Volume 1 of 9
Medi-Cal Managed Care Physical Health External Quality Review Technical Report

Contract Year 2023–24

Main Report

Quality and Population Health Management
California Department of Health Care Services

April 2025

HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Commonly Used Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

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

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

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

- **HHS**—U.S. Department of Health & Human Services
- **HIE**—health information exchange
- **HIV**—human immunodeficiency virus
- **HMO**—health maintenance organization
- **HPL**—high performance level
- **HSAG**—Health Services Advisory Group, Inc.
- **ISCAT**—Information Systems Capabilities Assessment Tool
- **LTC**—long-term care
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCO**—managed care organization
- **MCP**—managed care health plan
- **MPL**—minimum performance level
- **MRRV**—medical record review validation
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **O/E**—observed/expected
- **PAHP**—prepaid ambulatory health plan
- **PCCM**—primary care case management
- **PCP**—primary care provider
- **PHQ**—Patient Health Questionnaire
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project
- **PMV**—performance measure validation
- **PSP**—population-specific health plan
- **QAPI**—quality assessment and performance improvement
- **QPHM**—Quality and Population Health Management
- **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- **SCLC**—Statewide Collaborative Learning Call
- **SFTP**—secure file transfer protocol
- **SNF/ICF**—Skilled Nursing Facility/Intermediate Care Facility
- **SPD**—Seniors and Persons with Disabilities
- **SUD/SMH**—substance use disorder/specialty mental health

1. Introduction

External Quality Review

Title 42 Code of Federal Regulations (CFR) Section (§)438.320 defines "external quality review (EQR)" as an external quality review organization's (EQRO's) analysis and evaluation of aggregated information on the quality, timeliness, and accessibility of health care services that a managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) or their contractors furnish to Medicaid beneficiaries. Each state must comply with §457.1250,[3] and as required by §438.350, each state that contracts with MCOs, PIHPs, PAHPs, or PCCM entities must ensure that:

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

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

[3] Title 42 CFR §457.1250 may be found at: https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L/subject-group-ECFR9effb7c504b1d10/section-457.1250. Accessed on: Jan 3, 2025.

DHCS Comprehensive Quality Strategy.[4] Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS Comprehensive Quality Strategy goals as well as whether DHCS needs to revise the Comprehensive Quality Strategy based on the results presented in the EQR technical report.

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

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

[4] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

Unless noted otherwise in this report, DHCS provided HSAG with sufficient information to perform the EQR. Additionally:

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

Purpose of Report

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

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

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

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

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

This report provides a summary of the EQR activities for the MCMC physical health plans (i.e., MCPs and PSPs). HSAG summarizes the Medi-Cal Dental Managed Care (Dental MC) plan activities in the *2023–24 Medi-Cal Dental Managed Care External Quality Review Technical Report*. Except when citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable). This report will sometimes collectively refer to these MCPs and PSPs as "plans." Note that DHCS does not exempt any plans from EQR.

Quality, Timeliness, and Access

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

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

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

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

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

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

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

In *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes an assessment across all applicable EQR activities of each plan's strengths and weaknesses with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

Summary of Report Content

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

Volume 1—Main Report

- An overview of the MCMC physical health plan structure.
- A description of the DHCS Comprehensive Quality Strategy report.

- An aggregate assessment of MCPs and PSPs for the federally mandated and optional EQR activities conducted, identifying the following for each EQR activity, as applicable:
  - Objectives
  - Technical methodology used for data collection and analysis
  - Description of the data obtained
  - Conclusions based on the data analysis

Volume 2—Plan-Specific Information

- Appendix A—PSP-Specific Measurement Year 2023 Performance Measure Results
- Appendix B—Comparative Plan-Specific PIP Information
- Appendix C—Plan-Specific EQR Assessments and Recommendations
  - MCPs' and PSPs' self-reported follow-up on EQR recommendations from the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*
  - HSAG's assessment of MCPs' and PSPs' EQR strengths, weaknesses, and recommendations based on the activity results included in this EQR technical report

Volume 3—Comparative MCP-Specific Measurement Year 2023 Performance Measure Results

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

Volume 4—Statewide and MCP-Specific Measurement Year 2023 Performance Measure Results Stratified by Race and Ethnicity

- Statewide and MCP-specific performance measure results stratified by race and ethnicity.

Volume 5—Comparative Plan-Specific Compliance Review Scoring Results

- Comparative MCP- and PSP-specific scoring results for all compliance reviews DHCS conducted within the previous three-year period.

Volume 6—Validation of Network Adequacy

- Detailed methodology, results, conclusions, and recommendations related to the network adequacy validation (NAV) audits HSAG conducted of the MCPs, PSPs, and DHCS.
- Comparative MCP- and PSP-specific results for all audited network adequacy indicators.

Volume 7—Alternative Access Standards Reporting

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

Volume 8—Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

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

Volume 9—Timely Access Study Results

- Timely Access Study survey results, comparative analyses, conclusions, and considerations.

Medi-Cal Managed Care Physical Health Plan Overview

In the State of California, DHCS administers Medi-Cal through its fee-for-service (FFS) and managed care delivery systems. In California, the CHIP population is included in Medi-Cal. DHCS is responsible for assessing the quality of care delivered to members through its MCMC plans, making improvements to care and services, and ensuring that MCMC plans comply with federal and State standards.

During contract year 2023–24, DHCS contracted with 24 MCPs and two PSPs[5] to provide physical health care services in all 58 counties throughout California. MCMC members receive physical health care services through five main models of managed care as well as a model for

[5] Note: DHCS' contracts with two of the 24 MCPs, Aetna Better Health of California and California Health & Wellness Plan, ended December 31, 2023; therefore, as applicable in this report, HSAG includes information about activities completed by these two MCPs.

PSPs. DHCS monitors plan performance across model types. As of June 2024 (i.e., the end of the contract year), MCPs and PSPs provided physical health care services to more than 13.9 million members.[6]

Note that beginning January 1, 2024, MCPs began operating under a restructured contract that requires high-quality, equitable, and comprehensive coverage, and the number of MCPs as of January 1, 2024, was 22. A description of each MCP managed care model type may be found at MMCDModelFactSheet (ca.gov). The MCMC county map, which depicts the location of each MCP model type, may be found at https://www.dhcs.ca.gov/services/Documents/MMCD-Cnty-Map.pdf.

Following is a description of the PSP model type.

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

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

Table 1.1 shows plan names, model types, and reporting units for activities related to measurement year 2023 performance measure data. MCPs and PSPs submit data for some EQR activities at the plan level and submit data for other activities at the reporting unit level. The bundling of counties into a single reporting unit allows a population size to support valid rates.

Table 1.2 provides the updated plan names, model types, and counties as of January 1, 2024, as well as the enrollment information as of June 2024 (i.e., the end of the contract year).[7]

[6] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on Jul 16, 2024.

[7] Ibid.

Table 1.1—Medi-Cal Managed Care Physical Health Plan Names, Model Types, and Reporting Units for Measurement Year 2023 Performance Measure-Related Activities

* For measurement year 2023, Kaiser NorCal provided Medi-Cal services in Sacramento County as a Geographic Managed Care model type and in Amador, El Dorado, and Placer counties as a Regional model type; however, the MCP reported performance measure rates for all counties combined. DHCS' decision to have Kaiser NorCal report the combined rates ensured that the MCP had a sufficient sample size to compute accurate performance measure rates that represented the availability and quality of care provided to the region's population and assisted Kaiser NorCal with maximizing operational and financial efficiencies.

Plan Name	Model Type	Reporting Unit
Managed Care Health Plans		
Aetna Better Health of California	Geographic Managed Care	Sacramento County
		San Diego County
Alameda Alliance for Health	Two-Plan—Local Initiative	Alameda County
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Geographic Managed Care	Sacramento County
	Regional	Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)
		Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties)
	San Benito	San Benito County
	Two-Plan—Commercial	Alameda County
		Contra Costa County
		Fresno County
		Kings County
		Madera County
		San Francisco County

Plan Name	Model Type	Reporting Unit
		Santa Clara County
	Two-Plan—Local Initiative	Tulare County
Blue Shield of California Promise Health Plan	Geographic Managed Care	San Diego County
California Health & Wellness Plan	Imperial	Imperial County
	Regional	Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)
		Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties)
CalOptima	County Organized Health System	Orange County
CalViva Health	Two-Plan—Local Initiative	Fresno County
		Kings County
		Madera County
CenCal Health	County Organized Health System	San Luis Obispo County
		Santa Barbara County
Central California Alliance for Health	County Organized Health System	Merced County
		Monterey and Santa Cruz counties
Community Health Group Partnership Plan	Geographic Managed Care	San Diego County
Contra Costa Health Plan	Two-Plan—Local Initiative	Contra Costa County
Gold Coast Health Plan	County Organized Health System	Ventura County
Health Net Community Solutions, Inc.	Geographic Managed Care	Sacramento County
		San Diego County
	Two-Plan—Commercial	Kern County

Plan Name	Model Type	Reporting Unit
		Los Angeles County
		San Joaquin County
		Stanislaus County
		Tulare County
Health Plan of San Joaquin	Two-Plan—Local Initiative	San Joaquin County
		Stanislaus County
Health Plan of San Mateo	County Organized Health System	San Mateo County
Inland Empire Health Plan	Two-Plan—Local Initiative	Riverside and San Bernardino counties
Kaiser NorCal (KP Cal, LLC)*	Geographic Managed Care and Regional	KP North (Amador, El Dorado, Placer, and Sacramento counties)
Kaiser SoCal (KP Cal, LLC)	Geographic Managed Care	San Diego County
Kern Health Systems, DBA Kern Family Health Care	Two-Plan—Local Initiative	Kern County
L.A. Care Health Plan	Two-Plan—Local Initiative	Los Angeles County
Molina Healthcare of California	Geographic Managed Care	Sacramento County
		San Diego County
	Imperial	Imperial County
	Two-Plan—Commercial	Riverside and San Bernardino counties
Partnership HealthPlan of California	County Organized Health System	Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity counties)
		Northwest (Del Norte and Humboldt counties)
		Southeast (Napa, Solano, and Yolo counties)
		Southwest (Lake, Marin, Mendocino, and Sonoma counties)
San Francisco Health Plan	Two-Plan—Local Initiative	San Francisco County

Plan Name	Model Type	Reporting Unit
Santa Clara Family Health Plan	Two-Plan—Local Initiative	Santa Clara County
Population-Specific Health Plans		
AIDS Healthcare Foundation	Population-Specific Health Plan	Los Angeles County
SCAN Health Plan	Population-Specific Health Plan	Los Angeles, Riverside, San Bernardino, and San Diego counties

Table 1.2—Medi-Cal Managed Care Health Plan Names, Model Types, Counties, and County Enrollment as of June 2024

* DHCS' contract with Community Health Plan Imperial Valley became effective January 1, 2024; therefore, the MCP is only included in activities with review or implementation dates on or after January 1, 2024.

S = The number of members enrolled was too small to report based on the DHCS Data De-identification Guidelines v2.2 de-identification standard.

Plan Name	Model Type	Counties	County Enrollment as of June 2024
Managed Care Health Plans			
Alameda Alliance for Health	Single Plan	Alameda	399,019
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Geographic Managed Care	Sacramento	250,365
	Regional	Amador	6,253
		Calaveras	6,783
		Inyo	2,821
		Mono	1,845
		Tuolumne	7,765
	Two-Plan—Commercial	Alpine	239
		El Dorado	26,434
		Fresno	155,027
		Kern	32,725
		Kings	25,053

Plan Name	Model Type	Counties	County Enrollment as of June 2024
		Madera	28,785
		San Francisco	34,735
		Santa Clara	99,069
	Two-Plan—Local Initiative	Tulare	146,054
Blue Shield of California Promise Health Plan	Geographic Managed Care	San Diego	198,028
CalOptima	County Organized Health System	Orange	899,235
CalViva Health	Two-Plan—Local Initiative	Fresno	347,975
		Kings	38,404
		Madera	48,888
CenCal Health	County Organized Health System	San Luis Obispo	67,219
		Santa Barbara	172,113
Central California Alliance for Health	County Organized Health System	Mariposa	5,634
		Merced	149,135
		Monterey	194,415
		San Benito	20,548
		Santa Cruz	78,854
Community Health Group Partnership Plan	Geographic Managed Care	San Diego	406,782
Community Health Plan Imperial Valley*	Single Plan	Imperial	96,474
Contra Costa Health Plan	Single Plan	Contra Costa	258,693

Plan Name	Model Type	Counties	County Enrollment as of June 2024
Gold Coast Health Plan	County Organized Health System	Ventura	248,580
Health Net Community Solutions, Inc.	Geographic Managed Care	Sacramento	146,087
	Regional	Amador	1,914
		Calaveras	6,010
		Inyo	2,056
		Mono	1,055
		Tuolumne	6,480
	Two-Plan—Commercial	Los Angeles	1,180,736
		San Joaquin	34,207
		Stanislaus	68,785
		Tulare	138,453
Health Plan of San Joaquin	Two-Plan—Commercial	Alpine	34
		El Dorado	8,468
	Two-Plan—Local Initiative	San Joaquin	243,806
		Stanislaus	170,184
Health Plan of San Mateo	County Organized Health System	San Mateo	144,367
Inland Empire Health Plan	Two-Plan—Local Initiative	Riverside	765,017
		San Bernardino	722,884

Plan Name	Model Type	Counties	County Enrollment as of June 2024
Kaiser Permanente	County Organized Health System	Marin	6,943
		Mariposa	S
		Napa	7,482
		Orange	67,834
		Placer	17,510
		San Mateo	14,784
		Santa Cruz	344
		Solano	37,245
		Sonoma	25,340
		Sutter	S
		Ventura	7,671
		Yolo	5,668
		Yuba	591
	Geographic Managed Care	Sacramento	131,668
		San Diego	75,132
	Regional	Amador	302
	Single Plan	Alameda	67,471
		Contra Costa	54,109
		Imperial	16
	Two-Plan—Commercial	El Dorado	3,916
		Fresno	5,931
		Kern	19,916
		Kings	102
		Los Angeles	292,132
		Madera	987
		Riverside	84,623
		San Bernardino	90,500
		San Francisco	19,826

Plan Name	Model Type	Counties	County Enrollment as of June 2024
		San Joaquin	23,541
		Santa Clara	43,950
		Stanislaus	5,332
		Tulare	39
Kern Health Systems, DBA Kern Family Health Care	Two-Plan—Local Initiative	Kern	402,905
L.A. Care Health Plan	Two-Plan—Local Initiative	Los Angeles	2,348,891
Molina Healthcare of California	Geographic Managed Care	Sacramento	72,270
		San Diego	301,207
	Two-Plan—Commercial	Riverside	116,202
		San Bernardino	107,787
Partnership HealthPlan of California	County Organized Health System	Butte	84,293
		Colusa	10,189
		Del Norte	12,303
		Glenn	13,530
		Humboldt	58,513
		Lake	34,396
		Lassen	8,681
		Marin	46,373
		Mendocino	41,254
		Modoc	3,934
		Napa	26,946
		Nevada	28,263
		Placer	59,485
		Plumas	5,891

Plan Name	Model Type	Counties	County Enrollment as of June 2024
		Shasta	67,894
		Sierra	836
		Siskiyou	18,039
		Solano	101,881
		Sonoma	110,180
		Sutter	43,432
		Tehama	30,025
		Trinity	5,533
		Yolo	53,273
		Yuba	35,567
San Francisco Health Plan	Two-Plan—Local Initiative	San Francisco	175,674
Santa Clara Family Health Plan	Two-Plan—Local Initiative	Santa Clara	291,385
Population-Specific Health Plans			
AIDS Healthcare Foundation	Population-Specific Health Plan	Los Angeles	902
SCAN Health Plan	Population-Specific Health Plan	Los Angeles	12,231
		Riverside	3,286
		San Bernardino	2,516
		San Diego	1,361

Table 1.3 indicates the number of members served by each model type as of June 2024.

