CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES: INDEPENDENT ACCESS AND INTERIM IMPROVEMENT REPORT

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

CONTENTS

EXECUTIVE SUMMARY

Background

On December 29, 2021, the Centers for Medicare & Medicaid Services (CMS) approved a renewal of California's 1915(b) waiver titled California Advancing and Innovating Medi-Cal[1] for January 1, 2022, to December 31, 2026, and authorized a consolidation of the following four managed care delivery systems into this single waiver authority: Medi-Cal Managed Care (MCMC), Dental Managed Care (Dental MC), Specialty Mental Health Services (SMHS), and the Drug Medi-Cal Organized Delivery System (DMC-ODS). The renewed waiver enabled California to add new populations into managed care and to change the number and configuration of plans per county. To ensure sufficient oversight of member access under these changes to Medi-Cal, the CMS Special Terms and Conditions (STCs) required a work plan and three independent assessment reports of access to care under the waiver. The first of these three reports is the Independent Access and Interim Improvement Report (Interim Report). It includes an assessment of access to care during calendar year 2022 and provides recommendations for standardizing and improving access monitoring, as required by STCs A2, A6, A7, and C24.

Interim report methodology

The Interim Report is a baseline analysis of access to care across the four service delivery systems using data from calendar year 2022. To guide the access assessment, the California Department of Health Care Services (DHCS) first developed an access framework that includes five core domains informing the selection of measures for access monitoring. The framework supports DHCS' aim to standardize and streamline access monitoring by measuring the same access domains (Table ES1) for all four delivery systems using the same measures across delivery systems when possible.

Table ES1. Access to care domains

Member characteristics: population needs and demand for services
Provider availability and accessibility: the supply and distribution of providers and the accommodations made for members
Service use: utilization and quality of services
Member experience: members' ability to navigate the health care system, obtain timely care, receive culturally competent care, and their satisfaction with access to care
Member outcomes: access-related population health outcomes

[1] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-appvl-ltr.pdf.

The Interim Report employs a cross-sectional analysis methodology with different comparison strategies (Table ES2). Because the Interim Report is a baseline report with a single year of data, results of the analysis should be interpreted with caution and considered hypothesis-generating to inform efforts to improve Medi-Cal members' access to care.

Table ES2. Interim Report cross-sectional analysis methods

Analysis method	Description
Comparisons of plans by county size to a comparison value	This analysis shows plan-level values, with results grouped by county size (rural, small, medium, large, other).[2] The results are presented in relation to a comparison value that is either the state plan median performance or minimum performance standards as DHCS defines.
Comparison of plans within a given county	For counties with multiple Medicaid plans, this analysis shows how plans perform on a measure within a specific county. This analysis allows for comparison across plans that share a common member and provider population. The benchmark value for comparison is the top performing plan in each county.

[2] County sizes are defined by using these geographic distinctions made in the DHCS MCMC health plans' annual network certification requirements and All Plan Letter 23-0013. The county size "other" is used when a plan operates in multiple counties of different sizes but does not provide disaggregated rates by county that would allow them to be classified as rural, small, medium, or large.

Analysis method	Description
Baseline disparity analysis	This report includes a baseline analysis of racial and ethnic disparities for a subset of measures. The analysis of plan performance for each race and ethnicity category[3] illustrates which demographic groups experienced the greatest disparities at the 2022 baseline for these measures. The detailed results of these analyses are included in Appendix A. Noteworthy findings from the disparity analyses are described in the findings by delivery system sections of this report.[4, 5] Details of the baseline disparity analysis methodology are included in the methods section of this report.

Key findings by service delivery system

Key findings address (1) overall service delivery system results that provide general insight into access to care across the population; (2) findings by access domain; (3) findings by county size, county or both; and (4) a baseline disparity analysis with findings on a subset of measures to identify disparities and the counties in which they are most prevalent. Detailed results of the analysis are available in Appendix A.

Medi-Cal Managed Care

MCMC is the largest of the four service delivery systems by enrollment[6], with 135 plan-county combinations offering benefits in all 58 California counties through one of six models as of 2022. MCMC covers physical health services, including primary care, specialty care, and non-specialty mental health services.

[3] Race categories include *American Indian or Alaska Native*, *Asian*, *Black or African American*, *Native Hawaiian or Other Pacific Islander*, *White*, *No Race Selection and Hispanic or Latino Ethnicity*, *Some Other Race*, *Two or More Races*, and *Asked But No Answer/Unknown*. Ethnicity categories include *Hispanic or Latino*, *Not Hispanic or Latino*, and *Asked But No Answer/Unknown*.

[4] DHCS is committed to multiple subdimension analyses to evaluate health care inequities. The interim report includes racial and ethnic stratifications, which represents one dimension to identify parts of the health care system in which systemic racism has resulted in health care disparities. DHCS acknowledges that there are many societal forces impacting disadvantaged populations, such as geography, sexual orientation, and gender identity. DHCS is committed to honing the approach to subdimension analyses to answer questions about the intersection of systemic inequities on all populations while maintaining a decided focus on improving access to care for communities of color.

[5] The Bold Goals 50x2025 initiative focuses on improving quality and equity in care in three focus areas described in the DHCS 2022 Comprehensive Quality Strategy: (1) children's preventive care, (2) behavioral health integration, and (3) maternity care. The Bold Goals aim to reduce certain health care disparities and improve overall care by 50 percent by 2025.

[6] While MCMC may be considered the largest of the four service delivery systems by enrollment, all certified eligible Medi-Cal members are eligible to receive benefits from the SMHS and DMC-ODS delivery systems.

State-wide findings by access domain

Provider availability and accessibility

Positive findings include:

- All plans have a primary care member-to-provider ratio within the DHCS standard of 2,000 members per provider, suggesting plans may be contracting with sufficient numbers of primary care providers. (See Section III. Table III.A for more information.)
- The state-wide median rate of members living inside time and distance standards was 100 percent for primary care and OB/GYN care, and 99.1 percent for hospitals, suggesting there are a sufficient number of providers that are located close to members. (See Section III. Table III.A for more information.)

Areas for improvement include:

- DHCS made considerable progress towards the development and implementation of an "active providers" measure that can identify plans whose provider networks are not frequently providing services to members. Early attempts at this measure found the state-wide median plan rate for contracted providers (included on the 274 provider network file) that had zero encounters in 2022 was 51 percent, meaning it was common for less than half of a plan's providers included on the 274 provider file to deliver care within the year. This preliminary finding is not out of line with a study of Medicaid managed care networks in four states that found that care was highly concentrated among a small number of physicians (25 percent of primary care physicians provided 86 percent of the care and 25 percent of specialists provided 75 percent of the care).[7]

  As this measure is based on preliminary analyses, DHCS will continue to refine the measure, including exploring the provider types most commonly listed on the 274 provider network file but not appearing in encounters, the impact of encounter completeness[8], the impact of including dually eligible members, and

[7] Research shows it is common in Medicaid managed care networks that a small number of providers deliver the majority of services provided, indicating the need for states to audit for "ghost" networks (in-network providers treating 0 Medicaid individuals). For more information, see https://health.uconn.edu/pepper-center/wp-content/uploads/sites/272/2024/01/ludomirsky-et-al-2022-in-medicaid-managed-care-networks-care-is-highly-concentrated-among-a-small-percentage-of.pdf.

[8] For more information on encounter data completeness, see https://www.dhcs.ca.gov/dataandstats/reports/Documents/2022-23-Encounter-Data-Validation-Study-Report.pdf.

patterns in provider types included in encounter data that are not listed in the provider network file. (See Section III, Table III.A for more information.)[9]

Service use

Positive findings include:

- Most health plans met or exceeded the Medi-Cal Managed Care Accountability Set (MCAS) minimum performance level for timely prenatal and postpartum care, immunizations for adolescents, and for follow-up after an emergency department visit for alcohol or other drug abuse within 30 days. (See Section III, Table III.D for more information.)

Areas for improvement include:

- Many plans fell short of the MCAS minimum performance level for child and adolescent well-care visits, well-child visits in the first 15 and 30 months of life, and childhood immunization status, potentially suggesting the need for broader access to children's primary care. (See Section III, Table III.D for more information.)

Member experience

Positive findings include:

- Member responses to questions on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[10] survey suggested that most adults and children[11] served in the MCMC system were getting care when they needed it and received care quickly.[12] The state-wide median rates of adults and children indicating that they got needed care and got care quickly exceeded the CMS Core Sets median national rate for both measures, with even the lowest-performing county's rates outperforming the national median, indicating high performance relative to other states. (See Section III, Table III.E for more information.)

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[9] Most plans had providers included in encounter data that were not listed in the 274 provider network files. This suggests the 274 provider network file is not inclusive of all plan providers. Additional analyses are being conducted to understand the scope and trends in active providers not included in the 274 (for example, by provider type). DHCS will follow up with plans to improve the completeness of this data file. For more information, see Section IV. Recommendations For Standardizing and Improving Access Monitoring.

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

[11] The CAHPS survey defines adults as ages 18 and older and children as ages zero through 17.

[12] These findings were consistent across plans. The state-wide median rate for getting needed care was 77 percent for adults and children. The state-wide median rate for getting care quickly was 73 percent for adults and 80 percent for children.

- For each provider type, the state-wide median plan rate for "days to next available nonurgent appointment" is within the DHCS timely access standard, suggesting the majority of health plan networks have providers offering timely appointments. (See Section III. Table III.G for more information.)

Areas for improvement include:

- While the state-wide median plan rate for "days to next available nonurgent appointment" is within the DHCS timely access standard, there are plans where the average number of days to the next available appointment is significantly above the standard, suggesting targeted performance improvement may be necessary for specific plans. The maximum plan rate was highest for outpatient mental health child appointments and OB/GYN adult appointments. (See Section III. Table III.G for more information.)
- Member responses to the CAHPS survey suggested that they experienced low satisfaction with transportation help; fewer than 20 percent of adults and 12.5 percent of children said health plan assistance with transportation met their needs. This could suggest improvements to transportation benefits are needed. (See Section III, Table III.E for more information.)

Member outcomes

Notable findings include:

- Nearly all plans had similar rates, between 1 and 5 percent, of primary care avoidable emergency department visits. These results suggest members state-wide had consistent patterns of accessing emergency departments for conditions that could have been avoided by using primary care. (See Section III, Table III.H for more information.)

Baseline disparity analysis

The baseline disparity analysis identified the following measures and groups where the highest percentage of plans performed below the state-wide goal:

- *White* racial/ethnic group for child and adolescent well-care and well-child visits in the first 30 months of life, and timely postpartum care[13]

[13] When measures identify the *White* population as having the largest disparity, this reflects other forms of inequity (for example socioeconomic status) but does not minimize the impact of systemic racism. DHCS is committed to honing the approach to subdimension analyses to answer questions about the intersection of systemic inequities on all populations while maintaining a decided focus on improving access to care for communities of color.

- *Black or African American* racial/ethnic group for well-child visits in the first 15 months of life and timely prenatal care

Disparities in this plan-level assessment aligned with state-wide disparities identified in the DHCS 2022 Health Disparities Report. (See Section III, Table III.J for more information.)

Dental Managed Care

Dental MC is the smallest of the four service delivery systems and offers benefits in two counties: Los Angeles and Sacramento Counties. Dental MC plans cover all medically necessary dental services that primary care dentists, specialty care dentists, and other dental providers (such as safety net clinics) provide.

Findings by access domain

Provider availability and accessibility

Positive findings include:

- All plans have a member-to-provider ratio within the DHCS standard of 1200 members per provider. This shows there is a sufficient number of dental providers. (See Section III, Table III.L for more information.)
- Nearly all members live within time and distance standards of a dental provider, with no plans below 99 percent for this measure, suggesting there are a sufficient number of providers that are located close to members. (See Section III, Table III.L for more information.)
- In all plans, more than 80 percent of providers accept new patients, suggesting most members should be able to find a provider and receive a timely appointment. (See Section III, Table III.L for more information.)

Areas for improvement include:

- DHCS made considerable progress towards the development and implementation of an "active providers" measure that can identify plans whose provider networks are not frequently providing services to members. Early attempts at this measure found the plan range for contracted providers included in the Provider Network Report who had zero encounters during 2022 was 5.2 to 30.5 percent. This suggests that the Provider Network Report may be over-estimating the size of plan networks. This preliminary finding is not out of line with a study of Medicaid managed care networks in four states that found that care was highly concentrated among a small number of physicians (25 percent of

primary care physicians provided 86 percent of the care and 25 percent of specialists provided 75 percent of the care).[14]

As this measure is based on preliminary analyses, DHCS will continue to refine the measure, including exploring the provider types most commonly listed on the Provider Network Report but not appearing in encounters and patterns in provider types included in encounter data that are not listed in the provider network file. (See Section III, Table III.L for more information.)

Service use

Areas for improvement include:

- In all plans, fewer than 50 percent of adults and children received annual dental visits, and the preventive-service-to-fillings ratio was less than one, meaning that members received more care to treat dental issues than for preventive reasons. These results suggest that most members are not receiving recommended dental care and may only seek care when dental problems arise. (See Section III, Table III.J for more information.)
- Measures for child members outperform the same measure calculated for adult members across both counties[15] for annual dental visits and preventive-services-to-fillings ratio. This suggests there is room for improvement in adults accessing preventive dental care. (See Section III. Table III.M for more information.)

Member experience

Positive findings include:

- In all plans, providers' next available appointments are on average within 1 to 14 days, suggesting most members should be able to receive a timely appointment. (See Section III, Table III.N for more information.)

Areas for improvement include:

[14] Research shows it is common in Medicaid managed care networks that a small number of providers deliver the majority of services provided, indicating the need for states to audit for "ghost" networks (in-network providers treating 0 Medicaid individuals). For more information, see https://health.uconn.edu/pepper-center/wp-content/uploads/sites/272/2024/01/ludomirsky-et-al-2022-in-medicaid-managed-care-networks-care-is-highly-concentrated-among-a-small-percentage-of.pdf.

[15] Most dental measures in the Interim Report with child and adult rates define children as ages 0 through 20 and adults as ages 21 and older. See Section III. and Appendix A. for more details.

- Measures for child members outperform the same measure calculated for adult members across both counties[16] for "usual source of dental care" and "continuity of dental care." This suggests there are opportunities for improvement in adults accessing dental care. (See Section III, Table III.M for more information.)

Member outcome

Areas for improvement include:

- Across all plans in Sacramento and Los Angeles counties, more than 60 percent of dental-care related emergency department visits were for non-traumatic dental conditions. This indicates members had consistent patterns of accessing emergency department care for primary care preventable dental conditions. (See Section III. Table III.O for more information.)

Baseline disparity analysis

- The highest percentage of health plans performed below the state-wide goal for "avoidable dental emergency department visits" for the following racial/ethnic groups: *American Indian and Alaskan Native*, *Black or African American*, and *Not Hispanic or Latino*.

Specialty Mental Health Services

The SMHS delivery system offers mental health benefits in all 58 California counties. Although MCMC covers non-specialty mental health services, county mental health plans cover specialty mental health services, which include outpatient mental health care, residential treatment services, psychiatric facility or hospital services, case management, crisis intervention, and medication support services.

State-wide findings by access domain

Provider availability and accessibility

Positive findings include:

- The majority of plans were compliant with the DHCS standard for psychiatric member-to-provider ratios for both adults and children, suggesting plans may be contracting with a sufficient number of psychiatric providers. (See Section III. Table III.Q for more information.)
- The state-wide median rate of members living inside time and distance standards was 99.9 percent for outpatient mental health for both adults and

[16] Most dental measures in the Interim Report with child and adult rates define children as ages 0 through 20 and adults as ages 21 and older. See Section III. and Appendix A. for more details.

children, suggesting there are a sufficient number of providers that are located close to members. (See Section III. Table III.R for more information.)

Areas for improvement include:

- The majority of plans were non-compliant with the DHCS standard for outpatient mental health member-to-provider ratios for both adults and children, suggesting plans may not be contracting with a sufficient number of outpatient mental health providers. (See Section III. Table III.Q for more information.)

Service use

Positive findings include:

- State-wide median plan rates indicate that most members are receiving key coordination of care services such as step-down services after an inpatient discharge within 10 days for children and 15 days for adults,[17] and roughly two-thirds of follow-up appointments occur within 30 days after emergency department visit for mental illness. This suggests plans are ensuring adequate follow-up with their members. (See Section III, Table III.S for more information.)

Areas for improvement include:

- Average mental health case management service utilization varies considerably between adults and children, with a state-wide median plan rate of 280 minutes for children and 432 minutes for adults. These variances could represent different needs between the populations or potential issues with access to care that need further exploration. (See Section III, Table III.T for more information.)

Notable findings include:

- State-wide, the median penetration rate (defined as member receiving one service in 2022) was 5.3 percent for adults and 4.9 percent for children[18], and the median engagement rate (member received five services in 2022) was 3.5 percent for adults and 3.7 percent for children. These measures capture members receiving SMHS out of all members enrolled in MCMC instead of limiting to those requiring SMHS. DHCS is exploring alternative methodologies to better capture these measures. (See Section III, Table III.S for more information.)

[17] SMHS measures such as "time between inpatient discharge and stepdown services" and "mental health case management service utilization" define an adult as ages 21 and older and a child as ages zero through 20.

[18] SMHS measures such as "penetration rate" and "engagement rate" define an adult as ages 21 and older and a child as ages zero through 20.

Member experience

Positive findings include:

- Members reported high general satisfaction with SMHS among service utilizers, with a state-wide median plan rate of 91.9 percent for adults and 91.5 percent for children[19] who indicated they were satisfied with SMHS. (See Section III, Table III.T for more information.)

Member outcome

Areas for improvement include:

- Plans have a wide range of rates of psychiatric readmissions within 7 days and 30 days, though the state-wide median for each measure is skewed towards lower readmission rates. This suggests there may be room for improvement within the few plans with higher rates. (See Section III. Table III.U for more information.)

Baseline disparity analysis

The baseline disparity analysis identified the following measures and groups where the highest percentage of plans performed below the state-wide goal:

- *Asian* racial/ethnic group for penetration rates, engagement rates and accessibility of SMHS (adult).
- *White* racial/ethnic group for accessibility of SMHS[20] (adult).[21]
- *Black or African American* racial/ethnic group for accessibility of SMHS (adult).
- *No Race Selection and Hispanic or Latino Ethnicity* racial/ethnic groups for accessibility of SMHS (adult).

Although the baseline disparity analysis identifies the measure and racial/ethnic group with the highest percentage of plans below the goal, measures such as SMHS penetration and engagement rates also include two additional racial/ethnic groups that had more than 50 percent of state-wide health plans that were below the goal: *Native Hawaiian or Other Pacific Islander* and *No Race Selection and Hispanic or Latino Ethnicity*. (See Section III. Table III.W for more information.)

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[19] The Consumer Perception Survey defines adults as ages 18 through 59 and children as ages thirteen through 17.

[20] Accessibility of SMHS is measured by the Consumer Perception Survey question asking the how strongly respondents agree with the statement "The location of services was convenient."

[21] When measures identify the *White* population as having the largest disparity, this reflects other forms of inequity (for example socioeconomic status) but does not minimize the impact of systemic racism. DHCS is committed to honing the approach to subdimension analyses to answer questions about the intersection of systemic inequities on all populations while maintaining a decided focus on improving access to care for communities of color.

Drug Medi-Cal Organized Delivery System

DMC-ODS offers health benefits for substance use and treatment services in 37 California counties (as of 2022). DMC-ODS is an optional delivery system that counties may select to provide services for substance use disorder (SUD) under managed care. Covered services for DMC-ODS include outpatient treatment, hospitalization, residential treatment programs, care coordination, narcotic treatment, withdrawal management, and medications for addiction.

State-wide findings by access domain

Provider availability and accessibility

Positive findings include:

- The state-wide median rate of members living inside time and distance standards was 99.2 percent for adults and 96.3 percent for children, suggesting there are a sufficient number of providers that are located close to members. (See Section III. Table III.X for more information.)

Areas for improvement include:

- The state-wide plan median member-to-provider ratio for adults was 71 members per provider, though plans ranged from 6 to 225 members per provider. This range suggests targeted performance improvement may be necessary for specific plans. (See Section III. Table III.X for more information.)
- There was a wider range in performance on accessibility of services for children compared to adults. While more plans had 100 percent satisfaction with accessibility for children (8 plans for children, compared to 1 plan for adults), the lowest-performing plans for children have notably lower success rates than the lowest-performing plans for adults. This suggests more room for improvement in access for children. (See Section III. Table III.X for more information.)

Service Use

Areas for improvement include:

- The state-wide median plan rate for the DMC-ODS penetration rate (defined as member receiving one service in 2022) is 1.1 percent and the engagement rate (defined as member received five services in 2022) is 0.9 percent. This suggests that there is little difference between the rate of members who initiate treatment and the rate of members who remain engaged in treatment. Although these rates indicate low utilization, these measures capture members receiving DMC-

ODS out of all members enrolled in MCMC instead of limiting to those requiring DMC-ODS services.[22] DHCS is exploring alternative methodologies to better capture these measures. (See Section III, Table III.Y for more information.)

Member experience

Areas for improvement include:

- In general, satisfaction with children's services varied more than satisfaction for adults. Although more plans had 100 percent satisfaction for children (4 plans had 100 percent satisfaction for children, compared to 1 plan for adults), the lowest-performing plans for children had notably lower satisfaction rates than the lowest-performing plans for adults (64 percent satisfaction rate for children, compared to 79 percent satisfaction rate for adults). This potentially suggests more room for improvement in access for children. (See Section III, Table III.Z for more information.)

Member outcomes

Areas for improvement include:

- State-wide, plans have more variation in the success of SUD treatment rates for children than they do for adults. [23] Plans were more likely to report that 100 percent of their members responded that their health improved after treatment for children (two plans for children had a 100 percent success rate, compared to one plan for adults). However, the lowest-performing plans for children had notably lower success rates than the lowest-performing plans for adults (64 percent success rate for children, compared to 75 percent success rate for adults). This potentially suggests more room for improvement in access for children. (See Section III, Table III.AA for more information.)

Baseline disparity analysis

The baseline disparity analysis identified the following measures and groups where the highest percentage of plans performed below the state-wide goal:

- *Asian* racial/ethnic group for DMC-ODS penetration rate and accessibility of SUD[24] services (adult)

[22] Nationally, an estimated 12 percent of individuals enrolled in Medicaid have an SUD. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/substance-use-disorders/index.html

[23] The Treatment Perception Survey defines adults as ages 18 and older and children as ages 12 through 17.

[24] Accessibility of SUD is measured by the Treatment Perception Survey question asking the how strongly respondents agree with the statement "The location was convenient."

- *White* racial/ethnic group for accessibility of SUD services (adult)[25]
- *Black or African American* racial/ethnic group for accessibility of SUD services (adult)
- *No Race Selection and Hispanic or Latino Ethnicity* racial/ethnic groups for DMC-ODS engagement rate and accessibility of SUD services (adult). (See Section III, Table III.AC for more information.)

Recommendations

Measure and data alignment

1. Continue to standardize provider network files across service delivery systems. DHCS should move forward with its plan to enable more standardized provider-related measures of access, as outlined in the State Work Plan. (See page 101 for more details.)

2. Align secret shopper and revealed caller studies across service delivery systems. As DHCS works to ensure compliance with the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule, which requires states conduct annual secret shopper surveys, DHCS should explore ways to ensure comparable data is collected across delivery systems.[26] DHCS could also consider working to align survey methodologies, such as the provider types included, with the Department of Managed Health Care's provider appointment survey, to the extent that is in compliance with the Access, Finance, and Quality Final Rule, to enable comparisons with non-Medi-Cal managed care plans. (See page 101 for more details.)

3. Align member surveys across survey delivery systems. DHCS could explore the potential of a single survey for all four delivery systems. If this is not feasible, DHCS could explore options for closer alignment of survey questions. (See page 101 for more details.)

