to *Volume 4 of 6* of this EQR technical report for comparative measurement year 2022 results across all MCPs for all DHCS-required performance measures. The *Managed Care Health Plan Performance Measure Comparison* provides the following:

- Comparisons to the high performance levels and minimum performance levels for applicable performance measures.
- Comparative results for Report Only measures that were not compared to high performance levels and minimum performance levels.
- Comparative SPD and non-SPD stratification results for applicable measures.

Performance Measure Weighted Averages Compared to Benchmarks

Table 5.3 presents the MCMC weighted averages for measures for which DHCS required MCPs to meet minimum performance levels. DHCS organized the measures by domains based on the health care areas they affect. Organizing these measures by domain allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS. As applicable, the table displays three-year trending

[20] Public Health Alliance of Southern California. The California Healthy Places Index. Available at: https://www.healthyplacesindex.org/. Accessed on: Jan 5, 2024.

[21] All Plan Letter 23-012. Available at: APL 23-012 (ca.gov). Accessed on: Jan 5, 2024.

[22] Centers for Medicare & Medicaid Services. Technical Assistance Brief: Calculating State-Level Rates Using Data from Multiple Reporting Units. March 2023. Available at: Calculating State-Level Rates Using Data from Multiple Reporting Units (medicaid.gov). Accessed on: Jan 5, 2024.

for the MCMC weighted averages and a comparison of measurement year 2022 MCMC weighted averages to the measurement year 2021 MCMC weighted averages and to the DHCS-established high performance levels and minimum performance levels.

Please refer to Table 5.2 for the benchmarks HSAG used for high performance level and minimum performance level comparisons included in Table 5.3.

Table 5.3—Measurement Years 2020, 2021, and 2022 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results for Rates Compared to Benchmarks

= Rate indicates performance at or better than the high performance level.

Bolded Rate = Rate indicates performance worse than the minimum performance level.

= Statistical testing result indicates that the measurement year 2022 rate is significantly better than the measurement year 2021 rate.

= Statistical testing result indicates that the measurement year 2022 rate is significantly worse than the measurement year 2021 rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* For this measure, only the measurement years 2021 and 2022 rates are compared to the high performance levels and minimum performance levels based on DHCS' performance measure requirements.

** For this measure, only the measurement year 2022 rate is compared to the high performance level and minimum performance level based on DHCS' performance measure requirements.

^ A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2021–22 rate difference cannot be calculated because data are not available for both years.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Children's Health Domain				
*Child and Adolescent Well-Care Visits—Total**	41.13%	47.51%	**47.02%**	-0.49
Childhood Immunization Status—Combination 10	37.95%	**36.63%**	**34.69%**	-1.94

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Immunizations for Adolescents—Combination 2	43.05%	39.23%	39.97%	0.74
Lead Screening in Children	—	—	54.57%	Not Comparable
*Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits**	37.70%	**40.23%**	**49.56%**	9.33
*Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**	66.40%	**60.28%**	**64.33%**	4.05
Reproductive Health Domain				
Chlamydia Screening in Women—Total	61.63%	63.61%	63.56%	-0.05
Prenatal and Postpartum Care—Postpartum Care	78.87%	81.39%	81.90%	0.51
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**87.88%**	87.57%	88.55%	0.98
Cancer Prevention Domain				
Breast Cancer Screening—Total	**57.04%**	53.99%	55.73%	1.74
Cervical Cancer Screening	**59.90%**	**58.18%**	**56.80%**	-1.38
Chronic Disease Management Domain				
Controlling High Blood Pressure—Total*	58.41%	60.25%	62.93%	2.68

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	41.50%	37.50%	**35.60%**	-1.90
Behavioral Health Domain				
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total***	—	34.77%	**46.81%**	12.04
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total***	—	8.56%	28.61%	20.05

Report Only Performance Measures

Table 5.4 presents the MCMC weighted averages for Report Only measures (i.e., measures that HSAG did not compare to high performance levels and minimum performance levels). As applicable, the table displays three-year trending for the MCMC weighted averages and a comparison of measurement year 2022 MCMC weighted averages to the measurement year 2021 MCMC weighted averages. While DHCS does not require MCPs to meet minimum performance levels for Report Only measures, DHCS uses trending information as a way to assess MCP performance.

Table 5.4—Measurement Years 2020, 2021, and 2022 Statewide Medi-Cal Managed Care Weighted Average Report Only Performance Measure Results

= Statistical testing result indicates that the measurement year 2022 rate is significantly better than the measurement year 2021 rate.

= Statistical testing result indicates that the measurement year 2022 rate is significantly worse than the measurement year 2021 rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance.

^ A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A measurement year 2021–22 rate difference cannot be calculated because data are not available for both years.

Not Tested = A measurement year 2021–22 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Adults' Access to Preventive/Ambulatory Health Services—Total	—	—	64.43%	Not Comparable
*Ambulatory Care—Emergency Department (ED) Visits—Total**	31.96	33.67	458.06	Not Tested
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	60.05%	65.15%	66.10%	0.95
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.09%	48.52%	49.52%	1.00
Asthma Medication Ratio—Total	64.26%	65.04%	67.43%	2.39
Colorectal Cancer Screening	—	—	36.72%	Not Comparable

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15 to 20	14.70%	13.89%	12.69%	-1.20
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21 to 44	23.58%	23.21%	21.22%	-1.99
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—90 Days—Ages 15 to 20	37.34%	35.88%	33.72%	-2.16
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—90 Days—Ages 21 to 44	36.67%	35.18%	33.88%	-1.30
Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total	—	—	40.44%	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Remission—Total	—	—	7.50%	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Response—Total	—	—	13.40%	Not Comparable

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total	—	—	3.74%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total	—	—	72.40%	Not Comparable
Developmental Screening in the First Three Years of Life—Total	—	—	32.33%	Not Comparable
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.74%	79.89%	78.62%	-1.27
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	—	23.25%	33.57%	10.32
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	—	4.86%	18.36%	13.50
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	43.91%	42.14%	47.13%	4.99

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	49.28%	49.35%	52.39%	3.04
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	55.48%	62.61%	59.76%	-2.85
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	39.10%	45.33%	40.56%	-4.77
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	37.60%	43.98%	39.39%	-4.59
Pharmacotherapy for Opioid Use Disorder	—	—	21.60%	Not Comparable
*Plan All-Cause Readmissions—Observed Readmissions—Total^*	9.32%	9.19%	9.05%	-0.14
Plan All-Cause Readmissions—Expected Readmissions—Total	9.74%	9.54%	9.47%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total^*	0.96	0.96	0.96	Not Tested

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Postpartum Depression Screening and Follow-Up—Depression Screening	—	—	7.44%	Not Comparable
Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen	—	—	71.48%	Not Comparable
Prenatal Depression Screening and Follow-Up—Depression Screening	—	—	10.39%	Not Comparable
Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen	—	—	51.12%	Not Comparable
Prenatal Immunization Status—Influenza	—	—	30.91%	Not Comparable
Prenatal Immunization Status—Tdap	—	—	57.71%	Not Comparable
Prenatal Immunization Status—Combination	—	—	26.73%	Not Comparable
Topical Fluoride for Children—Dental Services—Total	—	—	7.54%	Not Comparable
Topical Fluoride for Children—Oral Health Services—Total	—	—	0.59%	Not Comparable
Topical Fluoride for Children—Dental or Oral Health Services—Total	—	—	9.91%	Not Comparable

Performance Measure Weighted Averages Compared to National Medicaid Averages

Table 5.5 presents the MCMC weighted averages for each MCAS measure that HSAG compared to the corresponding national Medicaid average and displays whether the weighted averages were better or worse than the national Medicaid averages.

Table 5.5—Measurement Years 2020, 2021, and 2022 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance at or better than the national Medicaid average.

Bolded Rate = Rate indicates performance worse than the national Medicaid average.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.

— Indicates that the rate is not available.

* A comparison cannot be made because no national benchmarks existed for this measure in measurement year 2020.

^ A lower rate indicates better performance for this measure.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	60.05%	65.15%	66.10%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.09%	48.52%	49.52%
Asthma Medication Ratio—Total	64.26%	**65.04%**	67.43%
Breast Cancer Screening—Total	**57.04%**	53.99%	55.73%
Cervical Cancer Screening	**59.90%**	58.18%	56.80%
Child and Adolescent Well-Care Visits—Total	41.13%*	47.51%	**47.02%**
Childhood Immunization Status—Combination 10	**37.95%**	36.63%	**34.69%**
Chlamydia Screening in Women—Total	61.63%	63.61%	58.85%

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate
Controlling High Blood Pressure—Total	**58.41%**	60.25%	62.93%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**75.74%**	79.89%	**78.62%**
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	—	**23.25%**	**33.57%**
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	—	**34.77%**	**46.81%**
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	—	**4.86%**	18.36%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	—	**8.56%**	28.61%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	43.91%	**42.14%**	47.13%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	**49.28%**	**49.35%**	52.39%
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	**41.50%**	37.50%	**35.60%**
Immunizations for Adolescents—Combination 2	43.05%	39.23%	39.97%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	**55.48%**	62.61%	59.76%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	**39.10%**	45.33%	40.56%

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	**37.60%**	43.98%	39.39%
Prenatal and Postpartum Care—Postpartum Care	78.87%	81.39%	81.90%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.88%	87.57%	88.55%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	37.70%*	**40.23%**	**49.56%**
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	66.40%*	**60.28%**	64.33%

Seniors and Persons with Disabilities

Table 5.6 presents the SPD and non-SPD MCMC weighted averages, a comparison of these averages, and the total MCMC weighted averages for the two measures MCPs stratified by SPD and non-SPD populations for measurement year 2022.

Table 5.6—Measurement Year 2022 Statewide Medi-Cal Managed Care Weighted Averages Comparison and Results for Measures Stratified by the SPD Population

= Statistical testing result indicates that the measurement year 2022 SPD rate is significantly better than the measurement year 2022 non-SPD rate.

= Statistical testing result indicates that the measurement year 2022 SPD rate is significantly worse than the measurement year 2022 non-SPD rate.

Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance.

^ A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Measurement 2022 SPD Rate	Measurement Year 2022 Non-SPD Rate	SPD/Non-SPD Rate Difference	Measurement Year 2022 Total Rate
*Ambulatory Care—Emergency Department (ED) Visits—Total**	689.64	450.85	Not Tested	458.04
*Plan All-Cause Readmissions—Observed Readmissions—Total^*	11.18%	8.55%	2.63	9.05%

Comparison Across All Managed Care Health Plans

For measures for which HSAG compared rates to high performance levels, HSAG calculated the percentage of reported rates that were at or better than the high performance levels for measurement year 2022 across all performance measure domains at the MCP level. Table 5.7 lists each MCP, the number of rates at or better than the high performance levels, the total number of reported rates compared to high performance levels, and the percentage of reported rates that were at or better than the high performance levels in measurement year 2022, from highest to lowest percentage.

Table 5.7—Percentage of Measurement Year 2022 Rates At or Better Than the High Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Number of Rates At or Better Than the High Performance Levels	Total Number of Reported Rates Compared to High Performance Levels	Percentage of Rates At or Better Than the High Performance Levels
Kaiser SoCal	9	15	60.00%
Kaiser NorCal	8	15	53.33%
Contra Costa Health Plan	5	15	33.33%
San Francisco Health Plan	5	15	33.33%
CenCal Health	9	30	30.00%
Alameda Alliance for Health	4	15	26.67%
Health Plan of San Mateo	4	15	26.67%

Medi-Cal Managed Care Health Plan	Number of Rates At or Better Than the High Performance Levels	Total Number of Reported Rates Compared to High Performance Levels	Percentage of Rates At or Better Than the High Performance Levels
Blue Shield of California Promise Health Plan	3	15	20.00%
CalOptima	3	15	20.00%
Central California Alliance for Health	6	30	20.00%
Partnership HealthPlan of California	9	60	15.00%
CalViva Health	6	45	13.33%
Gold Coast Health Plan	2	15	13.33%
California Health & Wellness Plan	5	45	11.11%
Anthem Blue Cross Partnership Plan	13	180	7.22%
Community Health Group Partnership Plan	1	14	7.14%
Inland Empire Health Plan	1	15	6.67%
Santa Clara Family Health Plan	1	15	6.67%
Aetna Better Health of California	1	30	3.33%
Molina Healthcare of California	2	60	3.33%
Health Net Community Solutions, Inc.	3	105	2.86%
Health Plan of San Joaquin	0	30	0.00%
Kern Family Health Care	0	15	0.00%
L.A. Care Health Plan	0	15	0.00%
UnitedHealthcare Community Plan	0	15	0.00%

For measures for which HSAG compared rates to minimum performance levels, HSAG calculated the percentage of reported rates that were worse than the minimum performance levels for measurement year 2022 across all performance measure domains at the MCP level. Table 5.8 lists each MCP, the number of rates worse than the minimum performance levels, the total number of reported rates compared to minimum performance levels, and the percentage of reported rates that were worse than the minimum performance levels in measurement year 2022, from highest to lowest percentage.

Table 5.8—Percentage of Measurement Year 2022 Rates Worse Than the Minimum Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Number of Rates Worse Than the Minimum Performance Levels	Total Number of Reported Rates Compared to Minimum Performance Levels	Percentage of Rates Worse Than the Minimum Performance Levels
UnitedHealthcare Community Plan	13	15	86.67%
Aetna Better Health of California	23	30	76.67%
Health Plan of San Joaquin	20	30	66.67%
Kern Family Health Care	10	15	66.67%
Health Net Community Solutions, Inc.	66	105	62.86%
Molina Healthcare of California	33	60	55.00%
Partnership HealthPlan of California	31	60	51.67%
California Health & Wellness Plan	23	45	51.11%
Anthem Blue Cross Partnership Plan	84	180	46.67%
Inland Empire Health Plan	6	15	40.00%
L.A. Care Health Plan	6	15	40.00%
CalViva Health	16	45	35.56%
Alameda Alliance for Health	5	15	33.33%
Blue Shield of California Promise Health Plan	5	15	33.33%
Central California Alliance for Health	8	30	26.67%
Gold Coast Health Plan	4	15	26.67%
CenCal Health	5	30	16.67%
Contra Costa Health Plan	2	15	13.33%
Kaiser NorCal	2	15	13.33%
Kaiser SoCal	2	15	13.33%
San Francisco Health Plan	2	15	13.33%
Community Health Group Partnership Plan	1	14	7.14%

Medi-Cal Managed Care Health Plan	Number of Rates Worse Than the Minimum Performance Levels	Total Number of Reported Rates Compared to Minimum Performance Levels	Percentage of Rates Worse Than the Minimum Performance Levels
CalOptima	1	15	6.67%
Health Plan of San Mateo	1	15	6.67%
Santa Clara Family Health Plan	1	15	6.67%

HSAG includes MCP-specific performance measure results for all required MCAS measures in *Volume 4 of 6* of this EQR technical report.