Table 1.3—Number of Members Served by Model Type

Plan Model Type	Number of Members Served as of June 2024
County Organized Health System	3,072,223
Geographic Managed Care	1,581,539
Population-Specific Health Plan	20,296
Regional	43,284
Single Plan	875,782
Two-Plan—Commercial	2,647,534
Two-Plan—Local Initiative	5,702,067

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

2. DHCS Comprehensive Quality Strategy

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

In the previous two annual EQR technical reports, HSAG indicated that DHCS submitted the *DHCS Comprehensive Quality Strategy 2022* to CMS on February 4, 2022.

Following this submission, DHCS regularly reviewed health care data to assess DHCS' progress toward meeting the Comprehensive Quality Strategy goals. To meet CMS' requirement of updating the DHCS Comprehensive Quality Strategy no less than once every three years, DHCS initiated a formal revision process in July 2024 and will submit the final version to CMS by July 2025. DHCS' revision process included DHCS leadership input and opportunities for stakeholders to review and provide feedback. DHCS will review stakeholder comments and will incorporate the feedback into the final version of the Comprehensive Quality Strategy.

Due to the timing of DHCS finalizing the Comprehensive Quality Strategy, HSAG was unable to review the final version of the Comprehensive Quality Strategy or include detailed information in this EQR technical report. HSAG will provide a summary of the final DHCS Comprehensive Quality Strategy in the 2024–25 MCMC Physical Health EQR technical report.

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

Recommendations

Because HSAG was not yet able to review DHCS' final Comprehensive Quality Strategy, HSAG has no recommendations for DHCS in this EQR technical report. If applicable, HSAG will provide recommendations in the 2024–25 MCMC Physical Health EQR technical report on how DHCS can target the Comprehensive Quality Strategy vision, goals, and guiding principles to better support improvement to the quality, timeliness, and accessibility of care for MCP and PSP members.

3. Validation of Performance Improvement Projects

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

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve quality improvement
- Evaluating intervention effectiveness
- Planning and initiating activities for increasing and sustaining improvement

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

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

Objectives

The purpose of HSAG's PIP validation is to ensure that MCPs, PSPs, DHCS, and stakeholders can have confidence that the plans executed a methodologically sound improvement project, and that any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted during the PIP.

As part of the annual validation, HSAG evaluates two key components of the quality improvement process:

- The technical structure of the PIP, to ensure that the plan designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements.
  - HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes.

Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

- The implementation of the PIP. Once designed, a plan's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, the identification of barriers, and subsequent development of relevant interventions.

Technical Methods of Data Collection and Analysis

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

Performance Improvement Project Overview

HSAG's PIP process is based on the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[8]

HSAG works with states for which it is the EQRO to ensure managed care plans meet the requirement to conduct clinical and nonclinical PIPs. HSAG's determination of whether a PIP topic is clinical or nonclinical is based on the performance indicator(s) defined for the PIP. HSAG determines a performance indicator to be clinical when it measures the occurrence of a clinical service in a clinical setting. A nonclinical PIP's performance indicator must be focused on a nonclinical aspect of care and not related to a clinical service or visit.

Performance Improvement Project Stages

The following are the three PIP stages:

- **Design**, which includes:
  - Selecting the topic based on data that identify an opportunity for improvement.
  - Defining the PIP Aim statement(s) to help maintain the PIP focus and set the framework for data collection, analysis, and interpretation.
  - Clearly defining the PIP population to represent the population to which the PIP Aim statement(s) and performance indicator(s) apply.
  - If sampling is used, using sound sampling methods to select members of the population.

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 3, 2025.

- Selecting the performance indicator(s) to track performance or improvement over time.
  - A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured.
  - The performance indicator(s) should be objective, clear and unambiguously defined, and based on current clinical knowledge or health services research.
- Defining a valid and reliable data collection process which ensures that the data collected for each indicator are valid and reliable.
  - Validity is an indication of the accuracy of the information obtained.
  - Reliability is an indication of the repeatability or reproducibility of a measurement.

- **Implementation**, which includes:
  - Completing data analysis and interpretation of performance indicator results.
  - Conducting causal/barrier analyses and processes to identify and prioritize barriers to desired outcomes.
  - Developing and testing/initiating interventions that are linked to the identified and prioritized barriers.
  - Ongoing data collection to evaluate the effectiveness of each intervention, and using data to determine whether to adopt, adapt, abandon, or continue testing each intervention.
- **Outcomes**, which includes evaluating performance indicator performance based on the following:
  - Non-statistically significant improvement over the baseline performance across all performance indicators.
  - Statistically significant improvement over the baseline performance across all performance indicators.
  - Sustained improvement is assessed after improvement over the baseline performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over the baseline performance indicator performance.

Throughout the duration of the PIP process, HSAG conducts trainings as needed and provides technical assistance to plans when requested.

Annual Submission and Validation

The duration of a PIP is a minimum of three years and includes the reporting of annual measurement periods for baseline, Remeasurement 1, and Remeasurement 2. Plans annually submit to HSAG a PIP Submission Form that documents the PIP activities to the point of progression. HSAG provides to plans the *PIP Submission Form Completion Instructions* that include the details regarding documentation requirements for each step in the PIP process.

As part of the annual validation, HSAG assigns *Met/Partially Met/Not Met* scores to evaluation elements within each of the following review steps, as applicable:

- Review the selected PIP topic.
- Review the PIP Aim statement(s).
- Review the identified PIP population.
- Review the sampling method.
- Review the selected performance indicator(s).
- Review the data collection procedures.
- Review the data analysis and interpretation of results.
- Assess the improvement strategies.
- Assess the likelihood that significant and sustained improvement occurred.

Based on the evaluation element scores, HSAG assesses the validity and reliability of PIP results by determining the confidence levels for the following:

- Overall confidence of adherence to acceptable PIP methodology.
- Overall confidence that the PIP achieved significant improvement.

HSAG shares the initial PIP validation findings with the MCPs and PSPs and provides an opportunity for these plans to address the identified findings and resubmit. The plans have an opportunity to seek technical assistance prior to resubmitting the PIPs for the final validation. HSAG provides final PIP validation findings to the plans and DHCS.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validations from the PIP Submission Forms that plans submitted in September 2023 and September 2024. The plans submitted one form for each required PIP for each annual submission. The September 2023 submissions included information about the PIP design. The September 2024 submissions included baseline data (calendar year 2023) and documented improvement strategies conducted in 2024 up to the date of submission.

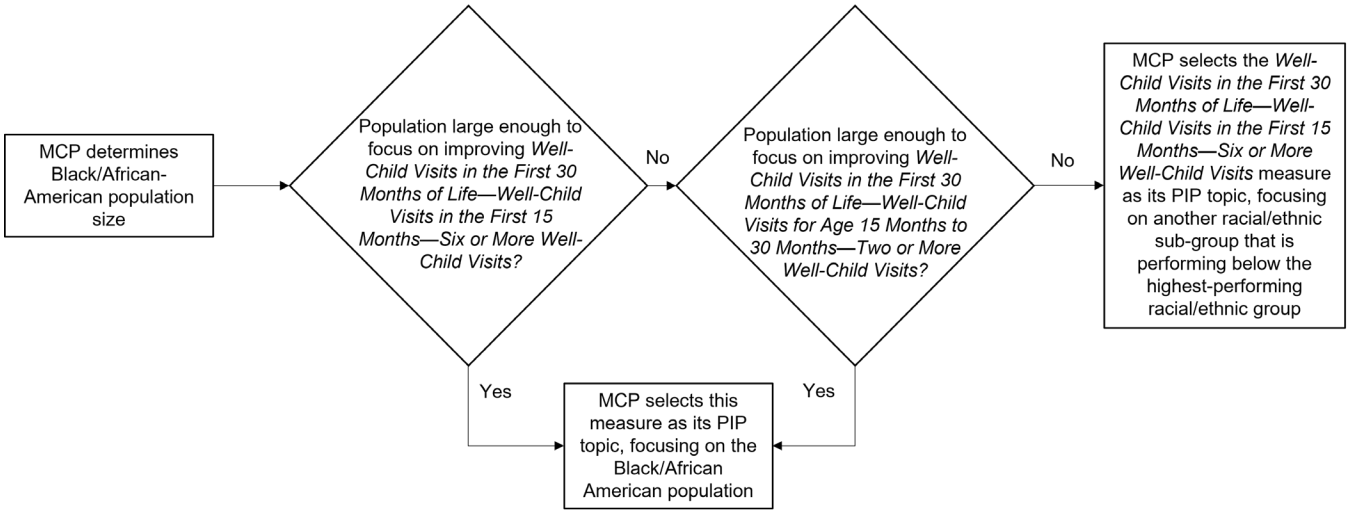
Requirements

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

For 2023–26 PIPs, DHCS worked individually with the two PSPs, based on their specialized populations, to identify PIP topics based on opportunities for improvement.

In alignment with DHCS' Comprehensive Quality Strategy Bold Goals,[9] DHCS required the following for the MCP PIP topics:

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



- Nonclinical PIP—DHCS designed the nonclinical PIP topic choices to support efforts to improve statewide performance on the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* and *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* measures. MCPs were given three topic choices:
  - Improve the percentage of provider notifications for members with substance use disorder/specialty mental health (SUD/SMH) diagnoses following or within seven days of emergency department visit.
  - Improve the percentage of referrals to Community Support programs (Sobering Centers, Day Habilitation programs) within seven days of visiting an emergency department for members with a SUD/SMH diagnosis and seen in the emergency department for the same diagnoses.
  - Improve the percentage of members enrolled into care management, complex care management, or enhanced care management within 14 days of a provider visit where the member was diagnosed with SUD/SMH.
    - MCPs were required to identify the provider type for the qualifying visit that started the 14-day time period and to select a provider type for which they have access to real-time data to avoid a claims lag that might impede the identification of these eligible members and their enrollment into one of the qualifying care management programs within the 14-day requirement.

[9] Ibid.

Results

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 3.1 and Figure 3.2 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 3.1—September 2023 Performance Improvement Project Submission Confidence Level Ratings

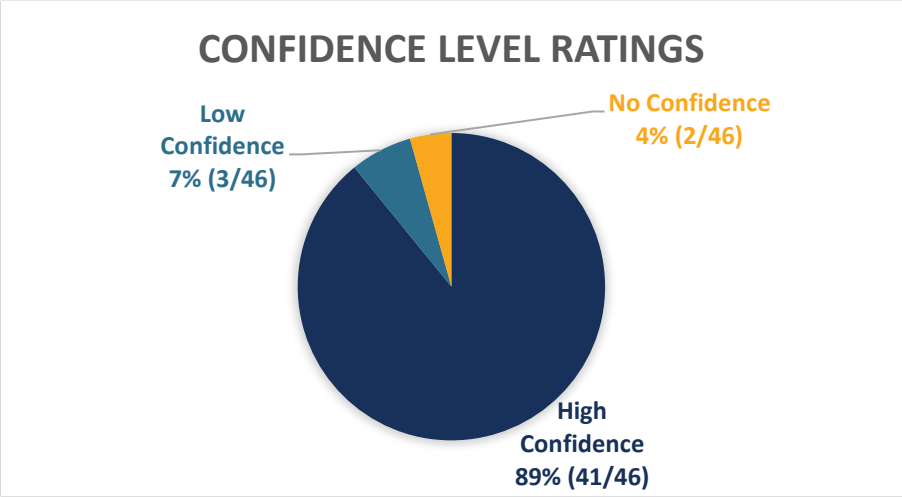
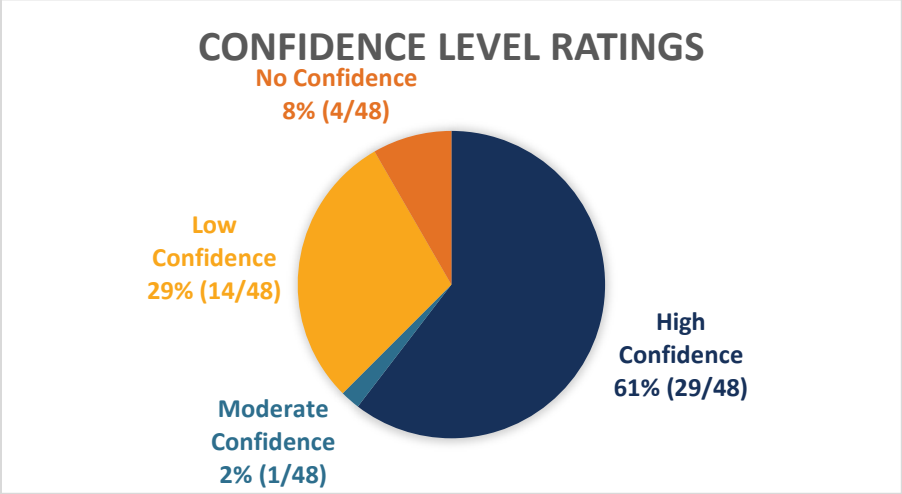


Figure 3.2— September 2024 Performance Improvement Project Submission Confidence Level Ratings



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.