4. Standardize and expand use of member-to-provider ratio logic across service delivery systems. DHCS could consider standardizing its approach to the application of full-time equivalent logic to accurately report providers' availability within provider ratio measures across all delivery systems. (See page 102 for more details.)

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[25] When measures identify the *White* population as having the largest disparity, this reflects other forms of inequity (for example socioeconomic status) but does not minimize the impact of systemic racism. DHCS is committed to honing the approach to subdimension analyses to answer questions about the intersection of systemic inequities on all populations while maintaining a decided focus on improving access to care for communities of color.

[26] The secret shopper provision of the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule has an effective date of July 9, 2028. For more information, see https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

Data improvements and measure refinement

5. Require plans to report plan-county rates. To receive more granular and actionable information, DHCS could consider requiring its health plans to collect and report plan county-level data from CAHPS[27] and the Healthcare Effectiveness Data and Informational Set (HEDIS®).[28] This consideration should include whether county-plan measure rates would have denominators that are too small to be actionable. (See page 102 for more details.)

6. Improve provider data for enhanced subcontractor monitoring. First, DHCS could explore whether it is possible to incorporate subcontractor entity into claims and encounter data without impacting standard 837 file transmissions. Second, DHCS could consider developing a unique list of subcontracted entities operating in Medi-Cal. Subcontracted entities could have unique IDs that could be tracked across plans as well as providers connected to those plans. DHCS could consider requiring health plans to update subcontractor details continuously like provider data. (See page 103 for more details.)

7. Improve provider data to accurately collect providers' spoken languages. DHCS could further explore and correct data issues in provider network files, such as the 274 file, to more accurately collect providers' spoken languages. This could include standardizing providers' responses to languages spoken across health plans and using the same language code set between provider data and the Medi-Cal enrollment data. (See page 103 for more details.)

8. Improve data on provider network for each plan. The **"**active provider" measure compares the number of providers included in the 274 provider file (for MCMC), Provider Network Report (for Dental MC), and the NACT file (for SMHS and DMC-ODS) with encounter data to determine the percentage of providers who are actively serving members. The measure can assist DHCS in identifying plans that may meet time and distance standards, for example, but whose provider networks are not frequently providing services to members. Early efforts to calculate this measure highlighted that not all providers identified in encounter data are included in the 274, Provider Network Report, and NACT files. DHCS could conduct analyses of the 274 file, the Provider Network Report, and the NACT file, and encounter data to determine where misalignment in provider participation is occurring. (See page 104 for more details.)

[27] CAHPS is a program of AHRQ, U. S. Department of Health and Human Services.

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

9. Capture the SMHS and DMC-ODS population more accurately. DHCS could continue to explore new approaches to calculating SMHS and DMC-ODS penetration and engagement rates, for example by applying updated prevalence rates for serious mental illness or substance use disorder to the measure denominator or utilizing claims to develop refined denominators that reflect the estimated share of total MCMC members who need these services. (See page 104 for more details.)

Alignment with strategic initiatives

10. Further align with DHCS Health Equity Roadmap. DHCS could continue to align approaches and methodologies for access monitoring with initiatives associated with the DHCS Health Equity Roadmap; for example, deploying standard approaches to race and ethnicity stratifications such as alignment with federal standards.[29] (See page 105 for more details.)

11. Expand measures that address Culturally and Linguistically Appropriate Services standards. DHCS could explore whether the 274 provider data or other sources of provider network data, such as licensure boards, could be used to collect data to support additional measures of accessibility, for example. (See page 105 for more details.)

Enhancements to performance standards

12. Consider expansion of minimum performance standards and goals for individual performance measures. DHCS could consider whether it is appropriate to set additional minimum performance standards and goals for metrics across service delivery systems to better reflect its strategic objectives and goals. DHCS may consider ways to align minimum performance standards with other state initiatives, such as the DHCS value-based payment program.[30] (See page 106 for more details.)

13. Revisit minimum performance standards and goals based on current performance. DHCS could explore whether minimum performance levels are appropriate or should be raised for measures for which most plans have met the goal, such as timely prenatal and postpartum care. (See page 106 for more details.)

Performance improvement activities

14. Conduct targeted performance improvement initiatives informed by key findings on access to care. DHCS could prioritize key findings for each service delivery

[29] For information on the Office of Management and Budget's Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, see https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and.

[30] https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx

system in the Interim Report and conduct quality assurance activities with individual plans or performance improvement initiatives in the counties where issues are more prevalent. (See page 106 for more details.)

I. INTRODUCTION AND BACKGROUND

Overview of California Advancing & Innovating Medi-Cal and the 1915(b) waiver

The California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to transform the Medi-Cal program through delivery system and payment reform to become a more equitable, coordinated, and person-centered system. CalAIM prioritizes prevention, applies a population health approach, and addresses social drivers of health. The program is authorized in part by federal waivers from the Centers for Medicare & Medicaid Services (CMS) related to managed care delivery systems.

Before January 2022, the California Department of Health Care Services (DHCS) operated four managed care delivery systems. Three of these systems—Medi-Cal Managed Care (MCMC), Dental Managed Care (Dental MC), and the Drug Medi-Cal Organized Delivery System (DMC-ODS)—operated under a 1115 demonstration. The fourth system—Specialty Mental Health Services (SMHS)—operated under 1915(b) waiver authority.

On December 29, 2021, CMS approved a renewal of California's 1915(b) CalAIM waiver[31] for the period from January 1, 2022, through December 31, 2026, and authorized a consolidation of all four managed care delivery systems into this single waiver authority.

CMS Special Terms and Conditions (STCs) for monitoring access within the 1915(b) waiver will create a broader and deeper understanding of access within the state's Medicaid managed care program and will result in increased accountability, improved data collection and analysis, and greater transparency into network adequacy and timely access.

CalAIM requirements for access monitoring and reporting

The renewed 1915(b) waiver enabled California to add additional populations into managed care and to change the number and configuration of managed care plans per county. To ensure sufficient oversight of member access under these changes to Medi-Cal, the STCs require a work plan describing methods for monitoring and oversight of all four delivery systems. The waiver STCs also require DHCS to submit three reports for public posting on DHCS' website:

- Independent Access and Interim Improvement Report (Interim Report)

[31] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-appvl-ltr.pdf.

- Medi-Cal Managed Care Plan (MCP) Access Report for Multiple Lines of Business
- Final Access Improvement Results Report

This Interim Report is the first of the three CMS-required reports. It evaluates access to care across the four delivery systems and provides recommendations for improving access monitoring.

The Medi-Cal MCP Access Report for Multiple Lines of Business will compare access to care for Medi-Cal beneficiaries to access among individuals in private insurance and Medicare Advantage plans. The Final Access Improvement Results Report will document any improvements in access across the four delivery systems that occurred since the publication of the Interim Report.

Independent access and interim improvement report

This Interim Report provides an assessment of access to care and recommendations for standardizing and improving access monitoring across California's four delivery systems, meeting the requirements of the CalAIM 1915(b) waiver STCs A6, A7, and C24:

- MCMC
- Dental MC
- SMHS
- DMC-ODS

The report includes recommendations for (1) improving the measurement and monitoring of member access and (2) standardizing access monitoring and compliance processes across delivery systems, as required by the State Work Plan for Access Improvement. It also includes the subcontractor network analysis required by STC A2.

The Interim Report draws on data concerning members, provider capacity and availability, service utilization and realized access, and member experience, in addition to other data sources. The report is a baseline analysis of access to care across the four service delivery systems in calendar year 2022.

Medi-Cal member population

DHCS is working to make Medi-Cal, the health coverage program serving one in three Californians, more effective at meeting the health needs of its members. Medi-Cal covers a diverse group of Californians. Compared to the national average among Medicaid members, Medi-Cal members are more likely to report Hispanic ethnicity, Asian or Pacific Islander race, and a primary language other than English.

Table I.A. Medi-Cal population at a glance

	Medi-Cal population	National Medicaid average
Female	53%	54.1%
Children (ages 0-17)	31%	42.7%
Adults aged 65 or older	10%	7.3%
Hispanic	51%	28%
Asian or Pacific Islander	9.3%	5.5%
Primary language other than English	35%	10.6%

Note: National averages are as of 2021. California averages include data as of July 2023.

Note: National averages reflect Medicaid enrollment in states that expanded eligibility to childless adults as well as states that did not expand Medicaid. Some differences in Medicaid population composition can be attributed to expansion status.

Sources: California Department of Health Care Services, Medi-Cal Monthly Eligible Fast Facts (October 2023) https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-July2023.pdf.

Data brief representing 50 Medicaid state agencies: https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/2020-race-etncity-data-brf.pdf.

Data brief representing 37 Medicaid state and territories: https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/prmary-lang-data-brf.pdf.

2023 Medicaid and CHIP Beneficiary Profile: Enrollment, Expenditures, Characteristics, Health Status, and Experience: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2023.pdf.

Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.

Health equity

The diversity among Medi-Cal beneficiaries makes it imperative to measure and monitor equitable access to care. To ensure access to quality, equitable, person-centered health care for underserved groups, California has a broader health equity strategy, called the Health Equity Roadmap Initiative, to guide DHCS' initiatives. The CalAIM waiver and Comprehensive Quality Strategy, including the Bold Goals: 50x2025 initiative, are some facets of this larger strategy. To align with this roadmap, this Interim Report includes a baseline analysis of potential disparities based on racial and ethnic stratifications. In addition, future reports will aim to incorporate other roadmap elements, such as analyses of compliance with Culturally and Linguistically Appropriate Services (CLAS) standards as they are implemented. Other elements of the roadmap include establishing the Medi-Cal Member Advisory Committee, creating a practice transformation program for primary care providers, making Medi-Cal available regardless of immigration status, solely using income to determine eligibility (eliminating the asset test requirement), and not requesting asset information for purposes of estate recovery.

DHCS is committed to multiple subdimension analyses to evaluate health care inequities. The interim report includes racial and ethnic stratifications, which represents one dimension, to identify parts of the health care system in which systemic racism has resulted in health care disparities. DHCS acknowledges that there are many societal

forces impacting disadvantaged populations, such as geography, sexual orientation, and gender identity. When measures identify the *White* population as having the largest disparity, this reflects other forms of inequity (for example, socioeconomic status) but does not minimize the impact of systemic racism. DHCS is committed to honing the approach to subdimension analyses to answer questions about the intersection of systemic inequities on all populations while maintaining a decided focus on improving access to care for communities of color.

Overview of delivery systems

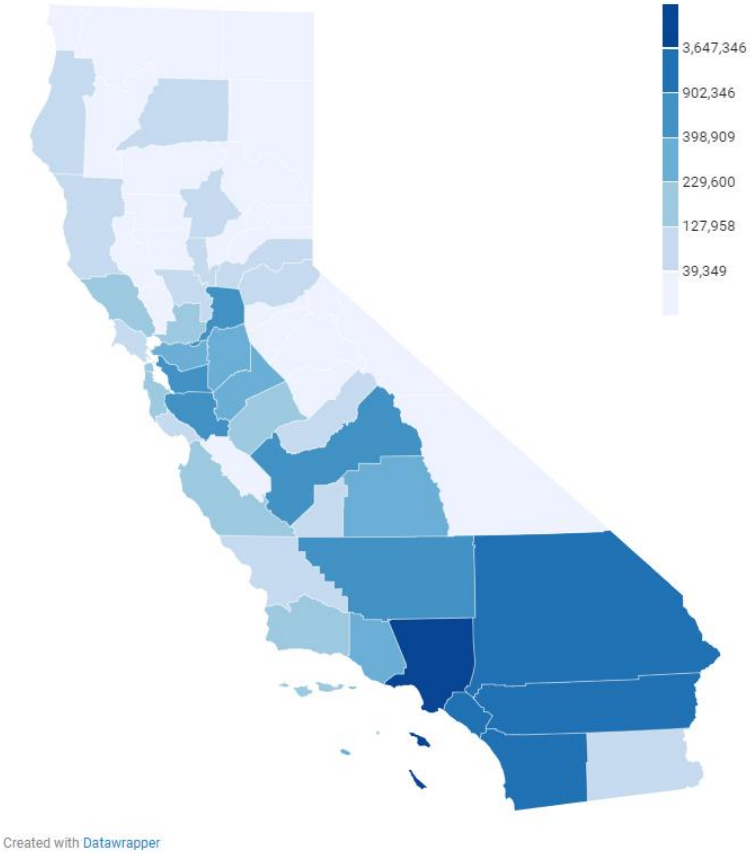
Medi-Cal Managed Care

MCMC is the largest of the four service delivery systems by enrollment, serving 94 percent of Medi-Cal certified eligibles,[32] offering benefits in all California counties through one of six models as of 2022. About half of MCMC members are female and report Hispanic ethnicity (Table I.B). Nearly one-third of MCMC members have a primary language other than English.

MCMC member enrollment varies significantly by county (Figure I.A), with the smallest counties (Alpine and Sierra) having fewer than 700 members and the largest county (Los Angeles) having over 3.6 million members. This is consistent with the large variation in total population across counties.

[32] https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal-at-a-Glance-Apr2024.pdf

Figure I.A. Total MCMC members by county



Source: California DHCS enrollment data for calendar year 2022. Results represent the average of 12 months of enrollment.

Table I.B. Demographics of MCMC members

Value	Percentage
Age	
0-5	9.4%
6-11	12.2%
12-20	18.9%
21–44	32.7%
45–64	18%
65-74	5.3%
>= 75	3.4%
Sex	
Female	53.2%
Male	46.8%
Primary language	
English	69.6%
Spanish	23.8%

Value	Percentage
Vietnamese	1.5%
Cantonese	0.9%
Mandarin	0.7%
Other	0.7%
Armenian	0.6%
Korean	0.4%
Russian	0.4%
Arabic	0.3%
Farsi	0.3%
Tagalog	0.3%
Unknown	0.2%
Hmong	0.1%
Cambodian	0.1%
American Sign Language	<0.1%
Race and ethnicity	
No Race Selection and Hispanic or Latino Ethnicity	42.2%
White	22.7%
Asian	8.8%
Unknown	8.1%
Black or African American	7.5%
Other	7.3%
Two or More	1.7%
Native Hawaiian or Other Pacific Islander	1.2%
American Indian or Alaska Native	0.5%
Ethnicity	
Not Hispanic or Latino	52.0%
Hispanic or Latino	48.0%
Immigration status	
Satisfactory immigration status	93.8%
Unsatisfactory immigration status	6.1%
Unknown documentation status	0.1%

Source: California DHCS enrollment data for calendar year 2022. Results represent the average of 12 months of enrollment.

Note: Beginning May 1, 2022, a new law in California gives full scope Medi-Cal to adults 50 years of age or older, regardless of immigration status. All other Medi-Cal eligibility rules, including income limits, still apply.[33]

[33] More information on Medi-Cal Older Adult Expansion can be found at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/OlderAdultExpansion.aspx.

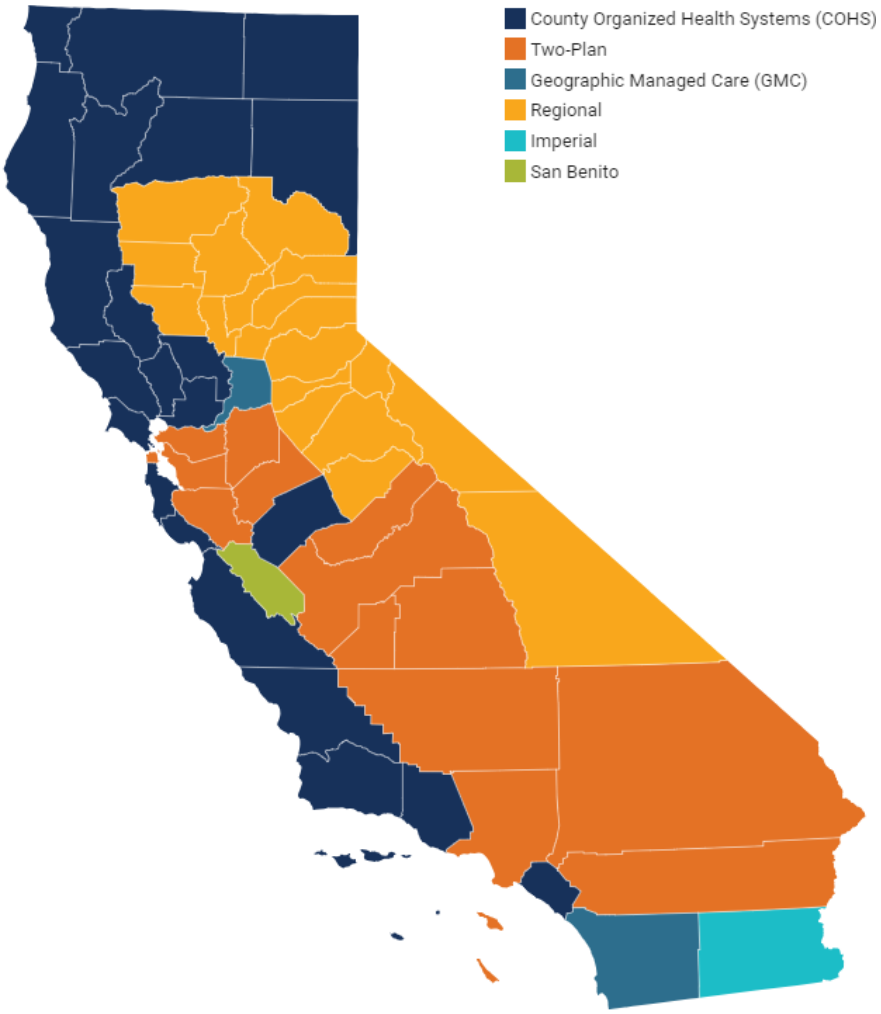
Models

As of 2022, all 58 counties offered MCMC through one of six models:

- County organized health system (COHS): DHCS contracts with a single Medi-Cal plan run by a county government entity, such as a county board of supervisors or other local health authority.
- Two-plan model: DHCS contracts with a single commercial plan as well as a single county-run plan.
- Regional model: DHCS contracts with two or more commercial plans serving two or more contiguous rural counties.
- Geographic managed care (GMC): DHCS contracts with multiple commercial plans within a single county.
- San Benito model: DHCS contracts with a single commercial plan and provides a fee-for-service (FFS) option. DHCS sunsetted this model in 2023.
- Imperial model: DHCS contracts with two commercial plans. DHCS sunsetted this model in 2023.

The MCMC model may impact members' access to care in a given county. This Interim Report attempts to control for regional variability by grouping counties and evaluating access within those groups (see the Methodology section for more information).

Figure I.B. MCMC models as of 2022



Covered services

MCMC covers physical health services, including primary care, specialty care, and non-specialty mental health services, serving more than 12.6 million Californians in all 58 counties in 2022.[34] The capitation payment to managed care plans includes physician services, inpatient and outpatient hospital services, immunizations, hospice care, radiology, and vision care. In 2022, the CalAIM waiver carved out pharmacy benefits and the Multipurpose Senior Services Program state-wide, and carved out SMHS for members in Solano and Sacramento Counties.

Covered populations

The 1915(b) waiver renewal expanded the populations required to enroll in MCMC. Before 2022, managed care plan enrollment was voluntary for several populations who

[34] For more information on MCMC, see https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.

could choose instead to receive benefits through Medicaid FFS coverage. Other populations were not eligible for managed care.

Table I.C. Changes in MCMC enrollment status for Medi-Cal population groups

Population	Enrollment status in MCMC before 2022	Enrollment status in MCMC after 2022
American Indians and Alaskan Natives	Voluntary	Voluntary in some counties
Dual eligibles (eligible for both Medicaid and Medicare)	Voluntary	Mandatory in 2023[35]
Beneficiaries in San Benito County	Voluntary	Mandatory
Beneficiaries in non-COHS counties who live in rural zip codes	Ineligible	Mandatory
Beneficiaries in non-COHS counties who have coverage other than Medi-Cal	Ineligible	Mandatory

COHS = County Organized Health System.

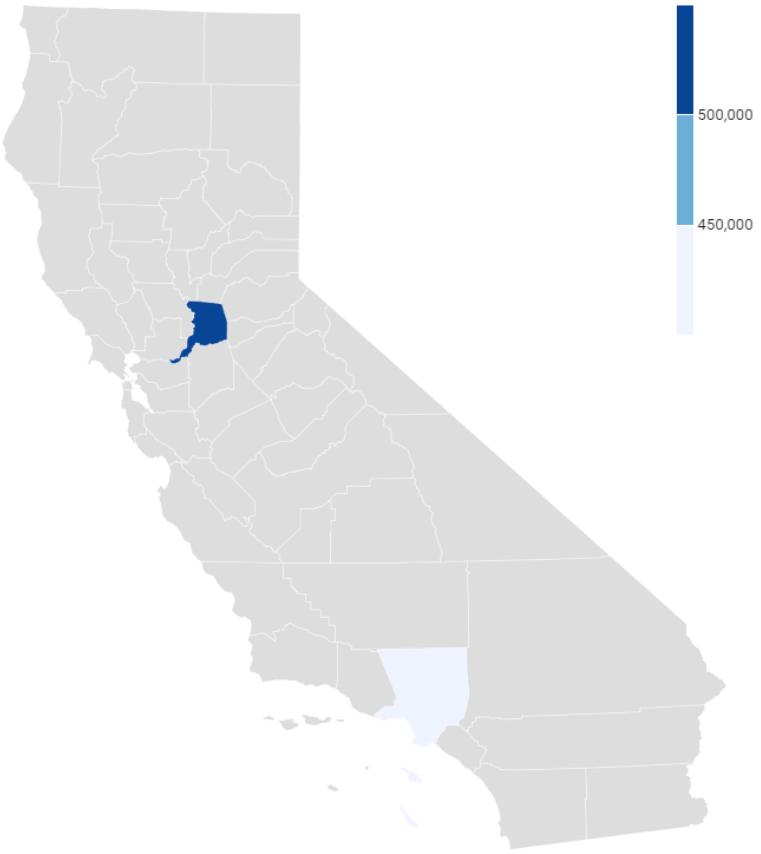
Dental Managed Care

Dental MC is the smallest of the four service delivery systems and offers benefits in two California counties. About half of Dental MC members in 2022 were female, over one-third are children (ages 0 to 20), and over one-third report Hispanic ethnicity. Nearly one-quarter of members had a primary language other than English in 2022.

Dental MC member enrollment is highest in Sacramento County (Figure I.C), with over 500,000 members in 2022, followed by Los Angeles County, with fewer members because the program is voluntary.

[35] For dual eligible members who opt to enroll in a Medicare Advantage plan, including a dual eligible special needs plan (D-SNP), DHCS will align these members' Medi-Cal MCP enrollment with their Medicare Advantage plan enrolment whenever possible to allow for greater integration and coordination of care. Source: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915bWaiver-CA-0017-R10-01-Application.pdf.

Figure I.C. Total Dental MC members by county



Source: California DHCS enrollment data for calendar year 2022.

Table I.D. Demographics of Dental MC members

Value	Percentage
Age	
0-5	8.4%
6-11	10.9%
12-20	17.1%
21-44	36.7%
45-64	20%
65-74	5.1%
>= 75	1.8%
Sex	
Female	53.2%
Male	46.8%
Primary language	
English	76.2%
Spanish	14.3%

Value	Percentage
Other	2%
Russian	1.9%
Vietnamese	1.1%
Cantonese	0.9%
Mandarin	0.7%
Farsi	0.6%
Hmong	0.5%
Armenian	0.4%
Arabic	0.4%
Korean	0.3%
Tagalog	0.3%
Unknown	0.1%
Cambodian	0.1%
American Sign Language	<0.1%
Race and ethnicity	
No Race Selection and Hispanic or Latino Ethnicity	30.7%
White	20.5%
Other	14.1%
Black or African American	12.9%
Asian	11.3%
Unknown	6.1%
Two or More	2.0%
Native Hawaiian or Other Pacific Islander	1.9%
American Indian or Alaska Native	0.5%
Ethnicity	
Not Hispanic or Latino	65.2%
Hispanic or Latino	34.8%

Source: California DHCS enrollment data for calendar year 2022. Results represent the average of 12 months of enrollment.

