Executive Summary of Findings
Medi-Cal Managed Care Physical Health External Quality Review Technical Report

Contract Year 2023–24

Quality and Population Health Management
California Department of Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Background

As required by Title 42 Code of Federal Regulations (CFR) Section (§)438.364, the California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent, technical report that summarizes findings on the quality, timeliness, and accessibility of health care services provided by Medi-Cal Managed Care program (MCMC) plans, including opportunities for quality improvement.

The *2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report* provides a summary of the external quality review (EQR) activities of DHCS' MCMC physical health plans (i.e., managed care health plans [MCPs] and population-specific health plans [PSPs]). DHCS does not exempt any plans from EQR.

In addition to summaries of EQR activity results, the *2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report* includes HSAG's assessment of the quality, timeliness, and accessibility of care delivered to MCMC members by MCPs and PSPs and, as applicable, recommendations as to how DHCS can use the EQR results in its assessment of and revisions to the DHCS Comprehensive Quality Strategy.[1] Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS Comprehensive Quality Strategy goals as well as whether DHCS needs to revise the Comprehensive Quality Strategy based on the results presented in the EQR technical report.

This *Medi-Cal Managed Care Physical Health External Quality Review Technical Report Executive Summary of Findings* provides a high-level summary of the notable findings included in the *2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report*. This executive summary will sometimes collectively refer to the MCPs and PSPs as "plans."

[1] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Feb 13, 2025.

Medi-Cal Managed Care Program by the Numbers

MCP and PSP members as of June 2024:[2] **More than 13.9 million**

DHCS' contracted physical health plans as of January 1, 2024: **22 MCPs** and **two PSPs**

Counties served: **All 58 counties across California**

Quality, Access, and Timeliness

The Centers for Medicare & Medicaid Services (CMS) requires that the EQR evaluate the performance of the managed care entities related to the quality, timeliness, and accessibility of care they deliver.

As part of producing the annual EQR technical report, HSAG draws conclusions related to plans' strengths and weaknesses with respect to the quality, timeliness, and accessibility of health care services furnished to MCP and PSP members. While quality, timeliness, and access are distinct aspects of care, most plan activities and services cut across more than one area. Collectively, all MCP and PSP activities and services affect the quality, timeliness, and accessibility of care delivered to plan members.

Summary of Findings

DHCS provided HSAG with a reporting structure to follow when producing this *Medi-Cal Managed Care Physical Health External Quality Review Technical Report Executive Summary of Findings*, including specific headings that represent select focus areas. While HSAG categorized each EQR activity under the heading that best reflects the activity's focus, in most instances, activities cut across multiple focus areas.

Following is a high-level overview of the notable EQR findings from the *2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report*.

[2] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on Feb 13, 2025.

Access

Alternative Access Standards Reporting

The measurement period for the 2023–24 Alternative Access Standards (AAS) reporting analyses is from March 28, 2024, through October 10, 2024.

Number of Alternative Access Standards Requests, Approvals, and Denials

During the measurement period, MCPs submitted 16,115 AAS requests to DHCS. There were 15,499 distinct combinations of request characteristics, of which DHCS approved 14,146 (91.3 percent), denied 1,351 (8.7 percent), and rendered no decision for two (<0.1 percent). The primary reason for not rendering a decision was that the ZIP Code in the request is a special, non-residential ZIP Code (e.g., a post office box-only ZIP Code), where an AAS request would not be appropriate because no members reside there. One MCP, San Francisco Health Plan, did not submit any requests.

Reasons for the Approval or Denial of Alternative Access Standards Requests

In the data provided for the 2023–24 analyses, the most common reasons for DHCS to approve or deny an AAS request included:

- Approval Reasons
  - The MCP is contracted with the closest provider (network or out-of-network), and DHCS did not identify a closer network or out of-network provider than the provider indicated on the request.
  - Although DHCS identified closer out-of-network providers than the network provider indicated on the request, the MCP has attempted to contract with those providers and clearly explained why they could not be added to the MCP's network.
- Denial Reasons
  - The MCP's AAS request is incomplete. The MCP is to revise the request that follows All Plan Letter 23-001[3] Attachment C instructions and resubmit.
  - DHCS located a closer out-of-network provider than the network provider and out-of-network provider that the MCP identified on the AAS request. The MCP is to revise the request for miles/minutes or provide a justification and resubmit.

[3] All Plan Letter 23-001. Available at: APL 23-001 (ca.gov). Accessed on: Feb 28, 2025.