In *Volume 2 of 9 (Appendix B)* of this EQR technical report, HSAG includes plan-specific PIP validation findings and intervention information.

Conclusions

To draw conclusions related to MCPs' and PSPs' PIPs, HSAG assessed the PIP validation results, including the confidence levels HSAG assigned to each PIP.

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.

In *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each plan's strengths and weaknesses related to PIPs with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

4. Validation of Performance Measures

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

To comply with §438.358, DHCS contracted with HSAG to conduct an independent audit in alignment with the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™,[10] standards, policies, and procedures to assess the validity of the DHCS-selected performance measures calculated and submitted by MCPs and PSPs. During each audit, HSAG assesses the validity of each plan's data using the CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[11] Following the audits, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about these plans' performance in providing quality, timely, and accessible care and services to their members.

Objectives

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

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

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

Note: MCPs and PSPs must calculate and report DHCS' required performance measure rates annually for a measurement year (January through December) at the reporting unit level.

[10] HEDIS Compliance Audit™ is a trademark of NCQA.
[11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 3, 2025.

DHCS defines a "reporting unit level" as a single county, a combined set of counties, or a region as determined and pre-approved by DHCS.

Technical Methods of Data Collection and Analysis

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

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

Performance Measure Validation Activities

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

Audit Validation Activities Phase (September 2023 through May 2024)

- Forwarded HEDIS measurement year 2023 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Forwarded an introductory packet that included the list of performance measures selected by DHCS for each population, the HEDIS measurement year 2023 Roadmap, a timeline for each of the required audit tasks, and guidance on the process requirements.
- Communicated frequently with the MCPs and PSPs throughout the audit season about important audit items, including reminders of upcoming deadlines, required processes, DHCS reporting requirements, performance measure clarifications, and NCQA updates.
- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS Compliance Audit processes, and ensure that MCPs and PSPs were aware of important deadlines.
- Scheduled virtual audit reviews with MCPs and PSPs.

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

Audit Review Meetings Phase (January 2024 through April 2024)

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

Follow-Up and Reporting Phase (May 2024 through July 2024)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final Information Systems standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS measurement year 2022 Audit Means and Percentiles. The report also included a comparison of the eligible populations for each measure to the prior year's eligible populations; and requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year. Additionally, auditors verified that MCPs and PSPs used HEDIS Certified Measures[12] to generate the final rates.
- Compared the final rates to the patient-level detail files required by DHCS, ensuring that member-level data matched the final rate submission and met DHCS requirements.

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

- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

Description of Data Obtained

Through the methodology, HSAG obtained a number of different information sources to conduct the measurement year 2023 HEDIS Compliance Audits. These included:

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

Performance Measure Results Analyses

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

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

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

Results

For measurement year 2023, HSAG conducted 26 HEDIS Compliance Audits for 24 MCPs and two PSPs. The 26 audits resulted in 57 separate data submissions for performance measure rates at the reporting unit level. HSAG also conducted PMV with the 24 MCPs for a select set of measures that DHCS required MCPs to stratify by the Seniors and Persons with Disabilities (SPD), non-SPD, and long-term care (LTC) populations.

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

Conclusions

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

HSAG identified the following strengths during the audit process, which contributed to the PSPs and the majority of MCPs being able to fully engage in the audit process and produce valid performance measure rates for all measures:

- DHCS continued to allow MCPs and PSPs to choose the data collection methodology for measures with both hybrid and administrative options, which may have saved some MCPs and PSPs the costs associated with using the hybrid methodology in instances wherein hybrid reporting did not improve their rates. Additionally, in instances wherein the MCPs and PSPs were unable to report a measure rate using the hybrid methodology, DHCS' decision provided them the opportunity to report the rate administratively, which resulted in a Reportable (R) rate instead of a Biased Rate (BR).
- HSAG auditors determined that both PSPs and 20 of the 24 MCPs were fully compliant with all information systems standards. The auditors determined that the four remaining MCPs were fully compliant with three of the four information systems standards.
- With few exceptions, MCPs and PSPs had integrated teams which included key staff members from both quality and information technology departments. HSAG observed that both areas worked closely together and had a sound understanding of the NCQA HEDIS Compliance Audit process. This multidisciplinary approach is crucial for reporting accurate and timely performance measure rates.
- MCPs and PSPs used enrollment data as the primary data source for determining the eligible population for most measures. The routine data transfer and longstanding relationship between PSPs/MCPs and DHCS continued to support implementation of best practices and stable processes for acquiring membership data.
- The two PSPs and the majority of MCPs continued to increase their use of supplemental data sources. These additional data sources offered MCPs and PSPs the opportunity to more accurately capture the services provided to their members. Moreover, reporting hybrid measures along with supplemental data reduced the amount of resources that MCPs and PSPs had to expend to abstract the clinical information, thus lessening their burden.
- MCPs and PSPs had rigorous editing processes in place to ensure accurate and complete pharmacy, laboratory, and provider claims data.

- With few exceptions, MCPs and PSPs received most claims data electronically and had a very small percentage of claims that required manual data entry, minimizing the potential for errors.

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

During the audit process, HSAG stressed the importance of MCPs and PSPs using all data that DHCS made available to them for performance measure reporting. HSAG also emphasized to MCPs and PSPs that it is essential they identify the various data sources needed for reporting early in the audit season and monitor the rates frequently to ensure that any potential issues are resolved prior to reporting final rates.

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

In *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each plan's strengths and weaknesses related to PMV with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

5. Managed Care Health Plan Performance Measures

Objective

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

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the analyses in this section from the MCPs during the PMV activities described in Section 4 of this report ("**Validation of Performance Measures**") and from NCQA via NCQA's Quality Compass®.[13]

Description of Data Obtained

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

- Performance measure data submitted by the MCPs, which included numerators, denominators, and calculated rates.
- NCQA's HEDIS 2023 Medicaid health maintenance organization (HMO) benchmarks (50th percentiles, 90th percentiles, and national Medicaid averages).
- CMS Federal Fiscal Year (FFY) 2022 Core Set of Children's Health Care Quality Measures for Medicaid and the CHIP (Child Core Set) state medians.

Requirements

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

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

accountability. The workgroup also ensures that all required measures are aligned with the Comprehensive Quality Strategy and its key objectives.[14] The performance measure requirements support the advancement of DHCS' Comprehensive Quality Strategy goals as well as DHCS' *Medi-Cal's Strategy to Support Health and Opportunity for Children and Families*, which is a forward-looking policy agenda for children and families enrolled in Medi-Cal.[15]

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

Medi-Cal Managed Care Accountability Set

DHCS' measurement year 2023[16] MCAS included select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also HEDIS measures. Several required measures include more than one indicator. In this report, HSAG uses "performance measure" or "measure" (rather than indicator) to reference required MCAS measures. Collectively, performance measure results reflect the quality, timeliness, and accessibility of care MCPs provide to their members.

NCQA required race and ethnicity stratifications for select HEDIS measures. DHCS also required MCPs to report the NCQA race and ethnicity stratifications for additional measures. The race stratifications are listed below:

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

[14] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

[15] *Medi-Cal's Strategy to Support Health and Opportunity for Children and Families*. March 2022. Available at: https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf. Accessed on: Jan 3, 2025.

[16] The measurement year is the calendar year for which MCPs report the rates. Measurement year 2023 represents data from January 1, 2023, through December 31, 2023.

The ethnicity stratifications are listed below:

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

Table 5.1 lists the measurement year 2023 MCAS measures by measure domain. DHCS organized the measures for which it holds MCPs accountable to meet MPLs into measure domains based on the health care areas they affect. Organizing these measures by domain allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS. Additionally, Table 5.1 includes descriptions and indicates the data capture method(s) for each measurement year 2023 MCAS measure. For some MCAS performance measures, the specifications allow for both administrative and hybrid reporting methods; for these measures, DHCS allows MCPs to choose either methodology. Note that when reporting performance measure rates using the hybrid methodology, MCPs are required to procure medical record data.

Note the following:

- For measurement year 2023, DHCS required MCPs to report rates at the SNF level for the following three LTC measures:
  - *Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days*
  - *Potentially Preventable 30-Day Post-Discharge Readmissions*
  - *Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*

  To ensure consistent calculation and reporting of rates for these measures, DHCS contracted with HSAG to update and test the measure specifications for each of the three measures. The MCPs used the revised measure specifications to calculate and report their measurement year 2023 rates.

  Because measurement year 2023 was the first year DHCS required MCPs to report the LTC measure rates and the rates were reported at the facility level rather than at the reporting unit level, MCPs and their measure vendors encountered challenges calculating the LTC measure rates. DHCS therefore elected to exclude the LTC measure rates from this EQR technical report. DHCS will review each MCP's facility-level rates and will address any identified concerns with MCPs.

  Prior to the measurement year 2024 performance measure audits, DHCS and HSAG will work with the MCPs to ensure they are able to consistently report the LTC measure rates. DHCS and HSAG will also determine the most meaningful way to present the LTC measure rate results in future EQR technical reports.

- DHCS included the *Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate* measure in the measurement year 2023 MCAS; however, because rates for this measure were not calculated, DHCS opted to not have HSAG present information related to this measure in this EQR technical report. To assess reduction of low-risk cesarean deliveries, DHCS will explore including this or a similar measure, such as the *Low-Risk Cesarean Delivery* measure, in future EQR technical reports.

Table 5.1—Measurement Year 2023 Managed Care Accountability Set Measures

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

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

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

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

^ NCQA requires race and ethnicity stratifications for this measure.

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

Measure	Method of Data Capture
Children's Health Domain (Measures held to MPLs.)	
*Child and Adolescent Well-Care Visits—Total^* The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.	Admin

Measure	Method of Data Capture
*Childhood Immunization Status—Combination 10^^* The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenza type B; three hepatitis B, one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday.	Admin or Hybrid*
Developmental Screening in the First Three Years of Life—Total The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Admin
*Immunizations for Adolescents—Combination 2^* The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus vaccine series by their 13th birthday.	Admin or Hybrid*
Lead Screening in Children The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	Admin or Hybrid*
Topical Fluoride for Children—Dental or Oral Health Services—Total The percentage of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as dental or oral health services within the measurement year.	Admin
*Well-Child Visits in the First 30 Months of Life^* Two rates are reported: ♦ *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*—The percentage of members who turned 15 months old during the measurement year who had six or more well-child visits with a PCP during the last 15 months. ♦ *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*—The percentage of members who turned 30 months old during the measurement year who had two or more well-child visits with a PCP during the last 15 months.	Admin

Measure	Method of Data Capture
Reproductive Health Domain (Measures held to MPLs.)	
Chlamydia Screening in Women—Total The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Admin
*Prenatal and Postpartum Care^* Two rates are reported: ♦ *Postpartum Care*—The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. ♦ *Timeliness of Prenatal Care*—The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	Admin or Hybrid*
Cancer Prevention Domain (Measures held to MPLs.)	
*Breast Cancer Screening—Total^* The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.	ECDS
Cervical Cancer Screening The percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: ♦ Women 21 to 64 years of age who had cervical cytology performed within the last 3 years. ♦ Women 30 to 64 years of age who had cervical high-risk human papillomavirus testing performed within the last 5 years. ♦ Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus within the last 5 years.	Admin or Hybrid*
Chronic Disease Management Domain (Measures held to MPLs.)	
*Asthma Medication Ratio—Total^* The percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Admin

Measure	Method of Data Capture
*Controlling High Blood Pressure—Total^* The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Admin or Hybrid*
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^* The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0 percent).	Admin or Hybrid*
Behavioral Health Domain (Measures held to MPLs.)	
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total^^* The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the emergency department visit (31 total days).	Admin
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total^* The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a follow-up visit within 30 days of the emergency department visit (31 total days).	Admin
Report Only Measures (Measures not held to MPLs.)	
Adults' Access to Preventive/Ambulatory Health Services—Total The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.	Admin
Ambulatory Care—Emergency Department (ED) Visits—Total This measure summarizes utilization of ambulatory care in the category of emergency department visits. The measure reports the number of visits per 1,000 member months. Member months are a member's "contribution" to the total yearly membership.	Admin

Measure	Method of Data Capture
Antidepressant Medication Management The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported: ♦ *Effective Acute Phase Treatment—Total*—The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ♦ *Effective Continuation Phase Treatment—Total*—The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	Admin
Colorectal Cancer Screening^ The percentage of members 45 to 75 years of age who had appropriate screening for colorectal cancer.	ECDS
Contraceptive Care—All Women—Most or Moderately Effective Contraception Among women at risk of unintended pregnancy, the percentage who were provided a most effective or moderately effective method of contraception. Two rates are reported: ♦ *Ages 15–20 Years* ♦ *Ages 21–44 Years*	Admin
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—90 Days Among women who had a live birth, the percentage who were provided a most effective or moderately effective method of contraception within 90 days of delivery. Two rates are reported: ♦ *Ages 15–20 Years* ♦ *Ages 21–44 Years*	Admin