Models

DHCS offers Dental MC in two counties: Sacramento and Los Angeles. Sacramento County uses a GMC model, whereas Los Angeles County offers prepaid health plans.

Covered services

Dental MC plans cover all medically necessary dental services that primary care dentists, specialty care dentists, and other dental providers (such as safety net clinics) provide. Specialty care includes endodontists, oral surgeons, orthodontists, pedodontists,

periodontists, and prosthodontists. Covered services include preventive care (for example, x-rays and cleanings), restorative care (for example, fillings and crowns), and major dental care (for example, root canals, scaling, and dentures). Medi-Cal covers up to $1,800 per year in covered dental services, though this limit does not apply to medically necessary dental services or individuals who are pregnant or under 21 years old.

Covered populations

In Sacramento County, members must enroll in Dental MC, with some exceptions. Populations in Sacramento County that were not allowed to enroll in Dental MC as of 2022 include those with presumptive eligibility, non-citizen pregnancy-related individuals, and incarcerated individuals. Individuals in Los Angeles County, minus the same exceptions as Sacramento County, had the option to enroll in Dental MC as of 2022.

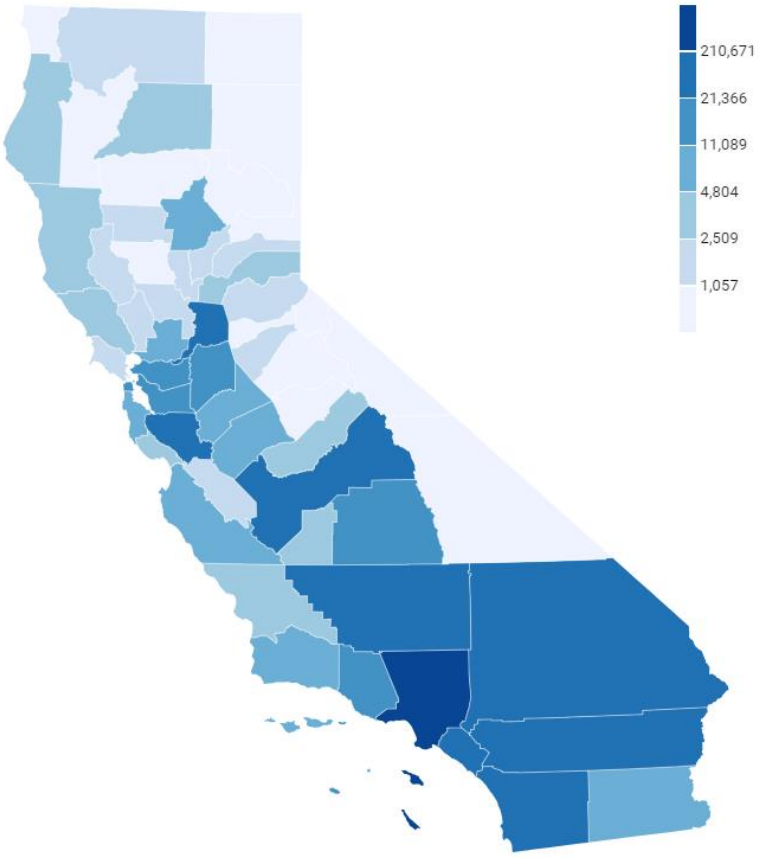
In 2022, MCMC covered dental services in San Mateo County. DHCS provides dental FFS care in the remaining counties, as well as to members in Los Angeles County who do not opt in to Dental MC, and to Kaiser members in San Mateo County. Dental MC provides the same coverage as Dental FFS.

Specialty Mental Health Services

The SMHS delivery system offers mental health benefits in all California counties. As of 2022, about half of SMHS members were female and nearly one-third reported Hispanic ethnicity. Most SMHS members reported English as their primary language; only 12 percent reported another primary language.

SMHS member enrollment varies significantly by county with the smallest counties (Alpine and Sierra) having fewer than 100 members and the largest county (Los Angeles) having over 200,000 members (Figure I.D). This is consistent with the large variation in total population across counties.

Figure I.D. Total SMHS members by county



Source: California DHCS enrollment data for calendar year 2022.

Table I.E. Demographics of SMHS members

Value	Percentage
Age	
0-5	3.2%
6-11	12.6%
12-20	28.9%
21-44	29.6%
45-64	20.6%
65-74	4.2%
>= 75	0.9%
Sex	
Female	52.2%
Male	47.8%
Primary Language	
English	81.2%
Spanish	15.6%

Value	Percentage
Unknown	0.7%
Vietnamese	0.2%
Cantonese	0.3%
Other	0.2%
Armenian	0.2%
Farsi	0.1%
Arabic	0.1%
Mandarin	0.2%
Cambodian	0.1%
Russian	0.1%
Korean	0.1%
Hmong	0.1%
Tagalog	0.1%
American Sign Language	<0.1%
Race/Ethnicity	
No Race Selection and Hispanic or Latino Ethnicity	33.9%
White	28.3%
Black or African American	12.5%
Unknown	11.6%
Other	6.4%
Asian	3.6%
Two or More	2.0%
Native Hawaiian or Other Pacific Islander	0.8%
American Indian or Alaskan Native	0.8%
Ethnicity	
Not Hispanic or Latino	60.1%
Hispanic or Latino	39.9%

Source: California DHCS enrollment data for calendar year 2022. Results represent the average of 12 months of enrollment.

Models

There are 56 county mental health plans (MHPs) covering California's 58 counties. There are two joint-county arrangements—one between Sutter and Yuba Counties and one between Placer and Sierra Counties—with the remaining counties each having their own MHP.

Covered services

Although MCMC covers non-specialty mental health services, county MHPs cover outpatient mental health care, residential treatment services, psychiatric facility or hospital services, case management, crisis intervention, and medication support services. Through the current 1915(b) waiver, DHCS added peer support specialist services to SMHS for counties that choose to make this available.

Covered populations

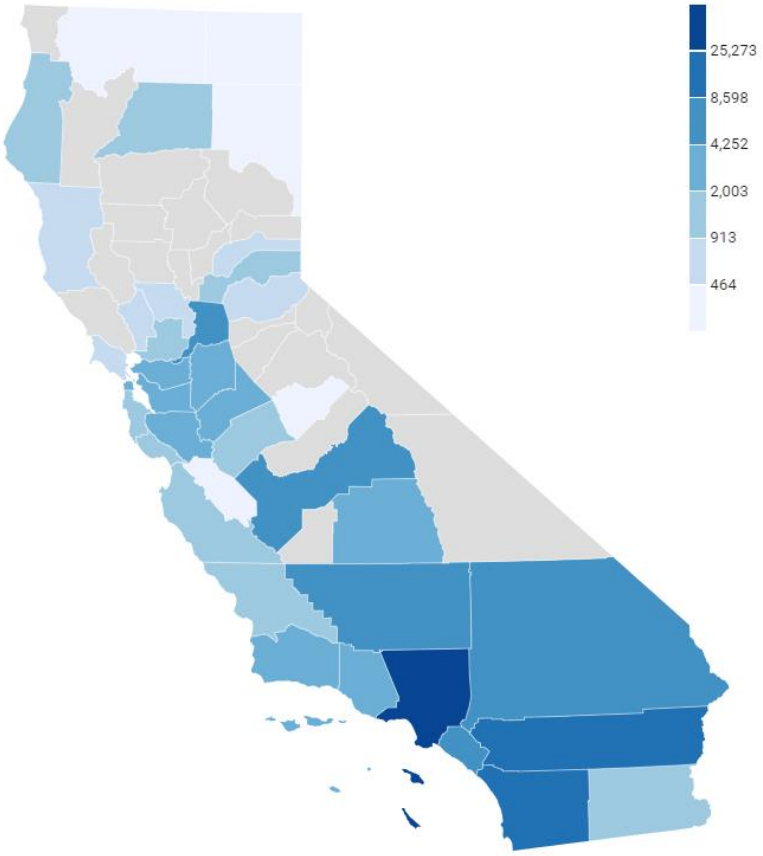
Members must meet certain criteria to be eligible for SMHS. Individuals 21 years or older must have a diagnosed or suspected mental health disorder and either significant functional impairment or a reasonable probability of deterioration in impairment. Children younger than 21 are eligible for SMHS if they are at a high risk for having a mental health disorder due to trauma, as evidenced by involvement in the child welfare system, involvement in the juvenile justice system, experiencing homelessness, or scoring in a high-risk range on a trauma screening tool. They may also be eligible for SMHS if they have significant trauma or a diagnosed or suspected mental health disorder and either significant functional impairment, a reasonable probability of impairment, a reasonable probability of not developing appropriately, or a need for specialty mental health services that MCMC plans do not provide.

Drug Medi-Cal Organized Delivery System

DMC-ODS offers mental health benefits in 37 California counties (as of 2022). Nearly three-fifths of DMC-ODS members were male as of 2022, most were working-age adults, and nearly one-third reported Hispanic ethnicity. Only 4 percent of DMC-ODS members had a primary language other than English.

DMC-ODS member enrollment varies significantly by county, with the smallest counties (Lassen, Mariposa, and Modoc) having fewer than 100 members and the largest county (Los Angeles) having over 25,000 members (Figure I.E). This is consistent with the large variation in total population across counties.

Figure I.E. Total DMC-ODS members by county



Source: California DHCS enrollment data for calendar year 2022.

Table I.F. Total DMC-ODS members by demographic breakouts

Value	Percentage
Age	
0-5	<0.1%
5-11	<0.1%
12-20	5.3%
21-44	64.2%
45-64	28.6%
65-74	1.9%
>= 75	0.1%
Sex	
Female	39.5%
Male	60.5%
Primary Language	
English	95.8%
Spanish	3.7%

Value	Percentage
Unknown	0.1%
Other	0.1%
Hmong	0.1%
Armenian	0.1%
Vietnamese	<0.1%
Russian	<0.1%
Farsi	<0.1%
American Sign Language	<0.1%
Arabic	<0.1%
Tagalog	<0.1%
Cambodian	<0.1%
Korean	<0.1%
Cantonese	<0.1%
Mandarin	<0.1%
Race/Ethnicity	
White	38.3%
No Race Selection and Hispanic or Latino Ethnicity	25.3%
Unknown	14.3%
Black or African American	9.3%
Other	7.7%
Two or More	2.2%
Asian	1.2%
American Indian or Alaskan Native	1.1%
Native Hawaiian or Other Pacific Islander	0.5%
Ethnicity	
Not Hispanic or Latino	68.5%
Hispanic or Latino	31.5%

Source: California DHCS enrollment data for calendar year 2022. Results represent the average of 12 months of enrollment.

Models

As of 2022, 37 of California's 58 counties had implemented DMC-ODS, with the majority administering the service delivery system through a single county health plan model. One Regional Model serves Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano Counties.

Covered services

DMC-ODS is an optional delivery system that counties may select to provide services for substance use disorder (SUD) under managed care. Covered services for DMC-ODS include outpatient treatment, hospitalization, residential treatment programs, care coordination, narcotic treatment, withdrawal management, and medications for addiction. The current 1915(b) waiver gives counties the option to offer peer support specialist services.

Covered populations

Like SMHS, members must meet certain diagnostic criteria to be eligible for DMC-ODS services. Members aged 21 years or older must have a diagnosed substance-related disorder or have previously been diagnosed with a substance-related disorder before or during incarceration. For members under age 21, DMC-ODS plans must cover all medically necessary SUD services in accordance with early and periodic screening, diagnostic, and treatment statutes and regulations.

II. METHODOLOGY SUMMARY

Access to care monitoring domains

DHCS developed a framework to define the core concepts of access to care and to inform selection of measures for monitoring access. The framework supports DHCS' aim to standardize and streamline access monitoring by measuring the same access domains for all four delivery systems and using the same measures across delivery systems when possible. To develop its access framework, DHCS considered frameworks that CMS uses, the Medicaid and CHIP Payment and Access Commission, other federal health agencies, and researchers studying health services. (See Appendix D for a detailed description of the methodology followed in developing the access framework and selecting measures.) The framework includes five domains of access to care:

- **Member characteristics:**[36] population needs and demand for services
- **Provider availability and accessibility**: the supply and distribution of providers and the accommodations made for members
- **Service use**: utilization and quality of services
- **Member experience**: members' ability to navigate the health care system, obtain timely care, receive culturally competent care, and their satisfaction with access to care
- **Member outcomes**: population health outcomes

Within each access domain, DHCS further identified subdomains and selected measures for each delivery system that were feasible to calculate, actionable, and aligned with DHCS' needs. (See Appendix D for more information on the subdomains and measure selection process.)

Findings overview

Each domain has a series of performance measures that create a baseline understanding of member access to care in the four delivery systems. For each performance measure, Appendix A of the Interim Report includes charts displaying plan performance and a brief description of results. Within the body of this Interim Report, each Key Findings section includes a narrative analysis synthesizing findings across access measures and

[36] This report uses member characteristic measures, such as the number and demographics of members, will be used in this report for informational purposes only and will not be used in the assessment of access to care.

domains. Table II.A compares material presented in the body of the report to details presented in the Appendix.

Table II.A. Comparison of key findings in the report narrative and Appendix A

	Key findings	Appendix A: Detailed Assessment of Access to Care
What is included?	Narrative description of access to care findings summarizing potential access issues identified in Appendix A (Detailed Assessment of Access to Care) across multiple performance measures and domains	Over 110 individual performance measure charts, each of which includes analysis and highlights potential access issues
What does it tell us?	Key findings that are informed by multiple performance measures	Details about a specific performance measure
How can it be used?	Taking informed steps to: • Further substantiate or remediate potential access issues with health plans • Inform access monitoring standardization, alignment, or improvement	Understanding details about specific performance measures

Cross-sectional analysis

The report narrative and Appendix A include three types of cross-sectional analyses:

Comparisons of plans by county size to a comparison value ("county size analysis")

» This analysis shows plan-level values, with results grouped by county size (rural, small, medium, large, other[37]), as defined by DHCS for MCMC health plans' annual network certification requirements[38] and All Plan Letter 23-001,[39] and presented in relation to a comparison value representing DHCS' expectation of performance.[40] This value will either be the California state plan median performance or, when available, the minimum performance standard from the

[37] County sizes are defined by using these geographic distinctions made in the DHCS MCMC health plans' annual network certification requirements and All Plan Letter 23-0013, which are based on population density categories. The county size "other" is used when a plan operates in multiple counties of different sizes but does not provide disaggregated rates by county that would allow their classification as rural, small, medium, or large.

[38] For more information on DHCS' network adequacy standards, see https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAStandards3-26-18.pdf.

[39] For more information, see https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-001.pdf and https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/Att-A-APL-23-001-NAU.pdf

[40] Dental MC measures do not include this type of analysis because the delivery system is only available in two counties.

Managed Care Accountability Set (MCAS) documented in the MCMC External Quality Review Technical Report July 1, 2022–June 30, 2023. Each chart also displays a box indicating plans falling between the 25th and 75th percentiles.

Comparison of plans within a given county ("internal county analysis")

» For counties with multiple Medicaid plans, this analysis shows how plans perform on a measure within a specific county.[41] This analysis allows for comparison across plans that share common member and provider populations, and other factors unique to receiving Medicaid services in the county. In this analysis, the benchmark value for comparison is the top performing plan in each county. Each chart also displays state-wide 25th and 75th percentile values.

Comparison of plans by racial and ethnic group ("baseline disparity analysis")

» This report includes a baseline analysis of disparities by racial and ethnic groups for twelve measures (see Table II.B). Appendix A includes plan-level values for each of these measures by race and ethnicity category for all plans in the state. Each Appendix chart displays the state-wide average for the measure along with the target for each race and ethnicity category calculated based on the goal of reducing disparities by 50 percent by 2025. Noteworthy findings from the disparity analyses are described in the above key findings by delivery system section of this report and in greater detail below in Section III. DHCS analyzed disparities by race and ethnicity only for a limited number of priority measures for this baseline analysis (for example, measures included in DHCS' Bold Goals) but anticipates that the number and breadth of measures included in the disparities analysis may increase in future years.[42]

Table II.B. Measures included in baseline disparity analysis by delivery system

Delivery System	Measure
MCMC	Child and Adolescent Well-Care Visits
MCMC	Postpartum Care
MCMC	Prenatal Care
MCMC	Well-Child Visits in the First 15 Months of Life
MCMC	Well-Child Visits in the First 30 Months of Life

[41] SMHS and DMC-ODS measures do not include this type of analysis because there is only one plan per county.

[42] The Bold Goals 50x2025 initiative focuses on improving quality and equity in care in three focus areas described in the DHCS 2022 Comprehensive Quality Strategy: (1) children's preventive care, (2) behavioral health integration, and (3) maternity care. The Bold Goals aim to reduce certain health care disparities and improve overall care by 50 percent by 2025.

Delivery System	Measure
Dental	Avoidable Dental ED Visits
SMHS	Accessibility of SMHS
SMHS	Engagement Rate
SMHS	Penetration Rate
DMC-ODS	Accessibility of DMC-ODS Services
DMC-ODS	Engagement Rate
DMC-ODS	Penetration Rate

DHCS explored testing for statistical significance between plan rates and the benchmark value for comparison. Due to large sample sizes, small differences were considered statistically significant, even in cases where there was not a meaningful difference between the plan's performance and the benchmark value. To limit the analysis to information that is useful and actionable, DHCS omitted statistical significance from Appendix A.

Medicare and Medicaid dually eligible members

The inclusion of members dually eligible for Medicare and Medicaid varies by measure. The plans calculated and reported many of the measure rates included in this analysis directly to DHCS based on specifications from different measure stewards, including AHRQ, NCQA, and CMS. For measures that DHCS calculated (for example, based on encounter data), or where DHCS otherwise had access to individual-level data to calculate plan rates, dually eligible members were included as follows:

- To accurately capture enrollment, dually eligible members were ***included in*** measures of member characteristics based on enrollment data.
- Dually eligible members were ***included in*** measures of provider availability and accessibility, such as member-to-provider ratios.
- Dually eligible members were ***excluded from*** some service use, member experience, and member outcome measures. The plans calculated most measures in these three domains, and may have not consistently included or excluded duals in these measures.
- Dual-only health plans were ***excluded from*** analyses because DHCS did not have access to comparable data to calculate many measures for these individuals who received care primarily provided via Medicare.

III. ASSESSMENT OF ACCESS TO CARE KEY FINDINGS

Medi-Cal Managed Care

This section describes key findings for the MCMC delivery system, looking across 36 access measures for calendar year 2022.[43] It includes five parts: (1) a summary of findings, (2) findings by access domain, (3) findings by county size, (4) a baseline disparity analysis with findings on a subset of measures to identify disparities and the counties in which they are most prevalent, and (5) analysis of subcontractor measures.

Summary of findings

Access to care in the MCMC service delivery system is variable throughout the state with no single county or county size showing the best results across all access domains.

State-wide findings

Provider availability and accessibility

Positive findings include:

- All plans have a primary care member-to-provider ratio within the DHCS standard of 2,000 members per provider. The state-wide median rate of members living inside time and distance standards was 100 percent for primary care and OB/GYN care, and 99.1 percent for hospitals. This shows there is a sufficient number of providers that are located close to members.
- The state-wide median rate of members living inside time and distance standards was 100 percent for primary care and OB/GYN care, and 99.1 percent for hospitals. This shows there is a sufficient number of providers that are located close to members.

Areas for improvement include:

- DHCS made considerable progress towards the development and implementation of an "active providers" measure that can identify plans whose provider networks are not frequently providing services to members. Early attempts at this measure found the state-wide median plan rate for contracted

[43] Findings presented in this chapter summarize the detailed measure results included in Appendix A. For each measure, Appendix A includes plan rates by county size, a description of plan performance by county size, and a table listing plans that performed below the comparison value (either the state-wide median or state benchmark). Illustrative data points from Appendix A are incorporated throughout this chapter.

providers (included on the 274 provider network file) that had zero encounters in 2022 was 51 percent, meaning it was common for less than half of a plan's providers included on the 274 provider file to deliver care within the year. This preliminary finding is not out of line with a study of Medicaid managed care networks in four states that found that care was highly concentrated among a small number of physicians (25 percent of primary care physicians provided 86 percent of the care and 25 percent of specialists provided 75 percent of the care).[44]

As this measure is based on preliminary analyses, DHCS will continue to refine the measure, including exploring the provider types most commonly listed on the 274 provider network file but not appearing in encounters, the impact of encounter completeness[45], the impact of including dually eligible members, and patterns in provider types included in encounter data that are not listed in the provider network file.

Most plans had providers included in encounter data that were not listed in the 274 provider network files. This suggests the 274 provider network file is not inclusive of all plan providers. Additional analyses are being conducted to understand the scope and trends in active providers not included in the 274 (for example, by provider type). DHCS will follow up with plans to improve the completeness of this data file. For more information, see Section IV. Recommendations For Standardizing and Improving Access Monitoring.

Service use

Positive findings include:

- Most health plans met or exceeded the MCAS minimum performance level for timely prenatal and postpartum care, immunizations for adolescents, and for "follow-up after emergency department visit for alcohol or other drug abuse within 30 days."

Areas for improvement include:

[44] Research shows it is common in Medicaid managed care networks that a small number of providers deliver the majority of services provided, indicating the need for states to audit for "ghost" networks (in-network providers treating 0 Medicaid individuals). For more information, see https://health.uconn.edu/pepper-center/wp-content/uploads/sites/272/2024/01/ludomirsky-et-al-2022-in-medicaid-managed-care-networks-care-is-highly-concentrated-among-a-small-percentage-of.pdf.

[45] For more information on encounter data completeness, see https://www.dhcs.ca.gov/dataandstats/reports/Documents/2022-23-Encounter-Data-Validation-Study-Report.pdf.

- Many plans continued to fall short of the MCAS minimum performance level for "child and adolescent well-care visits," "well-child visits in the first 15 and 30 months of life," and "childhood immunization status."

Member experience

Positive findings include:

- The majority of adults and children served in the MCMC system indicated that they were getting needed care and getting care quickly. The state-wide median rates of adults and children indicating that they got needed care and got care quickly exceeded the median national rate for both measures, with even the county at the bottom of the state-wide range outperforming the national median.
- For each provider type, the state-wide median plan rate for "days to next available nonurgent appointment" is within the DHCS timely access standard, suggesting the majority of health plan networks have providers offering timely appointments.

Areas for improvement include:

- While the state-wide median plan rate for "days to next available appointment" is within the DHCS timely access standard, there are plans where the average number of days to the next available appointment is significantly above the standard, suggesting targeted performance improvement may be necessary for specific plans. The maximum plan rate was highest for outpatient mental health child appointments and OB/GYN adult appointments.
- Satisfaction with transportation help was low; fewer than 20 percent of adults and 12.5 percent of children said health plan assistance met their needs, which could suggest improvements to transportation benefits are needed.

Member outcomes

Notable findings include:

- Nearly all plans had similar rates of primary care avoidable emergency department visits. These results suggest that members state-wide had consistent patterns of accessing emergency department care, instead of primary care and for conditions that could have been avoided with better primary care access.

Subcontractor analysis

Notable findings include:

- Two MCMC subcontractor network analysis compliance measures have low state-wide medians. This includes plan-level subcontractor timely access compliance rate with a state-wide median rate of 29 percent and plan-level subcontractor time and distance standard compliance rate with a state-wide median rate of 0 percent. These data reflect the first year of DHCS' Subcontractor Network Certification. To enhance monitoring of subcontractor performance, DHCS developed new compliance tools to evaluate the performance of individual subcontractors including reviewing the subcontractor's "active provider" rates and "providers accepting new patients" rates.