- DHCS located a network provider within the time or distance standards that the MCP did not identify on the AAS request. The MCP is to submit an updated accessibility analysis that shows the MCP is already meeting the time or distance standard.
- The MCP's justification as to why the MCP was unable to contract with the closer out-of-network provider is insufficient. The MCP is to revise the justification and resubmit.

Distance and Driving Time Between Nearest Network Provider and Farthest Member

Across all combinations of MCPs and ZIP Codes, the shortest median driving distance was 0 miles for Aetna Better Health of California and ZIP Codes 92103, 95630, and 95817. The shortest median driving time was 0 minutes for Aetna Better Health of California and ZIP Codes 95630 and 95817. DHCS instructed plans to submit AAS requests with a distance of 0 miles and a time of 0 minutes to represent an MCP's disagreement with the DHCS compliance assessment calculation. In these instances, DHCS reviews the MCP's analysis to determine whether the MCP's closest contracted provider is located within the time/distance standards. If DHCS confirms the MCP's closest contracted provider is located within the time/distance standards, an AAS request is not required, and no further action is required by the MCP. If DHCS concludes that the MCP's closest contracted provider is located outside of the time/distance standards, DHCS approves an AAS based on the DHCS-calculated miles and minutes of the closest contracted provider. The longest median driving distance was 207 miles for Anthem Blue Cross Partnership Plan and ZIP Code 93527, while the longest median driving time was 263 minutes for Anthem Blue Cross Partnership Plan and ZIP Code 93664.

The smallest median number of impacted members was 0 in 71 distinct combinations of MCPs and ZIP Codes associated with six different MCPs. A count of 0 impacted members most likely indicates that the MCP did not currently have any members residing in the ZIP Code. The MCP, however, would have been required to submit an AAS request because DHCS' model identified a Medi-Cal-eligible resident population in the ZIP Code that did not have access to providers of a given type within time or distance standards. The largest median number of impacted members was 42,633 individuals for Inland Empire Health Plan and ZIP Code 92345.

Time Frame for Approval or Denial of Requests

For requests submitted during the initial request and decision phase between March 25, 2024, and October 27, 2024, the median number of days to approval or denial across MCPs was 78 days. For requests submitted during the corrective action plan (CAP) resubmission phase between November 7, 2024, and November 21, 2024, the median number of days to approval

or denial was eight days for 25 requests from five MCPs.[4] This calculation includes only requests where a decision was rendered.

Approved Telehealth Requests

For 2023–24, DHCS approved 155 requests received from four MCPs: Central California Alliance for Health, CenCal Health, Health Plan of San Joaquin, and Partnership HealthPlan of California. Partnership HealthPlan of California received approval for 79 requests, which is more than any other MCP. DHCS approved requests for 14 provider types—all provider types for which telehealth could be requested except Ear, Nose, and Throat (ENT)/Otolaryngology and Obstetrics/Gynecology (OB/GYN). At least one adult and one pediatric request was received for 13 of the 14 provider types (93 percent); no requests were received for adult Ophthalmology. The population served and provider type for which requests were most frequently approved was adult Primary Care Provider (PCP), with 19 approved requests. Across all approved requests, the percentage of members with in-person access ranged from 85.7 percent to 99.6 percent, with a median of 92.2 percent. The number of full-time equivalent (FTE) providers required by DHCS ranged from 0.25 to 1.75, with a median of 0.75. The number of telehealth providers contracted by the MCP was greater than or equal to the number of providers required by DHCS for all approved requests.

Consumer Complaints

HSAG reviewed DHCS' quarterly grievance reports from State Fiscal Year (SFY) 2022–23 Quarter 3 through SFY 2023–24 Quarter 2 (January 2023 through December 2023) for member complaints related to access to providers. Grievance call frequencies were collected for four categories of complaints: "Timely Access," "Geographic Access," "Out-of-Network," and "Rural Member Denied Out-of-Network Request." Results were stratified by MCP and county.

Overall, 59,666 complaints were received across the four included categories, with 10.2 percent related to Geographic Access, 4.7 percent related to Out-of-Network provider issues, less than 0.1 percent related to Rural Member Denied Out-of-Network Request issues, and 84.9 percent related to Timely Access. On average, each MCP received 2,594.2 complaints across all categories. Across all MCPs that received complaints, the smallest number of complaints was 40 (CenCal Health), and the largest number of complaints was 18,220 (L.A. Care Health Plan).

[4] HSAG also calculated the median number of days to approval or denial across all distinct requests with approvals or denials, independent of MCP. Those medians are 83 days for the initial request and decision phase and 11 days for the CAP resubmission phase.