Summary of Measurement Year 2021 Quality Monitoring

For measurement year 2021, DHCS established accountability requirements based on quality improvement tiers. MCMC plans not meeting the minimum performance level for one or more measures within a performance measure domain were placed in a quality monitoring tier. Following are the requirements for each tier:

- Green Tier—One performance measure rate below the minimum performance level in any domain.
  - Quality Improvement Requirement: Plan-Do-Study-Act (PDSA) cycles
- Orange Tier—Two or more performance measure rates below the minimum performance levels in any one domain.
  - Quality Improvement Requirement: PDSA cycles and SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis projects.
  - DHCS required each MCMC plan to conduct no more than three quality improvement projects (i.e., PDSA cycles and/or SWOT analyses projects), not including PIPs. The MCMC plan-assigned DHCS nurse consultant, in collaboration with the MCMC plan, determined the number and project type (i.e., PDSA cycles or SWOT analyses).
- Red Tier—Three or more performance measure rates below the minimum performance levels in two or more domains.
  - Implement a CAP.
  - Quality Improvement Requirement: Quality Improvement Assessment.
  - Attend executive leadership meetings every four months.
  - Attend a nurse consultant meeting prior to each executive leadership meeting.

DHCS worked with each MCMC plan to determine specific quality improvement requirements. Additionally, DHCS provides ongoing technical assistance to plans and monitors their progress toward meeting the agreed-upon quality improvement goals.

Managed Care Health Plan Tier Placement

Table 5.9 through Table 5.11 list the MCPs that DHCS placed in each tier, the reporting units, and the measure domains based on measurement year 2021 performance measure results. Note that DHCS used measurement year 2021 performance measure domains, which are different than the measurement year 2022 domains.

Table 5.9—Managed Care Health Plan Green Tier Placement and Performance Measure Domains Based on Measurement Year 2021 Performance Measure Results and Domains

Medi-Cal Managed Care Health Plans	Reporting Units	Performance Measure Domains
CalOptima	Orange County	Children's Health
CenCal Health	Santa Barbara County San Luis Obispo County	Children's Health Women's Health
Kaiser NorCal	KP North (Amador, El Dorado, Placer, and Sacramento counties)	Children's Health
Kaiser SoCal	San Diego County	Children's Health

Table 5.10—Managed Care Health Plan Orange Tier Placement and Performance Measure Domains Based on Measurement Year 2021 Performance Measure Results and Domains

Medi-Cal Managed Care Health Plans	Reporting Units	Performance Measure Domains
Alameda Alliance for Health	Alameda County	Children's Health Women's Health
Blue Shield of California Promise Health Plan	San Diego County	Children's Health Women's Health
CalViva Health	Fresno County Kings County	Children's Health Women's Health
Central California Alliance for Health	Merced County Monterey/Santa Cruz counties	Children's Health Women's Health

Medi-Cal Managed Care Health Plans	Reporting Units	Performance Measure Domains
Community Health Group Partnership Plan	San Diego County	Children's Health
Contra Costa Health Plan	Contra Costa County	Children's Health
Gold Coast Health Plan	Ventura County	Children's Health Women's Health
Health Plan of San Joaquin	San Joaquin County Stanislaus County	Children's Health Women's Health
Health Plan of San Mateo	San Mateo County	Children's Health Women's Health
Inland Empire Health Plan	Riverside/San Bernardino counties	Children's Health Women's Health
L.A. Care Health Plan	Los Angeles County	Children's Health
San Francisco Health Plan	San Francisco County	Children's Health
Santa Clara Family Health Plan	Santa Clara County	Children's Health

Table 5.11—Managed Care Health Plan Red Tier Placement and Performance Measure Domains Based on Measurement Year 2021 Performance Measure Results and Domains

Medi-Cal Managed Care Health Plans	Reporting Units	Performance Measure Domains
Aetna Better Health of California	Sacramento County San Diego County	Acute and Chronic Disease Management Children's Health Women's Health
Anthem Blue Cross Partnership Plan	Fresno County Region 1 Region 2 Sacramento County San Francisco County San Benito County	Acute and Chronic Disease Management Children's Health Women's Health
California Health & Wellness Plan	Region 1 Region 2	Children's Health

Medi-Cal Managed Care Health Plans	Reporting Units	Performance Measure Domains
Health Net Community Solutions, Inc.	Kern County Los Angeles County Sacramento County San Joaquin County Stanislaus County	Acute and Chronic Disease Management Children's Health Women's Health
Kern Family Health Care	Kern County	Children's Health Women's Health
Molina Healthcare of California	Imperial County Riverside/San Bernardino counties Sacramento County	Acute and Chronic Disease Management (Riverside/San Bernardino counties only) Children's Health Women's Health
Partnership HealthPlan of California	Northeast Region Northwest Region	Acute and Chronic Disease Management (Northwest Region only) Children's Health Women's Health

DHCS Support to MCPs

Throughout the review period (July 1, 2022, through June 30, 2023), DHCS provided extensive support to MCPs related to ongoing quality improvement activities as well as upcoming contractual requirement changes. The technical assistance and resources that DHCS provided supported MCPs' efforts to provide quality, accessible, and timely health care to their members, including:

- Assisted MCPs with prioritizing areas in need of improvement and identifying performance measures for MCPs to use as focus areas for quality improvement activities.
- Conducted technical assistance calls for MCPs as needed to discuss ongoing quality improvement efforts and support these MCPs in continuing to improve performance.
- Provided opportunities through quarterly regional collaborative discussions for DHCS to present regional data and for MCPs to discuss possible barriers experienced in the applicable region, strategies for improving the lowest performance measure rates, and quality improvement approaches that have and have not worked in the region.
- Continued updating and promoting the Quality Improvement Toolkit, which provides information about resources, promising practices to improve quality of care, ways to improve performance on measures, and ways to promote health equity.

Conclusions

To draw conclusions related to MCPs' performance measure results, HSAG assessed the MCMC weighted averages to determine statewide performance and MCP performance related to DHCS' required minimum performance levels and required quality improvement activities.

DHCS' MCAS is comprehensive and includes measures that collectively assess the quality, accessibility, and timeliness of care MCPs provide to their adult and child members. Required performance measures assess screening, prevention, health care, and utilization services. DHCS requires all MCPs to conduct two PIPs, participate in quarterly regional collaborative discussions, and actively collaborate across delivery systems to support improvement across all required performance measures. Additionally, DHCS provides ongoing technical assistance to support MCPs in their quality improvement efforts and ensure MCPs understand all DHCS MCMC requirements.

HSAG drew the following conclusions based on its review of the MCPs' performance measure results:

- MCPs show varying levels of opportunities for improvement based on performance measure results, with the percentages of rates worse than the minimum performance levels ranging from 86.67 percent to 6.67 percent.
- While the MCMC weighted average for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure was below the minimum performance level for measurement year 2022, the MCMC weighted average for this measure, as well as the weighted averages for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and both *Follow-Up After Emergency Department Visit for Substance Use* measures, improved significantly from measurement year 2021 to measurement year 2022. These performance measure results show that MCPs are making progress toward ensuring that members with mental health and substance use disorders are seen for follow-up after an emergency department visit. Additionally, this improvement supports DHCS' Comprehensive Quality Strategy Bold Goal to improve follow-up for mental health and substance use disorders by 50 percent at the State level by 2025.[23]
- While the MCMC weighted averages for seven of the 15 performance measure weighted averages that HSAG compared to benchmarks (47 percent) were below the minimum performance levels for measurement year 2022, aggregate performance measure results show that for four of these measures, MCPs collectively made performance improvements that contributed to MCMC weighted averages improving significantly from measurement year 2021 to measurement year 2022:
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*

[23] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

- *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
- Both *Well-Child Visits in the First 30 Months of Life* measures

- In addition to the measures listed above, the MCMC weighted averages improved significantly from measurement year 2021 to measurement year 2022 for the following measures for which HSAG compared measurement year 2022 MCMC weighted averages to measurement year 2021 MCMC weighted averages:
  - Both *Antidepressant Medication Management* measures
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening—Total*
  - *Controlling High Blood Pressure—Total*
  - Both *Follow-Up Care for Children Prescribed ADHD Medication* measures
  - *Immunizations for Adolescents—Combination 2*
  - Both *Prenatal and Postpartum Care* measures

  This improvement shows that MCPs' quality improvement efforts are contributing to improved quality, accessible, and timely care to Medi-Cal members across the State.

- DHCS has the opportunity to support MCPs in determining priority quality improvement focus areas related to the following measures that had MCMC weighted averages below the minimum performance levels for measurement year 2022 and/or with MCMC weighted averages that declined significantly from measurement year 2021 to measurement year 2022:
  - *Cervical Cancer Screening*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Childhood Immunization Status—Combination 10*
  - Both *Contraceptive Care—All Women* measures
  - Both *Contraceptive Care—Postpartum Women* measures
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - All three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures
  - Both *Well-Child Visits in the First 30 Months of Life* measures

In *Volume 2 of 6 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each MCP's strengths and weaknesses related to performance measure results with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations. Additionally, in *Volume 4 of 6* of this EQR technical report, HSAG includes MCP-specific performance measure results for all required MCAS measures.

6. Population-Specific Health Plan Performance Measures

Objective

The primary objective related to PSP performance measures is for HSAG to assess PSPs' performance in providing quality, accessible, and timely care and services to members by organizing and analyzing the performance measure results.

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the analyses in this section from the PSPs during the PMV activities described in Section 4 of this report ("**Performance Measure Validation**") and from NCQA via NCQA's Quality Compass.

Description of Data Obtained

The data HSAG obtained for the analyses in this section were:

- Performance measure data submitted by the PSPs, which included numerators, denominators, and calculated rates.
- NCQA's Quality Compass HEDIS 2022 Medicaid HMO benchmarks (50th and 90th percentiles).

Requirements

To comply with 42 CFR §438.330, DHCS selects a set of performance measures to evaluate the quality of care PSPs delivered to their members. As stated previously, DHCS refers to the DHCS-required performance measure set as the MCAS. The measurement year 2022[24] MCAS included select CMS Adult and Child Core Set measures, some of which are also HEDIS measures. AIDS Healthcare Foundation and SCAN Health Plan provide services to specialized populations; therefore, DHCS' performance measure requirements for these PSPs are different than its requirements for MCPs. Section 5 of this report ("**Managed Care Health**

[24] The measurement year is the calendar year for which PSPs report the rates. Measurement year 2022 represents data from January 1, 2022, through December 31, 2022.

Plan Performance Measures") describes the role of DHCS' QPHM program in making recommendations for performance measure reporting. QPHM's role is further described in the DHCS Comprehensive Quality Strategy.[25] As with MCP performance measures, DHCS consults with HSAG and reviews feedback from PSPs and stakeholders to determine which CMS Core Set measures DHCS will require PSPs to report. PSPs must report county or regional rates unless otherwise approved by DHCS.

Table 6.1 and Table 6.2 list DHCS' performance measure requirements for AIDS Healthcare Foundation and SCAN Health Plan, respectively. Please refer to Table 5.1 for descriptions of all MCAS measures included in Table 6.1 and Table 6.2. For some MCAS performance measures, the specifications allow for both administrative and hybrid reporting methods; for these measures, DHCS allows PSPs to choose either methodology.

As with the MCPs, beginning with measurement year 2022, DHCS required PSPs to report the NCQA race and ethnicity stratifications for select measures. See Section 5 of this report ("**Managed Care Health Plan Performance Measures**") for a list of the required race and ethnicity stratifications.

AIDS Healthcare Foundation

Table 6.1 lists AIDS Healthcare Foundation's measurement year 2022 MCAS measures by measure domain and indicates the data capture method(s) for each measure.

Table 6.1—AIDS Healthcare Foundation Measurement Year 2022 Managed Care Accountability Set Measures

Admin = administrative method, which requires that the PSP identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, the PSP derives the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. The PSP may not use medical records to retrieve information. When using the administrative method, the PSP uses the entire eligible population as the denominator.

Hybrid = hybrid method, which requires that the PSP identify the eligible population using administrative data, then extract a systematic sample of members from the eligible population, which becomes the denominator. The PSP uses administrative data to identify services provided to these members. When administrative data do not show evidence that the PSP provided the service, the PSP reviews medical records for those members to derive the numerator.

ECDS = Electronic Clinical Data Systems method, which expands the use of electronic data for quality measurement. Data sources that PSPs may use to identify the denominator and derive the numerator include, but are not limited to, member eligibility files, EHRs, clinical registries,

[25] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

HIEs, administrative claims systems, electronic laboratory reports, electronic pharmacy systems, immunization information systems, and disease/case management registries.

* DHCS allows the PSP to choose the methodology for reporting the rate for this measure and expects that the PSP will report using the methodology that results in the higher rate.

^ DHCS requires race and ethnicity stratifications for this measure.

Measure	Method of Data Capture
Measures Held to Minimum Performance Levels	
Controlling High Blood Pressure—Total^	Admin or Hybrid*
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—18 Years and Older^	Admin
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18 Years and Older^	Admin
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)^	Admin or Hybrid*
Report Only Measures (Measures not held to minimum performance levels.)	
Adults' Access to Preventive/Ambulatory Health Services—Total	Admin
Colorectal Cancer Screening^	Admin
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	Admin
Depression Remission or Response for Adolescents and Adults—12 rates are reported: ♦ *Follow-up PHQ-9* ■ *Ages 18–44 Years* ■ *Ages 45–64 Years* ■ *65 Years and Older* ■ *Total* ♦ *Depression Remission* ■ *Ages 18–44 Years* ■ *Ages 45–64 Years* ■ *65 Years and Older* ■ *Total* ♦ *Depression Response* ■ *Ages 18–44 Years* ■ *Ages 45–64 Years*	ECDS

Measure	Method of Data Capture
■ *65 Years and Older* ■ *Total*	
Depression Screening and Follow-Up for Adolescents and Adults^—Six rates are reported: ♦ *Depression Screening* ■ *Ages 18–64 Years* ■ *65 Years and Older* ■ *Total* ♦ *Follow-Up on Positive Screen* ■ *Ages 18–64 Years* ■ *65 Years and Older* ■ *Total*	ECDS
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—18 Years and Older^	Admin
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—18 Years and Older^	Admin
Pharmacotherapy for Opioid Use Disorder	Admin

SCAN Health Plan

Table 6.2 lists SCAN Health Plan's measurement year 2022 MCAS measures by measure domain and indicates the data capture method(s) for each measure.