Baseline disparity analysis

Notable findings include:

- The baseline disparity analysis identified the following measures and groups where the highest percentage of plans performed below the state-wide goal:
  - *White* racial/ethnic group for child and adolescent well care, well-child visits in the first 30 months of life, and timely postpartum care
  - *Black or African American* racial/ethnic group for well-child visits in the first 15 months of life and timely prenatal care

  Disparities in this plan-level assessment aligned with state-wide disparities identified in the DHCS 2022 Health Disparities Report.

County and county size findings

- There were 20[46] access measures (out of 46 measures total) for which rural counties had the greatest percent of low performing plans, the most of any county size. Rural counties had the greatest percent of low performing plans on the majority of measures in the provider availability and accessibility (seven out of 11) and service use (nine out of 15) domains.

[46] 7b. Members inside primary care time and distance standards (adult 21+); 7b. Members inside primary care time and distance standards (child 0-20); 7a. Members inside hospital time and distance standards; 9. Active providers (provider billing 0 claims); 11. Resolved appeals; 11.1. Resolved appeals in favor of member; 12. Provision of telehealth services; 15. Child and adolescent well-care visits; 16. Well-child visits in the first 30 months of life (15 months); 17. Childhood immunization status (combination 10); 18. Immunizations for adolescents (combination 2); 24. Screening for depression and follow-up plan (ages 12 to 17); 25. Follow-up after hospitalization for mental illness in 7 days; 25. Follow-up after hospitalization for mental illness in 30 days; 26. Follow-up after emergency department visits for mental illness (7 day); 26. Follow-up after emergency department visits for mental illness (30 day); 31. Got help managing care (adult 18+); 31. Got help managing care (child 0-17); 32. Transportation help (adult 18+); 46. Rating of all health care (adult 18+).

- Plans serving large counties comparatively had the worst results in the member outcomes domain for measures such as "Prevention Quality Indicators (PQI) 90: prevention overall composite," "plan all-cause readmissions," and "primary care avoidable emergency department visits."
- Plans serving rural-sized counties performed best on measures in the member outcomes domain, such as "potentially avoidable readmissions" and "primary care treatable emergency department visits," compared to plans in other sized counties.

Findings by access domain

Provider availability and accessibility

This domain includes measures of the supply and distribution of providers and the accommodations made for members; for example, member-to-provider ratios, members living inside time and distance measures, and the percentage of providers accepting new patients. Table III.A below lists each measure in this domain and reports the state-wide performance range and the county size category with the highest number of low-performing plans.

Table III.A. MCMC provider availability and accessibility domain: state-wide performance range and counties with low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min – max)	Comparison value	County size with lowest-performing plans
Supply and distribution of services	Member-to-provider ratio (primary care)	122.6 members per provider	0.1–1652.6 members per provider	State-wide standard	None[47]
Supply and distribution of services	Member-to-provider ratio (specialist)	59.3 members per provider	0–1784.6 members per provider	State-wide standard	Small
Supply and distribution of services	Members living inside primary care time and distance standards (adult 21+)	100 percent	55.4–100 percent	State-wide median plan rate	Rural

[47] All plans were below the standard for primary care member-to-provider ratio.

Subdomain	Measure	State-wide median	State-wide range (min – max)	Comparison value	County size with lowest-performing plans
Supply and distribution of services	Members living inside primary care time and distance standards (child 0-20)	100 percent	54–100 percent	State-wide median plan rate	Rural
Supply and distribution of services	Members living inside OB/GYN time and distance standards	100 percent	84.5–100 percent	State-wide median plan rate	Large
Supply and distribution of services	Members living inside hospital time and distance standards	99.1 percent	6.5–100 percent	State-wide median plan rate	Rural
Supply and distribution of services	Accepting new patients	26.6 percent	0–99.6 percent	State-wide median plan rate	Small
Supply and distribution of services	Active providers (0 encounters)	51 percent	5.5–100 percent	State-wide median plan rate	Rural
Supply and distribution of services	Access to care grievances	0.239 per 10,000 member months	0–13.9 per 10,000 member months	State-wide median plan rate	Medium
Supply and distribution of services	Resolved appeals	0.69 per 10,000 member months	0–11.7 per 10,000 member months	State-wide median plan rate	Rural
Supply and distribution of services	Resolved appeals in favor of member	0.22 per 10,000 member months	0–3.1 per 10,000 member months	State-wide median plan rate	Rural
Supply and distribution of services	Provision of telehealth services	8 percent	0–38.3 percent	State-wide median plan rate	Rural

Note: DHCS analysis found many providers with encounters who were not found in the 274 provider file. This may result in data quality issues impacting member-to-provider ratio, accepts new patients, active providers, and provision of telehealth services. For more information, see Section IV. Recommendations For Standardizing and Improving Access Monitoring.

Source: Provider network report, MIS/DSS enrollment data, time and distance database, claims and encounter data, managed care performance monitoring dashboard report, and 274 provider file. Low-performing plans are defined as those with ratings below the comparison value (state-wide median plan rate or state-wide standard). For measures where low ratings are better, low performance is defined as ratings above comparison rate. Full results are available in Appendix A, pp. 4–45.

- All plans have a primary care member-to-provider ratio within the DHCS standard of 2,000 members per provider.[48] The state-wide median rate of members living inside time and distance standards was 100 percent for primary care and OB/GYN care, and 99.1 percent for hospitals. This shows there is a sufficient number of providers that are located close to members. However, the minimum plan compliance with hospital time and distance standards was 6.5 percent, showing room for improvement in access to hospitals.
- In most cases, counties with the most potential for improvement in "members living within time and distance standards" were not the lowest-performing counties in corollary service use domain measures (for example, "child and adolescent well-care visits" or "childhood immunization status") This suggests that other factors may be driving low utilization. For example, for plans in Los Angeles, Riverside, and San Bernardino Counties, fewer than 100 percent of members lived inside OB/GYN time and distance standards, but no plans were outliers in receipt of timely prenatal care. Plans in San Diego County did have low performance for both "members living inside OB/GYN time and distance standards" and "timely prenatal care." These findings could suggest members' ability to access timely prenatal care in San Diego County may be impacted by differences in the location of services compared to where members reside.
- The state-wide median plan rate for contracted providers included in the 274 provider file that had zero encounters in 2022 was 51 percent, meaning that it was common for less than half of a plan's providers included in the 274 provider file to deliver care within the year.[49] State-wide median plan rates for "active providers" for individual provider types were between 45 to 48 percent for primary care providers, OB/GYNs, and specialists, and the median rate for outpatient mental health providers was 75 percent.

Table III.B. MCMC active providers included in health plans' 274 provider file who had zero encounters: state-wide median plan rate

PCPs	Specialists	OB/GYNs	Outpatient mental health
46 percent	45 percent	48 percent	75 percent

[48] For more information on DHCS' network capacity and ratio standards, see https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-001.pdf.

[49] Most plans had providers included in encounter data that were not listed in the 274 provider network files, suggesting that the 274 provider network files are not inclusive of all plan providers.

- Access to care grievances may be too small[50] to draw meaningful conclusions for most counties; however, several plans operating in Riverside, San Bernardino, San Diego Counties had rates ten times greater than the 75th percentile of all state plan rates, suggesting the need for further investigation.[51]
- The state-wide median plan rate for "resolved appeals" was 0.69 per 10,000 member months, while the state-wide median plan rate for "resolved appeals in the member's favor" was 0.22 per 10,000 member months. These findings highlight that the median plan is resolving one out of every three appeals in the member's favor. It is better to have lower rates of resolved appeals in the member's favor because it means denials were appropriate and did not cause delays in accessing needed care.

Service use

The service use domain, sometimes called realized access, monitors service utilization and the quality of services that the member population receives. For the MCMC service delivery system, service use performance measures include measures of wellness and prevention, maternal health, and coordination of care. Many of the MCMC service use measures had an associated MCAS minimum performance level. Table III.C below lists each measure in this domain and reports the state-wide performance range and the county (or counties) with the highest number of low-performing plans.

[50] The median plan count of access to care grievances that members filed was 72 in all of calendar year 2022.

[51] DHCS believes some plans are mischaracterizing inquiries as grievances. DHCS is working on technical assistance to resolve reporting differences.

Table III.C. MCMC service use domain: state-wide performance range and counties with low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min – max)	Comparison value	County size with lowest-performing plans
Service utilization	Adults' access to preventive/ ambulatory health services	66.5 percent	48.8–79.8 percent	State-wide median plan rate	Large
Service quality	Screening for depression and follow-up plan[52]	4.1 percent	0–51.7 percent	State-wide median plan rate	Rural
Service quality	Follow-up after hospitalization for mental illness (7 days)	67.1 percent	41.3–87.5 percent	State-wide median plan rate	Rural
Service quality	Follow-up after hospitalization for mental illness in (30 days)	79.4 percent	57.9–92.8 percent	State-wide median plan rate	Rural
Service quality	Follow-up after emergency department visits for mental illness (7 day)	34.7 percent	7.7–74.3 percent	State-wide median plan rate	Rural
Service quality	Follow-up after emergency department visits for mental illness (30 day)	46.8 percent	16.3–80.6 percent	State-wide median plan rate	Rural, Large
Service quality	Follow-up after emergency department visit for alcohol or other drug abuse (7 day)	20.5 percent	9.7–35.5 percent	State-wide median plan rate	Medium, Large

Source: Medi-Cal Managed Care Accountability Sets, claims and encounter data, and T-MSIS data. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low

[52] This measure requires depression screening results and follow-ups that are mainly available through electronic health record data which may not be widely available for health plans to use. When data is not available for screening or a follow-up for a member, the measure considers the member to not have had a screening and/or follow-up. The lack of these data may be related to the low performance rates on this measure.

performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 68–98.

Table III.D. MCMC service use domain: MCAS state-wide performance range and counties with low-performing plans

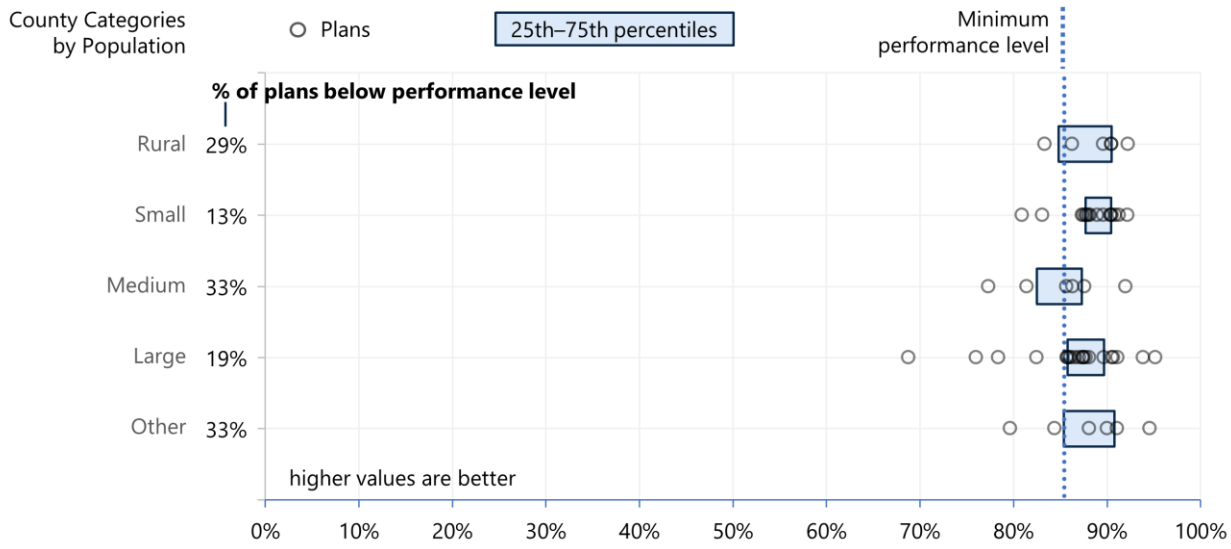
Subdomain	Measure	MCAS minimum performance level	State-wide range (min – max)	Comparison value	County size with lowest-performing plans
Service utilization	Child and adolescent well-care visits	48.9 percent	28.6–60.1 percent	State-wide standard	Rural
Service utilization	Well-child visits in the first 15 months of life (W15)	55.7 percent	19.2–75.7 percent	State-wide standard	Rural
Service utilization	Well-child visits in the first 30 months of life (W30)	65.8 percent	38.4–79.6 percent	State-wide standard	Medium
Service utilization	Childhood immunization status (Combination 10)	34.7 percent	16–57.6 percent	State-wide standard	Rural
Service utilization	Immunizations for adolescents (Combination 2)	35 percent	18.7–63.1 percent	State-wide standard	Rural
Service utilization	Prenatal care	85.4 percent	68.7–95.1 percent	State-wide standard	Medium
Service utilization	Postpartum care	77.3 percent	54.1–95.6 percent	State-wide standard	Medium
Service quality	Follow-up after emergency department visit for alcohol or other drug abuse (30 day)	21.2 percent	15.7–53.4 percent	State-wide standard	Medium

Source: Medi-Cal Managed Care Accountability Sets. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 45–100.

» Health plan performance relative to the MCAS minimum performance level varied. Most health plans met or exceeded the MCAS minimum performance level for timely prenatal and postpartum care (Figure III.A), immunizations for

adolescents, and for "follow-up after emergency department visit for alcohol or other drug abuse within 30 days." Many plans continued to fall short of the MCAS minimum performance level for "child and adolescent well-care visits," "well-child visits in the first 15 and 30 months of life," and "childhood immunization status."

Figure III.A. MCMC prenatal and postpartum care (prenatal care): county size visual



Note: Minimum performance level value is associated with the MCAS documented in the MCMC External Quality Review Technical Report July 1, 2022–June 30, 2023.

Note: For a description of the county size analysis, see Section II. Methodology Summary, page 37.

Source: MCAS.

Member experience

The member experience domain includes measures of members' ability to navigate the health care system, obtain timely care, and receive culturally relevant care, along with their satisfaction with access to care. For the MCMC service delivery system, member experience performance measures include results from the adult and child Consumer Assessment of Healthcare Provider and Systems (CAHPS®)[53] member experience of care survey (Table III.E), and grievances and appointment availability (Table III.F).

[53] MCMC plans administer the CAHPS survey annually. Child measures in this report contain responses from the child's parent or guardian. For more information about CAHPS, see https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html.

Table III.E. MCMC CAHPS adult and child state-wide performance range

Measure	Adult (18+)			Child (0-17)		
	State-wide median	State-wide range	National median	State-wide median	State-wide range	National median
Getting needed care	77.3 percent	65.9–86.8 percent	53.9 percent	77.4 percent	71.4–87.7 percent	60.5 percent
Getting care quickly	73.2 percent	64.3–84 percent	56.2 percent	80.2 percent	70–87.7 percent	70.9 percent
Rating of all health care	73.8 percent	63.7–81 percent	N/A	81.5 percent	76.5–88.5 percent	N/A
Got help managing care among different providers and services	58.2 percent	27.2–74 percent	N/A	59.7 percent	42.3–81.8 percent	N/A
Transportation help	10 percent	3.8–20 percent	N/A	6 percent	2.1–12.5 percent	N/A

Source: Consumer Assessment of Healthcare Providers and Systems. Full results are available in Appendix A, pp. 104–125.

- The majority of adults and children served in the MCMC delivery system indicated that they were getting care when they needed it and received care quickly (Table III.F).
- There was low satisfaction with transportation help; fewer than 20 percent of adults and 12.5 percent of children said health plan assistance met their needs, which could suggest improvements to transportation benefits are needed.
- The state-wide median rates of adults and children who said they got needed care and got care quickly exceeded the national median rate for these measures, with even the lowest-performing county outperforming the national rates, indicating high performance relative to most other states.[54]

[54] For more information on national CAHPS results, see https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html and https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

Table III.F. MCMC member experience domain: state-wide performance range and counties with low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min – max)	Comparison value	County size with lowest-performing plans
Connection to health care system	Continuity of care grievances	0 per 10,000 members months	0–5.2 per 10,000 member months	State-wide median plan rate	Medium
Timeliness of care	Days to next available appointments – nonurgent (adult)	14.9 average days	2.7–52 average days	State-wide median plan rate	Large
Timeliness of care	Days to next available appointments – nonurgent (child)	12.2 average days	1–30 average days	State-wide median plan rate	Medium

Source: Managed care performance monitoring dashboard report and timely access state-wide report. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 100–115.

» Continuity of care grievances were rare events for almost all plans. Two plans – one each in Riverside and San Bernardino Counties – had rates ten times greater than the next highest plan, which may require further investigation.

Table III.G. MCMC member experience domain: compliance with DHCS Timely Access Standards for days to next available appointments – nonurgent

Provider Type	Compliance Standard	State-wide median	State-wide range (min – max)
Primary Care (adult)	14 days	9.5 days	0 – 41 days
Primary Care (child)	14 days	8 days	0 – 41 days
Specialty Care (adult)	21 days	19 days	2 – 52 days
Specialty Care (child)	21 days	18.7 days	1 – 76 days
OB/GYN (adult)	14 days	13.5 days	0 – 92 days
OB/GYN (child)	14 days	11.1 days	0 – 66 days

Provider Type	Compliance Standard	State-wide median	State-wide range (min – max)
Outpatient Mental Health (adult)	14 days	6.2 days	0 – 69 days
Outpatient Mental Health (child)	14 days	6.3 days	0 – 105 days

Note: DHCS compliance standards are measured in business days. Standards were converted to calendar days for the purpose of this analysis.

Source: Timely access state-wide report. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates.

» For each provider type, the state-wide median plan rate for "days to next available nonurgent appointment" is within the DHCS timely access standard. However, there are plans where the average number of days to the next available appointment is significantly above the standard. The maximum plan rate was highest for outpatient mental health child appointments and OB/GYN adult appointments.

Member outcomes

For the MCMC system, there are four measures in the member outcome domain that represent the goal of improved access to care and monitor overall population outcomes (Table III.H).

Table III.H. MCMC member outcome domain: state-wide performance range and counties with low-performing plans

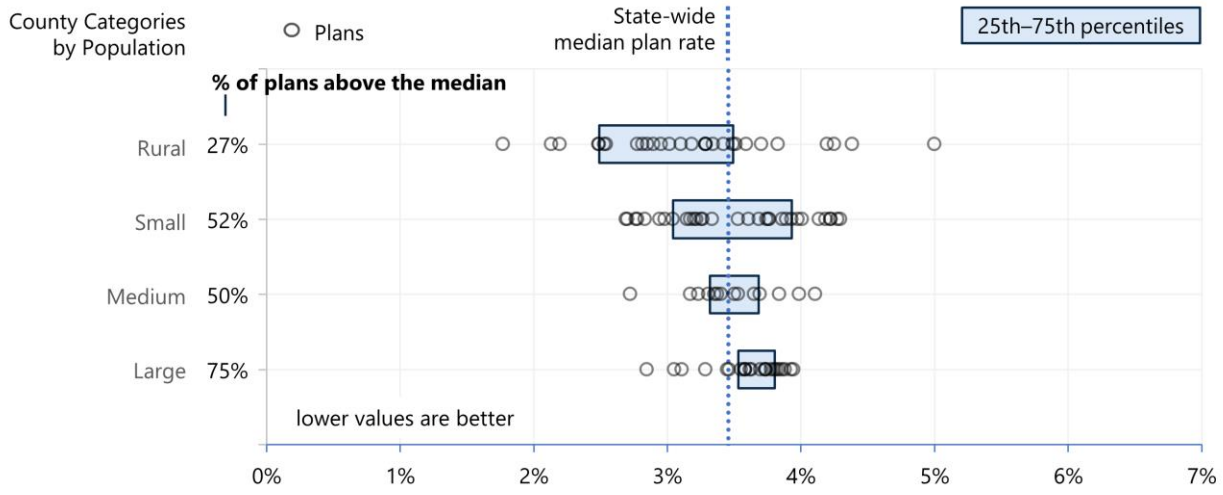
Subdomain	Measure	State-wide median	State-wide range (min – max)	Comparison value	County size with lowest-performing plans
Member outcomes	PQI 90: prevention overall composite	64.1 admissions per 100,000 member months	0–127 admissions per 100,000 member months	State-wide median plan rate	Large
Member outcomes	Plan all-cause readmission	8.8 percent	5.6–16.8 percent	State-wide median plan rate	Large
Member outcomes	Primary care treatable emergency department visits	43.6 percent	26.3–51.1 percent	State-wide median plan rate	Medium

Subdomain	Measure	State-wide median	State-wide range (min – max)	Comparison value	County size with lowest-performing plans
Member outcomes	Primary care avoidable emergency department visits	3.4 percent	1.7–5 percent	State-wide median plan rate	Large

Source: T-MSIS data and Medi-Cal Managed Care Accountability Sets. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 125–139.

» Nearly all plans, regardless of county, had similar rates of "primary care avoidable emergency department visits," as all plans were within a 3.3 percentage point range (Figure III.B). These results suggest members state-wide had consistent patterns of accessing emergency departments for conditions that could have been avoided through accessing primary care.

Figure III.B. MCMC primary care avoidable emergency department visits: county size visual



Note: For a description of the county size analysis, see Section II. Methodology Summary, page 37.

Source: Transformed Medicaid Statistical Information System (T-MSIS) data

» Single plans in Merced and Monterey Counties had rates three times higher than the best performing plan.

» Kings and San Bernardino Counties had low-performing plans for the outcome measures "primary care treatable emergency department visits" and "primary care avoidable emergency department visits." These findings highlight a potential cluster of emergency department utilization that could have been better impacted by accessing primary care.

County size results

This section summarizes findings for each county size group for overall results on the member outcome domain, which is the goal of access to care. Table III.I below lists each measure in the member outcome domain and reports the county size with the highest percentage of plans above and below the state-wide median rate. County size results for other domains can be found in Appendix A.

Table III.I. Summary of Appendix A county size analysis: MCMC member outcome domain

Measure	Percentage of plans below the state-wide standard			
	Rural	Small	Medium	Large
PQI 90: prevention overall composite	30 percent	58 percent	57 percent	63 percent
Plan all-cause readmission	29 percent	44 percent	50 percent	71 percent
Primary care treatable emergency department visits	45 percent	48 percent	57 percent	54 percent
Primary care avoidable emergency department visits	27 percent	52 percent	50 percent	75 percent

Source: T-MSIS data and Medi-Cal Managed Care Accountability Sets. The percentage of plans in each county size category is compared with the state-wide standard (state-wide median, compliance standard or MCAS minimum performance level) to determine the percentage below the standard. For measures where low values are better, the county size analysis determines the percentage of plans in each county size category that are above the state-wide standard. Full results are available in Appendix A, pp. 125–139.

- Plans serving rural counties (Table III.I) comparatively had the best results in the member outcomes domain for all measures.
- Plans serving large counties (Table III.I) comparatively had the worst results in the member outcomes domain for measures such as "PQI 90: prevention overall composite," "plan all-cause readmissions," and "primary care avoidable emergency department visits."

Baseline disparity analysis

The MCMC baseline disparity analysis included five measures (Table III.J). The analysis of plan performance for each race and ethnicity category illustrates which measures and demographic groups experienced the greatest disparities at the 2022 baseline. Future analyses may incorporate additional subdimensions beyond race and ethnicity breakouts, for example income, and sexual orientation and gender identity, which will allow additional exploration of intersectional impacts of factors of oppression.

For each race and ethnicity category, the baseline disparity analysis sets a target that is 50 percent of the disparity between the state-wide median plan value measured for the category and the overall state-wide median plan performance. For example, if a race or ethnicity category had a state-wide median plan performance of 30 percent on a given

measure at the 2022 baseline, while the overall state-wide median for the measure was 40 percent, the target performance for that race or ethnicity category would be 35 percent. Race or ethnicity categories that perform above the state-wide median level at baseline will have a target value equal to their baseline performance, signifying maintenance of performance. This methodology is similar to the CalAIM Bold Goals: 50x2025 initiative launched in 2022, which aimed to reduce disparities by 50 percent by 2025.