Contracting Efforts

HSAG reviewed data on MCP contracting efforts and the outcomes of those efforts as documented in AAS requests submitted between March 25, 2024, and November 21, 2024. The following bullet points summarize common themes in the current year's data:

- No contracting efforts were required
  - Network provider closer than out-of-network provider
  - Out-of-network provider's location outside of MCP's contracted service area
- Provider outreach in progress
  - Planning to contact provider in near future
  - Contacted or tried to contact provider by telephone, mail, or email
  - Contracting steps/negotiations in progress[5] or credentialing in progress
  - Provider already contracted with MCP but not yet credentialed
  - Provider already contracted with MCP but not yet contracted at location
  - Provider affiliated with network contracted with MCP but not yet credentialed or contracted at location
- Provider outreach unsuccessful
  - Provider unreachable due to incorrect/outdated phone and address information
  - Provider does not practice at specified location or is on extended leave
  - Provider is a hospitalist or administrator and does not take appointments
  - Members cannot make appointments for care at the specified location
  - Incorrect provider information regarding provider specialty or population served (e.g., seeking pediatric provider but provider does not see children)
- Contracting efforts were unsuccessful
  - Unable to resolve rate dispute with provider
  - Provider has policy against contracting with Medi-Cal or MCPs
  - Provider affiliated with closed network that prohibits additional contracts
  - Provider lacks capacity to take on new patients/new networks
  - Provider credentialing failed or quality of care issue

Some MCPs noted that when address or phone information was incorrect, they utilized internal databases, the National Provider Identifier (NPI) directory, Google Maps, and other tools to locate the suggested out-of-network providers. It is also noteworthy that when contracting efforts were unsuccessful, MCPs often indicated that providers' contractual relationships with other networks played an important role. This may be a particular problem in service areas shared by multiple MCPs and service areas where one or more MCPs sign providers to

[5] If applicable, the rationale must detail the targeted time frame for execution.

exclusive contracts. A small number of MCPs implied that Kaiser Permanente's expansion to new counties as an MCP may have made their contracting efforts more difficult.

Providers under Contract

The following are results of calculations based on 274 provider network data files distributed by DHCS for September 2024:

- For all MCPs, the median percentage of contracted providers across counties, populations served, and provider types was 38.4 percent (interquartile range [IQR] 6.2 percent–75.0 percent).[6] This indicates that an MCP typically contracts with roughly 38.4 percent of the providers who are contracted with any MCP in a county.
- The MCPs with the highest median percentage of contracted providers across counties and provider types were CenCal Health (100.0 percent; IQR 94.4 percent–100.0 percent) and Partnership HealthPlan of California (100.0 percent; IQR 52.9 percent–100.0 percent). These MCPs typically contract with a higher proportion of providers located within the counties they serve than other MCPs.
- The provider type with the highest median percentage of contracted providers across counties and MCPs was Hospitals (61.1 percent; IQR 40.0 percent–100.0 percent). MCPs typically contract with a higher proportion of providers of this type located within the counties they serve compared to other provider types.
- The provider type with the lowest median percentage of contracted providers across counties and MCPs was adult ENT/Otolaryngology (7.1 percent; IQR 0.0 percent–46.7 percent). MCPs typically contract with a lower proportion of providers of this type located within the counties they serve compared to other provider types.

Timeliness

Timely Access Study

Table 1 and Table 2 present calendar year 2023 and calendar year 2024 cumulative results, respectively, for providers' compliance with non-urgent and urgent in-person appointment wait times, stratified by adult and pediatric member populations. Providers for which HSAG obtained at least one appointment have been included. The rate is determined by the total number of providers with an appointment time obtained for the designated appointment that met the appointment wait time standards.

Note that on January 1, 2024, MCPs were subjected to new requirements to advance health equity, quality, access, accountability, and transparency to improve the Medi-Cal health care delivery system. As part of this transformation, some MCPs' service areas changed in 2024.

[6] The IQR of a distribution is the distance from the 25th percentile value to the 75th percentile value, delimiting the middle 50 percent (approximately) of values.

This included increases or reductions in the number of counties served by some plans, as well as changes in how counties were grouped into reporting units. Based on these changes, caution should be used when comparing calendar year 2024 results to calendar year 2023 results.

Table 1—Calendar Year 2023 Timely Access Study Statewide Provider Compliance for In-Person Appointment Wait Time Standards

* A single overall percentage is displayed for Ancillary providers and All Applicable Provider Types because in the Timely Access survey, Ancillary providers are not asked to distinguish between adult and child appointments.