Table 6.2—SCAN Health Plan Measurement Year 2022 Managed Care Accountability Set Measures

Admin = administrative method, which requires that the PSP identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, the PSP derives the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. The PSP may not use medical records to retrieve information. When using the administrative method, the PSP uses the entire eligible population as the denominator.

Hybrid = hybrid method, which requires that the PSP identify the eligible population using administrative data, then extract a systematic sample of members from the eligible population, which becomes the denominator. The PSP uses administrative data to identify services provided to these members. When administrative data do not show evidence that the PSP provided the service, the PSP reviews medical records for those members to derive the numerator.

ECDS = Electronic Clinical Data Systems method, which expands the use of electronic data for quality measurement. Data sources that PSPs may use to identify the denominator and derive the numerator include, but are not limited to, member eligibility files, EHRs, clinical registries, HIEs, administrative claims systems, electronic laboratory reports, electronic pharmacy systems, immunization information systems, and disease/case management registries.

* DHCS allows the PSP to choose the methodology for reporting the rate for this measure and expects that the PSP will report using the methodology that results in the higher rate.

^ DHCS requires race and ethnicity stratifications for this measure.

Measure	Method of Data Capture
Measures Held to Minimum Performance Levels	
Breast Cancer Screening—Total	Admin
*Controlling High Blood Pressure—Total^*	Admin or Hybrid*
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—65 Years and Older^*	Admin
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—65 Years and Older^*	Admin
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)^*	Admin or Hybrid*
Report Only Measures (Measures not held to minimum performance levels)	
Adults' Access to Preventive/Ambulatory Health Services—Total	Admin
*Colorectal Cancer Screening^*	Admin
Depression Remission or Response for Adolescents and Adults—Three rates are reported: ♦ *Follow-up PHQ-9—65 Years and Older* ♦ *Depression Remission—65 Years and Older* ♦ *Depression Response—65 Years and Older*	ECDS
*Depression Screening and Follow-Up for Adolescents and Adults^*—Two rates are reported: ♦ *Depression Screening—65 Years and Older* ♦ *Follow-Up on Positive Screen—65 Years and Older*	ECDS
*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—65 Years and Older^*	Admin
*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—65 Years and Older^*	Admin
Pharmacotherapy for Opioid Use Disorder	Admin

DHCS-Established Performance Levels

Like MCPs, PSPs are contractually required to perform at or above DHCS-established minimum performance levels; and DHCS uses the established high performance levels as performance goals, recognizing PSPs for outstanding performance. PSPs are subject to the same quality enforcement action processes as MCPs. See the description of these processes in Section 5 of this report (“**Managed Care Health Plan Performance Measures**”).

Results

Due to each PSP serving a specialized population, HSAG produces no aggregate information related to the PSP performance measures. Also, due to the PSPs serving separate, specialized populations, performance measure comparison across PSPs is not appropriate.

See *Volume 2 of 6 (Appendix A)* of this EQR technical report for measurement years 2020, 2021, and 2022 performance measure results for AIDS Healthcare Foundation and SCAN Health Plan.

Summary of Measurement Year 2021 Quality Monitoring

Based on measurement year 2021 performance measure results, DHCS did not place AIDS Healthcare Foundation or SCAN Health Plan into a quality monitoring tier.

Conclusions

To draw conclusions related to PSPs’ performance measure results, HSAG assessed the PSPs’ performance related to DHCS’ required minimum performance levels and required quality improvement activities.

For performance measure rates that were compared to the DHCS-established high performance levels and minimum performance levels, both PSPs performed above the high performance levels for all performance measure rates. The PSPs continue to perform above the DHCS-established minimum performance levels, reflecting the provision of quality, timely, and accessible health care services to their members.

In *Volume 2 of 6 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each PSP’s strengths and weaknesses related to performance measure results with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG’s recommendations.

7. Managed Long-Term Services and Supports Plan Performance Measures

Objective

The primary objective related to MLTSSP performance measures is for HSAG to assess MLTSSPs' performance in providing quality, accessible, and timely care and services to members by organizing, aggregating, and analyzing the performance measure results.

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the analyses in this section from the MLTSSPs during the PMV activities described in Section 4 of this report ("**Performance Measure Validation**").

Description of Data Obtained

The data HSAG obtained for the analyses in this section were the performance measure data submitted by the MLTSSPs, which included numerators, denominators, and calculated rates.

Requirements

As part of the CCI, DHCS held contracts with 13 MLTSSPs to provide managed long-term services and supports (MLTSS) and Medicare wraparound benefits to dual-eligible members who had opted out of or who were not eligible for Cal MediConnect.[26] Starting in January 2023, under the CalAIM initiative, DHCS began requiring all MCPs to cover and coordinate Medi-Cal institutional long-term care in all counites through a phased-in approach by facility type. This new requirement supports the DHCS Comprehensive Quality Strategy goal of transitioning to statewide MLTSS in Medi-Cal managed care by 2027 to advance DHCS' goals of whole-

[26] Cal MediConnect—All of a member's medical, behavioral health, long-term institutional, and home- and community-based services are combined into a single health plan. This allows providers to better coordinate care and to simplify for members the process of obtaining appropriate, timely, accessible care.

person care and aligned managed care delivery systems.[27] Based on DHCS now requiring all MCPs to cover and coordinate institutional long-term care, measurement year 2022 is the last year for MLTSSPs to report performance measure rates. Table 7.1 lists MLTSSPs and the counties in which they operated under CCI.

Table 7.1—Managed Long-Term Services and Supports Plan Names and Counties

Managed Long-Term Services and Supports Plans	Counties
Aetna Better Health of California	Sacramento and San Diego
Anthem Blue Cross Partnership Plan	Santa Clara
Blue Shield of California Promise Health Plan	San Diego
CalOptima	Orange
Community Health Group Partnership Plan	San Diego
Health Net Community Solutions, Inc.	Los Angeles and San Diego
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	Riverside and San Bernardino
Kaiser SoCal (KP Cal, LLC)	San Diego
L.A. Care Health Plan	Los Angeles
Molina Healthcare of California	Riverside, San Bernardino, and San Diego
Santa Clara Family Health Plan	Santa Clara
UnitedHealthcare Community Plan	San Diego

[27] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

Table 7.2 lists the four MCAS performance measures that DHCS required MLTSSPs to report for measurement year 2022 and indicates the data capture method DHCS required MLTSSPs to use. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Table 7.2—Measurement Year 2022 Managed Long-Term Services and Supports Plan Performance Measures

Admin = administrative method, which requires that MLTSSPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MLTSSPs derive the numerator, or services provided to members in the eligible population, from administrative data sources and auditor-approved supplemental data sources. MLTSSPs cannot use medical records to retrieve information. When using the administrative method, MLTSSPs use the entire eligible population as the denominator.

Measure	Method of Data Capture
Ambulatory Care—Emergency Department (ED) Visits—Total	Admin
Plan All-Cause Readmissions—Observed Readmissions—Total	Admin
Plan All-Cause Readmissions—Expected Readmissions—Total	Admin
Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total	Admin

Results

Table 7.3 presents the MLTSSP weighted averages for each required performance measure for measurement years 2020, 2021, and 2022.

Table 7.3—Measurement Years 2020, 2021, and 2022 Statewide Weighted Average Performance Measure Results for Managed Long-Term Services and Supports Plans

= Statistical testing result indicates that the measurement year 2022 rate is significantly better than the measurement year 2021 rate.

= Statistical testing result indicates that the measurement year 2022 rate is significantly worse than the measurement year 2021 rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance.

^ A lower rate indicates better performance for this measure.

Not Tested = A measurement year 2021–22 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
*Ambulatory Care—Emergency Department (ED) Visits—Total**	484.32	501.10	496.83	Not Tested
*Plan All-Cause Readmissions—Observed Readmissions—Total^*	10.21%	9.13%	8.78%	-0.35
Plan All-Cause Readmissions—Expected Readmissions—Total	10.54%	9.78%	9.81%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total^*	0.97	0.93	0.8957	Not Tested

Table 7.4 presents comparative measurement year 2022 performance measure results across all MLTSSPs.

Table 7.4—Measurement Year 2022 Managed Long-Term Services and Supports Plan Reporting Unit Performance Measure Results Comparison

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance.

^ A lower rate indicates better performance for this measure.

NA = The MLTSSP followed the specifications, but the denominator was too small (less than 150 for the *Plan All-Cause Readmissions* measures and less than 360 for the *Ambulatory Care* measure) to report a valid rate.

Managed Long-Term Services and Supports Plan Reporting Unit	Ambulatory Care—Emergency Department (ED) Visits—Total*	Plan All-Cause Readmissions—Observed Readmissions—Total^	Plan All-Cause Readmissions—Expected Readmissions—Total	Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total^
Aetna Better Health of California—Sacramento County	NA	NA	NA	NA
Aetna Better Health of California—San Diego County	NA	NA	NA	NA
Anthem Blue Cross Partnership Plan—Santa Clara County	898.64	NA	NA	NA
Blue Shield of California Promise Health Plan—San Diego County	1,175.45	NA	NA	NA
CalOptima—Orange County	470.45	8.90%	9.94%	0.8956
Community Health Group Partnership Plan—San Diego County	459.95	7.47%	9.18%	0.8142
Health Net Community Solutions, Inc.—Los Angeles County	699.70	12.41%	11.25%	1.1037
Health Net Community Solutions, Inc.—San Diego County	765.34	NA	NA	NA
Health Plan of San Mateo—San Mateo County	693.30	10.68%	12.07%	0.8852
Inland Empire Health Plan—Riverside/San Bernardino Counties	566.88	10.64%	10.87%	0.9785
Kaiser SoCal (KP Cal, LLC)—San Diego County	387.39	6.95%	9.24%	0.7518

Managed Long-Term Services and Supports Plan Reporting Unit	Ambulatory Care—Emergency Department (ED) Visits—Total*	Plan All-Cause Readmissions—Observed Readmissions—Total^	Plan All-Cause Readmissions—Expected Readmissions—Total	Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total^
L.A. Care Health Plan—Los Angeles County	549.19	11.31%	10.65%	1.0629
Molina Healthcare of California—Riverside/San Bernardino Counties	496.27	8.36%	9.40%	0.8898
Molina Healthcare of California—San Diego County	512.64	7.95%	9.49%	0.8375
Santa Clara Family Health Plan—Santa Clara County	600.50	10.48%	10.17%	1.0302
UnitedHealthcare Community Plan—San Diego County	NA	NA	NA	NA

Conclusions

To draw conclusions related to MLTSSPs' performance measure results, HSAG assessed the MLTSS statewide averages over time.

The MLTSS statewide weighted average for the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure remained stable from measurement year 2021 to measurement year 2022, reflecting no significant changes in hospital readmissions for the MLTSS population.

8. Performance Improvement Projects

Validating PIPs is one of the mandatory EQR activities described at 42 CFR §438.358(b)(1). In accordance with §438.330(d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and enrollee satisfaction, and (2) focuses on both clinical and nonclinical areas that involve the following elements:

- Measuring performance using objective quality indicators
- Implementing interventions to achieve improvement in access to and quality of care
- Evaluating intervention effectiveness based on objective quality indicators
- Planning and initiating activities for increasing or sustaining improvement

The EQR technical report must include information on the validation of PIPs required by the state and underway during the preceding 12 months.

To comply with the CMS requirements, since 2008 DHCS has contracted with HSAG to conduct an independent validation of PIPs submitted by MCMC plans. HSAG uses a two-pronged approach. First, HSAG provides training and technical assistance to MCMC plans on how to design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. Then, HSAG assesses the validity and reliability of PIP submissions to draw conclusions about the quality of, timeliness of, and access to care furnished by these plans.

Objectives

The purpose of HSAG's PIP validation is to ensure that MCMC plans, DHCS, and stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies conducted through the PIPs.

HSAG evaluates two key components of each PIP:

- Technical structure, to determine whether a PIP's initiation (i.e., topic rationale, PIP team, global aim, SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim, key driver diagram, and data collection methodology) is based on sound methodology and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- Conducting quality improvement activities. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing, evaluation using PDSA cycles, sustainability, and spreading successful

change. This component evaluates how well MCMC plans execute quality improvement activities and whether the PIP achieves and sustains the desired aim.

Technical Methods of Data Collection and Analysis

Following is a description of HSAG's PIP process, including how HSAG receives the PIP data from the MCMC plans and how HSAG analyzes the data.

Rapid-Cycle Performance Improvement Project Overview

HSAG's rapid-cycle PIP approach places emphasis on improving both health care outcomes and processes through the integration of quality improvement science. This approach guides MCMC plans through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of changes requires fewer resources and allows more flexibility for adjusting throughout the improvement process. By piloting changes on a smaller scale, MCMC plans have opportunities to determine the effectiveness of several changes prior to expanding the successful interventions.

The following modules guide MCMC plans through the rapid-cycle PIP approach:

- Module 1: PIP Initiation
- Module 2: Intervention Determination
- Module 3: Intervention Testing
- Module 4: PIP Conclusions

HSAG's rapid-cycle PIP process requires extensive, up-front preparation to allow for a structured, scientific approach to quality improvement, and it also provides sufficient time for MCMC plans to test interventions. Modules 1 through 3 create the basic infrastructure to help MCMC plans identify interventions to test. Once the plans achieve all validation criteria for modules 1 through 3, they test interventions using a series of PDSA cycles.

Once MCMC plans complete intervention testing, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was unsuccessful and should be stopped (abandon). MCMC plans complete Module 4 after testing all interventions and finalizing analyses of the PDSA cycles. Module 4 summarizes the results of the tested interventions. At the end of the PIP, the plans identify successful interventions that may be implemented on a larger scale to achieve the desired health care outcomes.

Module Submission, Validation, and Technical Assistance

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to these plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges. HSAG conducts PIP validation in accordance with the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*.[28] *Volume 2 of 6 (Appendix B)* of this EQR technical report includes a description of the validation criteria that HSAG uses for each module.