Measure	Method of Data Capture
Depression Remission or Response for Adolescents and Adults The percentage of members 12 years of age and older with a diagnosis of depression and an elevated Patient Health Questionnaire (PHQ-9) score, who had evidence of response or remission within 4 to 8 months of the elevated score. Three rates are reported: ♦ *Follow-Up PHQ-9*—The percentage of members who have a follow-up PHQ-9 score documented within 4 to 8 months after the initial elevated PHQ-9 Score. ♦ *Depression Remission*—The percentage of members who achieved remission within 4 to 8 months after the initial elevated PHQ-9 score. ♦ *Depression Response*—The percentage of members who showed response within 4 to 8 months after the initial elevated PHQ-9 score.	ECDS
Depression Screening and Follow-Up for Adolescents and Adults^^ The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates are reported: ♦ *Depression Screening*—The percentage of members who were screened for clinical depression using a standardized instrument. ♦ *Follow-Up on Positive Screen*—The percentage of members who received follow-up care within 30 days of a positive depression screen finding.	ECDS
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Admin
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total^^ The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the emergency department visit (8 total days).	Admin

Measure	Method of Data Capture
*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total^* The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a follow-up visit within 7 days of the emergency department visit (8 total days).	Admin
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication The percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the first ADHD medication being dispensed. Two rates are reported: ♦ *Initiation Phase*—The percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. ♦ *Continuation and Maintenance Phase*—The percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	Admin
Metabolic Monitoring for Children and Adolescents on Antipsychotics The percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: ♦ *Blood Glucose Testing—Total*—The percentage of children and adolescents on antipsychotics who received blood glucose testing. ♦ *Cholesterol Testing—Total*—The percentage of children and adolescents on antipsychotics who received cholesterol testing. ♦ *Blood Glucose and Cholesterol Testing—Total*—The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	Admin

Measure	Method of Data Capture
Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days^^ The number of outpatient emergency department visits that occurred among permanent (i.e., long-stay) residents of a nursing home during a one-year period, expressed as the number of outpatient emergency department visits for every 1,000 days that the long-stay residents were admitted to the facility (i.e., long-stay resident days).	Admin
Pharmacotherapy for Opioid Use Disorder^ The percentage of new opioid use disorder pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of opioid use disorder and a new opioid use disorder pharmacotherapy event.	Admin
Plan All-Cause Readmissions^^ For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure reports the count of observed 30-day readmissions. Three rates are reported: ♦ *Observed Readmissions—Total* ♦ *Expected Readmissions—Total* ♦ *Observed/Expected (O/E) Ratio—Total*	Admin
Postpartum Depression Screening and Follow-Up The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported: ♦ *Depression Screening*—The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. ♦ *Follow-Up on Positive Screen*—The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	ECDS
Potentially Preventable 30-Day Post-Discharge Readmissions^^ The percentage of unplanned, potentially preventable readmissions for residents who are Medi-Cal members and dual-eligible members. This outcome measure reflects readmission rates for residents who are readmitted to a short-stay acute-care hospital within a 30-day window following discharge from a SNF with a principal diagnosis considered to be unplanned and potentially preventable.	Admin

Measure	Method of Data Capture
Prenatal Depression Screening and Follow-Up The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported: ♦ *Depression Screening*—The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. ♦ *Follow-Up on Positive Screen*—The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	ECDS
Prenatal Immunization Status The percentage of deliveries in the measurement period in which women received influenza and Tdap vaccinations. Three rates are reported: ♦ *Influenza* ♦ *Tdap* ♦ *Combination*	ECDS
*Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization^^* The percentage of healthcare-associated infections that are acquired during SNF care and result in hospitalization.	Admin
Topical Fluoride for Children The percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications. Two rates are reported for the report only category: ♦ *Dental Services—Total* ♦ *Oral Health Services—Total*	Admin

Seniors and Persons with Disabilities Performance Measure Stratification

In addition to requiring MCPs to report rates for MCAS measures in measurement year 2023, DHCS required MCPs to report separate rates for their SPD and non-SPD populations for the following measures:

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

DHCS-Established Performance Levels

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

To establish the HPLs and MPLs for the measurement year 2023 MCAS HEDIS measures, DHCS used NCQA's Quality Compass HEDIS 2023 Medicaid HMO benchmarks, which reflect the previous year's benchmark percentiles (measurement year 2022). For measurement year 2023, DHCS based the HPLs on NCQA's Quality Compass HEDIS 2023 Medicaid HMO 90th percentiles and the MPLs on the Medicaid HMO 50th percentiles.

To establish the MPLs for the measurement year 2023 MCAS CMS Child Core Set measures, DHCS used the CMS FFY 2022 state medians.[17] DHCS established no HPLs for the Child Core Set measures.

HSAG includes in Table 5.2 the benchmarks that DHCS used to establish the HPLs and MPLs for the measurement year 2023 MCAS measures for which DHCS determined to hold MCPs accountable to meet the MPLs.[18] Note that according to DHCS' license agreement with NCQA, HSAG includes the NCQA Quality Compass benchmarks.

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[17] Centers for Medicare & Medicaid Services: *Quality of Care for Children in Medicaid and CHIP: Findings from the 2022 Child Core Set—Chart Pack*, January 2024. Available at: Quality of Care for Children in Medicaid and CHIP: Findings from the 2022 Child Core Set Chart Pack. Accessed on: Jan 3, 2025.

[18] The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the data") is Quality Compass® 2023 and is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on the data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

The data comprise audited performance rates and associated benchmarks for HEDIS® and HEDIS CAHPS® survey measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures, or any data or rates calculated using HEDIS measures and specifications, and NCQA has no liability to anyone who relies on such measures or specifications.

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Table 5.2—High Performance Level and Minimum Performance Level Benchmark Values for Measurement Year 2023

Measurement year 2023 HPL and MPL HEDIS benchmark values represent NCQA's Quality Compass HEDIS 2023 Medicaid HMO 90th and 50th percentiles, respectively, reflecting the measurement year from January 1, 2022, through December 31, 2022.

Measurement year 2023 MPL Child Core Set benchmark values represent services furnished to children covered by Medicaid and CHIP during FFY 2022, which generally covers care delivered in calendar year 2021. The Core Set benchmarks are denoted with an asterisk (*).

^ A lower rate indicates better performance for this measure.

Measure	Measurement Year 2023 High Performance Level	Measurement Year 2023 Minimum Performance Level
Children's Health Domain		
Child and Adolescent Well-Care Visits—Total	61.15%	48.07%
Childhood Immunization Status—Combination 10	45.26%	30.90%
Developmental Screening in the First Three Years of Life—Total	N/A	34.70%*
Immunizations for Adolescents—Combination 2	48.80%	34.31%
Lead Screening in Children	79.26%	62.79%
Topical Fluoride for Children—Dental or Oral Health Services—Total	N/A	19.30%*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	68.09%	58.38%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	77.78%	66.76%
Reproductive Health Domain		
Chlamydia Screening in Women—Total	67.39%	56.04%
Prenatal and Postpartum Care—Postpartum Care	84.59%	78.10%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.07%	84.23%

Measure	Measurement Year 2023 High Performance Level	Measurement Year 2023 Minimum Performance Level
Cancer Prevention Domain		
Breast Cancer Screening—Total	62.67%	52.60%
Cervical Cancer Screening	66.48%	57.11%
Chronic Disease Management Domain		
Asthma Medication Ratio—Total	75.92%	65.61%
Controlling High Blood Pressure—Total	72.22%	61.31%
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	29.44%	37.96%
Behavioral Health Domain		
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	73.26%	54.87%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	53.44%	36.34%

Quality Enforcement Actions

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

Enforcement Tiers

DHCS establishes accountability requirements based on enforcement tiers. MCPs not meeting the MPL for one or more measures within a performance measure domain will be placed in an enforcement tier. Note that for enforcement tier placement, DHCS uses the following four measure domains:

- Children's Health

[19] Cal. WIC §14197.7. Available at: California Code, WIC 14197. Accessed on: Jan 3, 2025.

- Reproductive Health and Cancer Prevention
- Chronic Disease Management
- Behavioral Health

Following are the criteria for each tier:

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

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

Monetary Sanctions

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

- Severity—The percentage point difference between the MCP's performance measure rate and the MPL.
- Trending—The difference between the MCP's most recent measurement year performance measure rate and the previous measurement year performance measure rate.
- Population Not Served—The number of affected members who did not receive the service based on the numerator and denominator data the MCP submitted during the MCAS PMV process.
- Healthy Places Index[20] Impact—DHCS will reduce the sanction amount for MCPs operating in underserved ZIP Codes.

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

[20] Public Health Alliance of Southern California. The California Healthy Places Index. Available at: https://www.healthyplacesindex.org/. Accessed on: Jan 3, 2025.

[21] All Plan Letter 23-012 *(Revised)*: Supersedes All Plan Letter 22-015. Available at: APL 23-012 (ca.gov). Accessed on: Jan 3, 2025.

MCP Statewide Weighted Average Calculation Methodologies

HSAG calculated the measurement years 2021, 2022, and 2023 MCP statewide weighted averages according to CMS' methodology.[22]

Results

Please refer to Table 5.1 for descriptions of all MCAS measures displayed within this "Results" heading. Additionally, refer to *Volume 3 of 9* of this EQR technical report for comparative measurement year 2023 results across all MCPs for all DHCS-required performance measures. The *Comparative Managed Care Health Plan-Specific Measurement Year 2023 Performance Measure Results* provides the following:

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

Lastly, *Volume 4 of 9* of this EQR technical report includes statewide and MCP-specific measurement year 2023 performance measure results stratified by race and ethnicity.

Performance Measure Weighted Averages Compared to Benchmarks

Table 5.3 presents the statewide weighted averages for measures for which DHCS required MCPs to meet MPLs. DHCS organized the measures by domains based on the health care areas they affect. Organizing these measures by domain allows HSAG to provide meaningful assessment of MCP performance and actionable recommendations to MCPs and DHCS. As applicable, the table displays three-year trending for the statewide weighted averages and a comparison of measurement year 2023 MCP statewide weighted averages to the measurement year 2022 MCP statewide weighted averages and to the DHCS-established HPLs and MPLs.

Please refer to Table 5.2 for the benchmarks HSAG used for HPL and MPL comparisons included in Table 5.3.

[22] Centers for Medicare & Medicaid Services. Technical Assistance Resource: Calculating State-Level Rates Using Data from Multiple Reporting Units. February 2024. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf. Accessed on: Jan 3, 2025.

Table 5.3—Measurement Years 2021, 2022, and 2023 Managed Care Health Plan Statewide Weighted Average Performance Measure Results for Rates Compared to Benchmarks

= Rate indicates performance at or better than the HPL.

Bolded Rate = Rate indicates performance worse than the MPL.

= Statistical testing result indicates that the measurement year 2023 rate is significantly better than the measurement year 2022 rate.

= Statistical testing result indicates that the measurement year 2023 rate is significantly worse than the measurement year 2022 rate.

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

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

Measurement year 2023 rates reflect data from January 1, 2023, through December 31, 2023.

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

* For this measure, only the measurement year 2023 rate is compared to a benchmark. In addition, DHCS did not establish an HPL for this measure; therefore, the rate is only compared to the MPL.

** For this measure, only the measurement year 2023 rate is compared to the HPL and MPL based on DHCS' performance measure requirements.

*** For this measure, only the measurement year 2022 and 2023 rates are compared to the HPLs and MPLs based on DHCS' performance measure requirements.

^ A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Children's Health Domain				
Child and Adolescent Well-Care Visits—Total	47.51%	**47.02%**	49.50%	2.48
Childhood Immunization Status—Combination 10	**36.63%**	**34.69%**	**30.64%**	-4.05
*Developmental Screening in the First Three Years of Life—Total**	—	32.33%	40.34%	8.01

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Immunizations for Adolescents—Combination 2	39.23%	39.97%	41.36%	1.39
Lead Screening in Children	—	54.57%	**58.46%**	3.89
*Topical Fluoride for Children—Dental or Oral Health Services—Total**	—	9.75%	**18.17%**	8.42
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	**40.23%**	**49.56%**	**53.56%**	4.00
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	**60.28%**	**64.33%**	**66.65%**	2.32
Reproductive Health Domain				
Chlamydia Screening in Women—Total	63.61%	63.56%	65.79%	2.23
Prenatal and Postpartum Care—Postpartum Care	81.39%	81.90%	82.62%	0.72
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.57%	88.55%	87.99%	-0.56
Cancer Prevention Domain				
Breast Cancer Screening—Total	53.99%	55.73%	58.00%	2.27
Cervical Cancer Screening	**58.18%**	**56.80%**	58.27%	1.47

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Chronic Disease Management Domain				
*Asthma Medication Ratio—Total***	65.04%	67.43%	**64.28%**	-3.15
Controlling High Blood Pressure—Total	60.25%	62.93%	66.72%	3.79
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	37.50%	**35.60%**	32.94%	-2.66
Behavioral Health Domain				
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total****	34.77%	**46.81%**	**38.15%**	-8.66
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total****	8.56%	28.61%	**29.17%**	0.56

Report Only Performance Measures

Table 5.4 presents the MCP statewide weighted averages for Report Only measures (i.e., measures that HSAG did not compare to HPLs and MPLs). As applicable, the table displays three-year trending for the statewide weighted averages and a comparison of measurement year 2023 MCP statewide weighted averages to the measurement year 2022 MCP statewide weighted averages. While DHCS does not require MCPs to meet MPLs for Report Only measures, DHCS uses trending information as a way to assess MCP performance.

Table 5.4—Measurement Years 2021, 2022, and 2023 Managed Care Health Plan Statewide Weighted Average Report Only Performance Measure Results

= Statistical testing result indicates that the measurement year 2023 rate is significantly better than the measurement year 2022 rate.

= Statistical testing result indicates that the measurement year 2023 rate is significantly worse than the measurement year 2022 rate.

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

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

Measurement year 2023 rates reflect data from January 1, 2023, through December 31, 2023.

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

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

^ A lower rate indicates better performance for this measure.

^^ The specification for the measure changed in measurement year 2022 from contraceptive provision within 60 days of delivery to contraceptive provision within 90 days of delivery; therefore, HSAG does not display a measurement year 2021 rate.