DHCS produces an annual Health Disparities Report that analyzes performance on MCAS measures by race and ethnicity and classifies disparities based on magnitude and trending compared to the prior year. While this analysis uses a different methodology, this report lists findings from the Health Disparities Report for additional context where available.[55]

Table III.J. Summary of MCMC baseline disparity analysis results

Measure	Racial/ethnic group with highest percentage of plans below the goal	Racial/ethnic group goal for the measure	Racial/ethnic group state-wide performance range
Child and adolescent well-care visits	White	41.9 percent	19.8–56.9 percent
Well-child visits in the first 15 months of life	Black or African American	42.8 percent	14.4–66 percent
Well-child visits in the first 30 months of life	White	62.9 percent	28.8–80 percent
Prenatal care	Black or African American	85.5 percent	57.6–100 percent
Postpartum care	White	78.7 percent	40–95.8 percent

Source: Medi-Cal Managed Care Accountability Sets. The racial/ethnic group with the highest percentage of plans below the goal is identified and then reviewed at the county or county size level to determine the counties or county sizes with the highest number of plans below the goal for the specific racial/ethnic group. Full results are available in Appendix A, pp. 45–80.

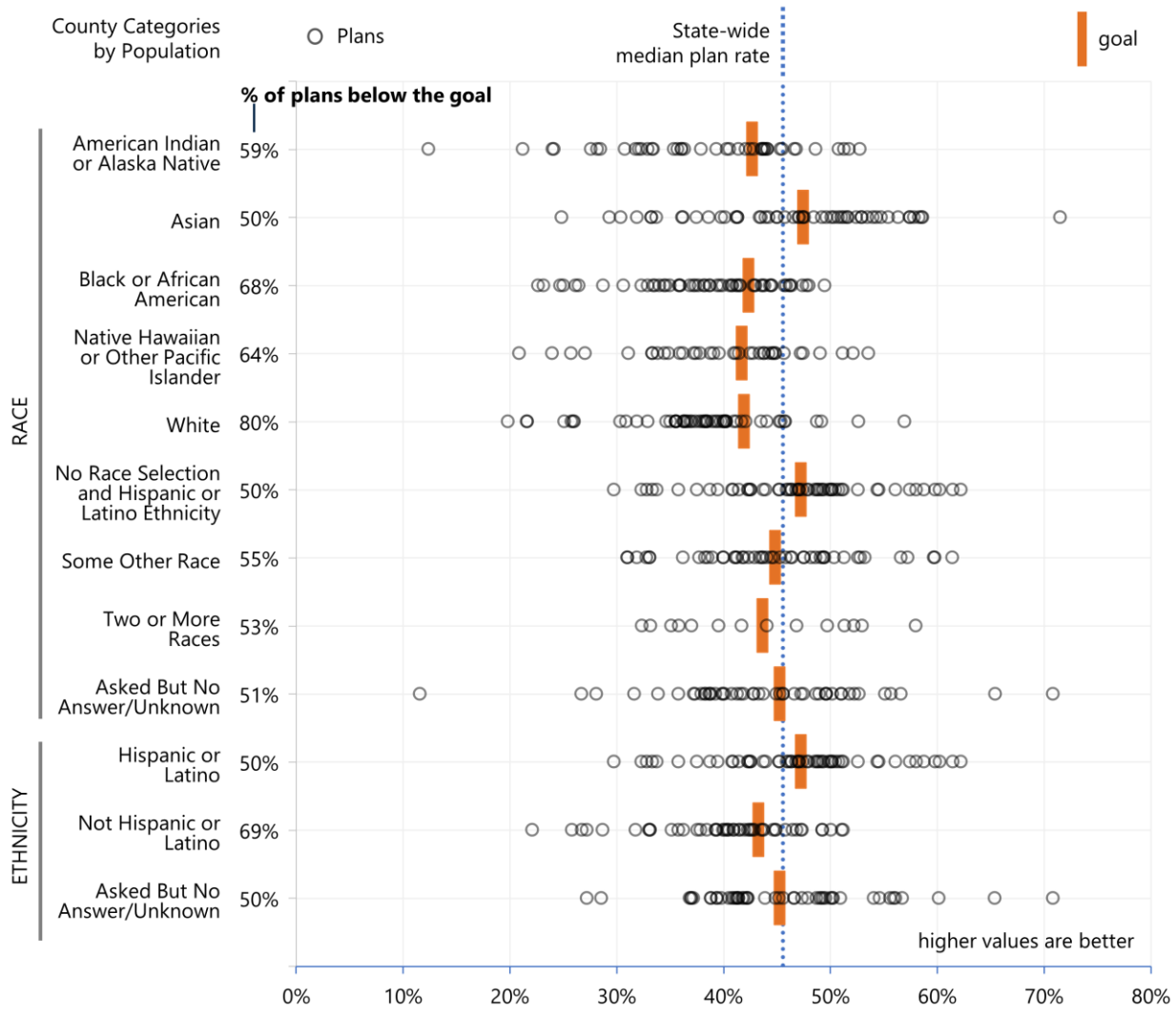
Child and adolescent well-care visits

The *White* racial/ethnic group had the highest percentage of plans below the goal for "child and adolescent well care visits" (Figure III.C). Other racial/ethnic groups with more than 50 percent of state-wide health plans below the goal include: *American Indian or Alaskan Native*, *Black or African American*, *Native Hawaiian or Other Pacific Islander*, and *Not Hispanic or Latino*.

[55] The Health Disparities Report is available at https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfDisp.aspx.

For comparison, the DHCS 2022 Health Disparities Report indicated that the *White* racial/ethnic group experienced worsening disparity for this measure from calendar year 2021 to 2022.

Figure III.C. MCMC child and adolescent well-care visits: baseline disparity visual



Note: Racial and ethnic plan rates that are suppressed for low numbers are not included on the chart. The goal is determined by targeting a 50 percent reduction in disparities. For more information, see Appendix C: Detailed Methodology.

Note: For a description of the baseline disparity analysis, see Section II. Methodology Summary, page 38.

Source: Medi-Cal Managed Care Accountability Sets

Well-child visits in the first 15 months of life

The *Black or African American* racial/ethnic group had the highest percentage of plans below the goal for "well-child visits in the first 15 months of life." Other racial/ethnic groups with more than 50 percent of state-wide health plans below the goal include: *Native Hawaiian or Other Pacific Islander*, *White*, and *Not Hispanic or Latino*.

For comparison, the DHCS 2022 Health Disparities Report indicated that the *Black or African American* racial/ethnic group experienced improvement in this measure from calendar year 2021 to 2022. Even with this improvement, the *Black or African American* racial/ethnic group still experienced a widespread disparity, defined in the Health Disparities Report as greater than 10 percent below the DHCS minimum performance rate.

Well-child visits in the first 30 months of life

The *White* racial/ethnic group had the highest percentage of plans below the goal for "well-child visits in the first 30 months of life." Other racial/ethnic groups with more than 50 percent of state-wide health plans below the goal include: *American Indian or Alaska Native*, *Black or African American*, *Native Hawaiian or Other Pacific Islander*, and *Not Hispanic or Latino*.

For comparison, the DHCS 2022 Health Disparities Report indicated that the *White* racial/ethnic group experienced improvement in this measure from calendar year 2021 to 2022. Even with this improvement, the *White* racial/ethnic group still experienced a widespread disparity, defined in the Health Disparities Report as greater than 10 percent below the DHCS minimum performance rate.

Prenatal care

The *Black or African American* racial/ethnic group had the highest percentage of plans below the goal for timely prenatal care. Other racial/ethnic groups with more than 50 percent of state-wide health plans below the goal include: *White* and *Not Hispanic or Latino*.

For comparison, the DHCS 2022 Health Disparities Report indicated that the *Black or African American* racial/ethnic group had a new disparity identified in 2022.

Postpartum care

The *White* racial/ethnic group had the highest percentage of plans below the goal for timely postpartum care. Other racial/ethnic groups with more than 50 percent of state-wide health plans below the goal include: *Black or African American* and *Not Hispanic or Latino*.

For comparison, the DHCS 2022 Health Disparities Report indicated that the *White* racial/ethnic group is at risk of having a disparity emerge in 2023.

Subcontractor analysis

The 2022 subcontractor analysis, which was the first year of DHCS' Subcontractor Network Certification, evaluated the percentage of subcontractors within a Medi-Cal plan and county that are compliant with standards governing timely access, member-to-provider ratio, time and distance, and mandatory provider types required by Title 42 CFR § 438.68 and Title 42 CFR § 438.206(d). The timely access, member-to-provider-ratio, and time and distance compliance measures include both fully and partially delegated subcontractors; the mandatory provider type compliance measures only include applicable subcontractors.[56] In 2022, these subcontractor compliance measures represent 21 plans operating in 34 counties and covering 335 subcontractors.

Table III.K. MCMC subcontractor network analysis

Measure	State-wide median	State-wide range (min–max)	County size with lowest-performing plans
Plan-level subcontractor timely access compliance rate	29 percent	0–100 percent	Rural
Plan-level subcontractor member-to-provider ratio	100 percent	100 percent	None
Plan-level subcontractor time and distance standard compliance rate	0 percent	0–100 percent	Small
Plan-level subcontractor mandatory provider type compliance rate	100 percent	0–100 percent	Small

Source: 2022 Subcontractor Network Compliance Results. Low-performing plans defined as those with ratings below the compliance standard. Full results are available in Appendix B, pp. 268–273.

- Plans serving small counties had the lowest performance on two of the four subcontractor network analysis measures. Small counties had especially lower rates of mandatory provider type compliance compared to medium-sized and large counties, suggesting focused improvement on small counties may have a high impact.
- Two MCMC subcontractor network analysis compliance measures have low state-wide medians. This includes the "plan-level subcontractor timely access compliance rate" with a state-wide median rate of 29 percent and the "plan-level

[56] Subcontractors were excluded from mandatory provider type analysis for subcontractors that are not contracted to provide a given service.

subcontractor time and distance standard compliance rate" with a state-wide median rate of 0 percent. To enhance monitoring of subcontractor performance, DHCS has developed new compliance tools to evaluate the performance of individual subcontractors, including reviewing the subcontractor's rates for "active providers" and "provider accepting new patients."

Dental Managed Care

This section describes key findings for the Dental MC delivery system, looking across 21 access measures for calendar year 2022.[57] It includes three parts: (1) a summary of findings, (2) findings by access domain (and within this section, findings by subdomain), and (3) a baseline disparity analysis with findings on a subset of measures to identify disparities and the county sizes in which they are most prevalent.

Summary of findings

Dental MC is the smallest of the four service delivery systems and offers benefits in Los Angeles and Sacramento Counties. Access to care in the Dental MC service delivery system is variable throughout the state with neither county showing the best results across all access domains.

State-wide findings

Provider availability and accessibility

Positive findings include:

- All plans have a member-to-provider ratio within the DHCS standard of 1200 members per provider. This shows there is a sufficient number of dental providers.
- Nearly all members live within time and distance standards of a dental provider, with no plans below 99 percent for this measure, suggesting there are a sufficient number of providers that are located close to members.
- In all plans, more than 80 percent of providers accept new patients, suggesting most members should be able to find a provider and receive a timely appointment.

Areas for improvement include:

[57] Findings presented in this chapter summarize the detailed measure results included in Appendix A. For each measure, Appendix A includes plan rates by county, a description of plan performance by county, and a table listing of plans that performed below the comparison value (either the state-wide median or state benchmark). Illustrative data points from Appendix A are incorporated throughout this chapter.

- DHCS made considerable progress towards the development and implementation of an "active providers" measure that can identify plans whose provider networks are not frequently providing services to members. Early attempts at this measure found the state-wide plan range for contracted providers included in the Provider Network Report who had zero encounters during 2022 was 5.2 to 30.5 percent. This preliminary finding is not out of line with a study of Medicaid managed care networks in four states that found that care was highly concentrated among a small number of physicians (25 percent of primary care physicians provided 86 percent of the care and 25 percent of specialists provided 75 percent of the care).[58]

  As this measure is based on preliminary analyses, DHCS will continue to refine the measure, including exploring the provider types most commonly listed on the Provider Network Report but not appearing in encounters and patterns in provider types included in encounter data that are not listed in the provider network file.

Service use

Areas for improvement include:

- All plans had rates lower than 50 percent of adults and children receiving annual dental visits and preventive-service-to-fillings ratios of less than one. These results suggest that the majority of members are not receiving recommended dental care and may only seek care when dental problems arise.
- Measures for child members outperform the same measure calculated for adult members across both counties. This includes measures of annual dental visits and preventive-services-to-fillings ratios.

Member experience

Positive findings include:

- In all plans, providers' next available appointments are on average within 1 to 14 days, suggesting most members should be able to receive a timely appointment.

Areas for improvement include:

[58] Research shows it is common in Medicaid managed care networks that a small number of providers deliver the majority of services provided, indicating the need for states to audit for "ghost" networks (in-network providers treating 0 Medicaid individuals). For more information, see https://health.uconn.edu/pepper-center/wp-content/uploads/sites/272/2024/01/ludomirsky-et-al-2022-in-medicaid-managed-care-networks-care-is-highly-concentrated-among-a-small-percentage-of.pdf.

» Measures for child members outperform the same measure calculated for adult members across both counties. This includes measures of "usual source of dental care" and "continuity of dental care."

Member outcome

Areas for improvement include:

» For all plans in these two counties, more than 60 percent of emergency department visits were for non-traumatic dental conditions. These results suggest that members in these two counties had consistent patterns of accessing emergency department care for non-traumatic dental conditions that could have been addressed in ambulatory dental care settings.

Baseline disparity analysis

Notable findings include:

» The baseline disparity analysis identified the *American Indian and Alaskan Native*, *Black or African American*, and *Not Hispanic or Latino* racial/ethnic groups had the highest percentage of health plans performing below the state-wide goal for "avoidable dental emergency department visits."

County findings

» Sacramento County had the highest number of access measures (n=19)[59] where the county had the greatest number of lower performing county-plans. These findings suggest that working with plans in Sacramento County could address multiple access issues across all domains.

Findings by access domain

Provider availability and accessibility

The provider availability and accessibility domain includes measures of the supply and distribution of providers and the accommodations made to members. Table III.L below lists each measure in this domain and reports the state-wide performance range and the county (or counties) with the highest number of low-performing plans.

[59] 6. member-to-provider ratio; 7. members living inside time and distance standards; 8. accepting new patients; 9. active providers; 10. access to care grievances; 11. resolved appeals; 21. annual dental visits (adult); 21. annual dental visits (child); 27. preventive-services-to-fillings (child); 33. usual source of dental care (adult); 33. usual source of dental care (child); 34. continuity of dental care (adult); 34. continuity of dental care (child); 35. finding a dentist (child); 37. days to next available appointment, 39; getting care quickly (child); 43. culturally competent dental care (child); 46. rating of all dental care (child); and 53. avoidable dental emergency department visits.

Table III.L. Dental MC provider availability and accessibility domain: state-wide performance range and counties with low-performing plans

Subdomain	Measure	State-wide 25th–75th percentile	State-wide range (min–max)	Counties with low-performing plans
Supply and distribution of services	Member-to-provider ratio	128.2–540.2 members per provider	63.7–666.1 members per provider	Sacramento
Supply and distribution of services	Members living inside time and distance standards	99–99.8 percent	99–100 percent	Los Angeles, Sacramento
Supply and distribution of services	Accepting new patients	86.3–87.1 percent	83.8–94 percent	Sacramento
Supply and distribution of services	Active providers (0 encounters)	5.4–18.8 percent	5.2–30.5 percent	Los Angeles, Sacramento
Supply and distribution of services	Access to care grievances	1.9–4.8 per 10,000 member months	1.3–7.2 per 10,000 member months	Los Angeles, Sacramento
Supply and distribution of services	Resolved appeals	7.3–17.2 per 10,000 member months	2.2–31.9 per 10,000 member months	Los Angeles, Sacramento
Supply and distribution of services	Resolved appeals in favor of member	0.2–0.7 per 10,000 member months	0.5–6.6 per 10,000 member months	Los Angeles, Sacramento
Supply and distribution of services	Provision of telehealth services	1.8–2.1 percent	0–3.4 percent	Los Angeles, Sacramento

Note: DHCS analysis found many providers billing claims not found in the Provider Network Report. This may result in data quality issues impacting member-to-provider ratio and the provision of telehealth services. For more information, see Section IV. Recommendations For Standardizing And Improving Access Monitoring.

Source: Provider network report, MIS/DSS enrollment data, time and distance database, claims and encounter data, and grievance appeal reports. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 140–146.

- All plans have a member-to-provider ratio within the DHCS standard of 1200 members per provider.
- Nearly all members live within time and distance standards of a dental provider, with no plans below 99 percent for this measure.
- All plans had rates higher than 80 percent of providers accepting new patients.

» The state-wide plan range for contracted providers included in the Provider Network Report who had zero encounters during 2022 was 5.2 to 30.5 percent (active providers). Among plans with the higher rates, this indicates that nearly one out of three contracted providers did not have an encounter in 2022.

Service use

The service use domain, sometimes called realized access, monitors service utilization and the quality of services that the member population receives. Table III.M below lists each measure in this domain and reports the state-wide performance range and the county (or counties) with the highest number of low-performing plans.

Table III.M. Dental MC service use domain: state-wide performance range and counties with low-performing plans

Subdomain	Measure	State-wide 25th–75th percentile	State-wide range (min–max)	Counties with low-performing plans
Service utilization	Annual dental visits (adult 21+)	18.9–22.3 percent	16.9–25 percent	Los Angeles and Sacramento
Service utilization	Annual dental visits (child 0–20)	37.1–42.2 percent	34.6–48.2 percent	Los Angeles and Sacramento
Service quality	Preventive-services-to-fillings (adult 21+)	0.44–0.52 preventive-services-to-fillings	0.43–0.54 preventive-services-to-fillings	Los Angeles
Service quality	Preventive-services-to-fillings (child 0–20)	0.84–0.87 preventive-services-to-fillings	0.78–0.88 preventive-services-to-fillings	Los Angeles and Sacramento

Source: Public dental plan performance data. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 146–149.

» Both counties experienced low service use for adults, with only 25 percent of members having at least one dental visit in the highest-performing plan.

» Although both plans had a higher percentage of annual dental visits for children, the best-performing plan was still under 50 percent.

» Los Angeles County comparatively had the highest number of low-performing plans for adult ratios of preventive-services-to-fillings, while both counties had the same number of performing plans for children. Both ratio results suggest that adults and children are receiving more fillings than preventive services. This may signal that they are only seeking care when problems arise.

Member experience

The member experience domain includes measures of members' ability to navigate the health care system, obtain timely care, and receive culturally relevant care, along with their satisfaction with access to care. For Dental MC, the member experience domain performance measures include measure results from the child CAHPS Dental Plan Survey,[60] usual source of dental care, and provider available appointments. Table III.N below lists each measure in this domain and reports the state-wide performance range and the county (or counties) with the highest number of low-performing plans.

Table III.N. Dental MC member experience domain: state-wide performance range and counties with low-performing plans

Subdomain	Measure	State-wide 25th–75th percentile	State-wide range (min–max)	Counties with low-performing plans
Connection to healthcare system	Usual source of dental care (adult 21+)	8.4–11.1 percent	7.4–12.6 percent	Los Angeles and Sacramento
Connection to healthcare system	Usual source of dental care (child 0–20)	20.8–30.3 percent	4.7–35.6 percent	Los Angeles and Sacramento
Connection to healthcare system	Continuity of dental care (adult 21+)	32.5–39.5 percent	30.9–41.2 percent	Los Angeles and Sacramento
Connection to healthcare system	Continuity of dental care (child 0–20)	60.8–66.4 percent	59.8–69.4 percent	Los Angeles and Sacramento
Connection to healthcare system	Finding a dentist (child 0–17)	33.7–45.3 percent	26.7–66.7 percent	Los Angeles and Sacramento
Timeliness of care	Days to next available appointment	8.2–13.5 days	1–14 days	Los Angeles and Sacramento
Timeliness of care	Getting care quickly (child 0–17)	22.7–26.5 percent	20.6–32.8 percent	Sacramento
Cultural competency	Culturally competent dental care (child 0–17)	52.4–58.8 percent	42.2–75.1 percent	Sacramento
Member satisfaction	Rating of all dental care (child 0–17)	46.8–56.5 percent	33.9–60.3 percent	Sacramento

Source: Public dental plan performance data, Consumer Assessment of Healthcare Providers and Systems, and network timely access reports. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For

[60] Dental MC plans administer CAHPS surveys annually. Child measures in this report contain responses from the child's parent or guardian. For more information about CAHPS, see https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html.

measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 149–157.

- Although the range of "average days to next available appointment" is 1 to 14 days, half of the plans had average wait times of 12 days or more to the next available appointment.
- Children consistently had higher rates than adults in the member experience domain. For example, children had higher rates in continuity of dental care and rates often twice as high for usual source of dental care.

Member outcomes

The member outcome domain represents the goal of improved access to care and monitors overall population outcomes. For Dental MC, the performance measures include the "percentage of emergency department visits for non-traumatic dental conditions."

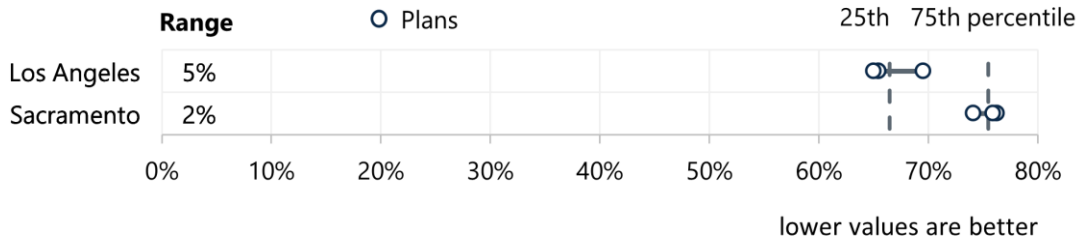
Table III.O. Dental MC member outcome domain: state-wide performance range and counties with low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min–max)	Counties with low-performing plans
Member outcome	Avoidable dental emergency department visits	71.8 percent	65–76.2 percent	Sacramento

Source: T-MSIS data. Low-performing plans defined as those with ratings below the 25th percentile of all state plan rates. For measures where low ratings are better, low performance is defined as ratings above the 75th percentile of all state plan rates. Full results are available in Appendix A, pp. 158-161.

- Both plans had rates higher than 60 percent of emergency department visits for non-traumatic dental conditions (Figure III.D). These results suggest that members state-wide had consistent patterns of accessing emergency department care for non-traumatic dental conditions that could have been addressed in ambulatory dental care settings.

Figure III.D. Dental MC avoidable dental emergency department visits: internal county visual



Note: For a description of the internal county analysis, see Section II. Methodology Summary, page 38.
Source: T-MSIS data.

Baseline disparity analysis

The baseline disparity analysis included one measure (Table III.P). The analysis of plan performance for each race and ethnicity category illustrates which measures and demographic groups experienced the greatest disparities at the 2022 baseline. Future analyses may incorporate additional subdimensions beyond race and ethnicity breakouts, for example income, and sexual orientation and gender identity, which will allow additional exploration of intersectional impacts of factors of oppression.