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

Provider Type	Percentage of First Available In-Person Appointment Meeting Wait Time Standards						
	Non-Urgent		Urgent		Preventive Care		Non-Urgent Follow-up
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	
PCP	75.3%	78.7%	52.5%	56.1%	—	—	—
Specialist	60.9%	64.3%	43.7%	48.4%	—	—	—
Non-Physician Mental Health Provider	82.8%	81.8%	61.6%	58.8%	—	—	84.9%
Dental Providers from Health Plan of San Mateo	81.8%	87.2%	55.2%	55.6%	82.7%	88.5%	—
Ancillary*	81.2%		—		—		—
All Applicable Provider Types*	**69.2%**		**49.1%**		**86.4%**		**84.9%**

Table 2—Calendar Year 2024 Timely Access Study Statewide Provider Compliance for In-Person Appointment Wait Time Standards

* A single overall percentage is displayed for Ancillary providers and All Applicable Provider Types because in the Timely Access survey, Ancillary providers are not asked to distinguish between adult and child appointments.

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

Provider Type	Percentage of First Available In-Person Appointment Meeting Wait Time Standards						
	Non-Urgent		Urgent		Preventive Care		Non-Urgent Follow-up
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	
PCP	80.8%	84.8%	64.4%	69.0%	—	—	—
Specialist	70.5%	74.0%	54.4%	60.4%	—	—	—
Non-Physician Mental Health Provider	86.6%	86.3%	54.3%	54.7%	—	—	87.6%
Dental Providers from Health Plan of San Mateo	86.9%	91.4%	37.5%	42.3%	85.5%	90.6%	—
Ancillary*	85.2%		—		—		—
All Applicable Provider Types*	**76.8%**		**58.9%**		**88.8%**		**87.6%**

Conclusions—Timely Access Study

The following are high-level conclusions based on the timely access study results:

- Across all appointment types, non-urgent appointments offered by providers were more likely to meet wait time standards than urgent appointments.
- In general, appointments offered for adults were slightly less likely to meet wait time standards than appointments offered for children.
- In general, appointments offered by PCPs were more likely to meet wait time standards than those offered by specialists, but less likely than those offered by non-physician mental health providers, dentists, and ancillary providers.
- In general, appointments offered by providers in 2023 were slightly less likely to meet wait time standards than appointments offered in 2024.
- At the statewide level, appointment wait time for non-physician mental health providers showed year-over-year improvement in some areas. Appointments were significantly more likely to be offered within wait time standards in 2024 than in 2023 for non-urgent adult appointments, non-urgent pediatric appointments, and non-urgent follow-up appointments. However, urgent appointments offered by non-physician mental health providers were less likely to meet wait time standards in 2024 than in 2023 for adults and did not differ significantly across years for children.

Quality

DHCS Comprehensive Quality Strategy

As required by CMS, DHCS drafts and implements a written quality strategy for assessing and improving the quality of health care and services furnished by the MCMC plans, and reviews and updates its quality strategy as needed, but no less than once every three years.

DHCS did not publicly post any formal updates to the Comprehensive Quality Strategy during the time frame that HSAG conducted the 2024–25 EQR; therefore, HSAG made no recommendations to DHCS regarding the quality strategy.

Compliance Reviews

HSAG reviewed the dates on which DHCS conducted compliance reviews of MCPs and PSPs and determined that DHCS is compliant with CMS' requirement that a review must be completed for each plan within the previous three-year period.

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

Performance Measure Results Analyses

All MCPs and PSPs fully engaged in HSAG's performance measure validation process and produced valid performance measure rates for all DHCS-required Managed Care Accountability Set (MCAS) measures.

Managed Care Health Plan Conclusions

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

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

- MCPs showed varying levels of opportunities for improvement based on performance measure results, with the percentages of rates worse than the minimum performance levels

(MPLs) ranging from 77.78 percent to 0.00 percent (i.e., MCPs having no rates worse than the MPLs).

- While the statewide weighted averages for eight of the 18 performance measure weighted averages that HSAG compared to benchmarks (44 percent) were below the MPLs for measurement year 2023, aggregate performance measure results show that for five of these measures, MCPs collectively made performance improvements that contributed to statewide weighted averages improving significantly from measurement year 2022 to measurement year 2023:
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Lead Screening in Children*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- In addition to the measures listed above, the statewide weighted averages for 26 of the measures for which HSAG compared measurement year 2023 statewide weighted averages to measurement year 2022 statewide weighted averages improved significantly from measurement year 2022 to measurement year 2023.