— Indicates that the rate is not available.

Not Tested = A measurement year 2022–23 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Adults' Access to Preventive/Ambulatory Health Services—Total	—	64.43%	65.31%	0.88
*Ambulatory Care—Emergency Department (ED) Visits—Total**	404.01	458.06	461.63	Not Tested
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	65.15%	66.10%	73.48%	7.38

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	48.52%	49.52%	57.72%	8.20
Colorectal Cancer Screening	—	36.72%	40.46%	3.74
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20	13.89%	12.69%	11.67%	-1.02
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44	23.21%	21.22%	20.49%	-0.73
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—90 Days—Ages 15–20	35.88%	33.31%	45.25%	11.94
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—90 Days—Ages 21–44	35.18%	33.51%	41.19%	7.68
Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total	—	40.44%	44.99%	4.55
Depression Remission or Response for Adolescents and Adults—Depression Remission—Total	—	7.50%	8.94%	1.44

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Depression Remission or Response for Adolescents and Adults—Depression Response—Total	—	13.40%	15.72%	2.32
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total	—	3.74%	8.78%	5.04
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total	—	72.40%	71.70%	-0.70
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.89%	78.62%	81.63%	3.01
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	—	33.57%	25.33%	-8.24
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	—	18.36%	18.96%	0.60
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	42.14%	47.13%	46.80%	-0.33

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	49.35%	52.39%	48.99%	-3.40
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	62.61%	59.76%	60.04%	0.28
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	45.33%	40.56%	40.89%	0.33
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	43.98%	39.39%	39.78%	0.39
Pharmacotherapy for Opioid Use Disorder	—	21.60%	21.34%	-0.26
*Plan All-Cause Readmissions—Observed Readmissions—Total^*	9.19%	9.05%	9.23%	0.18
Plan All-Cause Readmissions—Expected Readmissions—Total	9.54%	9.47%	9.54%	Not Tested
*Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total^*	0.96	0.96	0.97	Not Tested

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Postpartum Depression Screening and Follow-Up—Depression Screening	—	7.44%	13.11%	5.67
Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen	—	71.48%	71.13%	-0.35
Prenatal Depression Screening and Follow-Up—Depression Screening	—	10.39%	17.16%	6.77
Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen	—	51.12%	53.75%	2.63
Prenatal Immunization Status—Influenza	—	30.91%	31.02%	0.11
Prenatal Immunization Status—Tdap	—	57.71%	58.32%	0.61
Prenatal Immunization Status—Combination	—	26.73%	27.05%	0.32
Topical Fluoride for Children—Dental Services—Total	—	7.42%	12.56%	5.14
Topical Fluoride for Children—Oral Health Services—Total	—	0.57%	0.70%	0.13

Performance Measure Weighted Averages Compared to National Medicaid Averages

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

Table 5.5—Measurement Years 2021, 2022, and 2023 Managed Care Health Plan Statewide Weighted Average Performance Measure Results Compared to National Medicaid Averages

A = Rate indicates performance at or better than the national Medicaid average.
Bolded Rate = Rate indicates performance worse than the national Medicaid average.
Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.
Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.
Measurement year 2023 rates reflect data from January 1, 2023, through December 31, 2023.
— Indicates that the rate is not available.
^ A lower rate indicates better performance for this measure.

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate
Adults' Access to Preventive/Ambulatory Health Services—Total	—	**64.43%**	**65.31%**
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	65.15%	66.10%	73.48%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	48.52%	49.52%	57.72%
Asthma Medication Ratio—Total	**65.04%**	67.43%	**64.28%**
Breast Cancer Screening—Total	53.99%	55.73%	58.00%
Cervical Cancer Screening	58.18%	56.80%	58.27%
Child and Adolescent Well-Care Visits—Total	47.51%	**47.02%**	49.50%
Childhood Immunization Status—Combination 10	36.63%	**34.69%**	**30.64%**
Chlamydia Screening in Women—Total	63.61%	58.85%	65.79%

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate
Controlling High Blood Pressure—Total	60.25%	62.93%	66.72%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.89%	**78.62%**	81.63%
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	**23.25%**	**33.57%**	**25.33%**
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	**34.77%**	**46.81%**	**38.15%**
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	**4.86%**	18.36%	**18.96%**
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	**8.56%**	28.61%	**29.17%**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	**42.14%**	47.13%	46.80%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	**49.35%**	52.39%	**48.99%**
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	37.50%	**35.60%**	32.94%
Immunizations for Adolescents—Combination 2	39.23%	39.97%	41.36%
Lead Screening in Children	—	54.57%	**58.46%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	62.61%	59.76%	60.04%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	45.33%	40.56%	40.89%

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	43.98%	39.39%	39.78%
Pharmacotherapy for Opioid Use Disorder	—	21.60%	**21.34%**
Postpartum Depression Screening and Follow-Up—Depression Screening	—	7.44%	13.11%
Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen	—	71.48%	71.13%
Prenatal Depression Screening and Follow-Up—Depression Screening	—	10.39%	17.16%
Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen	—	51.12%	53.75%
Prenatal Immunization Status—Influenza	—	30.91%	31.02%
Prenatal Immunization Status—Tdap	—	57.71%	58.32%
Prenatal Immunization Status—Combination	—	26.73%	27.05%
Prenatal and Postpartum Care—Postpartum Care	81.39%	81.90%	82.62%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.57%	88.55%	87.99%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	**40.23%**	**49.56%**	**53.56%**
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	**60.28%**	64.33%	**66.65%**

Seniors and Persons with Disabilities

Table 5.6 presents the SPD and non-SPD statewide weighted averages, a comparison of these averages, and the total statewide weighted averages for the two measures MCPs stratified by SPD and non-SPD populations for measurement year 2023.

Table 5.6—Measurement Year 2023 Managed Care Health Plan Statewide Weighted Averages Comparison and Results for Measures Stratified by the SPD Population

= Statistical testing result indicates that the measurement year 2023 SPD rate is significantly better than the measurement year 2023 non-SPD rate.

= Statistical testing result indicates that the measurement year 2023 SPD rate is significantly worse than the measurement year 2023 non-SPD rate.

Measurement year 2023 rates reflect data from January 1, 2023, through December 31, 2023.

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

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

^ A lower rate indicates better performance for this measure.

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

Measure	Measurement Year 2023 SPD Rate	Measurement Year 2023 Non-SPD Rate	SPD Non-SPD Rate Difference	Measurement Year 2023 Total Rate
*Ambulatory Care—ED Visits—Total**	707.22	445.75	Not Tested	461.63
*Plan All-Cause Readmissions—Observed Readmissions—Total^*	11.56%	8.72%	2.84	9.23%

Comparison Across All Managed Care Health Plans

For measures for which HSAG compared rates to HPLs, HSAG calculated the percentage of reported rates that were at or better than the HPLs for measurement year 2023 across all performance measure domains at the MCP level. Table 5.7 lists each MCP, the number of rates at or better than the HPLs, the total number of reported rates compared to HPLs, and the percentage of reported rates that were at or better than the HPLs in measurement year 2023, from highest to lowest percentage.

Table 5.7—Percentage of Measurement Year 2023 Rates At or Better Than the High Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Number of Rates At or Better Than the High Performance Levels	Total Number of Reported Rates Compared to High Performance Levels	Percentage of Rates At or Better Than the High Performance Levels
Contra Costa Health Plan	10	18	55.56%
Kaiser NorCal	10	18	55.56%
Kaiser SoCal	10	18	55.56%
Central California Alliance for Health	14	36	38.89%
Health Plan of San Mateo	6	18	33.33%
San Francisco Health Plan	6	18	33.33%
CenCal Health	7	36	19.44%
Alameda Alliance for Health	3	18	16.67%
CalOptima	3	18	16.67%
Gold Coast Health Plan	3	18	16.67%
CalViva Health	8	54	14.81%
L.A. Care Health Plan	2	18	11.11%
Santa Clara Family Health Plan	2	18	11.11%
Health Plan of San Joaquin	2	36	5.56%
Inland Empire Health Plan	1	18	5.56%
Kern Family Health Care	1	18	5.56%
Partnership HealthPlan of California	4	72	5.56%
Anthem Blue Cross Partnership Plan	11	216	5.09%
Health Net Community Solutions, Inc.	6	126	4.76%
California Health & Wellness Plan	2	54	3.70%

Medi-Cal Managed Care Health Plan	Number of Rates At or Better Than the High Performance Levels	Total Number of Reported Rates Compared to High Performance Levels	Percentage of Rates At or Better Than the High Performance Levels
Aetna Better Health of California	1	36	2.78%
Molina Healthcare of California	1	71	1.41%
Blue Shield of California Promise Health Plan	0	18	0.00%
Community Health Group Partnership Plan	0	18	0.00%

For measures for which HSAG compared rates to MPLs, HSAG calculated the percentage of reported rates that were worse than the MPLs for measurement year 2023 across all performance measure domains at the MCP level. Table 5.8 lists each MCP, the number of rates worse than the MPLs, the total number of reported rates compared to MPLs, and the percentage of reported rates that were worse than the MPLs in measurement year 2023, from highest to lowest percentage.

Table 5.8—Percentage of Measurement Year 2023 Rates Worse Than the Minimum Performance Levels, by MCP

Medi-Cal Managed Care Health Plan	Number of Rates Worse Than the Minimum Performance Levels	Total Number of Reported Rates Compared to Minimum Performance Levels	Percentage of Rates Worse Than the Minimum Performance Levels
Aetna Better Health of California	28	36	77.78%
Health Net Community Solutions, Inc.	88	126	69.84%
California Health & Wellness Plan	36	54	66.67%
Molina Healthcare of California	44	71	61.97%
Health Plan of San Joaquin	22	36	61.11%
Anthem Blue Cross Partnership Plan	130	216	60.19%
Kern Family Health Care	10	18	55.56%

Medi-Cal Managed Care Health Plan	Number of Rates Worse Than the Minimum Performance Levels	Total Number of Reported Rates Compared to Minimum Performance Levels	Percentage of Rates Worse Than the Minimum Performance Levels
Partnership HealthPlan of California	40	72	55.56%
CalViva Health	22	54	40.74%
L.A. Care Health Plan	7	18	38.89%
Blue Shield of California Promise Health Plan	5	18	27.78%
Central California Alliance for Health	10	36	27.78%
San Francisco Health Plan	4	18	22.22%
Santa Clara Family Health Plan	4	18	22.22%
Alameda Alliance for Health	3	18	16.67%
CenCal Health	6	36	16.67%
Contra Costa Health Plan	3	18	16.67%
Gold Coast Health Plan	3	18	16.67%
Inland Empire Health Plan	3	18	16.67%
CalOptima	2	18	11.11%
Community Health Group Partnership Plan	2	18	11.11%
Kaiser NorCal	2	18	11.11%
Kaiser SoCal	2	18	11.11%
Health Plan of San Mateo	0	18	0.00%

HSAG includes MCP-specific performance measure results for all required MCAS measures in *Volume 3 of 9* of this EQR technical report.

Measurement Year 2022 Quality Monitoring

Based on measurement year 2022 performance measure results, DHCS placed MCPs not meeting the MPL for one or more measures within a performance measure domain into a quality monitoring tier as indicated under the "Enforcement Tiers" heading in this section of the report.

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

DHCS' Support Provided to MCPs

DHCS provides extensive support to MCPs related to ongoing quality improvement activities as well as new contractual requirements. The technical assistance and resources that DHCS provides support MCPs' efforts to provide quality, timely, and accessible health care to their members, including:

- Assisting MCPs with prioritizing areas in need of improvement and identifying performance measures for MCPs to use as focus areas for quality improvement activities.
- Conducting technical assistance calls for MCPs as needed to discuss ongoing quality improvement efforts and support these MCPs in continuing to improve performance.
- Providing opportunities through biannual regional collaborative calls, State collaborative learning calls, and calls with MCP county behavioral health plans. During these calls, DHCS presents regional data and provides opportunities for MCPs to discuss possible barriers experienced in the applicable region, strategies for improving the lowest performance measure rates, and quality improvement approaches that have and have not worked in the region.
- Continuing to update and promote the Quality Improvement Toolkit, which provides information about resources, promising practices to improve quality of care, ways to improve performance on measures, and ways to promote health equity.

Conclusions

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

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 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 MPLs ranging from 77.78 percent to 0.00 percent.
- 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 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:[23]

- 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 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 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

In *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each MCP's strengths and weaknesses related to performance measure results with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations. Additionally, in *Volume 3 of 9* of this EQR technical report, HSAG includes MCP-specific performance measure results for all required MCAS measures; and in *Volume 4 of 9* of this EQR technical report, HSAG includes statewide and MCP-specific performance measure results stratified by race and ethnicity.

[23] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

6. Population-Specific Health Plan Performance Measures

Objective

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

Technical Methods of Data Collection and Analysis

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

Description of Data Obtained

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

- Performance measure data submitted by the PSPs, which included numerators, denominators, and calculated rates.
- NCQA's Quality Compass HEDIS 2023 Medicaid HMO benchmarks (50th and 90th percentiles).

Requirements

To comply with 42 CFR §438.330, DHCS selects a set of performance measures to evaluate the quality of care PSPs delivered to their members. As stated previously, DHCS refers to the DHCS-required performance measure set as the MCAS. The measurement year 2023[24] MCAS included select CMS Adult and Child Core Sets measures, some of which are also HEDIS measures. AIDS Healthcare Foundation and SCAN Health Plan provide services to specialized populations; therefore, DHCS' performance measure requirements for these PSPs are different than its requirements for MCPs. Section 5 of this report ("**Managed Care Health**

[24] The measurement year is the calendar year for which PSPs report the rates. Measurement year 2023 represents data from January 1, 2023, through December 31, 2023.

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

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

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

AIDS Healthcare Foundation

Table 6.1 lists AIDS Healthcare Foundation's measurement year 2023 MCAS measures by measure domain and indicates the data capture method(s) for each measure.