For each race and ethnicity category, the baseline disparity analysis sets a target that is 50 percent of the disparity between the state-wide median plan value measured for the category and the overall state-wide median plan performance. For example, if a race or ethnicity category had a state-wide median plan performance of 30 percent on a given measure at the 2022 baseline, while the overall state-wide median for the measure was 40 percent, the target performance for that race or ethnicity category would be 35 percent. Race or ethnicity categories that perform above the state-wide median level at baseline will have a target value equal to their baseline performance, signifying maintenance of performance. This methodology is similar to the CalAIM Bold Goals: 50x2025 initiative launched in 2022

Table III.P. Summary of Dental MC baseline disparity analysis results

Measure	Racial/ethnic group with highest percentage of plans below the goal[61]	Racial/ethnic group goal for the measure	Racial/ethnic group state-wide performance range	County with low-performing plans[62]
Avoidable dental emergency department visits	American Indian or Alaska Native	79.3 percent	79.3–87.2 percent	Sacramento
Avoidable dental emergency department visits	Black or African American	75.2 percent	66.9–79.4 percent	Sacramento
Avoidable dental emergency department visits	Not Hispanic or Latino	73 percent	60.5–76.9 percent	Sacramento

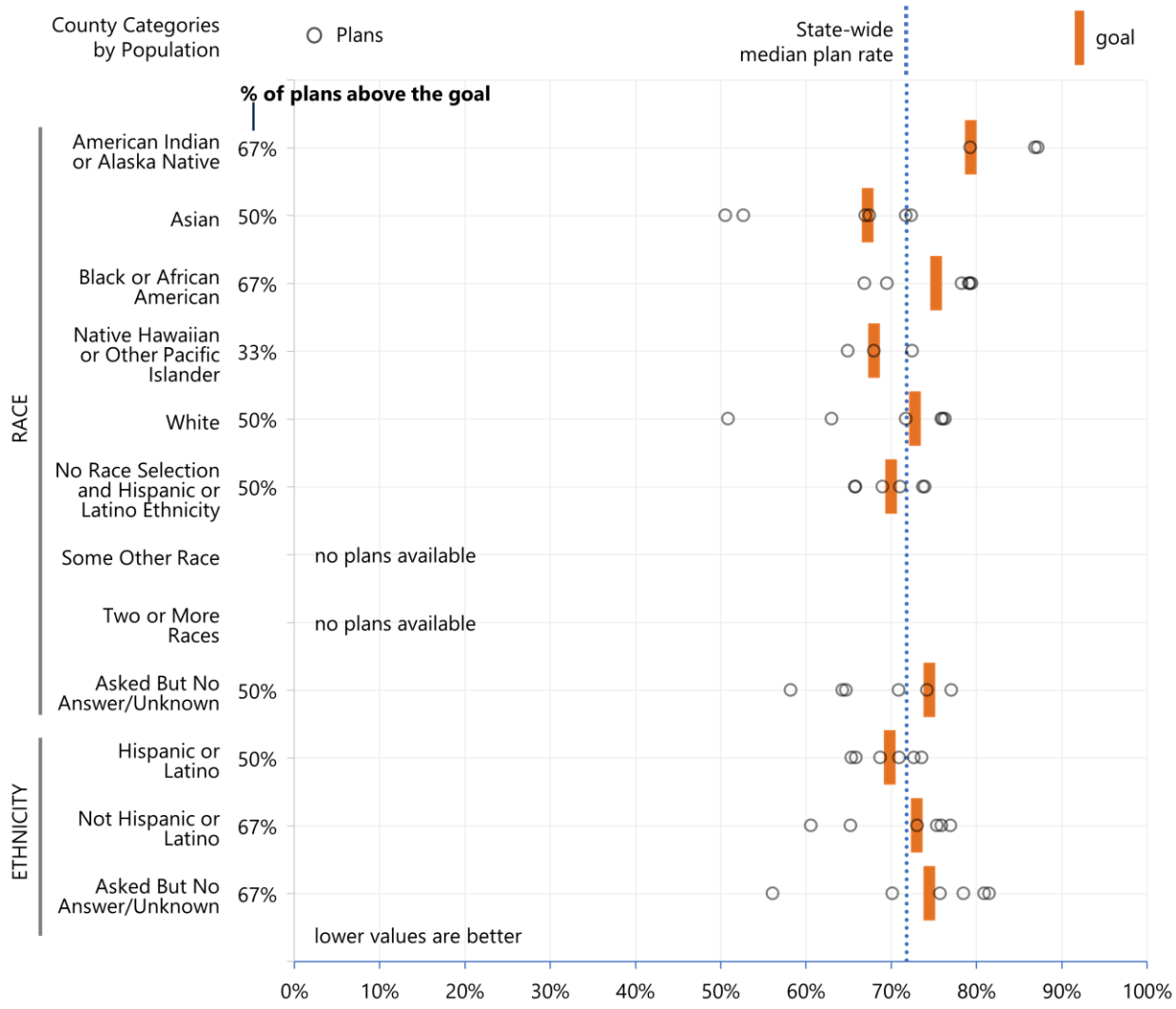
Source: T-MSIS data. The racial/ethnic group with the highest percentage of plans below the goal is identified and then reviewed at the county or county size level to determine the counties or county sizes with the highest number of plans not meeting the goal for the specific racial/ethnic group. Full results are available in Appendix A, pp. 158–161.

The *American Indian and Alaskan Native*, *Black or African American*, *Not Hispanic or Latino*, and *Asked but No Answer/Unknown* racial/ethnic groups had the highest percentage of plans below the goal for "avoidable emergency department visits" in Sacramento County. These findings suggest that focused improvement on plans serving Sacramento County may have a high impact on this disparity.

[61] *American Indian and Alaskan Native*, *Black or African American*, and *Not Hispanic or Latino* racial/ethnic groups had the same percentage of plans below the goal.

[62] County with the lowest-performing plans is determined by the county with the highest number of plans below the measure goal.

Figure III.E. Dental MC avoidable dental emergency department visits: baseline disparity visual



Note: Ethnic plan rates that are suppressed for low numbers are not included on the chart. Goal is determined by targeting a 50 percent reduction in disparities. For more information, see Appendix C: Detailed Methodology.

Note: For a description of the baseline disparity analysis, see Section II. Methodology Summary, page 38.

Source: T-MSIS data

Specialty Mental Health Services

This section describes key findings for the SMHS delivery system, looking across 30 access measures for calendar year 2022.[63] It includes four parts: (1) a summary of

[63] Findings presented in this chapter summarize the detailed measure results included in Appendix A. For each measure, Appendix A includes plan rates by county size, a description of plan performance by county size, and a table

findings, (2) findings by access domain (and within this section, findings by subdomain), (3) findings by county size, and (4) a baseline disparity analysis with findings on a subset of measures to identify disparities and the county sizes in which they are most prevalent.

Summary of findings

Access to care in the SMHS service delivery system is variable throughout the state with no single county or county size showing the best results across all access domains.

State-wide findings

Provider availability and accessibility

Positive findings include:

- The majority of plans were compliant with the DHCS standard for psychiatric member-to-provider ratios for both adults and children, suggesting plans may be contracting with a sufficient number of psychiatric providers.
- The state-wide median rate of members living inside time and distance standards was 99.9 percent for outpatient mental health for both adults and children, suggesting there are a sufficient number of providers that are located close to members.

Areas for improvement include:

- The majority of plans were non-compliant with the DHCS standard for outpatient mental health member-to-provider ratios for both adults and children, suggesting plans may not be contracting with a sufficient number of outpatient mental health providers.

Service use

Positive findings include:

- State-wide median plan rates indicate that most members are receiving key coordination of care services such as step-down services after an inpatient discharge within 10 days for children and 15 days for adults,[64] and roughly two-thirds of follow-up appointments occur within 30 days after emergency department visit for mental illness. This suggests plans are ensuring adequate follow-up with their members.

listing plans that performed below the comparison value (either the state-wide median or state benchmark). Illustrative data points from Appendix A are incorporated throughout this chapter.

[64] SMHS measures such as "time between inpatient discharge and stepdown services" and "mental health case management service utilization" define an adult as ages 21 and older and a child as ages zero through 20.

- State-wide median plan rates indicate that most members are receiving key coordination of care services like step-down services after an inpatient discharge within 10 days for children and 15 days for adults, and almost two-thirds of follow-up appointments occur within 30 days after emergency department visit for mental illness.

Areas for improvement include:

- Average mental health case management service utilization varies considerably between adults and children, with a state-wide median plan rate of 280 minutes for children and 432 minutes for adults. These variances could represent different needs between the populations or potential access issues for further exploration.

Notable findings include:

- State-wide, the median penetration rate (defined as member receiving one service in 2022) was 5.3 percent for adults and 4.9 percent for children, and the median engagement rate (member received five services in 2022) was 3.5 percent for adults and 3.7 percent for children.

Member experience

Positive findings include:

- State-wide, there was high general satisfaction with SMHS among service utilizers, with a median plan rate of 91.9 percent for adults and 91.5 percent for children indicating they were satisfied with SMHS.

Member outcome

Areas for improvement include:

- Plans have a wide range of rates of psychiatric readmissions within 7 days and 30 days, though the state-wide median for each measure is skewed towards lower readmission rates. This suggests there may be room for improvement within the few plans with higher rates.

Baseline disparity analysis

Notable findings include:

- The baseline disparity analysis identified the following measures and groups in which the highest percentage of plans performed below the state-wide goal:

- *Asian* racial/ethnic group for penetration rates, engagement rates, and accessibility of SMHS (adult)
- *White* racial/ethnic group for accessibility of SMHS (adult)
- *Black or African American* racial/ethnic group for accessibility of SMHS (adult)
- *No Race Selection and Hispanic or Latino Ethnicity* racial/ethnic groups for accessibility of SMHS (adult)

Although the baseline disparity analysis identifies the measure and racial/ethnic group with the highest percentage of plans below the goal, measures such as SMHS penetration and engagement rates also include two additional racial/ethnic groups that had more than 50 percent of state-wide health plans that were below the goal: *Native Hawaiian or Other Pacific Islander* and *No Race Selection and Hispanic or Latino Ethnicity*.

County size specific findings

- Plans serving rural counties and plans serving large counties each had the highest number of access measures (12)[65] where plans performed above the measure standard.
- Plans serving small counties and plans serving medium-sized counties each had the highest number of access measures (9)[66] where plans performed below the measure standard. These findings suggest that working with plans in small and medium-sized counties could address multiple access issues across all domains.

[65] **Rural:** 10. access to care grievances;, 11. resolved appeals;, 22. penetration rates (adult);, 22. engagement rates (adult);, 22. penetration rates (child); 22. engagement rates (child); 26. follow-up after emergency department visits for mental illness (7 day); 26. follow-up after emergency department visits for mental illness (30 day); 26. time between inpatient discharge and step-down service (adult); 44. culturally competent SMHS (child); 54. psychiatric readmission rate (7 day); and 54. psychiatric readmission rate (30 day). **Large:** 6d. outpatient mental health member-to-provider ratio (adult); 6d. outpatient mental health member-to-provider ratio (child); 6e. psychiatric member-to-provider ratio (child); 22. engagement rates (child); 25. follow-up after hospitalization for mental illness (7 day); 28. time between inpatient discharge and step-down service (child); 36. mental health case management service utilization (adult); 39.1 getting needed care (adult); 39.1 getting needed care (child); 44. culturally competent SMHS (adult); 47. general satisfaction with SMHS (adult); and 47. general satisfaction with SMHS (child).

[66] **Small:** 6d. outpatient mental health member-to-provider (child); 10. access to care grievances; 13. accessibility of SMHS (child); 22. engagement rates (adult); 28. time between inpatient discharge and step-down service (child); 36. mental health case management service utilization (adult); 39.1 getting needed care (child); 44. culturally competent SMHS (child); and 47. general satisfaction with SMHS (adult). **Medium:** 11. resolved appeals; 22. penetration rates (adult); 22. penetration rates (child); 22. engagement rates (child); 39.1 getting needed care (adult); 44. culturally competent SMHS (adult); 47. general satisfaction with SMHS (adult); 47. general satisfaction with SMHS (child); and 54. psychiatric readmission rate (7 day).

Findings by access domain

Provider availability and accessibility

The provider availability and accessibility domain includes measures of the supply and distribution of providers and the accommodations made to members. Table III.Q below lists each measure in this domain and reports the county size category with the highest percentage of low-performing health plans on the measure.

Table III.Q. SMHS provider availability and accessibility domain: state-wide performance range, compliance standards and county size categories with high- and low-performing plans

Subdomain	Measure	Compliance standard[67]	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Supply and distribution of services	Outpatient mental health member-to-provider[68] ratio (adult 21+)	85:1	21.3 – 644 members per provider	Rural	Medium
Supply and distribution of services	Outpatient mental health member-to-provider ratio (child 0-20)	43:1	21.6 – 271 members per provider	Medium, Large	Small
Supply and distribution of services	Psychiatric member-to-provider ratio (adult 21+)	524:1	59.3 – 828.3 members per provider	Small	Large
Supply and distribution of services	Psychiatric member-to-provider ratio (child 0-20)	323:1	76.4 – 1229 members per provider	Large	Small

Source: NACT and MIS/DSS enrollment data. The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 162–167.

- The majority of plans were non-compliant with the DHCS standard for outpatient mental health member-to-provider ratios for both adults and children.
- The majority of plans were compliant with the DHCS standard for psychiatric member-to-provider ratios for both adults and children. However, several plans were significantly above the DHCS standard for children, with the plan in

[67] Compliance standards for SMHS member-to-provider ratios are found in BHIN 22-033. For more information, see https://www.dhcs.ca.gov/Documents/BHIN-22-033-2022-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf.

[68] The number of SMHS members was calculated by applying a prevalence rate for the need for SMHS to the total MCMC enrollment. DHCS continues to explore methodologies for capturing the demand for SMHS.

Stanislaus County having a child member-to-provider ratio nearly four times the DHCS standard.

Table III.R. SMHS provider availability and accessibility domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide Median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Supply and distribution of services	Members inside outpatient mental health time or distance standards (adult 21+)	99.9 percent	81.1–100 percent	Small	Rural
Supply and distribution of services	Members inside outpatient mental health time or distance standards (child 0–20)	99.9 percent	88–100 percent	Small	Rural
Supply and distribution of services	Active providers	78 percent	30.1–100 percent	Large	Rural
Supply and distribution of services	Access to care grievances	3311.4 grievances per 10,000 months	0–363005.1 grievances per 10,000 months	Rural	Small
Supply and distribution of services	Resolved appeals	98.8 appeals per 10,000 member months	0–102104.9 appeals per 10,000 months	Rural	Medium
Provider accommodation	Provision of telehealth services	54 percent	0–100 percent	Large	Rural
Provider accommodation	Accessibility of SMHS (adult 18–59)	86.3 percent	67.8–100 percent	Medium	Large
Provider accommodation	Accessibility of SMHS (child 13–17)	89.4 percent	75.4–97.1 percent	Medium	Small

Source: MHC deficient ZIP Codes file, NACT, claims and encounter data, managed care program annual report, SMHS and MIS/DSS enrollment data, and Consumer Perception Survey. The highest-performing plans is determined by the county size with the highest percentage of plans above the state-wide median plan rate. County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the state-wide median plan rate. Full results are available in Appendix A, pp. 168 – 185.

» Only four plans had rates lower than 95 percent of adult members living inside outpatient mental time or distance standards, and only three plans had rates lower than 97 percent of child members living inside outpatient mental time or distance standards.

Service use

The service use domain, sometimes called "realized access," monitors service utilization and the quality of services used by the member population. Table III.S below lists each measure in this domain and reports the county size category with the highest percentage of low-performing health plans on the measure.

Table III.S. SMHS service use domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Service utilization	Penetration rates (adult 21+)[69]	5.3 percent	1.9–17.2 percent	Rural	Medium
Service utilization	Engagement rates (adult 21+)	3.5 percent	1.2–11.4 percent	Rural	Small
Service utilization	Penetration rates (child 0–20)	4.9 percent	2.2–11.1 percent	Rural	Medium
Service utilization	Engagement rates (child 0–20)	3.7 percent	1.7–10.4 percent	Rural	Medium
Service quality	Follow-up after hospitalization for mental illness (7 day)	61.6 percent	0–86.6 percent	Large	Rural

[69] SMHS penetration and engagement rates presented in this report will differ from those in the SMHS Performance Dashboard. The Dashboard uses data from SFY2022 and includes both inpatient and outpatient services, while this report uses data from CY2022 and includes only outpatient encounters and claims.

Subdomain	Measure	State-wide median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Service quality	Follow-up after emergency department visits for mental illness (7 day)	51.5 percent	0–78.9 percent	Rural	Large
Service quality	Follow-up after emergency department visits for mental illness (30 day)	63.9 percent	14.3–100 percent	Rural	Large
Service quality	Time between inpatient discharge and step-down service (adult 21+)	14.5 percent	0–74.9 days	Rural	Large
Service quality	Time between inpatient discharge and step-down service (child 0–20)	9.9 percent	0–29.5 days	Large	Small

Source: Specialty mental health services performance dashboard and SMHS managed care program annual report . The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 185–206.

- State-wide, all plans had penetration rates for adults and children (defined as member receiving one service in 2022) below 20 percent (median is 5.3 percent for adults and 4.9 percent for children), and engagement rates (member received five services in 2022) below 12 percent (median is 3.5 percent for adults and 3.7 percent for children). These rates indicate low utilization of SMHS, but state-wide median plan rates indicate that members are receiving key coordination of care services. For example, step-down services after an inpatient discharge occur within 10 days for children and 15 days for adults, and 64 percent of follow-up appointments occur within 30 days after emergency department visit for mental illness.

Member experience

The member experience domain includes measures of members' ability to navigate the health care system, obtain timely care, and receive culturally relevant care, along with their satisfaction with access to care. SMHS member experience performance measures include results from the adult and child Consumer Perception Survey,[70] access to language services, use of case management services, and a timely access of care study of provider availability. Table III.T below lists each measure in this domain and reports the county size category with the highest and lowest percentage of low-performing health plans on the measure.

[70] SMHS plans administer the Consumer Perception Survey annually to members receiving care. Child measures in this report only include responses collected from children receiving care, not their families. For more information about the Consumer Perception Survey, see https://www.dhcs.ca.gov/Documents/BHIN-24-009-MH-Consumer-Perception-Survey-Data-Collection.pdf.

Table III.T. SMHS member experience domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Connection to healthcare system	Mental health case management service utilization (adult 21+)	432.1 minutes	146.3–1283.9 minutes	Medium, Large	Small
Connection to healthcare system	Mental health case management service utilization (child 0–20)	280.8 minutes	91.2–629.2 minutes	Small	Rural
Timeliness of care	Days to first offered appointment for treatment	24.8 days	0–69.5 days	Medium	Large
Timeliness of care	Getting needed care (adult 18–59)	85.5 percent	73.7–95.4 percent	Large	Medium
Timeliness of care	Getting needed care (child 13–17)	88.5 percent	63.1–97.7 percent	Medium, Large	Small
Cultural competency	Culturally competent SMHS (adult 18–59)	85 percent	68.7–100 percent	Large	Medium
Cultural competency	Culturally competent SMHS (child 13–17)	85.7 percent	71.4–100 percent	Rural	Small
General satisfaction	General satisfaction with SMHS (adult 18–59)	91.9 percent	83.8–100 percent	Large	Small and medium
General satisfaction	General satisfaction with SMHS (child 13–17)	91.5 percent	63.1–100 percent	Large	Medium

Source: Specialty mental health services performance dashboard, timely access data tool, and Consumer Perception Survey. The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 206–219.

- The average number of mental health case management service utilization minutes varies considerably between adults and children, with a state-wide median plan rate of 280 minutes for children and 432 minutes for adults (Table III.T). These variances could represent different needs between the populations or potential access issues for further exploration.
- There was high general satisfaction with SMHS among service utilizers, with a state-wide median rate of 91.9 percent for adults and 91.5 percent for children. Plans operating in small and medium-sized counties had comparatively lower rates of members' satisfaction with SMHS for adults; there was lower satisfaction with SMHS for children in small counties.
- Although plans serving medium-sized counties had the lowest rate of adults receiving needed care and plans serving small counties had the lowest rate of children receiving needed care, the state-wide median survey rates were 85.5 percent for adults and 88.5 percent for children. These results suggest that the majority of adults and children surveyed are getting needed care.
- Plans in large counties comparatively had longer wait times for days to first offered appointments (Table III.T). However, only one plan in a large county had rates below 80 percent of adults or children who indicated that they were not getting care when they needed it.

Member outcomes

The member outcome domain represents the goal of improved access to care and monitors overall population outcomes. Table III.U below lists each measure in this domain and reports the county size category with the highest percentage of low-performing health plans on the measure.

Table III.U. SMHS member outcome domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide median	State-wide performance range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Member outcome	Psychiatric readmission rate (7 day)	2.6 percent	0–33.3 percent	Rural	Medium
Member outcome	Psychiatric readmission rate (30 day)	9.4 percent	0–36.8 percent	Rural	Large

Source: Claims and encounter data. The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 219–224.

» Although the range of state-wide performance for psychiatric readmission rates for 7 and 30 days each span over 30 percent, the state-wide median rates are considerably lower. The state-wide median plan rate for psychiatric readmission in 7 days is 2.6 percent and for 30 days is 9.4 percent.

County size results

This section summarizes findings for each county size. Table III.V lists each measure by domain and the percentage of plans below the comparison rate, either a performance standard or state-wide median plan rate.

Table III.V. SMHS county size analysis: percentage of plans below the comparison rate

Domain	Measure	Percentage of plans below the comparison rate			
		Rural	Small	Medium	Large
Provider availability and accessibility	Outpatient mental health member-to-provider ratio (adult 21+)	50	61	67	56
Provider availability and accessibility	Outpatient mental health member-to-provider ratio (child 0–20)	70	83	56	56
Provider availability and accessibility	Psychiatric member-to-provider ratio (adult 21+)	8	6	11	22
Provider availability and accessibility	Psychiatric member-to-provider ratio (child 0–20)	25	47	33	11

Domain	Measure	Percentage of plans below the comparison rate			
		Rural	Small	Medium	Large
Provider availability and accessibility	Members inside outpatient mental health time and distance standards (adult 21+)	52	33	44	44
Provider availability and accessibility	Members inside outpatient mental health time and distance standards (child 0–20)	48	33	44	44
Provider availability and accessibility	Access to care grievances	35	67	50	44
Provider availability and accessibility	Resolved appeals	10	67	88	67
Provider availability and accessibility	Accessibility of SMHS (adult)	50	50	44	56
Provider availability and accessibility	Accessibility of SMHS services (child)	35	67	33	56
Service use	Penetration rates (adult 21+)	10	68	100	56
Service use	Engagement rates (adult 21+)	19	79	67	44
Service use	Penetration rates (child 0–20)	19	63	100	44
Service use	Engagement rates (child 0–20)	33	63	78	33
Service use	Follow-up after hospitalization for mental illness (7 day)	70	53	38	11
Service use	Follow-up after emergency department visits for mental illness (7 day)	29	58	33	100
Service use	Follow-up after emergency department visits for mental illness (30 day)	29	58	44	89
Service use	Time between inpatient discharge and step-down service (adult 21+)	29	53	67	78
Service use	Time between inpatient discharge and step-down service (child 0-20)	42	68	44	33
Member experience	Mental health case management service utilization (adult 21+)	47	58	44	44
Member experience	Mental health case management service utilization (child 0–20)	61	42	44	44
Member experience	Days to first offered appointment for treatment	47	44	37	78

Domain	Measure	Percentage of plans below the comparison rate			
		Rural	Small	Medium	Large
Member experience	Getting needed care (adult 18–59)	45	50	67	44
Member experience	Getting needed care (child 13–17)	47	56	44	44
Member experience	Culturally competent SMHS (adult 18–59)	50	61	67	11
Member experience	Culturally competent SMHS (child 13–17)	35	61	56	44
Member experience	General satisfaction with SMHS (adult 18–59)	45	56	56	44
Member experience	General satisfaction with SMHS (child 13–17)	35	56	78	33
Member outcome	Psychiatric readmission rate (7 day)	30	47	67	61
Member outcome	Psychiatric readmission rate (30 day)	33	47	53	65

Source: NACT, MIS/DSS enrollment data, MHC deficient ZIP Codes file, claims and encounter data, SMHS managed care program annual report, Consumer Perception Survey, specialty mental health services performance dashboard, and timely access data tool. The percentage of plans in each county size category is compared with the state-wide comparison rate (state-wide median, compliance standard or MCAS minimum performance level) to determine the percentage below the comparison rate. For measures where low values are better, the county size analysis determines the percentage of plans in each county size category that are above the state-wide comparison rate. Full results are available in Appendix A, pp. 162–224.