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

- DHCS has the opportunity to support MCPs in determining priority quality improvement focus areas related to the following measures that had statewide weighted averages below the MPLs for measurement year 2023 and/or with statewide weighted averages that declined significantly from measurement year 2022 to measurement year 2023:
  - *Asthma Medication Ratio—Total*
  - *Childhood Immunization Status—Combination 10*
  - Both *Contraceptive Care—All Women—Most or Moderately Effective Contraception* measures
  - *Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total*
  - Both *Follow-Up After Emergency Department Visit for Mental Illness* measures
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase*
  - *Lead Screening in Children*
  - *Plan All-Cause Readmissions—Observed Readmissions—Total*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

HSAG drew the following conclusions related to DHCS' Comprehensive Quality Strategy Bold Goals:[7]

- The statewide weighted averages for the following measures improved significantly from measurement year 2022 to measurement year 2023, which supports DHCS' Comprehensive Quality Strategy Bold Goal to improve maternal and adolescent depression screening by 50 percent at the State level by 2025:
  - *Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total*
  - *Postpartum Depression Screening and Follow-Up—Depression Screening*
  - *Prenatal Depression Screening and Follow-Up—Depression Screening*
- The statewide weighted averages for the following measures improved significantly from measurement year 2022 to measurement year 2023, which supports DHCS' Comprehensive Quality Strategy Bold Goal to improve follow-up for members with mental health and SUDs by 50 percent at the State level by 2025:
  - *Depression Remission or Response for Adolescents and Adults—Follow-Up Patient Health Questionnaire (PHQ)-9—Total*
  - Both *Follow-Up After Emergency Department Visit for Substance Use* measures
- The statewide weighted averages for the following measures declined significantly from measurement year 2022 to measurement year 2023, reflecting opportunities for improvement in ensuring follow-up for members with mental health and substance use disorders (SUDs):
  - *Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total*
  - Both *Follow-Up After Emergency Department Visit for Mental Illness* measures

Population-Specific Health Plan Conclusions

Both PSPs exceeded the DHCS-established MPLs for all performance measure rates that HSAG compared to benchmarks. Additionally, AIDS Healthcare Foundation performed above the high performance level (HPL) for the *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure, and SCAN Health Plan performed above the HPLs for the following measures:

- *Breast Cancer Screening—Total*
- *Controlling High Blood Pressure—Total*
- *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*

[7] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Feb 13, 2025.

Preventive Services Study

The 2024 Preventive Services Report includes the results from the analysis of 28 indicators that assess the utilization of preventive services by pediatric MCMC members at the statewide and regional levels (i.e., delivery type model, population density, geographic region, and county) as well as by key demographic characteristics (i.e., race/ethnicity, primary language, gender, and age).

The *2024 Preventive Services Report* includes the detailed study methodology, key results and findings, conclusions, and considerations. At the time of production of this Executive Summary of Findings, the final version of the *2024 Preventive Services Report* was not yet available. The final report may be found at Medi-Cal Managed Care Quality Improvement Reports once it becomes available.

Technical Assistance

HSAG provided technical assistance to DHCS and plans via email, telephone, and Web conferences. The technical assistance activities resulted in:

- DHCS:
  - Gaining information to assist in making informed decisions regarding various EQR activities and MCP and PSP requirements.
  - Improving its understanding of the EQR activities to ensure it meets CMS' managed care and EQR requirements.
- MCPs and PSPs:
  - Receiving information needed to meet DHCS' requirements and for their internal quality improvement efforts.
  - Gaining knowledge and skills to apply to their quality improvement work to advance whole-person care.

Network Adequacy

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

Based on the results of the 2023–24 Skilled Nursing Facility (SNF) Experience and SNF/Intermediate Care Facility (ICF) Distance analyses, HSAG developed the following conclusions:

- For the SNF Experience analysis, the percentage of residents experiencing no events for the *Adverse Events* and *Behavioral Health* composite measures generally stayed the same

from calendar year 2022 to calendar year 2023. Performance for the *Physical Health* composite measure improved slightly from calendar year 2022 to calendar year 2023.

- *Hospital Admissions from SNFs* was the most common adverse event, with 18.79 percent of all residents experiencing at least one hospital admission during calendar year 2023, and this measure rate increased in calendar year 2023. However, the increase was partially attributable to the increasing age of the study population.
- The largest change within the *Adverse Events* composite measure was the increase from 2022 in the *Percent of Residents Who Received an Antipsychotic* measure, resulting in a 49.15 percent relative difference between calendar years 2022 and 2023. This measure excludes residents for whom antipsychotic medication is appropriate; therefore, more SNF residents may be inappropriately receiving antipsychotic medications.