Table 6.1—AIDS Healthcare Foundation Measurement Year 2023 Managed Care Accountability Set Measures

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

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

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

[25] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

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

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

^ NCQA requires race and ethnicity stratifications for this measure.

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

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

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

SCAN Health Plan

Table 6.2 lists SCAN Health Plan's measurement year 2023 MCAS measures by measure domain and indicates the data capture method(s) for each measure.

Note that for measurement year 2023, DHCS required SCAN to report rates at the SNF level for the following three LTC measures:

- *Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days*
- *Potentially Preventable 30-Day Post-Discharge Readmissions*
- *Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*

To ensure consistent calculation and reporting of rates for these measures, DHCS contracted with HSAG to update and test the measure specifications for each of the three measures. SCAN used the revised measure specifications to calculate and report its measurement year 2023 rates.

As indicated in Section 5 of this report ("**Managed Care Health Plan Performance Measures**") under the "Medi-Cal Managed Care Accountability Set" heading), DHCS elected to exclude the LTC measure rates from this EQR technical report. DHCS will review SCAN's

facility-level rates and will address any identified concerns with the PSP. Additionally, DHCS and HSAG will determine the most meaningful way to present the LTC measure rate results in future EQR technical reports.

Table 6.2—SCAN Health Plan Measurement Year 2023 Managed Care Accountability Set Measures

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

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

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

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

^ NCQA requires race and ethnicity stratifications for this measure.

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

Measure	Method of Data Capture
Cancer Prevention Domain (Measures held to MPLs.)	
*Breast Cancer Screening—Total^*	ECDS
Chronic Disease Management Domain (Measures held to MPLs.)	
*Controlling High Blood Pressure—Total^*	Admin or Hybrid*
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)^*	Admin or Hybrid*
Behavioral Health Domain (Measures held to MPLs.)	
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—65 Years and Older^^*	Admin

Measure	Method of Data Capture
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—65 Years and Older^*	Admin
Report Only Measures (Measures not held to MPLs.)	
Adults' Access to Preventive/Ambulatory Health Services—Total	Admin
*Colorectal Cancer Screening^*	Admin
Depression Remission or Response for Adolescents and Adults—Three rates are reported: ♦ *Follow-Up PHQ-9—65 Years and Older* ♦ *Depression Remission—65 Years and Older* ♦ *Depression Response—65 Years and Older*	ECDS
*Depression Screening and Follow-Up for Adolescents and Adults^^*—Two rates are reported: ♦ *Depression Screening—65 Years and Older* ♦ *Follow-Up on Positive Screen—65 Years and Older*	ECDS
*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—65 Years and Older^^*	Admin
*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—65 Years and Older^*	Admin
*Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days^^*	Admin
*Pharmacotherapy for Opioid Use Disorder^*	Admin
*Potentially Preventable 30-Day Post-Discharge Readmissions^^*	Admin
*Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization^^*	Admin

DHCS-Established Performance Levels

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

Results

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

See *Volume 2 of 9 (Appendix A)* of this EQR technical report for measurement years 2021, 2022, and 2023 performance measure results for AIDS Healthcare Foundation and SCAN Health Plan.

Measurement Year 2022 Quality Monitoring

Based on measurement year 2022 performance measure results, DHCS did not place AIDS Healthcare Foundation or SCAN Health Plan into a quality monitoring enforcement tier.

Conclusions

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

Both PSPs exceeded the DHCS-established MPLs for all performance measure rates that HSAG compared to benchmarks. Additionally, AIDS Healthcare Foundation performed above the 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%)*

The PSPs' performance measure results reflect continued provision of quality, timely, and accessible health care services to their members.

In *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each PSP's strengths and weaknesses related to performance measure results with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

7. Review of Compliance with Managed Care Regulations

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

DHCS directly conducts compliance reviews of MCPs and PSPs, rather than contracting with the EQRO to conduct reviews on its behalf. Transparency and accountability are important aspects of the DHCS Comprehensive Quality Strategy, and conducting compliance reviews is one of the ways DHCS holds plans accountable to meet federal and State requirements that support the delivery of quality, timely, and accessible health care services to Medi-Cal members.[26]

Objectives

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

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

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

- DHCS' compliance with conducting reviews of all plans within the previous three-year period.
- Plans' compliance with the areas that DHCS reviewed as part of the compliance review process.

[26] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

Technical Methods of Data Collection and Analysis

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

Scoring Methodology

To meet CMS' compliance review requirements, DHCS developed a compliance review scoring methodology that includes all federal standards required by CMS.

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

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

The presence of a finding or identified noncompliance with a corresponding CFR element resulted in DHCS scoring the CFR element as *Not Met* (score of 0 points). If DHCS identified no findings or no evidence of noncompliance with a corresponding CFR element, DHCS scored the element as *Met* (score of 2 points).

DHCS provided the plans with a compliance review scoring methodology and the definition DHCS will use to determine full compliance for each standard in the scope of the compliance review. Scores were individually shared with MCPs and PSPs prior to DHCS submitting the results to HSAG.

Timeliness of Compliance Reviews

HSAG determined, by assessing the dates DHCS conducted its compliance reviews, whether DHCS conducted the reviews for all MCPs and PSPs within the previous three-year period.

Results

After conducting the compliance review scoring, DHCS indicated that it shared the individual plan scores with each MCP and PSP, and DHCS took the plans' feedback into consideration before finalizing the scores.

Compliance review scores across all assessed plans show that the plans were fully compliant with most CFR standards, with all assessed plans receiving scores of 100 percent for at least

half of the 14 standards. All assessed MCPs and PSPs were fully compliant with the following three standards:

- §438.214—Provider Selection
- §438.56—Disenrollment: Requirements and Limitations
- §438.114—Emergency and Poststabilization Services

The following three MCPs were fully compliant with all CFR standards:

- CenCal Health
- Central California Alliance for Health
- Kern Family Health Care

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

- §438.210—Coverage and Authorization of Services
- §438.228—Grievance and Appeal Systems

Based on having the lowest total CFR compliance scores when compared to all other plans (90 percent), the plans with the greatest opportunities for improvement are listed below:

- Alameda Alliance for Health
- Health Plan of San Mateo

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

Comparative plan-specific compliance review results are included in *Volume 5 of 9* of this EQR technical report.

Conclusions

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

To assess DHCS' compliance with §438.358, HSAG reviewed the dates when DHCS conducted compliance reviews of MCPs and PSPs and determined that DHCS conducted the reviews for all applicable MCPs and PSPs within the previous three-year period.

Note that DHCS' contract with Community Health Plan Imperial Valley went into effect January 1, 2024; therefore, DHCS did not conduct a compliance review for this MCP. DHCS conducted a readiness review of Community Health Plan Imperial Valley, which involved DHCS reviewing

documentation the MCP submitted to demonstrate having policies and procedures in place to meet the DHCS contract requirements. DHCS will conduct its first CFR compliance review with this new MCP in fall 2025.

DHCS' compliance review scores reflect that all assessed MCPs and PSPs were compliant with at least 50 percent of 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.

In *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each plan's strengths and weaknesses related to compliance reviews with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations.

8. Validation of Network Adequacy

States that contract with MCOs, PIHPs, or PAHPs to deliver Medicaid services must develop and enforce network adequacy standards in accordance with 42 CFR §438.68—and if the state enrolls American Indians and Alaska Natives in the MCOs, PIHPs, or PAHPs, in accordance with §438.4(b)(1). Validation of network adequacy is one of the mandatory EQR activities described in §438.358(b)(1)(iv). The EQRO must summarize the validation of network adequacy conducted during the preceding 12 months in the EQR technical report.

Objectives

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the DHCS-defined network adequacy indicators reported by the MCPs and PSPs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine the indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by DHCS.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from MCPs, PSPs, and DHCS via a secure file transfer protocol (SFTP) site and virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023.[27]

[27] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 3, 2025.

Description of Data Obtained

HSAG obtained the following data from MCPs, PSPs, and DHCS to conduct the NAV audits for the calendar year 2023 reporting period:

- Information systems data from the Information Systems Capabilities Assessment Tool (ISCAT)
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

Validation of Network Adequacy Summary

HSAG includes the validation of network adequacy detailed methodology, results, conclusions, and recommendations in *Volume 6 of 9* of this EQR technical report. HSAG also includes in this volume the comparative plan-specific NAV audit results.

Additionally, in *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes an assessment of each plan's strengths and weaknesses related to NAV audits with respect to the quality, timeliness, and accessibility of care furnished to its members as well as HSAG's recommendations, as applicable.

9. Additional Network Adequacy Activities

To assist DHCS with assessing and monitoring network adequacy across contracted plans as described in the DHCS Comprehensive Quality Strategy,[28] DHCS contracted with HSAG to conduct the following additional network adequacy activities:

- AAS Reporting
- SNF/ICF Experience and Distance Reporting
- Timely Access Study

Objective

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

Technical Methods of Data Collection and Analysis

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

Description of Data Obtained

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

- Administrative
- AAS request
- AAS administrative
- Annual network certification documentation

[28] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

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

Alternative Access Standards Reporting

DHCS is responsible for the ongoing monitoring and oversight of its contracted MCPs and PSPs, including the assurance that MCPs' and PSPs' provider networks are adequate to deliver services to Medi-Cal members. If health care providers are unavailable or unwilling to serve Medi-Cal members such that the MCP or PSP is unable to meet provider network standards, MCPs and PSPs may request that DHCS allow an alternative provider network access standard for specified provider scenarios (e.g., provider type, geographic area). The DHCS APL 23-001[29] provides DHCS' clarifying guidance regarding network certification requirements, including requests for AAS. Additionally, CA WIC §14197.05[30] requires DHCS' annual EQR technical report to present information related to MCPs' AAS requests. As such, DHCS contracted with HSAG to process and report on data related to AAS for provider networks.

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

HSAG includes the AAS reporting methodology, results, conclusions, and considerations in *Volume 7 of 9* of this EQR technical report.

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

[30] Cal. WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05. Accessed on: Jan 3, 2025.

Skilled Nursing Facility/Intermediate Care Facility Experience and Distance Reporting

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

HSAG includes the SNF/ICF experience and distance reporting analyses methodology, results, key findings, conclusions, and considerations in *Volume 8 of 9* of this EQR technical report.

Timely Access Study

DHCS requires its MCPs and PSPs to ensure their participating providers offer appointments that meet the timely access standards. Prior to the CMS release of EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023, California had already begun implementing statutes to effectuate network adequacy standards and to implement a system of oversight. California's law for appointment wait time standards is in California Health and Safety Code §1367.03[31] for commercial plans and incorporated by reference in CA WIC §14197(d)(1)(A)[32] for plans. The rules are further defined in CA 28 California Code of Regulations (CCR) §1300.67.2.2(c).[33] In APL 23-001, DHCS clarifies the network adequacy wait time standards policy.[34] This policy includes a description of the use of a retrospective timely access survey that measures network providers' and plans' overall compliance with appointment wait time standards.

Beginning in contract year 2016–17, DHCS contracted with HSAG to conduct an annual study to evaluate the extent to which plans are meeting the DHCS wait time standards. To ensure that plans and their providers could prioritize coronavirus disease 2019 (COVID-19) response efforts, DHCS canceled this study for calendar years 2020 and 2021. In July 2021, DHCS determined to resume the Timely Access Study activities beginning January 2022.

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[31] California Health and Safety Code §1367.03. Available at: Law section (ca.gov). Accessed on: Jan 3, 2025.

[32] Cal. WIC §14197(d)(1)(A). Available at: Law section (ca.gov). Accessed on: Jan 3, 2025.

[33] CA 28 CCR §1300.67.2.2(c). Available at: Section 1300.67.2.2 - Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements, Cal. Code Regs. tit. 28 § 1300.67.2.2 | Casetext Search + Citator. Accessed on: Apr 23, 2025.

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

The purpose of the Timely Access Study is to determine and publicly report on the extent to which plans are meeting or not meeting those standards. Following is a summary of the Timely Access Study activities and analyses from calls placed in calendar years 2023 and 2024, which correspond with contract years 2022–23 and 2023–24, respectively.

Methodology—Timely Access Study

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

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

Table 9.1—Timely Access Standards

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

- Note that due to data issues:
  - HSAG paused the evaluation of Alameda Alliance for Health's specialists for quarter 1 (Q1) of calendar year 2023.
  - HSAG began placing calls to providers from AIDS Healthcare Foundation in Q2 of calendar year 2023.
  - HSAG paused the evaluation of PCP, specialist, and ancillary samples for three of Health Net Community Solutions, Inc.'s reporting units (Kern, Los Angeles, and San Diego counties) for Q2 of calendar year 2023.

Appointment Type	Wait Time Standard			
	Non-Urgent Appointments	Urgent Appointments	Preventive Care Appointments	Non-Urgent Follow-Up Appointments
Primary care appointment	10 business days	48 hours	—	—
Specialist appointment	15 business days	96 hours	—	—
Appointment with a mental health care provider (who is not a physician)	10 business days	96 hours	—	10 business days

Appointment Type	Wait Time Standard			
	Non-Urgent Appointments	Urgent Appointments	Preventive Care Appointments	Non-Urgent Follow-Up Appointments
Appointment with ancillary providers	15 business days	—	—	—
Dental appointment for Health Plan of San Mateo's dental providers only	36 business days	72 hours	40 business days	—

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

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

HSAG conducts the Timely Access Study calls and compiles the results for a calendar year (i.e., January 1 through December 31). Following are descriptions of the methodologies HSAG used for calendar years 2023 and 2024 calls.

Note that DHCS entered into new contracts with MCMC plans beginning January 1, 2024, resulting in some new plans entering a county, existing plans entering new counties, or existing plans expanding/reducing their provider networks considerably in a county and contiguous counties. These changes resulted in a delay in HSAG receiving some of the data for the Q1 calendar year 2024 calls. After receiving the data from DHCS for the affected reporting units, HSAG distributed the total sample sizes across the remaining quarters.

Calls to Providers

For both calendar years 2023 and 2024 calls, the provider sample size was 411 providers across all provider types and specialties per plan reporting unit. If there were less than 411 providers in a provider category for a reporting unit, all providers were selected. When more than one site existed, HSAG randomly selected one site from each sampled provider.