- Plans serving rural counties had the best results in the member outcomes domain for measures such as "psychiatric readmission rates."
- Plans serving rural counties had the greatest opportunity for improvement in the percentage of members living within time or distance standards.
- Plans serving small counties had the greatest opportunity for improvement in the member experience domain, which included "mental health case management service utilization (adult)," "culturally competent SMHS (child)," and "getting needed care (child)."
- Plans serving medium-sized counties had the greatest opportunity for improvement in the member experience domain, which included "getting needed care (adult)," "culturally competent SMHS (adult)," and "general satisfaction with SMHS (child)."
- Plans serving large counties had the greatest opportunity for improvement in the service use domain, which included "follow-up after emergency department

visits (7 and 30 days)" and "time between inpatient discharge and stepdown services (adult)."

Baseline disparity analysis

The baseline disparity analysis included three measures (Table III.W). The analysis of plan performance for each race and ethnicity category illustrates which measures and demographic groups experienced the greatest disparities at the 2022 baseline. Future analyses may incorporate additional subdimensions beyond race and ethnicity breakouts, for example income, and sexual orientation and gender identity, which will allow additional exploration of intersectional impacts of factors of oppression.

For each race and ethnicity category, the baseline disparity analysis sets a target that is 50 percent of the disparity between the state-wide median plan value measured for each race and ethnicity category and the overall state-wide median plan performance. For example, if a race or ethnicity category had a state-wide median plan performance of 30 percent on a given measure at the 2022 baseline, while the overall state-wide median for the measure was 40 percent, the target performance for that race or ethnicity category would be 35 percent. Race or ethnicity categories that perform above the state-wide median level at baseline will have a target value equal to their baseline performance, signifying maintenance of performance. This methodology is similar to the CalAIM Bold Goals: 50x2025 initiative launched in 2022, which aimed to reduce disparities by 50 percent by 2025.

Table III.W. Summary of SMHS baseline disparity analysis results

Measure	Racial/ethnic group with highest percentage of plans below the goal	Racial/ethnic group goal for the measure	Racial/ethnic group state-wide performance range
Penetration rate	Asian	3.6 percent	0.9–4.3 percent
Engagement rate	Asian	2.3 percent	0.6–2.6 percent
Accessibility of SMHS[71] (adult 18–59)	American Indian or Alaskan Native	86.6 percent	83.3–88.2 percent
Accessibility of SMHS (adult 18–59)	Black or African American	89.1 percent	72.5–95.4 percent

[71] Accessibility of SMHS is measured by the Consumer Perception Survey question asking the how strongly respondents agree with the statement "The location of services was convenient."

Measure	Racial/ethnic group with highest percentage of plans below the goal	Racial/ethnic group goal for the measure	Racial/ethnic group state-wide performance range
Accessibility of SMHS (adult 18–59)	White	86.2 percent	73.6–100 percent
Accessibility of SMHS (adult 18–59)	Not Hispanic or Latino	87 percent	62.5–96.6 percent

Source: Specialty mental health services performance dashboard and Consumer Perception Survey. The racial/ethnic group with the highest percentage of plans below the goal is identified and then reviewed at the county or county size level to determine the counties or county sizes with the highest number of plans below the goal for the specific racial/ethnic group. Full results are available in Appendix A, pp. 177–197.

Penetration rates

The *Asian* racial/ethnic group had the highest percentage of plans below the goal for SMHS penetration rate. Two additional racial/ethnic groups also had more than 50 percent of state-wide health plans that were below the goal: *Native Hawaiian or Other Pacific Islander* and *No Race Selection and Hispanic or Latino Ethnicity*.

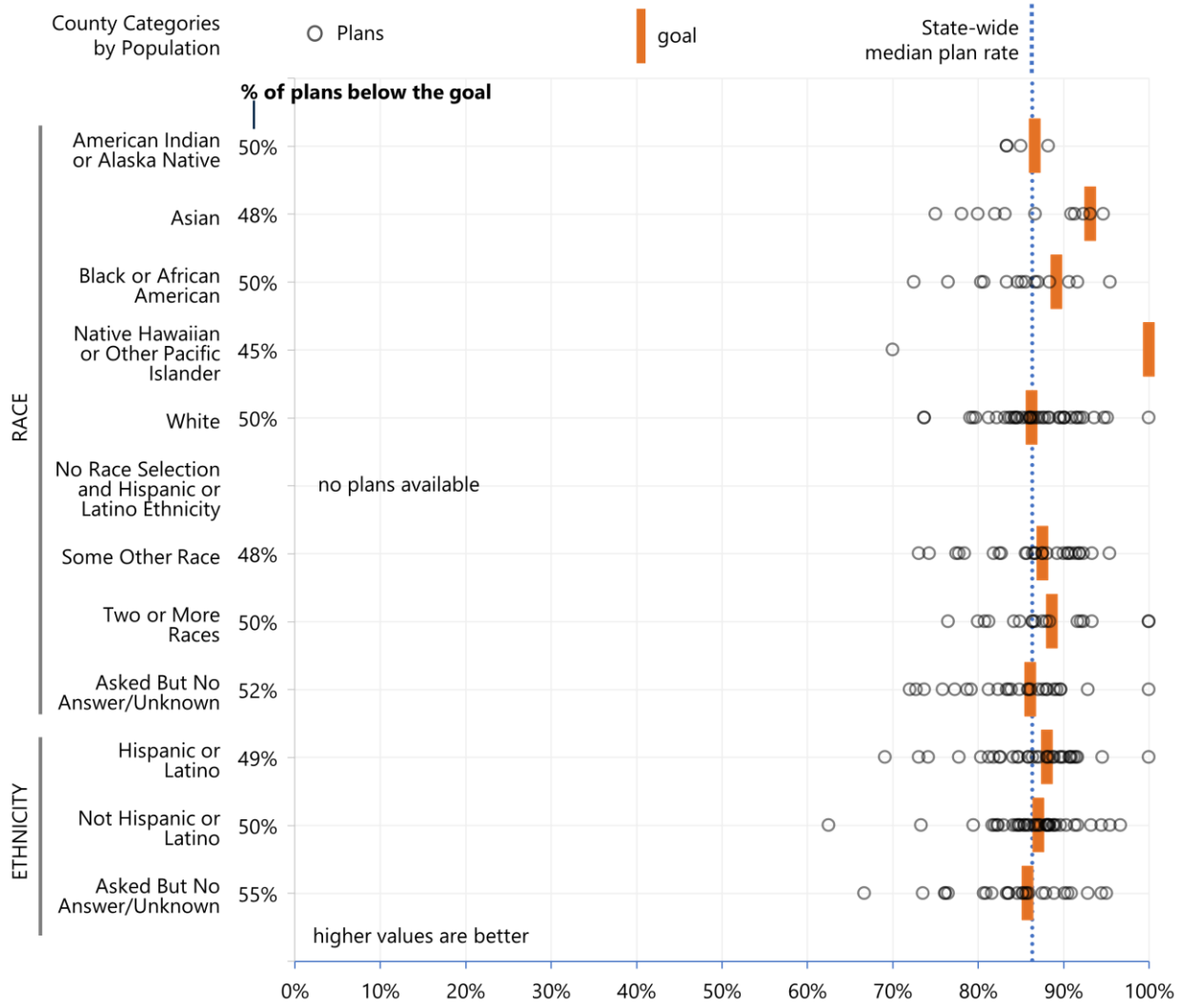
Engagement rates

The *Asian* racial/ethnic group had the highest percentage of plans below the goal for SMHS penetration rate. Two additional racial/ethnic groups also had more than 50 percent of state-wide health plans that were below the goal: *Native Hawaiian or Other Pacific Islander* and *No Race Selection and Hispanic or Latino Ethnicity*.

Accessibility of SMHS (adult)

The *Asian*, *Black or African American*, *White*, and *No Race Selection and Hispanic or Latino Ethnicity* racial/ethnic groups had the highest percentage of plans below the goal for "accessibility of SMHS." No other racial/ethnic groups identified in the data had more than 50 percent of state-wide health plans that were below the goal (Figure III. F).

Figure III.F. SMHS accessibility of services (adult 18–59): baseline disparity visual



Note: Racial and ethnic plan rates that are suppressed for low numbers are not included on the chart.
Note: For a description of the baseline disparity analysis, see Section II. Methodology Summary, page 38.
Source: Consumer Perception Survey.

Drug Medi-Cal Organized Delivery System

This section describes key findings for the DMC-ODS delivery system looking across 23 access measures for calendar year 2022.[72] It includes four parts: (1) a summary of findings, (2) findings by access domain (and within this section, findings by subdomain),

[72] Findings presented in this chapter summarize the detailed measure results included in Appendix A. For each measure, Appendix A includes plan rates by county size, a description of plan performance by county size, and a table listing plans that performed below the comparison value (either the state-wide median or state benchmark). Illustrative data points from Appendix A are incorporated throughout this chapter.

(3) findings by county size, and (4) a baseline disparity analysis with findings on a subset of measures to identify disparities and the counties in which they are most prevalent.

Summary of findings

Access to care in the DMC-ODS service delivery system is variable throughout the state, with no county size showing the best results across all access domains.

State-wide findings

Provider availability and accessibility

Positive findings include:

- The state-wide median rate of members living inside time and distance standards was 99.2 percent for adults and 96.3 percent for children, suggesting there are a sufficient number of providers that are located close to members.

Areas for improvement include:

- The state-wide plan median member-to-provider ratio for adults was 71 members per provider, though plans ranged from 6 to 225 members per provider. This range suggests targeted performance improvement may be necessary for specific plans.
- There was a wider range in performance on accessibility of services for children compared to adults. While more plans had 100 percent satisfaction with accessibility for children (8 plans for children, compared to 1 plan for adults), the lowest-performing plans for children have notably lower success rates than the lowest-performing plans for adults. This suggests more room for improvement in access for children.

Service Use

Areas for improvement include:

- The state-wide median plan rate for the DMC-ODS penetration rate is one percent and the engagement rate is 0.9 percent. This suggests that there is little difference between the rate of members who initiate treatment (received one service in 2022) and members who remain engaged in treatment (received five services in 2022).

Member experience

Areas for improvement include:

- In general, satisfaction with children's services varied more than satisfaction for adults. Although more plans had 100 percent satisfaction for children (4 plans had 100 percent satisfaction for children, compared to 1 plan for adults), the lowest-performing plans for children had notably lower success rates than the lowest-performing plans for adults (64 percent satisfaction rate for children, compared to 79 percent satisfaction rate for adults).

Member outcomes

Areas for improvement include:

- State-wide, plans have more variation in success of SUD treatment rates for children than they do for adults. Although more plans had 100 percent of members responding that their health improved after treatment for children (two plans had a 100 percent success rate for children, compared to one plan for adults), the lowest-performing plans for children had notably lower success rates than the lowest-performing plans for adults (64 percent success rate for children, compared to 75 percent success rate for adults).

Baseline disparity analysis

Notable findings include:

- The baseline disparity analysis identified the following measures and groups where the highest percentage of plans performed below the state-wide goal:
  - *Asian* racial/ethnic group for DMC-ODS penetration rate and accessibility of SUD services (adult)
  - *White* racial/ethnic group for accessibility of SUD services (adult)
  - *Black or African American* racial/ethnic group for accessibility of SUD services (adult)
  - *No Race Selection and Hispanic or Latino Ethnicity* racial/ethnic groups for DMC-ODS engagement rate and accessibility of SUD services (adult)

County size specific findings

- Plans serving rural counties had the highest number of access measures (14)[73] where plans performed above the measure standard.
- Plans serving large and medium-sized counties each had the highest number of access measures (9)[74] where plans performed below the measure standard. These findings suggest that working with plans in large and medium-sized counties could address multiple access issues across all domains.

Findings by access domain

Provider availability and accessibility

The provider availability and accessibility domain includes measures of the supply and distribution of providers and the accommodations made to members. Table III.X below lists each measure in this domain and reports the county size category with the highest percentage of low-performing health plans on the measure.

[68] 6. member-to-provider ratio; 7h. members inside SUD outpatient time and distance standards (adult); 7h. members inside outpatient time and distance standards (youth); 10. access to care grievances; 11. resolved appeals; 10. accessibility of SUD services (adult); 22. penetration rates; 22. engagement rates; 29. follow-up after emergency department visit for alcohol and other drug abuse (7 days); 29. follow-up after emergency department visit for alcohol and other drug abuse (30 days); 48. general satisfaction with SUD services (adult); 48. general satisfaction with SUD services (child); 55. success of SUD treatment (adult); and 55. success of SUD treatment (child).

[74] **Large:** 7h. members inside SUD outpatient time and distance standards (adult); 10. access to care grievances; 11. resolved appeals; 22. penetration rates; 22. engagement rates; 29. follow-up after emergency department visit for alcohol and other drug abuse (7 days); 29. follow-up after emergency department visit for alcohol and other drug abuse (30 days); 40. availability of SUD services (adult); and 55. success of SUD treatment (child). **Medium-sized:** 6. member-to-provider ratio; 14. accessibility of SUD services (child); 23.1 initiation and engagement of SUD treatment (engagement); 40. availability of SUD services (child); 45. culturally competent SUD services (adult); 45. culturally competent SUD services (child); 48. general satisfaction with SUD services (adult); and 55. success of SUD treatment (adult).

Table III.X. DMC-ODS provider availability and accessibility domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Supply and distribution of services	Member-to-provider[75] ratio (adult 21+)	71 members per provider	6.2 – 225.1 members per provider	Rural	Large
Supply and distribution of services	Members inside SUD outpatient time and distance standards (adult 18+)	99.7 percent	91.7–100 percent	Small	Rural
Supply and distribution of services	Members inside SUD outpatient time and distance standards (child 0–17)	99.8 percent	0–100 percent	Small	Rural
Supply and distribution of services	Members inside SUD outpatient time and distance standards (adult 18+)	99.2 percent	72.7–100 percent	Rural	Large
Supply and distribution of services	Members inside SUD outpatient time and distance standards (child 0–17)	96.3 percent	0–100 percent	Rural	Small
Supply and distribution of services	Active providers	89.1 percent	55–100 percent	Large	Small
Supply and distribution of services	Access to care grievances	0.01 grievances per 10,000 member months	0–1.8 grievances per 10,000 member months	Rural	Large

[75] The number of DMC-ODS members was calculated by applying a prevalence rate for the need for DMC-ODS services to the total MCMC enrollment. DHCS continues to explore methodologies for capturing the demand for DMC-ODS services.

Subdomain	Measure	State-wide median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Supply and distribution of services	Resolved appeals	0 grievances per 10,000 member months	0–8.2 appeals per 10,000 member months	Rural	Large
Provider accommodation	Provision of telehealth services	34.3 percent	0–87.5 percent	Small	Medium
Provider accommodation	Accessibility of SUD services (adult 18+)	85.2 percent	66.6–100 percent	Rural	Small
Provider accommodation	Accessibility of SUD services (child 12–17)	89 percent	62.6–100 percent	Small	Medium

Source: NACT, MIS/DSS enrollment data, DMC-ODS network data, claims and encounter data, DMC-ODS managed care program annual report, Treatment Perception Survey. The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 224–242.

- Although plans serving rural counties overall had the lowest-performing plans for "members inside SUD outpatient time or distance standards" (adult and youth), the only plans scoring lower than 99 percent on these measures were in San Diego County and the Regional Model (for adults) and Contra Costa, Sacramento, San Diego and Yolo Counties, and the Regional Model (for children).
- Although plans serving large counties overall had the lowest-performing plans for members inside SUD outpatient time or distance standards (adult), the small county of El Dorado had the lowest-performing plan.
- There was a wider range in performance on accessibility of services for children compared to adults. Although more plans had 100 percent satisfaction with accessibility for children (eight plans for children, compared to one plan for adults), the lowest-performing plans for children have notably lower success rates than the lowest-performing plans for adults.

Service use

The service use domain, sometimes called "realized access," monitors service utilization and the quality of services used by the member population. Table III.Y below lists each measure in this domain and reports the county size category with the highest percentage of low-performing health plans on the measure.

Table III.Y. DMC-ODS service use domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Service utilization	Penetration rates	1.1 percent	0.5–2.7 percent	Rural	Large
Service utilization	Engagement rates	0.9 percent	0.4–2.4 percent	Rural	Large
Service utilization	Initiation and engagement of SUD treatment (initiation)	20.2 percent	13.8–39.5 percent	Medium	Rural
Service utilization	Initiation and engagement of SUD treatment (engagement)	6.2 percent	3–13 percent	Small	Rural, Medium
Service quality	Follow-up after emergency department visit for alcohol and other drug abuse (7 days)	10.3 percent	3.7–54.1 percent	Rural	Large
Service quality	Follow-up after emergency department visit for alcohol and other drug abuse (30 days)	18.3 percent	6.9–58.5 percent	Rural, Medium	Large

Source: MIS/DSS Short Doyle claims and enrollment data, Medicaid and CHIP managed care reporting, DMC-ODS managed care program annual report. The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 243–257.

» The state-wide median plan rate for the DMC-ODS penetration rate is one percent and the engagement rate is 0.9 percent. This suggests that there is little difference between the rate of members who initiate treatment (received one service in 2022) and members who remain engaged in treatment (received five services in 2022).

Member experience

The member experience domain includes measures of members' ability to navigate the health care system, obtain timely care, and receive culturally relevant care, along with their satisfaction with access to care. For DMC-ODS, member experience performance measures include results from the adult and child Treatment Perception Survey.[76] Table III.Z below lists each measure in this domain and reports the county size category with the highest and lowest percentage of low-performing health plans on the measure.

Table III.Z. Member experience domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide median	State-wide performance range	County size category with the highest-performing plans	County size category with the lowest-performing plans
Timeliness of care	Availability of SUD services (adult 18+)	51.9 percent	32.4–80.9 percent	Medium	Large
Timeliness of care	Availability of SUD services (child 12–17)	33.3 percent	22–41.9 percent	Small	Medium
Cultural competency	Culturally competent SUD services (adult 18+)	90.5 percent	77.7–100 percent	Small	Medium
Cultural competency	Culturally competent SUD services (child 12–17)	80.6 percent	59.3–100 percent	Small	Medium
Member satisfaction	General satisfaction with SUD services (adult 18+)	90.5 percent	78.9–100 percent	Rural	Medium

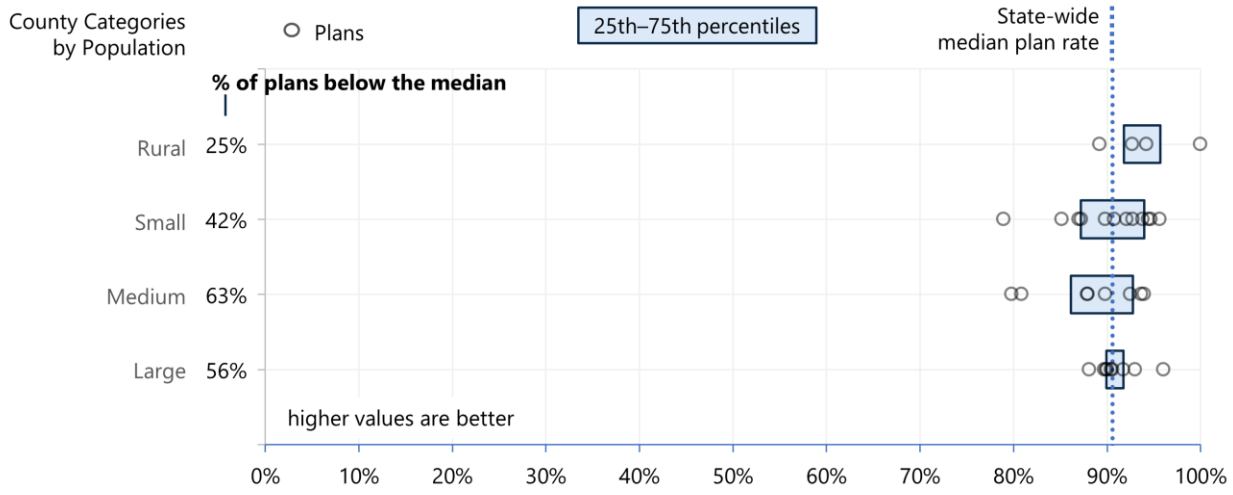
[76] DMC-ODS plans administer the Treatment Perception Survey annually to members receiving care. Child measures consist of data collected from the child receiving care. For more information about the Treatment Perception Survey, see https://www.dhcs.ca.gov/Documents/BHIN-23-024-DMC-ODS-Treatment-Perception-Survey.pdf.

Subdomain	Measure	State-wide median	State-wide performance range	County size category with the highest-performing plans	County size category with the lowest-performing plans
Member satisfaction	General satisfaction with SUD services (child 12–17)	100 percent	63.6–100 percent	Rural	Medium

Source: Treatment Perception Survey. The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 257–263.

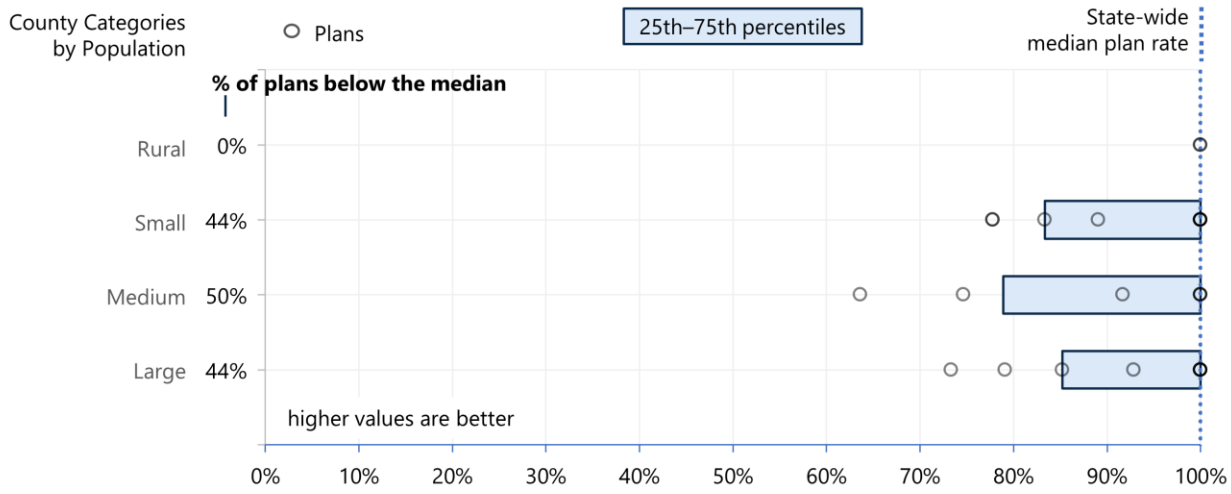
- In general, the availability of SUD services for children was lower than availability of SUD services for adults. The highest scoring plan for children's availability had 42 percent of children satisfied with availability, while the highest scoring plan for adults' availability scored nearly twice as high (81 percent).
- In general, satisfaction with children's services varied more than satisfaction for adult services. More plans had 100 percent satisfaction for children (four plans for children, one plan for adults), though the 25th percentile values for children (Figure III.G) were significantly lower than the 25th percentile values for adults (Figure III.H).