- The *Percent of Residents Who Have Depressive Symptoms* rate increased substantially over the coronavirus disease 2019 (COVID-19) public health emergency; however, the rate stabilized for the first time in calendar year 2023 at 6.69 percent. In calendar year 2019 (i.e., prior to the impacts of COVID-19), this rate was 1.07 percent.
- MCMC members residing in California SNFs experienced better outcomes than SNF residents nationally for eight of 11 long-stay quality measures that could be compared to national averages in both calendar years 2022 and 2023. The measures with rates worse than the national averages were *Percent of High-Risk Residents With Pressure Ulcers*, *Percent of Residents Who Were Physically Restrained*, and *Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder*.
- For the SNF Distance analysis, the statewide average driving distance for long-stay SNF residents from their place of residence to a facility was longer than for short-stay residents for calendar year 2023. Additionally, both long- and short-stay SNF residents who had a psychiatric diagnosis other than Alzheimer's disease, who had intellectual disability or developmental disability (ID/DD) indicated, or who entered the facility from the community or a psychiatric hospital had longer than average driving distances from their place of residence to a facility. As expected, short- and long-stay SNF residents who resided in rural areas had a longer average driving distance (24.33 and 37.35 miles, respectively) from their place of residence to a facility than SNF residents who resided in urban areas (11.38 and 15.60 miles, respectively). However, the average driving distance for rural areas improved by 2.64 miles in calendar year 2023.
- As expected, ICF residents who resided in rural areas had a longer average driving distance (38.48 miles) from their place of residence to a facility than ICF residents who resided in urban areas (17.78 miles). Additionally, the average driving distance for rural areas increased in calendar year 2023 by approximately 7.5 miles.
  - The statewide average driving distance for ICF residents was generally the same from calendar year 2022 to calendar year 2023, with an increase of 0.15 miles.

Member Perceptions of Care

During contract year 2023–24, DHCS contracted with HSAG to administer and report the results of the following Consumer Assessment of Healthcare Providers and Systems[8] (CAHPS®) surveys:

- CAHPS 5.1 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®)[9] and Children with Chronic Conditions (CCC) measurement sets to meet CMS' Children's Health Insurance Program (CHIP) Reauthorization Act requirements.
- CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the 21 MCPs[10] at the plan level and the fee-for-service (FFS) program and PSP population at the statewide level.
- CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set without the CCC measurement set for the 21 MCPs at the MCP level and FFS program at the statewide level.
- CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental items set and the CCC measurement set for the statewide child population.

Children's Health Insurance Program Survey

HSAG mailed 6,680 child surveys to a sample of CHIP members selected for surveying. Of these, 854 child surveys were completed for the CHIP sample.

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

The following findings indicate notable results in member experience for several areas of care:

- The general child population scored above the 2023 National Committee for Quality Assurance (NCQA) general child Medicaid national 50th percentile for the *Getting Needed Care* composite measure.
- The 2024 score was statistically significantly higher than the 2022 score for the *Getting Needed Care* composite measure for the general child population.
- The CCC population scored above the 2023 NCQA CCC Medicaid national 50th percentiles for the following reportable measures:
  - Global Rating:

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

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

[10] Note that Community Health Plan Imperial Valley members were not included in the surveys because DHCS' contract with the MCP went into effect after the survey sampling time frame.

    - *Rating of Specialist Seen Most Often*
  - CCC Item Measures:
    - *Family-Centered Care (FCC): Getting Needed Information*
    - *Access to Prescription Medicines*

The following findings indicate opportunities for improvement in member experience for several areas of care:

- The general child population scored below the 2023 NCQA general child Medicaid national 50th percentiles for the following reportable measures:
  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
  - Composite Measures:
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
- The CCC population scored below the 2023 NCQA CCC Medicaid national 50th percentiles for the following reportable measures:
  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
  - Composite Measures:
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
  - CCC Composite Measure:
    - *FCC: Personal Doctor Who Knows Child*

Medi-Cal Adult and Child Survey

HSAG determined the sample sizes for the 2024 CAHPS Survey with the goal of obtaining 411 completed surveys at the MCP level. While the sample sizes were determined based on these goals, some measures at the MCP level, PSP statewide level, and FFS level had fewer than 100 responses for the adult and/or child populations. According to NCQA HEDIS

Specifications for Survey Measures, if a measure has fewer than 100 responses, the measure is not reportable.[11]

HSAG calculated State weighted scores for the adult and child Medi-Cal populations. Overall, the differences between the State weighted scores and the NCQA Medicaid national 50th percentiles ranged from 8.15 percentage points below to 0.21 percentage points above the NCQA adult Medicaid national 50th percentiles, with an average of 3.83 percentage points below the NCQA adult Medicaid national 50th percentiles, and from 6.16 to 0.16 percentage points below the NCQA child Medicaid national 50th percentiles, with an average of 3.28 percentage points below the NCQA child Medicaid national 50th percentiles.