Quarterly, during standard operating hours (i.e., 9 a.m. to 5 p.m. Pacific Time), HSAG's trained callers made phone calls to all selected provider offices. During the calls, the callers followed

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

HSAG surveyed Kaiser NorCal and Kaiser SoCal separately for calendar year 2023; for calendar year 2024, these MCPs were combined into one contract, Kaiser Permanente. HSAG had a separate process for collecting appointment availability information from Kaiser NorCal and Kaiser SoCal providers for calendar year 2023 and Kaiser Permanente providers for calendar year 2024 due to their automated appointment scheduling systems.

Calls to Plan Call Centers

For calendar years 2023 and 2024 calls, HSAG adjusted the sample size based on the results from the previous calendar year calls. HSAG used the following criteria to determine the sample sizes at the plan level:

- If the Q3 cumulative rate from the previous year was 85 percent or higher, the sample size was 100.
- If the Q3 cumulative rate from the previous year was below 85 percent, the sample size was 219.
- If a plan's rate was above 90 percent for two consecutive quarters in the current year, HSAG may reduce the sample size with DHCS' approval.

HSAG spread the calendar years 2023 and 2024 calls to the call centers as evenly as possible across all four quarters.

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

Calls to Plan Nurse Triage/Advice Lines

For calendar years 2023 and 2024 calls, the sample size was 100 for each plan. HSAG spread the calls evenly across all four quarters (i.e., 25 calls were made each quarter).

For each quarter, HSAG's trained callers made a call to each nurse triage/advice line no more than once per day during normal business hours (i.e., 9 a.m. to 5 p.m. Pacific Time), with the call time varying from day to day. The callers ended the call if the hold time reached 30 minutes. The hold time began from the time the phone connected (or after pressing the correct

option on the call tree) to the time when the callers reached a qualified health professional such as a medical doctor, physician's assistant, registered nurse, licensed clinical social worker, or licensed marriage and family therapist. Note that for Kaiser Permanente, the total number of calls to the nurse triage/advice lines for calendar year 2023 was split between Kaiser NorCal and Kaiser SoCal.

Submit Quarterly Deliverables to DHCS

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

- Executive summary
- Statewide report and raw data files
- Plan-specific reports and raw data files

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

HSAG includes the timely access study results, comparative analyses, conclusions, and considerations in *Volume 9 of 9* of this EQR technical report.

10. Annual Health Equity Study

The objective of the Annual Health Equity Study is to provide results and conclusions for DHCS to use to identify and address health care disparities affecting Medi-Cal members. DHCS may use the results from these studies to inform strategies to contribute toward achieving the DHCS Comprehensive Quality Strategy vision of eliminating health care disparities as well as to inform the Comprehensive Quality Strategy Health Equity Roadmap.[35]

At the time this EQR technical report was produced, DHCS and HSAG were in the process of confirming the scope and methodology for the Annual Health Equity Study.

Once HSAG produces and finalizes the 2023 health equity report, DHCS will post the final report at Medi-Cal Managed Care Quality Improvement Reports.

[35] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

11. Preventive Services Study

At the request of the Joint Legislative Audit Committee, the California State Auditor published an audit report in March 2019 regarding DHCS' oversight of the delivery of preventive services to children enrolled in MCMC. The audit report recommended that DHCS expand the performance measures it collects and reports on to ensure all age groups receive preventive services from MCPs.[36] In response to this recommendation, DHCS requested that HSAG produce an annual Preventive Services Report beginning in 2020. This report is published on the DHCS website annually.

Objective

The objective of the Preventive Services Study is to provide results and conclusions for DHCS to use to identify and monitor appropriate utilization of preventive services for MCMC children. Additionally, the results from this study support DHCS' renewed emphasis on prevention as described in the DHCS Comprehensive Quality Strategy.[37]

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the Preventive Services Study from DHCS, the MCPs, NCQA, and CMS. For the DHCS data, HSAG submitted to DHCS the required DHCS Data Release Form and detailed data request instructions to ensure all needed data were submitted for the analyses. DHCS submitted the data to HSAG via a SFTP site. The MCP data were submitted to HSAG during the PMV activities described in Section 4 of this report ("**Validation of Performance Measures**"). NCQA data were obtained via NCQA's Quality Compass, and CMS data were obtained via CMS' website.[38]

[36] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Jan 3, 2025.

[37] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

[38] Centers for Medicare & Medicaid Services: *Quality of Care for Children in Medicaid and CHIP: Findings from the 2022 Child Core Set—Chart Pack*, January 2024. Available at: Quality of Care for Children in Medicaid and CHIP: Findings from the 2022 Child Core Set Chart Pack. Accessed on: Jan 3, 2025.

Description of Data Obtained

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

- Claims
- CMS' FFY 2022 Child Core Set National Medians
- Encounter
- Member demographic
- Member eligibility
- Member enrollment
- Member-level blood lead screening
- NCQA's HEDIS 2023 Medicaid HMO 50th percentiles
- Performance measure

Preventive Services Study Summary

For the 2024 Preventive Services Study, HSAG continued to analyze child and adolescent performance measures that were calculated by HSAG and DHCS, and reported by the 24 full-scope MCPs from the MCAS. MCAS measures reflect clinical quality, timeliness, and accessibility of care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. DHCS can leverage the findings from the Preventive Services Study to address the clinical focus area of children's preventive care identified in its 2022 Comprehensive Quality Strategy[39] and monitor appropriate utilization of preventive services for MCMC children.

For the 2023–24 contract year, HSAG evaluated measure data collected for HEDIS measurement year 2023, which consists of data collected during calendar year 2023. The indicator set for this analysis included a total of 13 MCP-calculated indicators, 11 HSAG-calculated indicators (i.e., administrative indicators calculated by HSAG for DHCS), and four DHCS-calculated indicators. For each MCP-calculated indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the HEDIS specification for the Medicaid population or by the CMS Child Core Set. For the HSAG-calculated indicators, HSAG developed specifications for four indicators and used the CMS Child Core Set specifications for the remaining indicators. For the DHCS-calculated indicators, DHCS developed specifications for the four indicators. To focus the 2024 Preventive Services Report on more actionable results for stakeholders, HSAG and DHCS developed criteria to

[39] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

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

The *2024 Preventive Services Report* includes the detailed study methodology, key results and findings, conclusions, and considerations. The report may be found at Medi-Cal Managed Care Quality Improvement Reports.

12. Consumer Surveys

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

The DHCS Comprehensive Quality Strategy includes the goal to engage members to be actively involved in their own health care and to provide input to DHCS about Medi-Cal policy.[40] DHCS also seeks to prioritize member experience in all quality improvement efforts. To help DHCS assess perceptions and experiences of members as part of its evaluation of the quality of health care services provided by MCPs to their members, DHCS contracts with HSAG to administer and report the results of the CAHPS Health Plan Surveys for the CHIP and Medi-Cal populations.

During contract year 2023–24, DHCS contracted with HSAG to administer and report the results of the following CAHPS surveys:

- CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS and Children with Chronic Conditions (CCC) measurement sets to meet CMS' CHIP Reauthorization Act requirements.
- CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the 21 MCPs[41] at the plan level and the 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.

HSAG includes a summary of the 2024 CHIP CAHPS survey results in this EQR technical report. HSAG also includes in this report a high-level summary of the 2024 Medi-Cal survey.

[40] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

[41] 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.

Objective

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

Technical Methods of Data Collection and Analysis

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

Description of Data Obtained

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

- NCQA's 2023 Medicaid national 50th and 90th percentiles
- Sample frame
- Survey response

2024 Children's Health Insurance Program Survey

The *2024 CHIP CAHPS Survey Summary Report* includes the survey's detailed methodology, results, conclusions, and recommendations. Following is a high-level summary of the survey.

Methodology—Children's Health Insurance Program Survey

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

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

Table 12.1—CAHPS Measures

Global Ratings	Composite Measures	CCC Composite Measures and Items
Rating of Health Plan	*Getting Needed Care*	*Access to Specialized Services*
Rating of All Health Care	*Getting Care Quickly*	*Family-Centered Care (FCC): Personal Doctor Who Knows Child*
Rating of Personal Doctor	*How Well Doctors Communicate*	*Coordination of Care for Children with Chronic Conditions*
Rating of Specialist Seen Most Often	*Customer Service*	*FCC: Getting Needed Information*
		Access to Prescription Medicines

Survey Sampling Procedures

The members eligible for sampling included those who were CHIP members at the time the sample was drawn and who were continuously enrolled in the same MCP for at least five of the six months of the measurement period (July through December 2023). The members eligible for sampling included those who were 17 years of age or younger (as of December 31, 2023).

All CHIP members within the sample frame file were given a chronic condition prescreen status code of 1 or 2. A prescreen code of 1 indicated that the member had claims or encounters which did not suggest that the member had a greater probability of having a chronic condition. A prescreen code of 2 (also known as a positive prescreen status code) indicated that the member had claims or encounters which suggested that the member had a greater probability of having a chronic condition. After selecting a random sample of 3,065 CHIP members (i.e., general population of children enrolled in CHIP), HSAG selected a CCC supplemental sample of 3,615 CHIP members with a prescreen code of 2 (i.e., the population of children who were more likely to have a chronic condition).[42] HSAG drew the supplemental sample to increase the number of responses from children with chronic conditions.

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

Survey Protocol

The survey administration process allowed for two methods by which parents/caretakers of child members could complete a survey: (1) mail or (2) Internet. A cover letter was mailed to all parents/caretakers of sampled child members that provided two options to complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope; or (2) complete the web-based survey via a URL or quick response (QR) code and designated username. Members who were identified as Spanish speaking through administrative data were mailed a Spanish version of the cover letter and survey. Members who were not identified as Spanish speaking received an English version of the cover letter and survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing parents/caretakers of child members that they could call the toll-free number to request a Spanish version of the CAHPS survey. The cover letter included with the Spanish version of the survey had an English cover letter on the back side informing parents/caretakers of child members that they could call the toll-free number to request an English version of the CAHPS survey. In addition, respondents had the option to choose an English or Spanish version of the Web survey. All non-respondents received a reminder postcard, followed by a second survey mailing, second reminder postcard, and third survey mailing.

Survey Analysis

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS Measurement Year 2023, Volume 3: Specifications for Survey Measures*. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed the following analyses to comprehensively assess member experience:

- Response Rates
- Respondent Analysis
- Top-Box Scores[43]
- Comparative Analysis

Results—Children's Health Insurance Program Survey

Response Rates

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

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

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

Table 12.2 presents the total number of CHIP members sampled, the number of ineligible and eligible members, the number of surveys completed, and the response rate for the CHIP population selected for surveying. The survey dispositions and response rates are based on the responses of parents/caretakers of children in the general child and CCC supplemental samples. The CHIP response rate of 12.82 percent was greater than the CCC Medicaid national response rate reported by NCQA for 2023, which was 12.2 percent.[44,45] In 2023, the CHIP response rate was 14.67 percent, which was 1.85 percentage points higher than the 2024 CHIP response rate. HSAG has observed an overall decline in CAHPS survey response rates over the past several years, so this decline falls in line with national trends.

Table 12.2—Total Number of Respondents and Response Rate

Response rate is calculated as Number of Completed Surveys/Eligible Sample.

Population	Total Sample Size	Ineligible Sample	Eligible Sample	Completed Surveys	Response Rate
General Child Sample	3,065	10	3,055	361	11.82%
CCC Supplemental Sample	3,615	9	3,606	493	13.67%
CHIP	**6,680**	**19**	**6,661**	**854**	**12.82%**

Respondent Analysis

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

[44] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023, Survey Vendor Update Training*. October 12, 2023.

[45] Please note, 2024 national response rate information was not available at the time this report was produced.

HSAG's analysis did not identify any statistically significant differences between the demographic characteristics of children whose parents/caretakers responded to the survey and the demographic characteristics of those in the sample frame.

General Child Performance Highlights

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

- The differences between the NCQA child Medicaid national 50th and 90th percentiles ranged from 2.34 to 6.28 percentage points, with an average of 3.97 percentage points for the general child population, indicating that the distributions of national performance were close together.
- The differences between the CHIP general child population reportable scores and the NCQA general child Medicaid national 50th percentiles ranged from 3.43 percentage points below to 1.57 percentage points above the NCQA general child Medicaid national 50th percentiles, with an average of 1.45 percentage points below the NCQA general child Medicaid national 50th percentiles.

Top-Box Scores

The findings indicate opportunities for improvement in member experience for several areas of care, as all reportable measures except the *Getting Needed Care* composite measure scored below the NCQA general child Medicaid national 50th percentiles.

Comparative Analysis

The 2024 score was statistically significantly higher than the 2022 score for the *Getting Needed Care* composite measure. The 2024 scores were not statistically significantly lower than the 2022 scores for any measure. The 2024 scores were not statistically significantly higher or lower than the 2023 scores for any measure.

Children with Chronic Conditions Performance Highlights

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

- The differences between the NCQA CCC Medicaid national 50th and 90th percentiles ranged from 2.36 to 5.06 percentage points, with an average of 3.56 percentage points for the CCC population, indicating that the distributions of national performance were close together.

- The differences between the CHIP CCC population reportable scores and the NCQA CCC Medicaid national 50th percentiles ranged from 8.27 percentage points below to 2.57 percentage points above the NCQA CCC Medicaid national 50th percentiles, with an average of 2.12 percentage points below the NCQA CCC Medicaid national 50th percentiles.

Top-Box Scores

The findings indicate opportunities for improvement in member experience for several areas of care, as all reportable measures except the *Rating of Specialist Seen Most Often* global rating and *FCC: Getting Needed Information* and *Access to Prescription Medicines* CCC item measures scored below the NCQA CCC Medicaid national 50th percentiles.

Comparative Analysis

The 2024 scores were not statistically significantly higher or lower than the 2023 and 2022 scores for any measure.