After validating each PIP module, HSAG provides written feedback to MCMC plans summarizing HSAG's findings and whether the plans achieved all validation criteria. Through an iterative process, plans have opportunities to revise modules 1 through 3 to achieve all validation criteria. Once MCMC plans achieve all validation criteria for modules 1 through 3, they test intervention(s) through the end of the SMART Aim end date. HSAG requests status updates from MCMC plans throughout the PIP intervention testing phase and, when needed, provides technical assistance.

Once a PIP reaches completion, HSAG assesses the validity and reliability of the results to determine whether key stakeholders may have confidence in the reported PIP findings. HSAG assigns the following confidence levels for each PIP:

- High confidence
- Moderate confidence
- Low confidence
- No confidence

In *Volume 2 of 6 (Appendix B)* of this EQR technical report, HSAG includes the definition for each confidence level assigned for the 2020–22 PIPs.

[28] Note that for the 2020–22 PIPs, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 5, 2024. Beginning with the 2023–26 PIPs, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 5, 2024.

Description of Data Obtained

HSAG obtained the data for the analyses in this section from the Module 4s submitted to HSAG by the MCMC plans. The submissions included:

- A summary of PDSA cycles completed.
- Interpretation of PIP results related to the SMART Aim goal.
- Final key driver diagram with determination of whether each listed intervention was adopted, adapted, abandoned, not tested, or will require continued testing.
- A summary of conclusions including whether the intervention(s) had an impact on the SMART Aim, a description of plans for spreading successful interventions, a summary of challenges and lessons learned, and a description of plans for sustaining any improvement achieved beyond the SMART Aim end date.

Requirements

DHCS requires that each MCMC plan conduct a minimum of two DHCS-approved PIPs.

2020–22 Performance Improvement Projects

For the 2020–22 PIPs, DHCS required that one PIP be on the topic of Health Equity and the other PIP be related to Child and Adolescent Health.

DHCS required that MCMC plans' Health Equity PIPs focus on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. DHCS strongly encouraged MCMC plans to select a health disparity related to an MCAS measure for which they are not performing well, with a particular focus on a disparity that may have been exacerbated by COVID-19. DHCS allowed MCMC plans that could not identify a health disparity based on population size to conduct their PIP on the entire population instead of a disparate subgroup.

For the Child and Adolescent Health PIPs, DHCS required MCMC plans to identify an area in need of improvement related to child and adolescent health. DHCS required PSPs that do not serve the child and adolescent populations to choose a PIP topic for any area in need of improvement, supported by plan-specific data.

DHCS' Health Equity PIP requirement supports DHCS in accomplishing its Comprehensive Quality Strategy vision of eliminating health care disparities; and the Child and Adolescent Health PIP requirement supports the Comprehensive Quality Strategy's children's preventive

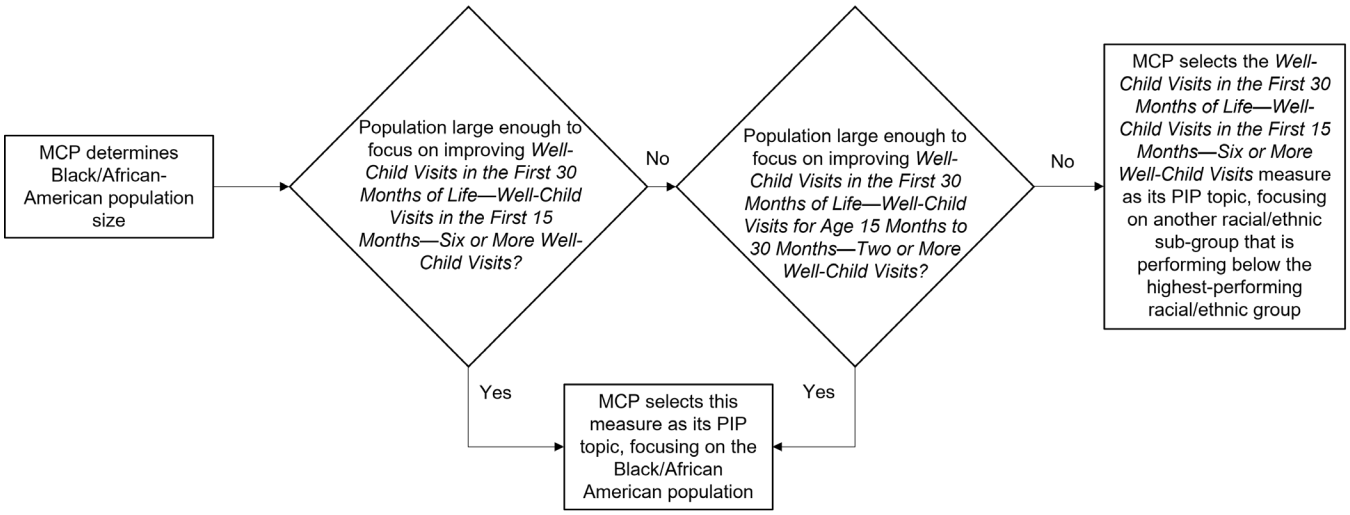
care clinical focus area and DHCS' goals to improve child and adolescent preventive services.[29]

The SMART Aim end date for the 2020–22 PIPs was December 31, 2022. In April and May 2023, MCMC plans submitted their final Module 4s to HSAG for validation.

2023–26 Performance Improvement Projects

DHCS and HSAG began planning for the 2023–26 PIPs in August 2022. DHCS worked individually with the two PSPs, based on their specialized populations, to identify PIP topics based on opportunities for improvement. In alignment with DHCS' Comprehensive Quality Strategy Bold Goals,[30] DHCS required the following for the MCP PIP topics:

- Clinical PIP—To determine a clinical PIP topic, each MCP first had to confirm the size of its Black/African-American population. The following diagram depicts how the MCP chose an appropriate topic.



- Nonclinical PIP—DHCS designed the nonclinical PIP topic choices to support efforts to improve statewide performance on the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* and *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* measures. MCPs were given three topic choices:
  - Improve the percentage of provider notifications for members with SUD/SMH substance use disorder/specialty mental health (SUD/SMH) diagnoses following or within seven days of emergency department visit.

[29] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

[30] Ibid.

- Improve the percentage of referrals to Community Support programs (Sobering Centers, Day Habilitation programs) within seven days of visiting an emergency department for members with a SUD/SMH diagnosis and seen in the emergency department for the same diagnoses.
- Improve the percentage of members enrolled into care management, complex care management, or enhanced care management within 14 days of a provider visit where the member was diagnosed with SUD/SMH.
    - MCPs were required to identify the provider type for the qualifying visit that started the 14-day time period and to select a provider type for which they have access to real-time data to avoid a claims lag that might impede the identification of these eligible members and their enrollment into one of the qualifying care management programs within the 14-day requirement.

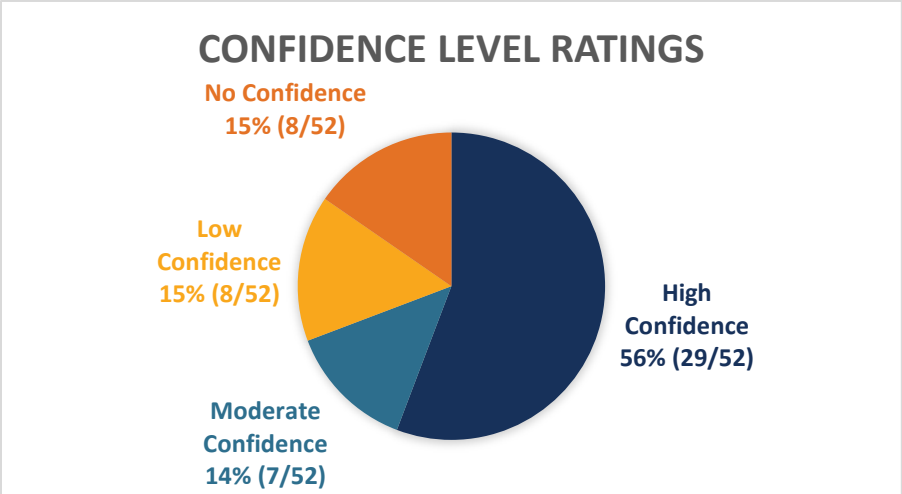
On April 26, 2023, HSAG conducted a PIP training for the MCMC plans. HSAG provided an overview of its updated PIP process and information regarding the PIP Submission Form requirements. In September 2023, MCMC plans will submit their first annual PIP Submission Form for the 2023–26 PIPs to HSAG for validation. HSAG will include more detailed information about the 2023–26 PIPs in the *2023–24 Medi-Cal Managed Care External Quality Review Technical Report*.

Results

Validation of Performance Improvement Projects

During the review period, MCMC plans completed the 2020–22 rapid-cycle PIPs. HSAG validated 52 PIP Module 4s that the MCMC plans submitted. In its PIP validation, HSAG assessed the validity and reliability of the PIP results to determine whether DHCS and key stakeholders can have confidence in the reported PIP findings. Figure 8.1 depicts the distribution of the confidence level ratings for all 52 PIPs that HSAG validated:

Figure 8.1—2020–22 Performance Improvement Project Confidence Level Ratings



Performance Improvement Project Interventions

Of the 72 interventions tested through the 2020–22 PIPs, MCMC plans adopted 32 interventions, adapted 16 interventions, and will continue to test five interventions beyond the life of the PIPs. The MCMC plans determined to abandon 19 interventions due to the interventions not being impactful and/or resource constraints.

Most tested interventions directly targeted members, which included member outreach to provide health education and appointment scheduling assistance. Following is a summary of the interventions:

- For cancer screening PIP topics, such as breast cancer screening and cervical cancer screening, MCMC plans tested member outreach and care coordination interventions. Additionally, some MCMC plans hosted mobile mammography events.
- For chronic disease management PIP topics, such as controlling high blood pressure and diabetes control, MCMC plans tested member outreach to provide more individualized care management, such as conducting medication reconciliation and ensuring members have 90-day medication supplies. MCMC plans also tested interventions that supported members in managing their chronic diseases at home, such as providing blood pressure reading and recording education and diabetes home care kits.
- For postpartum care PIP topics, MCMC plans tested ways to identify pregnant members with whom they could conduct health education about the importance of postpartum care and ensure that these members scheduled timely postpartum care visits.
- For childhood immunization PIP topics, MCMC plans tested hosting vaccination day events, as well as outreaching to members' parents/guardians to provide vaccination reminders, education, and scheduling assistance. The MCMC plans also worked with the California Immunization Registry for data exchange and reconciliation.

- For children and adolescent well-care visit PIP topics, MCMC plans conducted outreach to members' parents/guardians to remind them of upcoming or missed well-care visits for their children and provide appointment scheduling assistance. Some MCMC plans offered incentives upon completion of well-care visits, while other MCMC plans worked with providers to enhance data exchange processes to improve the quality and timeliness of the data.

In *Volume 2 of 6 (Appendix B)* of this EQR technical report, HSAG includes MCMC plan-specific PIP topics and module progression, as well as descriptions of interventions MCMC plans tested related to the PIP topics during the review period.

Conclusions

To draw conclusions related to MCMC plans' PIP validation results, HSAG assessed the PIP validation results, including the confidence levels HSAG assigned to each PIP.

MCMC plans successfully completed their 2020–22 PIPs through the SMART Aim end date of December 31, 2022, and submitted Module 4s for HSAG's final PIP validation. HSAG assessed the validity and reliability of each PIP's results and assigned a confidence level for the PIP findings. Of the 52 PIPs validated, HSAG rated 29 PIPs (56 percent) with a *High Confidence* level and seven PIPs (14 percent) with a *Moderate Confidence* level. This indicates that 70 percent of the PIPs conducted were methodologically sound and achieved improvement as a result of the tested interventions. While the types of interventions tested varied by the PIP topics and each MCMC plan's barrier analyses, most tested interventions directly targeted members. Of the 72 interventions tested, MCMC plans determined to adopt, adapt, and continue to test 53 of the interventions (74 percent) beyond the life of the PIPs.

HSAG's PIP methodology transitioned to annual submissions for the 2023–26 PIPs. On April 26, 2023, HSAG conducted a PIP training to ensure MCMC plans have a thorough understanding of the new PIP submission requirements and validation criteria. HSAG will provide ongoing technical assistance to MCMC plans, as requested, throughout the life of the PIPs.

In *Volume 2 of 6 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each MCMC plan's strengths and weaknesses related to PIPs with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

9.Validation of Network Adequacy

Validation of network adequacy is a mandatory EQR activity; and states must begin conducting this activity, described at 42 CFR §438.358(b)(1)(iv), no later than one year from CMS' issuance of the associated EQR protocol. CMS issued *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity* in February 2023.[31] Since CMS released the new protocol, HSAG and DHCS have been working together to assess current validation of network adequacy activities being conducted by HSAG and DHCS and determine actions needed to ensure DHCS' network adequacy activities are in alignment with the new protocol. DHCS and HSAG will ensure that the *2023–24 Medi-Cal Managed Care External Quality Review Technical Report* includes findings from all required validation of network adequacy activities.

To assist DHCS with assessing and monitoring network adequacy across contracted MCMC plans as described in the DHCS Comprehensive Quality Strategy,[32] DHCS contracted with HSAG to conduct the following network adequacy activities during the review period for this report:

- Alternative Access Standards Reporting
- SNF/ICF Experience and Distance Reporting
- Timely Access Study

Objective

The objective for all network adequacy analyses is to provide results and conclusions for DHCS to use in monitoring MCMC plan adherence to the required federal and State network adequacy standards.

[31] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 5, 2024.

[32] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

Technical Methods of Data Collection and Analysis

DHCS provided data to HSAG via a secure file transfer protocol (SFTP) site for all analyses described in this section. The California Department of Public Health (CDPH) provided data for the SNF/ICF study. For the Timely Access Study, HSAG collected and used data from survey calls HSAG made to providers, call centers, and nurse triage/advice lines. HSAG submitted to DHCS the required DHCS Data Release Forms and detailed data request instructions to ensure all needed data were submitted for the analyses.