The following MCPs showed the greatest level of performance by scoring statistically significantly above the 2023 NCQA Medicaid national 50th percentiles for the following reportable measures:

- Contra Costa Health Plan—*How Well Doctors Communicate* (adult population only)
- Inland Empire Health Plan—*Rating of Health Plan* (adult population only)
- Community Health Group Partnership Plan—*Rating of Personal Doctor* (child population only)
- Kaiser Permanente
  - Adult and Child Populations
    - *Rating of Health Plan*
  - Child Population Only
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Specialist Seen Most Often*
    - *Getting Needed Care*
    - *How Well Doctors Communicate*

The PSP statewide adult population scored statistically significantly above the 2023 NCQA Medicaid national 50th percentiles for the following reportable measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*

Anthem Blue Cross Partnership Plan showed the greatest opportunity for improvement for the adult population, and Health Net Community Solutions, Inc. and San Francisco Health Plan showed the greatest opportunity for improvement for the child population, with these MCPs

[11] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2023.

having the most reportable measures demonstrating statistically significantly lower performance than the 2023 NCQA Medicaid national 50th percentiles.

DHCS demonstrates a commitment to monitor and improve members' experiences through the CAHPS Survey administration. The CAHPS Survey plays an important role as a quality improvement tool. The standardized data and results can be used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time.

Based on 2024 CAHPS performance, the MCPs have opportunities to improve members' experience with care and services. The *Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly* measures show the greatest opportunities for improvement for the adult population, and the *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly* measures show the greatest opportunities for improvement for the child population, since these measures had the most MCPs with scores lower than the 50th percentiles. Low performance in these areas may point to issues with access to and timeliness and quality of care.

Performance Improvement Projects

Validation of Performance Improvement Projects

HSAG validated both 2023 and 2024 annual PIP submissions received from the MCPs and PSPs. In its PIP validation, HSAG assigned evaluation element scores and determined confidence levels for the overall confidence of MCPs' and PSPs' adherence to an acceptable PIP methodology. Figure 1 and Figure 2 depict the distribution of the confidence level ratings for the 46 PIPs that HSAG validated in 2023 and the 48 PIPs it validated in 2024.

Figure 1—September 2023 Performance Improvement Project Submission Confidence Level Ratings

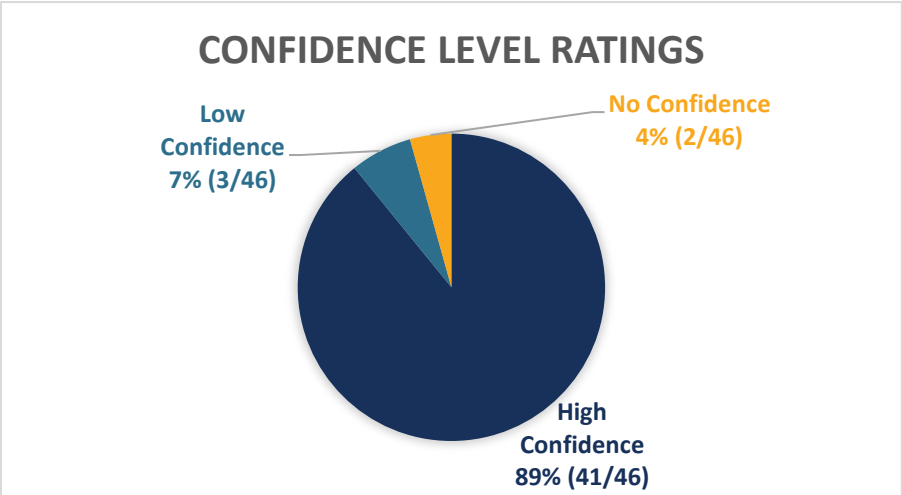
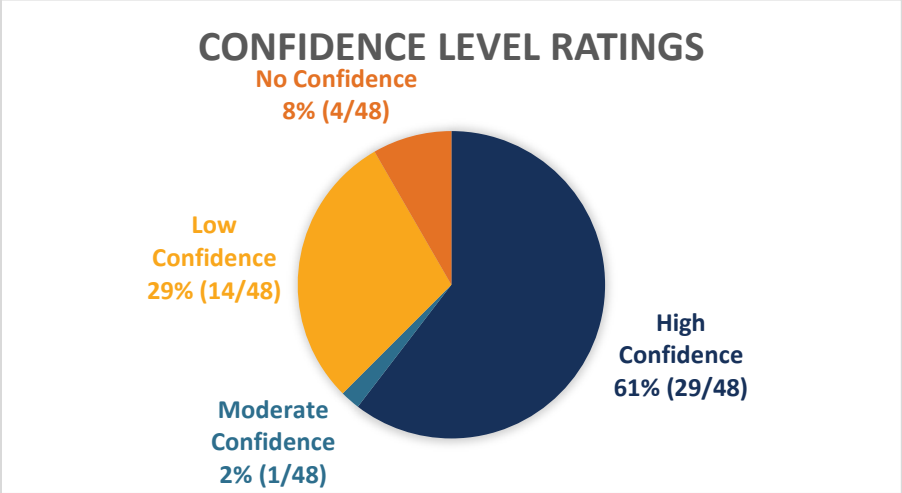