Conclusions—Children's Health Insurance Program Survey

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

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

- The general child population scored above the 2023 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:
    - *Rating of Specialist Seen Most Often*
  - CCC Item Measures:
    - *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*

2024 Medi-Cal Survey Summary

DHCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Survey for both adult Medi-Cal members and parents/caretakers of child Medi-Cal members. The survey results represent adult members and parents/caretakers of child members enrolled in an MCP, FFS, or PSP, as applicable, who completed surveys from February to May 2024, and represent members' experiences with care and services over the prior six months. Twenty-one MCPs participated in the survey. The two PSPs, AIDS Healthcare Foundation and SCAN Health Plan, were sampled at the statewide level to provide a sufficient number of eligible members for the survey due to small enrollment numbers.

HSAG used the CAHPS scoring approach recommended by NCQA in *HEDIS Measurement Year 2023, Volume 3: Specifications for Survey Measures*. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed the following analyses to comprehensively assess member experience:

- Response Rates
- Respondent Analysis

- Top-Box Scores[46]
- State-Level Scores and Comparisons
- Comparative Analysis

The *2024 Medi-Cal CAHPS Survey Summary Report* includes the adult and child surveys' detailed methodologies, results, conclusions, and considerations. The report may be found at Mgd Care Qual Perf CAHPS.

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

13. Encounter Data Validation Study

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

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DHCS requires its contracted MCPs and PSPs to submit high-quality encounter data. The completeness and accuracy of these data are essential to the success of DHCS' overall management and oversight of MCMC.

DHCS contracts with HSAG to conduct EDV studies as an optional EQR activity. In addition to the procedures and quality assurance protocols DHCS maintains internally, according to 42 CFR §438.242, to ensure that enrollee encounter data submitted by MCPs and PSPs are a complete and accurate representation of the services provided to Medi-Cal members under the plans' contracts with the State, the EDV studies HSAG conducts are designed to meet the periodicity schedule required in 42 CFR §438.602(e) for an independent audit of the accuracy, truthfulness, and completeness of encounter data submitted by, or on behalf of, each plan. Note that §438.602(e) originated in the 2016 CHIP and Medicaid Final Rule and is effective for Medicaid managed care contracts started on or after July 1, 2017.[47] Additionally, DHCS agreed to conduct the EDV study annually in response to findings and recommendations from the California State Auditor in an audit report published in March 2019.[48] Finally, the EDV study results support DHCS' efforts to improve data quality and reporting, which will help DHCS meet its Comprehensive Quality Strategy goal to improve the quality of care for Medi-Cal members.[49]

[47] Medicaid and CHIP Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability (CHIP and Medicaid Final Rule), (May 6, 2016) Federal Register Document Citation No. 81 FR 27497. Available at: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Jan 3, 2025.

[48] California State Auditor. Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services, March 2019. Available at: https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf. Accessed on: Jan 3, 2025.

[49] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

Objective

The objective of the 2023–24 EDV Study was to continue to examine, through a review of medical records, the completeness and accuracy of the professional encounter data that the MCPs and PSPs submitted to DHCS. HSAG assessed the encounter data submitted by the 21 MCPs and two PSPs included in the study.

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the EDV study from MCPs, PSPs, and DHCS via a SFTP site.

Description of Data Obtained

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

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

Encounter Data Validation Medical Record Review Study Summary

Medical and clinical records are considered the "gold standard" for documenting access to and the quality of health care services. During contract year 2023–24, HSAG evaluated MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2022, and December 31, 2022. The study answered the following question:

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

HSAG conducted the following actions to answer the study question:

- Identified the eligible population and generated samples from data extracted from the DHCS data warehouse.
- Assisted the plans with the procurement of medical records from providers, as appropriate.

- Reviewed medical records against DHCS encounter data.
- Calculated study indicators.

The *2023–24 Encounter Data Validation Study Report* includes the detailed methodology, results, conclusions, and recommendations. The report may be found at Medi-Cal Managed Care Quality Improvement Reports.

14. Focus Studies

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

DHCS contracts with HSAG to conduct focus studies to gain better understanding of and identify opportunities for improving care provided to members, which supports the DHCS Comprehensive Quality Strategy goals and vision.[50]

HSAG conducts each focus study in accordance with the CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[51]

Under the focus study category, DHCS contracted with HSAG to conduct race/ethnicity analyses related to measurement year 2023 MCAS patient-level detail file data for DHCS' internal use only. Following is a summary of the analyses.

Objective

The objective of the Measurement Year 2023 MCAS Race/Ethnicity Analyses was for HSAG to provide analyses results to DHCS related to select demographics to inform DHCS' quality improvement and early intervention work as well as other initiatives.

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the Measurement Year 2023 MCAS Race/Ethnicity Analyses from DHCS and MCPs. For the DHCS data, HSAG submitted to DHCS the required DHCS Data Release Form and detailed data request instructions to ensure all needed data were submitted for the analyses. DHCS submitted the data to HSAG via a SFTP site. MCPs submitted the data to HSAG during the PMV activities described in Section 4 of this report ("**Validation of Performance Measures**").

[50] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

[51] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 3, 2025.

Description of Data Obtained

The data types HSAG obtained for the Measurement Year 2023 MCAS Race/Ethnicity Analyses are listed below:

- Member demographic
- Patient-level detail

Summary of Analyses and Deliverable for DHCS' Internal Use

HSAG used the measurement year 2023 MCAS patient-level detail files submitted by the MCPs to calculate statewide MCAS indicator rates stratified by the following demographics:

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

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

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

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

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

15. Technical Assistance

At the State's direction, the EQRO may provide technical assistance to groups of MCOs, PIHPs, PAHPs, or PCCM entities as described at 42 CFR §438.358(d). The technical assistance HSAG provides supports DHCS and the plans in making progress toward accomplishing the DHCS Comprehensive Quality Strategy goals and vision, improving the health care services provided to Medi-Cal members, and achieving health equity.[52]

In addition to the technical assistance provided to MCPs and PSPs as part of the PIP process, DHCS contracted with HSAG to provide supplemental technical assistance to help improve overall statewide performance. DHCS selected three technical assistance categories for HSAG to conduct.

Technical Assistance for Plans' Quality Improvement

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

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

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

[52] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Jan 3, 2025.

Objective—Technical Assistance for Plans' Quality Improvement

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

Methodology—Technical Assistance for Plans' Quality Improvement

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

Results—Technical Assistance for Plans' Quality Improvement

Following is a high-level summary of the notable technical assistance HSAG provided to DHCS, MCPs, and PSPs to support quality improvement efforts.

Performance Measures and Audits

- Forwarded to DHCS, NCQA and CMS updates to ensure DHCS is aware of NCQA and CMS requirements, knows of NCQA and CMS resources, and has the pertinent information needed to make performance measure requirement decisions.
- Responded to DHCS' questions and provided feedback to DHCS related to NCQA benchmarks, HEDIS Compliance Audit processes, HEDIS data, NCQA and CMS performance measure specifications, hybrid measure reporting methodology, and historical and future performance measure requirements.
- Provided guidance to MCPs about performance measure requirements and DHCS' expectations for plans' use of preventive services data for quality improvement activities.
- Provided information to DHCS about MCPs' inclusion of Medicare-Medicaid dual eligible members in performance measure reporting, including a summary of what NCQA specifies in the performance measure specifications regarding inclusion of dual eligible members.

Consumer Assessment of Healthcare Providers and Systems

- Provided guidance to DHCS regarding how to respond to an NCQA inquiry related to the CAHPS survey sample frame certification process.
- Responded to MCPs' requests for information and data related to the CAHPS survey HSAG administers on behalf of DHCS.

Other Technical Assistance

- Reviewed CMS' feedback to DHCS on the 2021–22 EQR MCMC and Dental MC technical reports and provided recommended responses to DHCS to submit to CMS.
- Provided clarification and information to individual DHCS staff members about CMS' EQR requirements, specific EQR activities and deliverables, HSAG's role as the EQRO, and processes and tools that are in place to ensure efficient and thorough project management of all activities.
- Forwarded to DHCS announcements and updates from various organizations, such as CMS, to ensure DHCS is up to date on relevant information and requirements that may affect MCMC.
- Sent newly created and existing resources to DHCS staff members to support them in gaining a better understanding of the EQR activities and CMS' EQR requirements.
- Provided suggested responses to DHCS for questions from the California State Auditor and Mathematica Policy Research regarding various EQRO activities. HSAG also sent DHCS historical reports that HSAG produced to help DHCS respond to the California State Auditor and Mathematica Policy Research requests. Finally, HSAG answered DHCS' questions regarding historical EQRO reports and processes to help DHCS respond to CMS with the requested information.
- Upon request, provided MCPs and PSPs with historical information to help with their quality improvement processes (i.e., PIP validation findings, collaborative discussion presentations, and quality conference presentations).

Conclusions—Technical Assistance for Plans' Quality Improvement

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

Technical Assistance for Priority Quality Improvement Collaboration

Under this technical assistance category, HSAG supports DHCS by facilitating and providing logistical support for collaborative calls with the plans. These collaborative calls provide DHCS the opportunity to share statewide and plan-specific performance measure data, highlight instances of high performance, and communicate opportunities for improvement. Depending on the discussion topic, DHCS invites internal and external partners to present information aimed at fostering collaboration among the plans and with the identified partners. During each call, DHCS requests that plans share about quality improvement successes as well as identified challenges and barriers.

Objective—Technical Assistance for Priority Quality Improvement Collaboration

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

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

Methodology—Technical Assistance for Priority Quality Improvement Collaboration

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

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

Additionally, HSAG:

- In partnership with DHCS, facilitated each collaborative call.

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

HSAG conducted the collaborative calls through webinars.

Results—Technical Assistance for Priority Quality Improvement Collaboration

Contract Year 2023–24 Quarter 1

During Q1 of contract year 2023–24, all MCPs and PSPs were required to attend a regional collaborative call debrief from the calls that occurred during contract year 2022–23. The purpose of the regional collaborative call debrief was to provide the opportunity for MCPs and PSPs to discuss lessons learned, developments, promising practices, and projects related to improving performance for measures with the lowest rates and highest disparities. Plans within each region were given time to discuss methods for improving rates through collaboration, what did and did not work for their specific regions, and initiatives they will carry forward. The goal of the regional collaborative call debrief was to foster the MCPs and PSPs in creating meaningful connections and identifying quality improvement methods that account for regional variation.

Contract Year 2023–24 Quarter 4

As part of the calendar year 2024 Quality Improvement and Health Equity accountability, beginning in Q4 of contract year 2023–24, DHCS began requiring all MCPs and PSPs to attend and participate in two Statewide Collaborative Learning Calls (SCLCs) each calendar year. The SCLCs replaced the Regional Collaborative calls previously conducted as part of Technical Assistance for Priority Quality Improvement Collaboration.

The purpose of the Q4 SCLC, held in April 2024, was to provide a platform for MCPs and PSPs to interact with each other to discuss and share resources and meaningful practices that can be applied within their respective regions to improve the quality of care and advance health equity. The April 2024 SCLC focused on opportunities for improvement based on statewide data, including evolving promising practices and lessons learned. During the call, two organizations that serve the child population conducted presentations about ways the organizations can partner with MCPs and PSPs to improve the health of the Medi-Cal child population. Immediately following the April 2024 SCLC, HSAG invited participants to complete a survey to provide anonymous feedback about the call, share information about quality improvement activities, and provide additional information regarding their community partnerships. The survey link appeared immediately after participants exited the webinar, and

HSAG also emailed the survey link to participants following each call. HSAG provided DHCS with a summary of the survey results once they became available.

Conclusions—Technical Assistance for Priority Quality Improvement Collaboration

The collaborative calls resulted in MCPs, PSPs, and DHCS sharing valuable information regarding quality improvement efforts for each measure domain for which DHCS identified opportunities for improvement. Plan participants actively engaged in discussions related to the data DHCS presented, sharing about potential partners, lessons learned, and strategies to improve performance. Participants also shared about challenges and received feedback and ideas from each other regarding how to overcome the challenges. MCPs and PSPs may apply the information gained to their quality improvement efforts to improve performance within the measure domains demonstrating the most opportunities for improvement.

Technical Assistance for Consultative Services

Objective—Technical Assistance for Consultative Services

The objective of Technical Assistance for Consultative Services is for HSAG to assist DHCS with additional activities undertaken as part of DHCS' quality strategy, or in response to newly enacted EQR-related federal- or state-directed activities.

Methodology—Technical Assistance for Consultative Services

HSAG used a team approach to provide the requested technical assistance, identifying the most pertinent subject matter experts to ensure the most efficient provision of technical assistance to meet DHCS' stated goals. HSAG provided the technical assistance to DHCS via email and Web conferences.

Results—Technical Assistance for Consultative Services

During contract year 2023–24, DHCS requested HSAG's consultative services to assess the feasibility of conducting secret shopper surveys to evaluate providers' adherence to wait time

standards, in response to a California State Auditor report.[53] HSAG submitted a document to DHCS for internal use that outlined the advantages and disadvantages of a secret shopper approach, with comparisons to the Timely Access Study described in Section 9 of this report ("**Additional Network Adequacy Activities**").

Conclusions—Technical Assistance for Consultative Services

As a result of HSAG's consultative services, DHCS received the information needed to inform its decisions regarding conducting secret shopper surveys.

[53] Department of Health Care Services and Department of Managed Health Care. Children Enrolled in Medi-Cal Face Challenges in Accessing Behavioral Health Care. November 28, 2023. Available at: https://auditor.ca.gov/reports/2023-115/index.html. Accessed on: Jan 3, 2025.

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

External Quality Review Recommendations for DHCS

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

External Quality Review Recommendations for MCPs and PSPs

HSAG provided each plan an opportunity to summarize actions taken to address recommendations HSAG made in the *2022–23 Medi-Cal Managed Care Technical Report*. In *Volume 2 of 9 (Appendix C)* of this EQR technical report, HSAG includes each plan's self-reported follow-up on the 2022–23 EQR recommendations as well as HSAG's assessment of the self-reported actions. HSAG also includes in *Appendix C* its recommendations for each plan based on the 2023–24 EQR.