Description of Data Obtained

The data types HSAG obtained for the analyses in this section included the following:

- Administrative
- Alternative access standard request
- Alternative access standard administrative
- Annual network certification documentation
- Appointment availability data
- Claims
- Encounter
- Grievances and appeals
- Member demographic
- Member eligibility
- Member enrollment
- Minimum Data Set 3.0 resident assessment and facility data
- Provider
- Survey call, including appointment availability, knowledge of select provider accessibility requirements, and call center and nurse triage/advice line wait times

Alternative Access Standards Reporting

DHCS is responsible for the ongoing monitoring and oversight of its contracted MCPs and PSPs, including the assurance that MCPs' and PSPs' provider networks are adequate to deliver services to Medi-Cal members. If health care providers are unavailable or unwilling to serve Medi-Cal members such that the MCP or PSP is unable to meet provider network standards, MCPs and PSPs may request that DHCS allow an alternative provider network access standard for specified provider scenarios (e.g., provider type, geographic area). The

DHCS APL 23-001[33] provides DHCS' clarifying guidance regarding network certification requirements, including requests for alternative access standards. Additionally, CA WIC §14197.05[34] requires DHCS' annual EQR technical report to present information related to MCPs' alternative access standard requests. As such, DHCS contracted with HSAG to process and report on data related to alternative access standards for provider networks.

The measurement period for the 2022–23 alternative access standards reporting analyses is from February 6, 2023, through September 29, 2023.

HSAG includes the alternative access standards reporting methodology, results, conclusions, and considerations in *Volume 5 of 6* of this EQR technical report.

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

CA WIC §14197.05 requires DHCS' annual EQR technical report to present information related to the experience of individuals placed in SNFs/ICFs and the distance that these individuals are placed from their residences. As such, DHCS contracted with HSAG beginning in contract year 2018–19 to develop a methodology to assess this SNF/ICF information, and HSAG subsequently worked with DHCS to obtain the necessary data and to conduct the analyses annually.

HSAG includes the SNF/ICF experience and distance reporting analyses methodology, results, key findings, conclusions, and considerations in *Volume 6 of 6* of this EQR technical report.

Timely Access Study

DHCS requires its MCMC plans to ensure their participating providers offer appointments that meet the timely access standards. Prior to CMS' release of *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023, California had already begun implementing statutes to effectuate network adequacy standards and to implement a system of oversight. California's law for appointment wait time standards is in California Health and Safety Code §1367.03[35] for commercial plans and incorporated by reference in CA WIC

[33] All Plan Letter 23-001. Available at: APL 23-001 (ca.gov). Accessed on: Jan 5, 2024.

[34] Cal. WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05. Accessed on: Jan 5, 2024.

[35] California Health and Safety Code §1367.03. Available at: Law section (ca.gov). Accessed on: Jan 5, 2024.

§14197(d)(1)(A)[36] for MCMC plans. The rules are further defined in CA 28 California Code of Regulations (CCR) §1300.67.2.2(c).[37] In APL 21-006, DHCS clarifies the network adequacy wait time standards policy.[38] This policy includes a description of the use of a retrospective timely access survey that measures network providers' and MCMC plans' overall compliance with appointment wait time standards.

Beginning in contract year 2016–17, DHCS contracted with HSAG to conduct an annual study to evaluate the extent to which MCMC plans are meeting the DHCS wait time standards. To ensure that MCMC plans and their providers could prioritize COVID-19 response efforts, DHCS canceled this study for calendar years 2020 and 2021. In July 2021, DHCS determined to resume the Timely Access Study activities beginning January 2022.

The purpose of the Timely Access Study is to determine and publicly report on the extent to which MCMC plans are meeting or not meeting those standards. Following is a summary of the Timely Access Study activities and analyses that took place during the review period for this EQR technical report.

Methodology—Timely Access Study

HSAG conducts the Timely Access Study to evaluate the following three questions:

- To what extent are the plans meeting the wait time standards listed in Table 9.1?
- To what extent are the plans meeting the 10-minute wait time standard for their call centers?
- To what extent are the plans meeting the 30-minute wait time standard for their nurse triage/advice lines?

Table 9.1—Timely Access Standards

The em dash "—" in the table denotes that the wait time standard is not applicable to an appointment type.

Note the following:

- The non-urgent follow-up appointment standard became effective July 1, 2022; therefore, HSAG began conducting evaluation for this standard in Quarter 3 of contract year 2021–22.

[36] Cal. WIC §14197(d)(1)(A). Available at: Law section (ca.gov). Accessed on: Jan 5, 2024.

[37] CA 28 CCR §1300.67.2.2(c). Available at: View Document - California Code of Regulations (westlaw.com). Accessed on: Jan 5, 2024.

[38] All Plan Letter 21-006. Available at: APL 21-006 (ca.gov). Accessed on: Jan 5, 2024.

- Due to data issues:
  - HSAG paused the evaluation of Alameda Alliance for Health's specialists for Quarter 3 and Quarter 4 of contract year 2021–22, and for Quarter 1 of contract year 2022–23.
  - HSAG began the evaluation for Health Plan of San Mateo's dental providers in Quarter 3 of contract year 2021–22.
  - HSAG began placing calls to providers from AIDS Healthcare Foundation in Quarter 2 of contract year 2022–23.
  - HSAG paused the evaluation of PCP, specialist, and ancillary samples for three of Health Net Community Solutions, Inc.'s reporting units (Kern, Los Angeles, and San Diego counties) for Quarter 2 of contract year 2022–23.

Appointment Type	Wait Time Standard			
	Non-Urgent Appointments	Urgent Appointments	Preventive Care Appointments	Non-Urgent Follow-Up Appointments
Primary care appointment	10 business days	48 hours	—	—
Specialist appointment	15 business days	96 hours	—	—
Appointment with a mental health care provider (who is not a physician)	10 business days	96 hours	—	10 business days
Appointment with ancillary providers	15 business days	—	—	—
Dental appointment for Health Plan of San Mateo's dental providers only	36 business days	72 hours	40 business days	—

HSAG collaborates with DHCS staff members to perform the following key quarterly activities primarily based on the most recent provider data submitted to DHCS by the MCMC plans:

- Submit data requirements document to DHCS for provider data extraction.
- Submit provider classification document to DHCS to define the study population (i.e., eligible providers for each appointment type).
- Review provider data extracted by DHCS and select sample providers.
- Conduct telephone surveys to sample providers, call centers, and nurse triage/advice lines.
- Calculate results for the study indicators.
- Submit deliverables to DHCS.

HSAG conducts the Timely Access Study calls and compiles the results for a calendar year (i.e., January 1 through December 31). During the review period, HSAG completed the calendar year 2022 calls from contract year 2021–22 and conducted the first two quarters of calendar year 2023 calls for contract year 2022–23. Following are descriptions of the methodologies HSAG used for the calls.

Calls to Providers

For both contract years 2021–22 and 2022–23 (i.e., calendar years 2022 and 2023 calls, respectively), the provider sample size was 411 providers across all provider types and specialties per MCMC plan reporting unit, with approximately 25 percent of the total sample being surveyed each quarter. If there were less than 411 providers in a provider category for a reporting unit, all providers were selected. When more than one site existed, HSAG randomly selected one site from each sampled provider.

Quarterly, during standard operating hours (i.e., 9 a.m. to 5 p.m. Pacific Time), HSAG's trained callers made phone calls to all selected provider offices. During the calls, the callers followed tightly regulated scripts with designated response options to various questions that provider office personnel may ask. This allowed data collection to be controlled and accurate. If a provider was selected for more than one reporting unit, HSAG's methodology included processes to minimize interruptions to provider offices. The calls were monitored consistently and on a regular schedule via audio and visual monitoring systems. A full-time monitoring staff member reviewed at least 10 percent of all calls made, and information collected during the phone calls was saved in an electronic tool for further analysis.

HSAG had a separate process for collecting appointment availability information from Kaiser NorCal and Kaiser SoCal providers due to these MCMC plans' automated appointment scheduling systems.

Calls to MCMC Plan Call Centers

For contract year 2021–22 (i.e., calendar year 2022 calls), HSAG made 73 calls to each MCMC plan's call center. To minimize the interruption to the call centers, HSAG made 19 calls per MCMC plan for the first quarter, then 18 calls per quarter for the remaining three quarters.

For contract year 2022–23 (i.e., calendar year 2023 calls), HSAG adjusted the sample size based on the results from calendar year 2022 calls. HSAG used the following criteria to determine the calendar year 2023 sample sizes at the plan level:

- If the quarter 3 cumulative rate from the 2021–22 Timely Access Study was 85 percent or higher, the sample size was 100.
- If the quarter 3 cumulative rate from the 2021–22 Timely Access Study was below 85 percent, the sample size was 219.
- If a plan's rate was above 90 percent for two consecutive quarters in the 2022–23 Timely Access Study, HSAG may reduce the sample size with DHCS' approval.

As with the 2021–22 calls, HSAG spread the 2022–23 calls to the call centers as evenly as possible across all four quarters.

For each quarter during the review period, HSAG's trained callers made a call to each call center no more than once per day during normal business hours (i.e., 9 a.m. to 5 p.m. Pacific Time), with the call time varying from day to day. The callers ended the call if the hold time reached 10 minutes. The hold time began from the time the phone connected (or after pressing the correct option on the phone tree) to the time when a call center staff member could assist the caller.

Calls to MCMC Plan Nurse Triage/Advice Lines

For contract year 2021–22 (i.e., calendar year 2022 calls), HSAG made 73 calls to each MCMC plan's nurse triage/advice line. To minimize the interruption to the nurse triage/advice lines, HSAG made 19 calls per MCMC plan for the first quarter, then 18 calls per quarter for the remaining quarters.

For the 2022–23 contract year (i.e., calendar year 2023 calls), DHCS requested that the sample size be 100 for each plan. Thus, for quarter 1 and quarter 2 of contract year 2022–23, HSAG made 25 nurse triage/advice line calls per plan each quarter. For the remaining two quarters of contract year 2022–23, HSAG will make 25 nurse triage advice line calls per plan each quarter.

For each quarter during the review period, HSAG's trained callers made a call to each nurse triage/advice line no more than once per day during normal business hours (i.e., 9 a.m. to 5 p.m. Pacific Time), with the call time varying from day to day. The callers ended the call if the hold time reached 30 minutes. The hold time began from the time the phone connected (or after pressing the correct option on the call tree) to the time when the callers reached a qualified health professional such as a medical doctor, physician's assistant, registered nurse, licensed clinical social worker, or licensed marriage and family therapist. Note that for Kaiser, the total number of calls to the nurse triage/advice lines each quarter of contract year 2022–23 is split between Kaiser NorCal and Kaiser SoCal. For quarter 1 and quarter 2 of contract year 2022–23, HSAG made 12 calls for Kaiser NorCal and 13 calls for Kaiser SoCal. For the remaining two quarters, HSAG will make 13 calls for Kaiser NorCal and 12 calls for Kaiser SoCal.

Submit Quarterly Deliverables to DHCS

To assess and report the calls to the providers, call centers, and nurse triage/advice lines, HSAG used multiple study indicators. HSAG submitted the following quarterly deliverables to DHCS to report the study indicator results and summarize the findings:

- Executive summary
- Statewide report and raw data files
- MCMC plan-specific reports and raw data files

Based on the findings, HSAG provided in the quarterly reports specific and actionable considerations for DHCS and MCMC plans, as applicable.

Results—Timely Access Study

This section provides a summary of the calendar year 2022 calls (contract year 2021–22) as well as a summary of the first two quarters of calendar year 2023 calls for contract year 2022–23.

Calendar Year 2022

Calls to Providers

During calendar year 2022, HSAG obtained at least one non-urgent in-person appointment time from 11,478 of 35,480 providers (i.e., a statewide weighted rate of 32.7 percent) and at least one urgent in-person appointment time from 9,255 of 29,508 applicable providers (i.e., a statewide weighted rate of 31.9 percent) included in the telephone survey and who met the study population criteria based on the survey calls.

Table 9.2 presents calendar year 2022 cumulative results for providers' compliance with non-urgent and urgent in-person appointment wait times, stratified by adult and pediatric member populations. Providers for which HSAG obtained at least one appointment have been included. The rate is determined by the total number of providers with an appointment time obtained for the designated appointment that met the appointment wait time standards.

Table 9.2—Calendar Year 2022 Timely Access Study Statewide Provider Compliance for In-Person Appointment Wait Time Standards

The em dash "—" in the table denotes that the wait time standard is not applicable to an appointment type.

Provider Type	Percentage of First Available In-Person Appointment Meeting Wait Time Standards				Percentage of Available In-Person Appointment Meeting Wait Time Standards		
	Non-Urgent		Urgent		Preventive Care		Non-Urgent Follow-up
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	
PCP	76.6%	81.0%	48.4%	54.8%	—	—	—
Specialist	63.2%	63.5%	40.6%	43.7%	—	—	—

Provider Type	Percentage of First Available In-Person Appointment Meeting Wait Time Standards				Percentage of Available In-Person Appointment Meeting Wait Time Standards		
	Non-Urgent		Urgent		Preventive Care		Non-Urgent Follow-up
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	
Non-Physician Mental Health Provider	78.5%	75.3%	62.0%	55.2%	—	—	79.0%
Dental Providers from Health Plan of San Mateo	90.0%	90.0%	31.6%	26.3%	85.0%	85.0%	—
Ancillary	83.0%		—		—		—
All Applicable Provider Types	**71.0%**		**46.4%**		**84.0%**		**79.0%**

Calls to MCMC Plan Call Centers

During calendar year 2022, HSAG made calls to each MCMC plan's call center. Of the 1,825 calls placed, 82.0 percent met the wait time standard of 10 minutes.

Calls to MCMC Plan Nurse Triage/Advice Lines

During calendar year 2022, HSAG made calls to each MCMC plan's nurse triage/advice line. Of the 1,898 calls placed, 89.7 percent met the wait time standard of 30 minutes.

Cumulative First Two Quarters of Calendar Year 2023

Calls to Providers

During the first two quarters of calendar year 2023, HSAG obtained a non-urgent in-person appointment time from 6,166 of 16,389 providers (i.e., a statewide weighted rate of 39.0 percent) and an urgent in-person appointment time from 5,053 of 14,116 applicable providers (i.e., a statewide weighted rate of 36.7 percent) included in the telephone survey and who met the study population criteria based on the survey calls.

Table 9.3 presents cumulative results from the first two quarters of calendar year 2023 for providers' compliance with non-urgent and urgent in-person appointment wait times, stratified by adult and pediatric member populations. Providers for which HSAG obtained an appointment have been included. The rate is determined by the total number of providers with

an appointment time obtained for the designated appointment that met the appointment wait time standards.

Table 9.3— Cumulative First Two Quarters of Calendar Year 2023 Timely Access Study Statewide Provider Compliance for In-Person Appointment Wait Time Standards

The em dash "—" in the table denotes that the wait time standard is not applicable to an appointment type.