Figure 2—September 2024 Performance Improvement Project Submission Confidence Level Ratings



Performance Improvement Project Interventions

For clinical PIPs, most MCPs and PSPs tested interventions directly targeting members, which included member outreach to provide health education and appointment scheduling assistance. Additionally, MCPs and PSPs implemented provider-focused interventions to improve their clinical PIP topics, such as providing education and offering incentive programs. For nonclinical PIPs, MCPs and PSPs mainly focused on implementing systemic changes to develop new or improve existing provider notification processes.

Conclusions

All MCPs and PSPs successfully submitted their 2023 and 2024 annual submissions for their clinical and nonclinical PIPs. HSAG assessed the validity and reliability of each PIP submission and assigned a confidence level for the overall confidence of MCPs' and PSPs' adherence to an acceptable PIP methodology. Of the 46 PIPs validated in 2023, HSAG rated 41 PIPs (89 percent) with a *High Confidence* level. Additionally, of the 48 PIPs validated in 2024, HSAG rated 29 PIPs (61 percent) with a *High Confidence* level and one PIP (2 percent) with a *Moderate Confidence* level. These PIP validation findings indicate that most plans built a robust foundation in the Design and Implementation stages of their PIPs. HSAG's 2024 PIP validations determined that for PIPs which received *Low Confidence* and *No Confidence* level ratings, MCPs and PSPs did not include all required details about their PIP processes in the PIP submissions. While HSAG conducts PIP trainings to ensure MCPs and PSPs have a thorough understanding of the PIP submission requirements and validation criteria, plans should review the PIP Submission Form Completion Instructions to ensure the plans include all required information in the 2025 annual PIP submissions. HSAG will provide ongoing technical assistance to plans, as requested, throughout the life of the PIPs.

Information Systems

Encounter Data Validation—Medical Record Review

For the 2023–24 Encounter Data Validation (EDV) study, HSAG evaluated plan encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2022, and December 31, 2022. Table 3 displays the statewide results for each study indicator. Of note, for the medical record omission rate and encounter data omission rate, lower values indicate better performance.

Table 3—Statewide Results for Study Indicators

Rates shaded in gray and denoted with a cross (+) indicate having met the EDV study standards.

— indicates that the study indicator is not applicable for a data element.

* This data element is calculated based on the results from the *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements.

Key Data Elements	Medical Record Omission Rate	Encounter Data Omission Rate	Element Accuracy Rate
EDV Study Standards	Less than 10 percent	Less than 10 percent	More than 90 percent for each data element or 80 percent for all-element accuracy rate
Date of Service	8.2%+	3.3%+	—
Diagnosis Code	10.7%	1.8%+	99.7%+
Procedure Code	17.3%	8.3%+	98.6%+
Procedure Code Modifier	23.5%	4.1%+	99.9%+
Rendering Provider Name	9.6%+	3.4%+	64.2%
All-Element Accuracy	—	—	45.5%
All-Element Accuracy Excluding Rendering Provider Name*	—	—	70.5%

When comparing the 2023–24 results to the 2022–23 EDV study, the number of statewide rates meeting the EDV study standards remained the same.

Potential Concerns

Addressing External Quality Review Recommendations

The *CMS External Quality Review (EQR) Protocols, February 2023* indicate that, in the EQR technical report, the EQRO should include recommendations about how the state can target its quality strategy goals and objectives to support improvements in quality of care.[12]

In the *2022–23 Medi-Cal Managed Care Technical Report* and *2023–24 Medi-Cal Managed Care Technical Report*, HSAG made no recommendations to DHCS as part of the EQR; however, HSAG presents considerations and makes recommendations to DHCS as part of the analytic activities it conducts for DHCS. In conversations with HSAG about completed and new analytic activities, DHCS has indicated to HSAG that it reviews and takes HSAG's recommendations into account when planning future analytic activities, making policy changes, and determining guidance to provide to plans for their quality improvement efforts.

[12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 13, 2025.