Figure III.G. DMC-ODS general satisfaction with SUD services (adult 18+): county size visual



Note: For a description of the county size analysis, see Section II. Methodology Summary, page 37.
Source: Treatment Perception Survey.

Figure III.H. DMC-ODS general satisfaction with SUD services (child 12–17): county size visual



Note: For a description of the county size analysis, see Section II. Methodology Summary, page 37.
Source: Treatment Perception Survey.

Member outcomes

The member outcome domain represents the goal of improved access to care and monitors overall population outcomes. For DMC-ODS, performance measures include the portion of members who say their health improved following SUD treatment. Table III.AA below lists each measure in this domain and reports the county size category with the highest percentage of low-performing health plans on the measure.

Table III.AA. DMC-ODS member outcome domain: state-wide performance range and county size categories with high- and low-performing plans

Subdomain	Measure	State-wide median	State-wide range (min–max)	County size category with the highest-performing plans	County size category with the lowest-performing plans
Member outcome	Success of SUD treatment (adult 18+)	87.8 percent	75.3–100 percent	Rural	Medium
Member outcome	Success of SUD treatment (child 12–17)	85.7 percent	63.6–100 percent	Rural	Large

Source: Treatment Perception Survey . The highest-performing plan determined by the county size with the highest percentage of plans above the state-wide performance standard (state-wide median, compliance standard or MCAS minimum performance level). County size with the lowest-performing plans is determined by the county size with the lowest percentage of plans below the performance standard. Full results are available in Appendix A, pp. 263–266.

- State-wide, plans have more variation in "success of SUD treatment" rates for children than they do for adults. Although more plans had 100 percent of child members compared to adult members responding that their health improved after treatment (seven plans for children, one plan for adults), the lowest-performing plans for children have notably lower success rates than the lowest-performing plans for adults.
- Although plans operating in medium-size counties overall had the lowest performance on "success of SUD treatment (adult)," plans operating in the small counties of San Luis Obispo, Napa, and Nevada Counties were the three plans with the lowest rates.
- Although plans operating in large counties overall had the lowest performance on "success of SUD treatment (child)," plans operating in Marin, Riverside, and Santa Barbara Counties were the three plans with the lowest rates.

County size results

This section summarizes findings for each county size. Table III.AB lists each measure by domain and the percentage of plans below the performance standard.

Table III.AB. DMC-ODS county size analysis: percentage of plans below the performance standard

Domain	Measure	Percentage of plans below the state-wide standard			
		Rural	Small	Medium	Large
Provider availability and accessibility	Member-to-provider ratio (adult 21+)	0	50	50	63
Provider availability and accessibility	Members inside SUD outpatient time or distance standards (adult 18+)	100	17	33	56
Provider availability and accessibility	Members inside SUD outpatient time or distance standards (youth 0–17)	100	25	50	56

Domain	Measure	Percentage of plans below the state-wide standard			
		Rural	Small	Medium	Large
Provider availability and accessibility	Members inside SUD outpatient time or distance standards (adult 18+)	0	50	17	67
Provider availability and accessibility	Members inside SUD OTP time or distance standards (youth 0–17)	0	58	17	56
Provider availability and accessibility	Access to care grievances	38	42	50	67
Provider availability and accessibility	Resolved appeals	0	33	38	67
Provider availability and accessibility	Accessibility of SUD services (adult 18+)	25	58	50	44
Provider availability and accessibility	Accessibility of SUD services (child 12–17)	50	33	67	56
Service use	Penetration rates	11	67	38	78
Service use	Engagement rates	11	67	38	78
Service use	Initiation and engagement of SUD treatment (initiation)	63	42	38	56
Service use	Initiation and engagement of SUD treatment (engagement)	63	17	63	56
Service use	Follow-up after emergency department visit for alcohol and other drug abuse (7 days)	38	42	50	67

Domain	Measure	Percentage of plans below the state-wide standard			
		Rural	Small	Medium	Large
Service use	Follow-up after emergency department visit for alcohol and other drug abuse (30 days)	38	42	38	78
Member experience	Availability of SUD services (adult 18+)	50	50	38	56
Member experience	Availability of SUD services (child 12–17)	50	33	67	44
Member experience	Culturally competent SUD services (adult 18+)	50	33	75	44
Member experience	Culturally competent SUD services (child 12–17)	50	33	67	56
Member experience	General satisfaction with SUD services (adult 18+)	25	42	63	56
Member experience	General satisfaction with SUD services (child 12–17)	0	44	50	44
Member outcome	Success of SUD treatment (adult 18+)	25	50	63	44
Member outcome	Success of SUD treatment (child 12–17)	0	44	50	56

Source: NACT, MIS/DSS enrollment data, DMC-ODS network data, MIS/DSS Short Doyle claims and enrollment data, DMC-ODS managed care program annual report, Treatment Perception Survey, and Medicaid and CHIP managed care reporting. The percentage of plans in each county size category is compared with the state-wide standard (state-wide median, compliance standard or MCAS minimum performance level) to determine the percentage below the standard. For measures where low values are better the county size analysis determines the percentage of plans in each county size category that are above the state-wide standard. Full results are available in Appendix A, pp. 224–266.

- Plans serving rural counties had the greatest opportunity for improvement in the provider availability and accessibility and service use domains, which included "initiation and engagement of SUD treatment and "members inside SUD outpatient time or distance standards (adults and youth)."
- Plans serving small counties had the greatest opportunity for improvement in the provider availability and accessibility domain, which included "member-to-provider ratio" and "members inside SUD outpatient time or distance standards (child)".
- Plans serving medium-sized counties had the greatest opportunity for improvement in the member experience domain, which included "availability of substance use disorder services (child)" and "culturally competent substance use disorder services (child and adult)" measures.
- Plans serving large counties had the greatest opportunity for improvement in the service use domain, which included penetration rate, engagement rate, and "follow-up after emergency department visits for alcohol and other drug abuse (7 and 30 days)."

Baseline disparity analysis

The baseline disparity analysis included three measures (Table III.AC). The analysis of plan performance for each race and ethnicity category illustrates which measures and demographic groups experienced the greatest disparities at the 2022 baseline. Future analyses may incorporate additional subdimensions beyond race and ethnicity breakouts, for example income, and sexual orientation and gender identity, which will allow additional exploration of intersectional impacts of factors of oppression.

For each race and ethnicity category, the baseline disparity analysis sets a target that is 50 percent of the disparity between the state-wide median plan value measured for the category and the overall state-wide median plan performance. For example, if a race or ethnicity category had a state-wide median plan performance of 30 percent on a given measure at the 2022 baseline, while the overall state-wide median for the measure was 40 percent, the target performance for that race or ethnicity category would be 35 percent. Race or ethnicity categories that perform above the state-wide median level at baseline will have a target value equal to their baseline performance, signifying maintenance of performance. This methodology is similar the CalAIM Bold Goals: 50x2025 initiative launched in 2022, which aimed to reduce disparities by 50 percent by 2025.

Table III.AC. Summary of DMC-ODS baseline disparity analysis results

Measure	Racial/ethnic group with highest percentage of plans below the goal	Racial/ethnic group goal for the measure	Racial/ethnic group state-wide performance range
Penetration rate	Asian	0.6 percent	0–0.7 percent
Engagement rate	No Race Selection and Hispanic or Latino Ethnicity	0.7 percent	0.2–1.3 percent
Accessibility of SUD services[77] (adult 18+)	Asian	87.2 percent	82.2–92.3 percent
Accessibility of SUD services (adult 18+)	Black or African American	87.7 percent	78.5–100 percent
Accessibility of SUD services (adult 18+)	White	85.4 percent	68–100 percent
Accessibility of SUD services (adult 18+)	No Race Selection and Hispanic or Latino Ethnicity	88.4 percent	61.1–100 percent

Source: Treatment Perception Survey and MIS/DSS Short Doyle claims and enrollment data The racial/ethnic group with the highest percentage of plans below the goal is identified and then reviewed at the county or county size level to determine the counties or county sizes with the highest number of plans below the goal for the specific racial/ethnic group. Full results are available in Appendix A, pp. 236–251.

Penetration rates

The *Asian* racial/ethnic group had the highest percentage of plans below the goal for the engagement rate. Two additional racial/ethnic groups had more than 50 percent of state-wide health plans below the goal: *Native Hawaiian or Other Pacific Islander* and *No Race Selection and Hispanic or Latino Ethnicity*.

Engagement rates

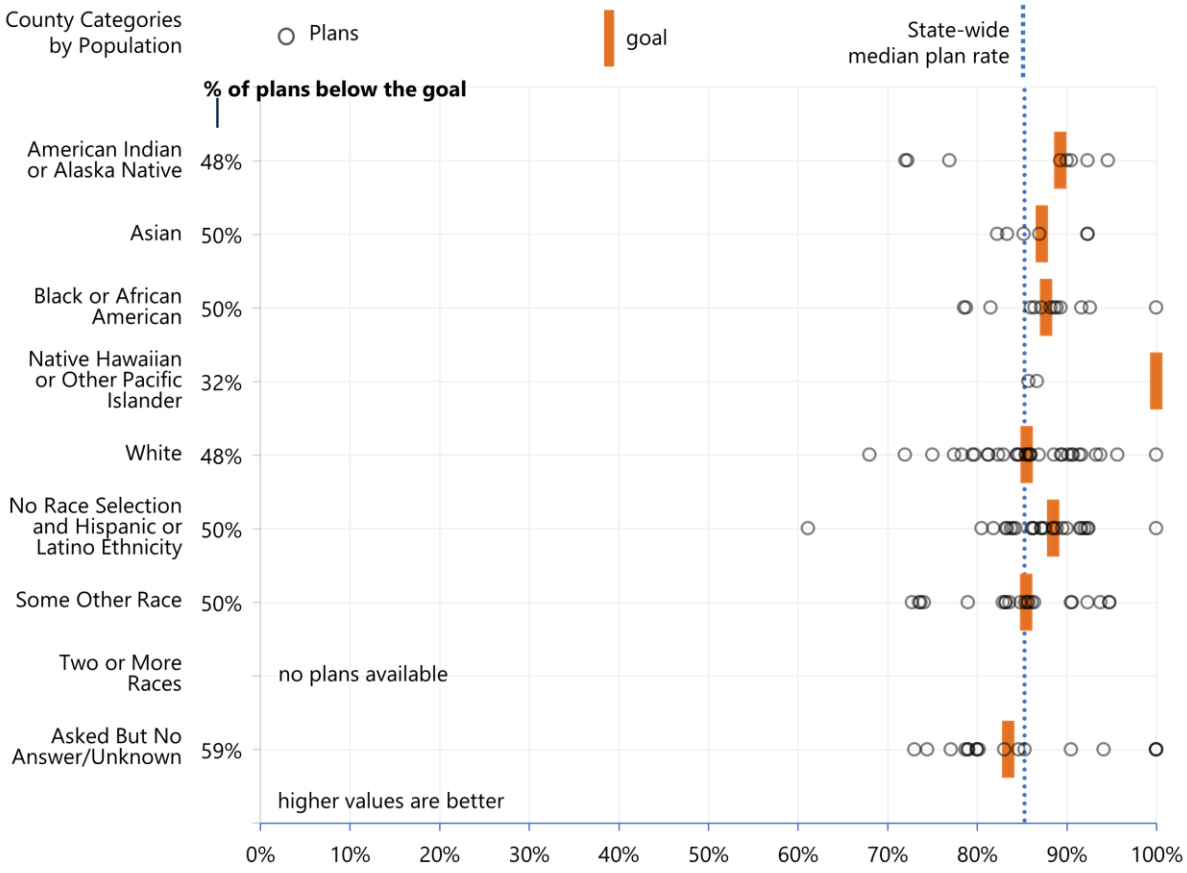
The *No Race Selection and Hispanic or Latino Ethnicity* racial/ethnic group had the highest percentage of plans below the goal for the engagement rate. Two additional racial/ethnic groups had more than 50 percent of state-wide health plans below the goal: *Asian* and *Native Hawaiian or Other Pacific Islander*.

Accessibility of DMC-ODS services (adult)

The *Asian*, *Black or African American*, *White*, and *No Race Selection and Hispanic or Latino Ethnicity* racial/ethnic groups had the highest percentage of plans below the goal for "accessibility of SUD services" (Figure III.I).

[77] Accessibility of SUD is measured by the Treatment Perception Survey question asking the how strongly respondents agree with the statement "The location was convenient."

Figure I. DMC-ODS accessibility of SUD services (adult 18+): baseline disparity visual



Note: Racial and ethnic plan rates that are suppressed for low numbers are not included on the chart.

Note: For a description of the baseline disparity analysis, see Section II. Methodology Summary, page 38.

Source: Treatment Perception Survey.

IV. RECOMMENDATIONS FOR STANDARDIZING AND IMPROVING ACCESS MONITORING

Recommendations for measure alignment, monitoring process alignment, and operational efficiencies

Measure and data alignment

1. Continue to standardize provider network files across service delivery systems. For the data year included in this report (2022), DHCS used three types of provider files[78] across the four service delivery systems. The State Work Plan for Access Improvement indicates that DHCS plans to transition to the monthly 274 file for all four service delivery systems. DHCS should move forward with this plan to enable more standardized measures of provider-related measures of access.

2. Align secret shopper and revealed caller studies across service delivery systems. Currently DHCS conducts a revealed caller survey for MCMC and a secret shopper survey Dental MC to determine appointment availability directly from providers. As indicated in the State Work Plan for Access Improvement, DHCS is assessing use of secret shopper surveys for the SMHS and DMC-ODS service delivery systems. In addition, DHCS could consider working to align survey methodologies, such as the provider types included, with the California Department of Managed Health Care provider appointment availability survey, to the extent that is in compliance with the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule,[79] to enable comparisons of results between Medi-Cal and non-Medi-Cal managed care plans operating in California.

3. Align member surveys across survey delivery systems. Currently, DHCS conducts different surveys[80] for three of the four delivery systems. DHCS could explore the

[78] The MCMC and Dental MC service delivery systems receive a standard monthly provider network file (274). The Dental MC delivery system also submits provider network files. The SMHS and DMC-ODS service delivery systems receive an annual NACT and Timely Access Data Tool (TADT).

[79] The secret shopper provision of the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule has an effective date of July 9, 2028. For more information, see https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

[80] DHCS conducts the adult and child CAHPS survey for MCMC, a child CAHPS survey for Dental MC, an adult and child Consumer Perceptions Survey (CPS) for SMHS, and an adult and child Treatment Perceptions Survey (TPS) for DMC-ODS.

potential of a single survey for all four delivery systems. If this is not feasible, DHCS could explore options for closer alignment of questions within each survey to enable comparisons across service delivery systems.

4. Standardize and expand use of member-to-provider ratio logic across service delivery systems. DHCS currently uses different approaches and data files to apply full-time equivalent (FTE) logic to their member-to-provider ratios to accurately report provider availability. (The MCMC delivery system uses logic applied to 274 provider data, and the SMHS delivery system captures FTE information in the Network Adequacy and Certification Tool [NACT].[81]) FTE adjustments account for providers who work part-time to better reflect how often they are available to see patients. DHCS could consider standardizing their approach to the application of FTE logic across all delivery systems to align measures. In addition, the MCMC delivery system applies FTE logic to primary care physicians, physicians, and a rolled-up measure for specialists. DHCS could consider expanding the FTE logic to ratios for additional provider types such as OB/GYNs, certified nurse midwives, and psychiatrists. In addition, DHCS could use the Department of Health Care Assess and Information's Health Care Payments Data to assess FTE by payers.

Data improvements and measure refinement

5. Require plans to report plan-county rates. Health plans operating in different counties often submit a single state-wide plan-level rate for the Healthcare Effectiveness Data and Informational Set (HEDIS). Similarly, DHCS conducts a CAHPS survey through their External Quality Review Organization, which includes state-wide CAHPS measure rates. Performance rates representing broad populations can limit the insight provided by line-of-business (for example, Medi-Cal), plan-county specific rates. More granular rates are more actionable; for example, enabling DHCS to focus on access to a specified provider type in a specific county. To receive more granular and actionable information, DHCS could consider requiring its health plans to collect and report plan county-level CAHPS and HEDIS data. This consideration should include whether county-plan measure rates would have denominators that are too small to be actionable. Alternatively, for HEDIS metrics, DHCS could consider calculating state-wide rates for administrative measures and then stratify results by health plans and or county-level results. In selecting an approach, DHCS would need to consider whether they or the plans should have the responsibility of calculating HEDIS data. Similarly, DHCS should consider whether the plans or the External Quality Review Organization should be responsible for

[81] DHCS will begin using the 274 file for SMHS reporting beginning in FY 2024-2025 and will begin using the 274 file for DMC-ODS reporting beginning in FY 2025-2026.

costs associated with conducting county-level oversampling for CAHPS surveys, as this will increase survey administration costs.

6. Improve provider data for enhanced subcontractor monitoring. DHCS could consider improving subcontractor data in two ways to support analysis of access under subdelegated arrangements.

First, DHCS could explore whether it is possible to incorporate subcontractor entity into claims and encounter data without impacting standard 837 file transmissions to clearly identify which subcontracted entity and plan a service was billed under. Currently, DHCS claims and encounter data identify multiple provider roles (rendering, servicing, etc.) using providers' National Provider Identifier for each service, and the plan responsible for the Medi-Cal managed care claim is always included. However, the subcontractor responsible for the service is not included on the claim, making it impossible to uniquely attribute services to a single subcontractor within a plan (unless the provider only contracts with a single subcontractor within a plan). This break in the plan–subcontractor–provider chain impedes the ability to understand provider supply and "active providers" at the subcontract or plan level. To address this data limitation, in the subcontractor measures of access to care, the claim activity and provider attributes (that is, "accepting new patients") of a provider are counted for each subcontractor the provider belongs to. Capturing the subcontractor that is responsible for the service on the claim would facilitate accurate and unique attribution of service at the subcontractor and plan level.

Second, DHCS could consider developing a unique list of subcontracted entities operating in Medi-Cal. Further, without standard IDs for the subcontractor groups, the 274 provider record may include various permutations of similar names (for example, Aetna Health, Aetna Health LLC). This report uses "fuzzy logic" to complete name matching to build a standardized list of subcontractors. A standard register of subcontractors listed in the 274 provider file combined with the subcontractor inclusion on the claim would improve DHCS' understanding of the universe of subcontractors, and their aggregate performance and availability operating in each county and under each plan. This would also ensure accurate attribution of provider activity to subcontractors. For example, subcontracted entities could be assigned unique IDs that could be tracked across plans, as well as providers connected to those plans. DHCS could consider requiring health plans to continuously update subcontractor details, similar to provider data.

7. Improve provider data to accurately collect providers' spoken languages. Access to language services is a measure that evaluates the number of providers available in a

health plan's network who speak members' language. The measure can help DHCS in understanding the extent to which health plans are able to meet the language needs of its members. The measure is calculated by combining eligibility data on enrollment by plan and members' spoken language with provider data from the 274 file, which identifies the languages spoken by each provider in the health plan. Early efforts to calculate this measure identified data quality issues in the reported provider language in the 274 file. These issues included variation in individual provider responses when asked which languages are spoken across health plans (for example, a provider indicating speaking Spanish in one plan, but not another), and using a different language code set than the Medi-Cal enrollment data. DHCS could further explore and correct data issues in provider network files, such as the 274 file, to more accurately collect data on provider spoken language to calculate the measure.

8. Improve data on provider network for each plan. The "active providers" measure compares the number of providers included in the 274 file (for MCMC), Provider Network Report (for Dental MC), and the NACT file (for SMHS and DMC-ODS) with encounter data to determine the percentage of providers who are actively serving members. The measure can help DHCS identify plans whose provider networks are not frequently providing services to members. Early efforts to calculate this measure highlighted that not all providers identified in encounter data are included in the 274 and NACT files. DHCS could conduct analyses of the 274 file, the Provider Network Report, the NACT file, and encounter data to determine where misalignment in provider participation is occurring. Such a review could include analysis of whether misalignment varies by provider type. DHCS could also work with plans to communicate these findings and consider new or revised plan requirements for 274 file data (for example more frequent updates or data quality checks and/or penalties for non-compliance or persistent data errors) to ensure it is complete and accurate ongoing.

9. Capture the SMHS and DMC-ODS population more accurately. Member measures for these two systems use "distinct members ever enrolled over the year" instead of average member months. Counts of members ever enrolled can overestimate member counts, leading to less reliable measures. Additionally, having data on when a member is referred to the plan and when they are discharged or released from the plan would enable a variety of additional measures to be used. These measures could evaluate the ability of members referred to the plan to be connected to providers and the ability of those providers to serve those patients. Measures of penetration and engagement rates (which measure the share of members receiving at least one service or receiving five or more services, respectively) use total managed care enrollment as denominators,

without limiting to those members needing these services. Capturing data on individuals referred to these services could more accurately capture the penetration and engagement rates, as calculations would limit to those truly needing services. One option would be to explore applying the prevalence rates for the need for SMHS outlined in the California Mental Health and Substance Use System Needs Assessment and Service Plan.[82] DHCS could also explore the possibility of creating new measures of how many individuals received one or more services in the SMHS or DMC-ODS delivery systems among those referred by an MCMC plan for these services, as well as when members are "discharged" or "released" from the plan. However, these recommendations would likely require significant resources within DHCS to collect new data and determine a methodology to identify these individuals. DHCS could continue to explore developing a member measure informed by behavioral health diagnosis codes or updated survey-based prevalence rates. These measures might more accurately inform DHCS about whether SMHS and DMC-ODS services are being delivered to populations in need.

Alignment with strategic initiatives

10. Further align with DHCS Health Equity Roadmap. DHCS could continue to align access monitoring approaches and methodologies with initiatives associated with the DHCS Health Equity Roadmap, such as approaches to race and ethnicity stratifications. DHCS may seek to adopt approaches to stratifications such as alignment with federal standards.[83] To the extent possible, DHCS could aim to deploy these approaches across delivery systems considering data availability.

11. Expand measures that address CLAS standards. CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities. DHCS is currently working to develop tools to assess plan compliance with CLAS standards, including cultural competency plan compliance and identifying potential new measures such as members' access to providers with the same spoken language. In addition, DHCS could identify and implement additional measures to assess member access to culturally and linguistically appropriate services to further CLAS goals. For example, DHCS could explore whether the 274 provider data or other sources support additional measures of accessibility.

[82] For more information, see https://www.dhcs.ca.gov/provgovpart/Documents/CABridgetoReformWaiverServicesPlanFINAL9013.pdf.

[83] For information on the Office of Management and Budget's Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, see https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and.

Enhancements to performance standards

12. Consider expansion of minimum performance standards and goals for individual performance measures. DHCS has minimum performance standards for most of the MCMC service use measures in this Interim Report. These targets are used to compare plan rates against DHCS performance expectations. For measures without DHCS performance targets, the Interim Report uses the state-wide median plan rate to evaluate health plan performance. Although this approach can identify plans performing lower than middle performing plans, it may not reflect DHCS' true performance expectations. DHCS could explore whether there are additional measures for which a minimum performance standard would be appropriate and would reflect DHCS' strategic objectives and goals. This exploration would require gathering input from impacted groups, such as managed care plans. DHCS may consider ways to align minimum performance standards with other state initiatives, such as value-based payment strategies.

13. Revisit minimum performance standards and goals based on current performance. DHCS has set minimum performance levels for the MCAS measure set. The Interim Report found nearly all plans were meeting minimum performance levels for measures such as timely prenatal and postpartum care. DHCS could explore whether higher performance standards would be appropriate for measures in which the majority of plans have met the minimum performance standard. This exploration would require gathering input from impacted groups, such as managed care plans.

Performance improvement activities

14. Conduct targeted performance improvement initiatives informed by key findings on access to care. The Interim Report includes a list of key findings that provide a variety of potential access issues. DHCS could prioritize key findings for each service delivery system and conduct performance improvement initiatives in the counties and county sizes where issues are more prevalent.