Provider Type	Percentage of Available In-Person Appointment Meeting Wait Time Standards						
	Non-Urgent		Urgent		Preventive Care		Non-Urgent Follow-up
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	
PCP	74.3%	78.8%	50.0%	54.6%	—	—	—
Specialist	61.1%	64.8%	45.2%	47.3%	—	—	—
Non-Physician Mental Health Provider	80.4%	79.9%	61.2%	55.2%	—	—	87.0%
Dental Providers from Health Plan of San Mateo	82.3%	86.3%	62.6%	61.9%	93.3%	95.2%	—
Ancillary	82.5%		—		—		—
All Applicable Provider Types	**68.9%**		**49.0%**		**95.2%**		**87.0%**

Calls to MCMC Plan Call Centers

During the first two quarters of calendar year 2023, HSAG made calls to each MCMC plan's call center. Of the 1,730 calls placed, 78.6 percent met the wait time standard of 10 minutes.

Calls to MCMC Plan Nurse Triage/Advice Lines

During first two quarters of calendar year 2023, HSAG made calls to each MCMC plan's nurse triage/advice line. Of the 1,250 calls placed, 93.4 percent met the wait time standard of 30 minutes.

Conclusions—Timely Access Study

The calendar year 2022 results reflect opportunities for improvement across all provider types and for both non-urgent and urgent appointment availability. Urgent adult and pediatric specialist and Health Plan of San Mateo's dental provider appointment availability presented the greatest opportunities for improvement. DHCS works continually with the MCMC plans to address performance related to all Timely Access Study indicators, and the quarterly deliverables HSAG submits to DHCS provide extensive data to help DHCS and the MCMC plans investigate the areas in most need of improvement.

Note that the calendar year 2023 calls are not yet completed; therefore, HSAG does not draw any conclusions related to these calls. HSAG will include conclusions related to the calendar year 2023 calls in the 2023–24 EQR technical report.

10. Annual Health Disparities Study

Objective

The objective of the Annual Health Disparities Study is to provide results and conclusions for DHCS to use to identify and address health care disparities affecting Medi-Cal members. DHCS may use the results from these studies to inform strategies to contribute toward achieving the DHCS Comprehensive Quality Strategy vision of eliminating health care disparities as well as to inform the Comprehensive Quality Strategy Health Equity Roadmap.[39]

Technical Methods of Data Collection and Analysis

Most of the data HSAG obtained for the Annual Health Disparities Study were from DHCS and the MCPs. For the DHCS data, HSAG submitted to DHCS the required DHCS Data Release Form and detailed data request instructions to ensure all needed data were submitted for the analyses. DHCS submitted the data to HSAG via a SFTP site. The MCP data were submitted to HSAG during the PMV activities described in Section 4 of this report ("**Performance Measure Validation**"). HSAG also downloaded data from the HPI Master File from the Public Health Alliance of Southern California website.[40]

Description of Data Obtained

The data types HSAG obtained for the Annual Health Disparities Study analyses included the following:

- HPI demographic composition data stratified by ZIP Code
- Member demographic
- Patient-level detail
- Performance measure

[39] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

[40] Public Health Alliance of Southern California. The California Healthy Places Index. Available at: https://www.healthyplacesindex.org/. Accessed on: Jan 5, 2024.

Annual Health Disparities Study Summary

The goal of the annual health disparities studies is to improve health care for Medi-Cal members by evaluating the health care disparities affecting members enrolled in Medi-Cal MCPs. HSAG does not include data for FFS members in the analyses.

For the 2022 Annual Health Disparities Study, HSAG used measurement year 2022 performance measure data from the 25 MCPs. HSAG evaluated measure data collected for measurement year 2022 at the statewide level. HSAG aggregated results from 25 MCPs and then stratified the statewide rates for the MCAS measures by the following demographic stratifications:

- Race/Ethnicity
- Primary Language
- Age
- Gender
- SPD and non-SPD populations
- HPI Quartile (for select measures)
- County

Although HSAG stratified all indicators by the demographic stratifications listed above, HSAG only identified racial/ethnic health disparities. HSAG presented comparisons to measurement year 2021 results, when applicable.

The *2022 Health Disparities Report* includes the detailed study methodology, key results and findings, conclusions, and considerations. The report may be found at Medi-Cal Managed Care Quality Improvement Reports.

11. Preventive Services Study

At the request of the Joint Legislative Audit Committee, the California State Auditor published an audit report in March 2019 regarding DHCS' oversight of the delivery of preventive services to children enrolled in MCMC. The audit report recommended that DHCS expand the performance measures it collects and reports on to ensure all age groups receive preventive services from MCPs.[41] In response to this recommendation, DHCS requested that HSAG produce an annual Preventive Services Report beginning in 2020. This report is published on the DHCS website annually.

Objective

The objective of the Preventive Services Study is to provide results and conclusions for DHCS to use to identify and monitor appropriate utilization of preventive services for MCMC children. Additionally, the results from this study support DHCS' renewed emphasis on prevention as described in the DHCS Comprehensive Quality Strategy.[42]

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the Preventive Services Study from DHCS, the MCPs, NCQA, and CMS. For the DHCS data, HSAG submitted to DHCS the required DHCS Data Release Form and detailed data request instructions to ensure all needed data were submitted for the analyses. DHCS submitted the data to HSAG via a SFTP site. The MCP data were submitted to HSAG during the PMV activities described in Section 4 of this report ("**Performance Measure Validation**"). NCQA data were obtained via NCQA's Quality Compass, and CMS data were obtained via CMS' website.[43]

[41] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Jan 4, 2024.

[42] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

[43] Centers for Medicare and Medicaid Services: Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set, Chart Pack, November 2021. Available at: Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set Chart Pack. Accessed on: Jan 5, 2024.

Description of Data Obtained

The data types HSAG used for the Preventive Services Study analyses included the following:

- Claims
- CMS' Child Core Set National Medians
- Encounter
- Member demographic
- Member eligibility
- Member enrollment
- Member-level blood lead screening
- NCQA's HEDIS 2022 Medicaid HMO 50th percentiles
- Performance measure

Preventive Services Study Summary

For the 2023 Preventive Services Study, HSAG continued to analyze child and adolescent performance measures that were calculated by HSAG and DHCS, and reported by the 25 full-scope MCPs from the MCAS. MCAS measures reflect clinical quality, timeliness, and accessibility of care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. DHCS can leverage the findings from the Preventive Services Study to address the clinical focus area of children's preventive care identified in its 2022 Comprehensive Quality Strategy[44] and monitor appropriate utilization of preventive services for MCMC children.

For the 2023 study, HSAG evaluated measure data collected for HEDIS measurement year 2022, which consists of data collected during calendar year 2022. The indicator set for this analysis included 12 MCP-calculated indicators, nine HSAG-calculated indicators (i.e., administrative indicators calculated by HSAG for DHCS), and four DHCS-calculated indicators. For each MCP-calculated indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the HEDIS specification for the Medicaid population or by the CMS Child Core Set. For the HSAG-calculated indicators, HSAG developed specifications for four indicators and used the CMS Child Core Set specifications for the remaining indicators. For the DHCS-calculated indicators, DHCS developed specifications for the four indicators. To focus the 2023 Preventive Services Report on more actionable results for stakeholders, HSAG and DHCS developed criteria to determine which results would

[44] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

be considered as key findings. HSAG included key findings in the body of the report and all other findings in an appendix.

The *2023 Preventive Services Report* includes the detailed study methodology, key results and findings, conclusions, and considerations. The report may be found at Medi-Cal Managed Care Quality Improvement Reports.

12. Consumer Surveys

Administration of consumer surveys of quality of care is one of the optional EQR activities described at 42 CFR §438.358(c)(2).

The DHCS Comprehensive Quality Strategy includes the goal to engage members to be actively involved in their own health care and to provide input to DHCS about Medi-Cal policy.[45] DHCS also seeks to prioritize member experience in all quality improvement efforts. To help DHCS assess perceptions and experiences of members as part of its evaluation of the quality of health care services provided by MCPs to their members, DHCS contracts with HSAG to administer and report the results of the CAHPS Health Plan Surveys for the CHIP and Medi-Cal populations.

During contract year 2022–23, DHCS contracted with HSAG to administer and report the results of the following CAHPS surveys:

- CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS and Children with Chronic Conditions (CCC) measurement sets to meet CMS' Children's Health Insurance Program Reauthorization Act requirements.
- CAHPS 5.1 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set (i.e., CAHPS 5.1H Adult and Child Medicaid Health Plan Surveys) for the adult and child Medicaid populations for the 24 MCPs and Medi-Cal FFS.

HSAG includes a summary of the 2023 CHIP CAHPS survey results in this EQR technical report. HSAG also includes in this report a high-level summary of the 2023 Medi-Cal survey.

Objective

The primary objective of the CAHPS surveys is to obtain information about how CHIP and Medi-Cal members experienced or perceived key aspects of their health care services.

[45] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

Technical Methods of Data Collection and Analysis

HSAG obtained data from DHCS via a SFTP site to conduct the CAHPS surveys and collected the member experience data from the Medi-Cal members who completed the surveys. HSAG also obtained data from NCQA.

Description of Data Obtained

The data types HSAG obtained for the CAHPS survey analyses included:

- NCQA's 2021 Medicaid national 50th and 90th percentiles
- Sample frame
- Survey response

2023 Children's Health Insurance Program Survey

The *2023 CHIP CAHPS Survey Summary Report* includes the survey's detailed methodology, results, conclusions, and recommendations. Following is a high-level summary of the survey.

Methodology—Children's Health Insurance Program Survey

During the review period, HSAG administered the standardized survey instrument CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS and CCC measurement sets to a statewide sample of CHIP members enrolled in MCPs and FFS.

Table 12.1 lists the measures included in the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set.

Table 12.1—CAHPS Measures

Global Ratings	Composite Measures	CCC Composite Measures and Items
Rating of Health Plan	*Getting Needed Care*	*Access to Specialized Services*
Rating of All Health Care	*Getting Care Quickly*	*Family-Centered Care (FCC): Personal Doctor Who Knows Child*

Global Ratings	Composite Measures	CCC Composite Measures and Items
Rating of Personal Doctor	*How Well Doctors Communicate*	*Coordination of Care for Children with Chronic Conditions*
Rating of Specialist Seen Most Often	*Customer Service*	*Access to Prescription Medicines*
		FCC: Getting Needed Information

Survey Sampling Procedures

The members eligible for sampling included those who were CHIP members at the time the sample was drawn and who were continuously enrolled in the same MCP for at least five of the six months of the measurement period (July through December 2022). The members eligible for sampling included those who were 17 years of age or younger (as of December 31, 2022).

All CHIP members within the sample frame file were given a chronic condition prescreen status code of 1 or 2. A prescreen code of 1 indicated that the member had claims or encounters which did not suggest that the member had a greater probability of having a chronic condition. A prescreen code of 2 (also known as a positive prescreen status code) indicated that the member had claims or encounters which suggested that the member had a greater probability of having a chronic condition. After selecting a random sample of 3,065 CHIP members (i.e., general population of children enrolled in CHIP), HSAG selected a CCC supplemental sample of 3,615 CHIP members with a prescreen code of 2 (i.e., the population of children who were more likely to have a chronic condition).[46] HSAG drew the supplemental sample to ensure an adequate number of responses from children with chronic conditions.

Survey Administration

The survey administration process allowed for two methods by which parents/caretakers of child members could complete a survey: 1) mail or 2) Internet. A cover letter was mailed to all parents/caretakers of sampled child members that provided two options to complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope; or (2) complete the web-based survey via a URL or quick response (QR) code and designated username. Members who were identified as Spanish speaking through administrative data were mailed a Spanish version of the cover letter and survey. Members who were not identified as Spanish speaking received an English version of the cover letter

[46] The general child sample includes an oversample of 1,415 child members, and the CCC supplemental sample includes an oversample of 1,775 child members.

and survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing parents/caretakers of child members that they could call the toll-free number to request a Spanish version of the survey. The cover letter included with the Spanish version of the survey had an English cover letter on the back side informing parents/caretakers of child members that they could call the toll-free number to request an English version of the survey. In addition, respondents had the option to choose an English or Spanish version of the Web survey. All non-respondents received a reminder postcard, followed by a second survey mailing, second reminder postcard, and third survey mailing.

Survey Analysis

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS Measurement Year 2022, Volume 3: Specifications for Survey Measures*. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed the following analyses to comprehensively assess member experience:

- Response Rates
- Respondent Analysis
- Top-Box Scores[47]
- Comparative Analysis

Results—Children's Health Insurance Program Survey

Response Rates

HSAG mailed 6,680 child surveys to a sample of CHIP members selected for surveying. Of these, 979 child surveys were completed for the CHIP sample.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members in the sample. If the parent/caretaker of the CHIP member appropriately answered at least three of five NCQA-specified questions in the survey instrument, HSAG counted the survey as complete.

Table 12.2 presents the total number of CHIP members sampled, the number of ineligible and eligible members, the number of surveys completed, and the response rate for the CHIP population selected for surveying. The survey dispositions and response rates are based on the responses of parents/caretakers of children in the general child and CCC supplemental samples. The CHIP response rate of 14.67 percent was greater than the CCC Medicaid

[47] The percentage of survey respondents who chose the most positive score for a given item's response scale.

national response rate reported by NCQA for 2022, which was 12.2 percent.[48,49] In 2022, the CHIP response rate was 19.31 percent, which was 4.64 percentage points higher than the 2023 CHIP response rate. HSAG has observed an overall decline in CAHPS survey response rates over the past several years, so this decline falls in line with national trends.

Table 12.2—Total Number of Respondents and Response Rate

Response rate is calculated as the number of Completed Surveys divided by the Eligible Sample.

Population	Total Sample Size	Ineligible Sample	Eligible Sample	Completed Surveys	Response Rate
General Child Sample	3,065	2	3,063	414	13.52%
CCC Supplemental Sample	3,615	3	3,612	565	15.64%
CHIP	**6,680**	**5**	**6,675**	**979**	**14.67%**

Respondent Analysis

For the respondent analysis, HSAG compared the demographic characteristics of CHIP members whose parents/caretakers responded to the survey to the demographic characteristics of all CHIP members in the sample frame for statistically significant differences. The demographic characteristics evaluated as part of the respondent analysis included member age, gender, ethnicity, and race. HSAG identified the following notable results:

- A statistically significantly higher percentage of parents/caretakers of children whose ethnicity was Hispanic responded to the survey (67.4 percent) compared to those in the sampling frame (61.8 percent).
- A statistically significantly lower percentage of parents/caretakers of children whose ethnicity was non-Hispanic responded to the survey (32.6 percent) compared to those in the sampling frame (38.2 percent).

[48] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022, Survey Vendor Update Training*. October 5, 2022.

[49] Please note, 2023 national response rate information was not available at the time this report was produced.

General Child Performance Highlights

Differences in scores should be evaluated from a clinical perspective. While the CHIP general child population results may be above or below the national 50th percentiles, differences in scores may not be important from a clinical point of view. HSAG observed the following:

- The gaps between the NCQA child Medicaid national 50th and 90th percentiles were on average 3.7 percentage points for the general child population, indicating that the distributions of national performance were close together.
- The differences between the CHIP general child population reportable scores and the NCQA child Medicaid national 50th percentiles ranged from 9.1 to 1.5 percentage points below the NCQA child Medicaid national 50th percentiles, with an average of 4.0 percentage points below the NCQA child Medicaid national 50th percentiles for the general child population.

Top-Box Scores

The findings indicate opportunities for improvement in member experience for several areas of care, as all reportable measures scored below the NCQA child Medicaid national 50th percentiles.

Comparative Analysis

The 2023 score was statistically significantly lower than the 2021 score for the *Rating of All Health Care* global rating. The 2023 scores were not statistically significantly higher than the 2021 scores for any measure. The 2023 scores were not statistically significantly higher or lower than the 2022 scores for any measure.

Children with Chronic Conditions Performance Highlights

As with the CHIP general child population results, differences in CHIP CCC population scores should be evaluated from a clinical perspective. While the CHIP CCC population results may be above or below the national 50th percentiles, differences in scores may not be important from a clinical point of view. HSAG observed the following:

- The gaps between the NCQA CCC Medicaid national 50th and 90th percentiles were on average 3.3 percentage points for the CCC population, indicating that the distributions of national performance were close together.
- The differences between the CHIP CCC population reportable scores and the NCQA CCC Medicaid national 50th percentiles ranged from 10.4 percentage points below and 1.8 percentage points above the NCQA CCC Medicaid national 50th percentiles, with an average of 2.6 percentage points below the NCQA CCC Medicaid national 50th percentiles for the CCC population.

Top-Box Scores

The findings indicate opportunities for improvement in member experience for several areas of care, as all reportable measures except the *Access to Prescription Medicines* CCC item scored below the NCQA CCC Medicaid national 50th percentiles.

Comparative Analysis

The 2023 scores were not statistically significantly higher than the 2021 or 2022 scores for any measure.

Conclusions—Children's Health Insurance Program Survey

To draw conclusions related to the experiences of the CHIP population related to the care and services they received, HSAG assessed the CHIP CAHPS survey results.

The following findings indicate opportunities for improvement in member experience for several areas of care that could affect the quality, accessibility, and timeliness of health care services provided to Medi-Cal members:

- The general child population scored below the 2022 NCQA child Medicaid national 50th percentiles for all reportable measures, which included:
  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
  - Composite Measures:
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
- The CCC population scored below the 2022 NCQA CCC Medicaid national 50th percentiles for all reportable measures, except the *Access to Prescription Medicines* CCC item. These measures included:
  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Specialist Seen Most Often*
  - Composite Measures:
    - *Getting Needed Care*
    - *Getting Care Quickly*

    - *How Well Doctors Communicate*
  - CCC Composite Measures and Items:
    - *FCC: Personal Doctor Who Knows Child*
    - *FCC: Getting Needed Information*
- The 2023 score for the *Rating of All Health Care* global rating was statistically significantly lower than the 2021 score for the general child population.

2023 Medi-Cal Survey Summary

DHCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Survey for both adult Medi-Cal members and parents/caretakers of child Medi-Cal members. The survey results represent adult members and parents/caretakers of child members enrolled in an MCP or FFS who completed surveys from February to May 2023, and represent members' experiences with care and services over the prior six months. Twenty-four MCPs participated in the survey. The two PSPs, AIDS Healthcare Foundation and SCAN Health Plan, were not included in the survey due to small enrollment numbers and an insufficient number of eligible members for the survey.

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS Measurement Year 2022, Volume 3: Specifications for Survey Measures*. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed the following analyses to comprehensively assess member experience:

- Response Rates
- Respondent Analysis
- Top-Box Scores[50]
- State-Level Scores and Comparisons
- Comparative Analysis

The *2023 Medi-Cal CAHPS Survey Summary Report* includes the adult and child surveys' detailed methodologies, results, conclusions, and considerations. The report may be found at Mgd Care Qual Perf CAHPS.

[50] The percentage of survey respondents who chose the most positive score for a given item's response scale.

13. Encounter Data Validation Study

Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity is one of the optional EQR activities described at 42 CFR §438.358(c)(1).

Accurate and complete encounter data are critical to assessing health care quality, monitoring program integrity, and making financial decisions. Therefore, DHCS requires MCMC plans to submit high-quality encounter data. DHCS relies on the quality of the encounter data to accurately and effectively monitor and improve quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS' overall management and oversight of MCMC.

DHCS contracts with HSAG to conduct EDV studies as an optional EQR activity. In addition to the procedures and quality assurance protocols DHCS maintains internally, according to 42 CFR §438.242, to ensure that enrollee encounter data submitted by MCMC plans provide a complete and accurate representation of the services provided to Medi-Cal members under the plans' contracts with the State, the EDV studies HSAG conducts are designed to meet the periodicity schedule required in 42 CFR §438.602(e) for an independent audit of the accuracy, truthfulness, and completeness of encounter data submitted by, or on behalf of, each MCMC plan. Note that §438.602(e) originated in the 2016 CHIP and Medicaid Final Rule and is effective for Medicaid managed care contracts started on or after July 1, 2017.[51] Additionally, DHCS agreed to conduct the EDV study annually in response to findings and recommendations from the California State Auditor in an audit report published in March 2019.[52] Finally, the EDV study results support DHCS' efforts to improve data quality and reporting, which will help DHCS meet its Comprehensive Quality Strategy goal to improve the quality of care for Medi-Cal members.[53]

[51] Medicaid and CHIP Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability (CHIP and Medicaid Final Rule), (May 6, 2016) Federal Register Document Citation No. 81 FR 27497. Available at: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Jan 5, 2024.

[52] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Jan 5, 2024.

[53] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

Objective

The objective of the 2022–23 EDV Study was to continue to examine the completeness and accuracy of the professional encounter data submitted to DHCS by the MCMC plans through a review of medical records. HSAG assessed the encounter data submitted by the 26 MCMC plans included in the study.

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the EDV Study from DHCS and the MCMC plans via a SFTP site.

Description of Data Obtained

The data types HSAG obtained for the EDV Study analyses included the following:

- Member demographic
- Member enrollment
- Encounter
- Provider
- Medical records

Although HSAG concluded the 2022–23 EDV Study outside the review period for this EQR technical report, HSAG includes a high-level summary of the study because the information was available at the time this EQR technical report was produced.

Encounter Data Validation Medical Record Review Study Summary

Medical and clinical records are considered the "gold standard" for documenting access to and quality of health care services. During contract year 2022–23, HSAG evaluated MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2021, and December 31, 2021. The study answered the following question:

- Are the data elements *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Rendering Provider Name*, found on the professional encounters, complete and accurate when compared to information contained within the medical records?

HSAG conducted the following actions to answer the study question:

- Identified the eligible population and generated samples from data extracted from the DHCS data warehouse.
- Assisted MCMC plans to procure medical records from providers, as appropriate.
- Reviewed medical records against DHCS encounter data.
- Calculated study indicators.

The *2022–23 Encounter Data Validation Study Report* includes the detailed methodology, results, conclusions, and recommendations. The report may be found at Medi-Cal Managed Care Quality Improvement Reports.

14. Focus Studies

Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time is one of the optional EQR activities described at 42 CFR §438.358(c)(5).

DHCS contracts with HSAG to conduct focus studies to gain better understanding of and identify opportunities for improving care provided to members, which supports the DHCS Comprehensive Quality Strategy goals and vision.[54]

HSAG conducts each focus study in accordance with the CMS *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[55]

Under the focus study category, DHCS contracted with HSAG to conduct race/ethnicity analyses related to measurement year 2022 MCAS patient-level detail file data for DHCS' internal use only. Following is a summary of the analyses.

Objective

The objective of the Measurement Year 2022 MCAS Race/Ethnicity Analyses was for HSAG to provide analyses results to DHCS related to select demographics to inform DHCS' quality improvement and early intervention work as well as other initiatives.

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the Measurement Year 2022 MCAS Race/Ethnicity Analyses from DHCS and MCPs. For the DHCS data, HSAG submitted to DHCS the required DHCS Data Release Form and detailed data request instructions to ensure all needed data were submitted for the analyses. DHCS submitted the data to HSAG via a SFTP site. MCPs submitted the data to HSAG during the PMV activities described in Section 4 of this report ("**Performance Measure Validation**").

[54] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

[55] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 5, 2024.

Description of Data Obtained

The data types HSAG obtained for the Measurement Year 2022 MCAS Race/Ethnicity Analyses are listed below:

- Member demographic
- Patient-level detail

Summary of Analyses and Deliverable for DHCS' Internal Use

HSAG used the measurement year 2022 MCAS patient-level detail files submitted by the MCPs to calculate statewide MCAS indicator rates stratified by the following demographics:

- Race
- Ethnicity
- Combined race/ethnicity
- County
- MCP reporting unit
- Region

HSAG calculated indicator rates stratified by various combinations of the demographic elements listed above. These combinations included:

- An MCP reporting unit rate for each racial and ethnic group and combined racial/ethnic group.
- A county rate for each racial and ethnic group and combined racial/ethnic group.
- A county-specific MCP reporting unit rate for each racial and ethnic group and combined racial/ethnic group.
- A region rate for each racial and ethnic group and combined racial/ethnic group.

After performing the analyses, HSAG compiled and produced a Microsoft Excel MCAS Race/Ethnicity Rate Spreadsheet for DHCS' internal use. The spreadsheet included applicable numerator, denominator, eligible population, demographic, and rate data for each combination and individual stratification. HSAG presented all results in pivot tables to allow DHCS to easily filter for each demographic stratification and combination of the demographic stratifications.

DHCS will use the results in the spreadsheet to assess for differences across the multiple demographic variables to inform various Medi-Cal initiatives.

15. Technical Assistance

At the State's direction, the EQRO may provide technical assistance to groups of MCOs, PIHPs, PAHPs, or PCCM entities as described at 42 CFR §438.358(d). The technical assistance HSAG provides supports DHCS and the MCMC plans in making progress toward accomplishing the DHCS Comprehensive Quality Strategy goals and vision, improving the health care services provided to Medi-Cal members, and achieving health equity.[56]

In addition to the technical assistance provided to MCMC plans as part of the PIP process, DHCS contracted with HSAG to provide supplemental technical assistance to help improve overall statewide performance. DHCS selected three technical assistance categories for HSAG to support during the July 1, 2022, through June 30, 2023, review period.

Technical Assistance for Plans' Quality Improvement

Under this technical assistance category, HSAG supports DHCS by providing technical assistance to each MCMC plan with performance measure rates worse than the minimum performance levels. Additionally, HSAG provides technical assistance to DHCS in various areas related to quality improvement.

Specifically, HSAG conducts the following activities as requested by DHCS:

- Provide performance measure expertise to DHCS in identifying and researching performance measures regarding updates to measure specifications and to the CMS Core Sets, trends, and best practices.
- Collaborate with DHCS to provide technical assistance to MCMC plans related to DHCS' quality monitoring and enforcement actions and CAP processes.
- Provide technical assistance to MCMC plans requiring additional guidance with quality improvement activities being conducted as part of DHCS' quality monitoring and enforcement actions and CAP processes.
- Review and provide feedback to DHCS on an array of documents related to quality improvement activities, including providing subject matter expertise on quality performance measures to be included in or excluded from MCAS.
- Respond to requests from DHCS for input on a variety of quality improvement-related issues and topics.

[56] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 5, 2024.

Objective—Technical Assistance for Plans' Quality Improvement

The objective of Technical Assistance for Plans' Quality Improvement is for HSAG to assist MCMC plans in improving the quality of care they provide to members, which will help to improve their performance measure rates and, ultimately, improve overall statewide performance.

Methodology—Technical Assistance for Plans' Quality Improvement

HSAG used a team approach to provide technical assistance, identifying the most pertinent subject matter experts for each request to ensure the most efficient provision of technical assistance with the greatest likelihood of resulting in enhanced skills and, ultimately, improved performance. To promote timely and flexible delivery, HSAG provided technical assistance to DHCS and MCMC plans via email, telephone, and Web conferences.

Results—Technical Assistance for Plans' Quality Improvement

Following is a high-level summary of the notable technical assistance HSAG provided to DHCS and MCMC plans during the review period to support quality improvement efforts.

Performance Measures and Audits

- Forwarded to DHCS, NCQA and CMS updates to ensure DHCS is aware of NCQA and CMS requirements, knows of NCQA and CMS resources, and has the pertinent information needed to make performance measure requirement decisions.
- Responded to DHCS' questions and provided feedback to DHCS related to NCQA benchmarks, HEDIS Compliance Audit processes, HEDIS data, NCQA and CMS performance measure specifications, and historical and future performance measure requirements.
- Provided guidance to MCMC plans about performance measure requirements and DHCS' expectations for MCMC plans' use of preventive services and health disparities data for quality improvement activities.

Consumer Assessment of Healthcare Providers and Systems

- Provided guidance to DHCS regarding how to navigate the NCQA CAHPS survey sample frame certification process.

- Responded to MCMC plans' requests for information and data related to the CAHPS survey HSAG administers on behalf of DHCS.

External Quality Review Technical Report

- Reviewed CMS' feedback to DHCS on the 2020–21 EQR technical report and provided recommendations to DHCS about how to respond to the feedback.
- Provided DHCS with considerations for changes to ensure meeting CMS' EQR technical report content requirements.

Other Technical Assistance

- Provided clarification and information to individual DHCS staff members about specific EQR activities and deliverables, HSAG's role as the EQRO, and processes and tools that are in place to ensure efficient and thorough project management of all activities.
- Forwarded to DHCS announcements and updates from various organizations, such as CMS, to ensure DHCS is up to date on relevant information and requirements that may affect MCMC.
- Provided feedback and considerations to DHCS regarding various DHCS-proposed analyses.
- Provided information regarding CMS' *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023[57] to help DHCS determine the steps it needs to take to meet CMS' validation of network adequacy requirements. HSAG also met with DHCS to review current DHCS and MCMC plan network adequacy activities and discuss the timeline for when HSAG will begin conducting the validation of network adequacy activities to meet the CMS requirements.
- Provided historical information to DHCS regarding CMS' feedback to DHCS about the compliance reviews DHCS conducts and HSAG's recommendations to DHCS regarding how to meet the compliance review requirements as outlined in 42 CFR §438.358(b)(1)(iii).
- Provided guidance to DHCS regarding EQR requirements for MCMC plans that are exiting Medi-Cal and answered individual MCMC plan questions related to closeout activities.
- Upon request, provided MCMC plans with historical information to help with their quality improvement processes (i.e., PIP validation findings, collaborative discussion presentations, and quality conference presentations).

[57] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 5, 2024.

Conclusions—Technical Assistance for Plans' Quality Improvement

HSAG's technical assistance resulted in DHCS gaining information to assist in making informed decisions regarding various EQR activities and MCMC plan requirements. HSAG's technical assistance regarding various EQR activities helped DHCS to better understand how to ensure it meets CMS' managed care and EQR requirements. Additionally, HSAG's technical assistance to MCMC plans resulted in the plans receiving information needed to meet DHCS' requirements and for their internal quality improvement efforts.

Technical Assistance for Priority Quality Improvement Collaboration

Starting in contract year 2022–23, DHCS required all MCMC plans to participate in region-specific collaborative calls. DHCS divided the State into six distinct regions based on similarities in rates, access to services, and demographics. MCMC plans were required to attend the call(s) relevant to the region(s) in which they provide services. During each regional collaborative call, DHCS presented regional data, highlighting the highest and lowest MCAS measure rates and evident disparities. MCMC plans discussed possible barriers experienced in the region for which DHCS presented data, strategies for improving the lowest rates, and quality improvement approaches that have and have not worked in the region. DHCS encouraged partners, such as the CDPH, to attend the calls and provide additional resources to the plans.

All MCMC plans are required to attend a debrief call that will take place in August 2023 to provide the opportunity for plans to discuss lessons learned, developments, promising practices, and projects related to improving performance for measures with the lowest rates and highest disparities. MCMC plans within each region will be given time to discuss methods for improving rates through collaboration, what did and did not work for their specific regions, and initiatives they will carry forward.

Objective—Technical Assistance for Priority Quality Improvement Collaboration

Under the Technical Assistance for Priority Quality Improvement Collaboration, HSAG implements, facilitates, supports, and manages collaborative calls for each DHCS-identified region. The objectives of the regional collaborative calls are:

- To foster collaboration among MCMC plans that share regional similarities.

- To encourage the MCMC plans to identify quality improvement methods that account for regional variation.
- To improve rates for measures with the lowest rates and highest disparities in the regions through meaningful collaboration and teamwork among MCMC plans and the community.

Methodology—Technical Assistance for Priority Quality Improvement Collaboration

Through joint planning meetings, HSAG and DHCS discussed potential topics for the regional collaborative calls and the appropriate structure for the meetings based on the topics. DHCS and HSAG collaboratively determined the topic for each quarterly collaborative call based on:

- Feedback received from MCMC plans about what they would like discussed.
- Issues that DHCS and HSAG identified through their EQR work with the MCMC plans, including but not limited to PIPs, MCAS performance measures and associated PDSA cycles, and MCMC plan-specific technical assistance sessions.

Additionally, HSAG:

- In partnership with DHCS, facilitated each regional collaborative call.
- Collaborated with DHCS regarding the agenda and prepared agendas.
- Prepared and coordinated webinar presentations with DHCS.
- Tracked participant attendance.
- Compiled and disseminated notes to DHCS and MCMC plans within five State working days following each regional collaborative call.

HSAG conducted the regional collaborative calls through webinars and conference calls. Immediately following each regional collaborative call, HSAG invited participants to complete a post-collaborative discussion survey to provide anonymous feedback about the call and their input for future calls. The survey link appeared immediately after participants exited the Webex, and HSAG also emailed the survey link to participants following each call. Once survey results became available, HSAG provided DHCS with a summary of the survey results.

Results—Technical Assistance for Priority Quality Improvement Collaboration

HSAG and DHCS facilitated regional collaborative calls in all four quarters of the review period for this report. At the beginning of each call, DHCS informed the participants of which counties and MCMC plans were represented on the call. DHCS then presented regional performance measure data by domain (i.e., Acute and Chronic Disease Management, Children's Health,

Women's Health) that demonstrated opportunities for improvement. DHCS prompted participants to share about:

- Best practices for successful performance on measures within each domain.
- Challenges to meeting the DHCS-established minimum performance levels.
- Regional resources for supporting members with accessing needed services.

In all four quarters, most post-regional collaborative call survey respondents completed the surveys on the days of the calls.

Conclusions—Technical Assistance for Priority Quality Improvement Collaboration

The regional collaborative calls resulted in MCMC plans and DHCS sharing valuable information regarding quality improvement efforts for each measure domain for which DHCS identified opportunities for improvement. MCMC plan participants actively engaged in discussions related to the data DHCS presented, sharing about potential partners, lessons learned, and strategies to improve performance. MCMC plan participants also shared about challenges and received feedback and ideas from each other regarding how to overcome the challenges. The post-regional collaborative call survey results revealed that MCMC plans found the discussions to be informative and that they likely would apply the information discussed, share the information with others, and collaborate with other MCMC plans within their same region.

Quality Improvement Conference Technical Assistance Activity

DHCS contracted with HSAG to jointly host and facilitate the 2023 Quality Conference, *Quality & Health Equity Through the Lifecycle: Advancing Whole-Person Quality Improvement*, on October 18, 2023. This in-person conference was held in Sacramento, California.

The conference focused on how to imbed quality and equity within organizations; build partnerships with community organizations; and integrate quality, health equity, and member experiences to improve whole-person care. The conference also provided MCMC plans the opportunity to learn from each other about successful quality improvement collaborations with community partners.

The primary audience for the conference included MCMC staff members involved in quality improvement activities as well as MCMC plan community partners. The secondary audience included DHCS staff members who support and monitor MCMC plans in the areas of contract compliance, performance measurement, and quality improvement. Other DHCS staff members

who work in areas that impact the quality of, timeliness of, and access to care for Medi-Cal members also attended the conference.

Note that planning for this conference began during the review period for this EQR technical report; however, the conference took place and HSAG submitted the conference evaluation report to DHCS outside the review period for this report. While the conference occurred and HSAG submitted the report outside the review period, HSAG includes a summary of the 2023 Quality Conference because the information was available at the time this EQR technical report was produced.

Objective—Quality Improvement Conference Technical Assistance Activity

The objective of the Quality Improvement Conference Technical Assistance Activity is to provide MCMC plans the opportunity to learn up-to-date information regarding quality improvement issues, best practices, and lessons learned. Additionally, the quality conference provides MCMC plans the opportunity to build skills that they can apply in their quality improvement efforts.

Methodology—Quality Improvement Conference Technical Assistance Activity

DHCS and HSAG began logistical planning for the conference in October 2022, which continued up to the event in October 2023. DHCS identified the conference theme; however, to inform DHCS' decisions regarding the content, DHCS and HSAG collaborated to develop an online survey to obtain the plans' input on the topics to be presented at the conference. In January 2023, DHCS sent an email to the MCMC plans to announce the conference and included the online survey link.

DHCS identified MCMC plan staff members who served as panelists for the conference sessions and provided guidance to these panelists regarding the content DHCS wanted them to share. DHCS also encouraged MCMC plan staff members to invite community organization partners to join them on the panels. The structure of the conference was discussion-focused rather than the panelists conducting formal presentations. DHCS staff members moderated the discussions to foster collaboration among the panelists and conference participants. HSAG facilitated all logistics with the panelists as well as for the conference venue.

Quality Conference Content

HSAG created a conference webpage that included the registration link and conference materials. Following is a high-level summary of the conference agenda, including organizations represented on the panels.

- DHCS Welcome and Opening Presentation
- *MCMC Plan Systemic Quality Transformation* Panel Session
  - Health Net Community Solutions, Inc.
  - Inland Empire Health Plan
  - Kern Family Health Care
- *Maternal, Infant, and Reproductive Health: Integrating Quality, Health Equity, and Community Partnerships to Improve Whole-Person Care* Panel Session
  - HealthNet Community Solutions, Inc., with its partner, California Coalition for Black Birth Justice
  - Health Plan of San Joaquin with its partner, San Joaquin County Public Health Services
  - Inland Empire Health Plan with its partner, Riverside University Health System—Public Health
  - Partnership HealthPlan of California with its partner, Enterprise Elementary School District
- DHCS Quality Award Presentation
- *Behavioral Health: Integrating Quality, Health Equity, and Community Partnerships to Improve Whole-Person Care* Panel Session
  - Anthem Blue Cross Partnership Plan with its partner, University of California, San Francisco
  - CalOptima with its partners, Healthcare in Action and Sutter Health
  - Health Plan of San Mateo with its partner, San Mateo County Health
- *MCMC Plans and Community Partnerships: Leveraging Local Resources to Improve Chronic Conditions, Disease Prevention, and Wellness* Panel Session
  - Blue Shield of California Promise Health Plan
  - Gold Coast Health Plan with its partner, St. John's Regional Medical Center, St. John's Hospital Camarillo
  - San Francisco Health Plan with its partner, San Francisco Department of Public Health
- Participant Sharing of Major Take-Aways
- Innovative Poster Award Presentation and DHCS Closing

Continuing Education Units

HSAG obtained approval for continuing education units for:

- Physicians.
- Registered nurses.
- Certified Professionals in Healthcare Quality (CPHQs).
- Certified Health Education Specialists (CHESs) Master CHES.

Evaluation Methodology

Participants were asked to evaluate the overall conference, panel sessions, and the physical environment/logistics. Participants were also given the opportunity to provide open-ended comments related to the conference content, panelists, recommendations for the next conference, and general comments.

The evaluation form provided respondents with a scale to rank each statement. The scale included the following choices:

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Not Applicable (for Physical Environment/Logistics questions 1 and 2 only)

2022–23 Quality Awards Presentation

DHCS presented the following 2022–23 quality awards:

- Quality and Health Equity Achievement Award—Health Plan of San Mateo—High Performance with Greatest Improvement for Measurement Year 2022 Medi-Cal Managed Care Accountability Set Measures
- Certificate of Achievement in recognition of hard work and high achievement on the Bold Goals aggregated quality factor score:
  - CenCal Health—Central Coast Region
  - California Health & Wellness Plan—Southeastern Region
  - Health Plan of San Mateo—San Francisco/Sacramento Region
  - Anthem Blue Cross Partnership Plan—North Mountain Region
  - CalViva Health—San Joaquin Valley Region
  - Kaiser South—Southern Coast Region

Unattended Poster Presentations

DHCS and HSAG requested volunteers from MCMC plans to create posters for unattended poster presentations at the 2023 conference. The poster presentations provided the opportunity for MCMC plans to share about quality improvement interventions, innovations, or initiatives that promote health equity and system-level improvements.

Eleven MCMC plans created posters. Throughout the day, conference attendees reviewed the poster information and had the opportunity to vote for the most innovative poster. Santa Clara

Family Health Plan's poster titled, *Comprehensive Diabetes Management Program*, received the most votes; and DHCS acknowledged this MCMC plan during the Innovative Poster Award Presentation.

Results—Quality Improvement Conference Technical Assistance Activity

The conference drew 206 attendees, of which 153 represented MCMC plans, 31 represented DHCS, and 22 represented other stakeholders. Of the 227 attendees who pre-registered, 188 attended; and 18 individuals registered on-site as walk-in participants.

HSAG issued the following number and type of CEUs:

- 31 physician
- 21 registered nurse
- 12 CPHQ
- 12 CHES

Of the 206 conference participants, 110 (53 percent) submitted a completed or partially completed conference evaluation form when exiting the conference. Note that 83 of the 110 participants who completed or partially completed the conference evaluation form (76 percent) were MCMC plan staff members, 19 (17 percent) were DHCS staff, and eight (7 percent) were stakeholders.

Conclusions—Quality Improvement Conference Technical Assistance Activity

Overall, the feedback from respondents about the 2023 Quality Conference was positive. Most evaluation respondents indicated that as a result of participating in the conference, they gained knowledge and skills to apply to their quality improvement work to advance whole-person care and would recommend the conference to other staff members at their organizations who work in quality improvement and health equity.

While the majority of evaluation respondents indicated that the structure of the day had an appropriate balance of panel sessions and opportunities to engage with others and found the fireside chat style of the panel discussions engaging and conducive for learning, some DHCS and MCMC plan respondents noted that they did not find the conference structure and panel format conducive to their learning. While some MCMC respondents did not think that enough time was allocated for panel sessions and lunch, most MCMC respondents and all DHCS and other organization respondents indicated that enough time was allocated.

Most evaluation respondents indicated that the panel sessions met the stated learning objectives and provided positive comments about the content of the sessions as well as the panelists.

Open-ended responses were generally positive, and respondents provided constructive feedback about the conference as well as recommendations to DHCS for future conferences.

Based on the conference evaluation results, discussion during the DHCS and HSAG debrief meeting, and HSAG's observations, HSAG provided DHCS with a list of items for DHCS' consideration when planning future conferences.

16. Follow-Up on Prior Year's EQR Recommendations

External Quality Review Recommendations for DHCS

In the *2021–22 Medi-Cal Managed Care Technical Report*, HSAG made no recommendations to DHCS as part of the EQR. Note that throughout the review period, HSAG made recommendations to DHCS as part of various analytic activities it conducts for DHCS. In conversations with HSAG about completed and new analytic activities, DHCS has indicated to HSAG that it reviews and takes HSAG's recommendations into account when planning future analytic activities, making policy changes, and determining guidance to provide to MCMC plans for the plans' quality improvement efforts.

External Quality Review Recommendations for MCMC Plans

DHCS provided each MCMC plan an opportunity to summarize actions taken to address recommendations HSAG made in the *2021–22 Medi-Cal Managed Care Technical Report*. In *Volume 2 of 6 (Appendix C)* of this EQR technical report, HSAG includes each MCMC plan's self-reported follow-up on the 2021–22 EQR recommendations as well as HSAG's assessment of the self-reported actions. HSAG also includes in *Appendix C* its recommendations for each MCMC plan based on the 2022–23 EQR.