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

July 1, 2022–June 30, 2023

Quality and Population Health Management
California Department of Health Care Services

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Table of Contents

Table of Tables

Table of Figures

Executive Summary of Findings

Background

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

The *2022–23 Medi-Cal Managed Care External Quality Review Technical Report* provides a summary of the external quality review (EQR) activities of DHCS' contracted Medi-Cal managed care health plans (MCPs) and population-specific health plans (PSPs). DHCS does not exempt any MCMC plans from EQR.

In addition to summaries of EQR activity results, the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report* includes HSAG's assessment of the quality of, timeliness of, and access to care delivered to MCMC members by MCMC plans and as applicable, recommendations as to how DHCS can use the EQR results in its assessment of and revisions to the DHCS Comprehensive Quality Strategy.[1] Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS Comprehensive Quality Strategy goals as well as whether DHCS needs to revise the Comprehensive Quality Strategy based on the results presented in the EQR technical report.

The review period for the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report* is July 1, 2022, through June 30, 2023. HSAG will report on activities that take place beyond the report's review period in the *2023–24 Medi-Cal Managed Care External Quality Review Technical Report*.

This *Medi-Cal Managed Care External Quality Review Technical Report Executive Summary of Findings* provides a high-level summary of the notable findings included in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*. This executive summary will sometimes collectively refer to the MCPs and PSPs as "MCMC plans."

[1] *Department of Health Care Services Comprehensive Quality Strategy 2022*. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf. Accessed on: Mar 6, 2024.

Medi-Cal Managed Care Program by the Numbers

Statewide MCMC members as of June 2023:[2] **More than 14.1 million**

DHCS' contracted MCMC plans: **25 MCPs** and **two PSPs**

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

Quality, Access, and Timeliness

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

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

Summary of Findings

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

Following is a high-level overview of the notable EQR findings for the July 1, 2022, through June 30, 2023, review period.

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

Access

Alternative Access Standards Reporting

Number of Alternative Access Standard Requests, Approvals, and Denials

During the measurement period of February 6, 2023, through October 9, 2023, MCPs submitted 7,479 alternative access standard requests to DHCS. There were 6,897 distinct combinations of request characteristics, of which DHCS approved 5,265 (76.3 percent), denied 531 (7.7 percent), and rendered no decision for 1,101 (16.0 percent). The primary reason for not rendering a decision, according to DHCS, was that the ZIP Code in the request is a special, non-residential ZIP Code (e.g., a post office box only ZIP Code), where an alternative access standard would not be appropriate because no members reside there.

Reasons for the Approval or Denial of Alternative Access Standard Requests

In the data provided for the 2022–23 alternative access standard requests analyses, the most common reasons for DHCS to approve or deny an alternative access standard request included:

- Approval Reasons
  - The MCP is contracted with the closest provider (network or out-of-network), and DHCS did not identify a closer network or out of-network provider than the provider indicated on the request.
  - Although DHCS identified closer out-of-network providers than the network provider indicated on the request, the MCP has attempted to contract with those providers and clearly explained why they could not be added to the MCP's network.
- Denial Reasons
  - The MCP's alternative access standard request is incomplete. The MCP is to revise the request that follows All Plan Letter 23-001[3] Attachment C instructions and resubmit.
  - DHCS located a closer out-of-network provider than the network provider and out-of-network provider that the MCP identified on the alternative access standard request. The MCP is to revise the request for miles/minutes or provide a justification and resubmit.
  - DHCS located a network provider within the time or distance standards that the MCP did not identify on the alternative access standard request. The MCP is to submit an updated accessibility analysis that shows the MCP is already meeting the time or distance standard.
  - The MCP's justification as to why the MCP was unable to contract with the closer out-of-network provider is insufficient. The MCP is to revise the justification and resubmit.

[3] All Plan Letter 23-001. Available at: APL 23-001 (ca.gov). Accessed on: Jan 25, 2024.

Distance and Driving Time Between Nearest Network Provider and Farthest Member

Across all combinations of MCPs and ZIP Codes, the shortest median driving distance was one mile for Molina Healthcare of California and ZIP Code 92311, while the longest median driving distance was 178.5 miles for California Health & Wellness Plan and ZIP Code 92389. The shortest median driving time was one minute for Molina Healthcare of California and ZIP Code 92311, while the longest median driving time was 222 minutes for Inland Empire Health Plan and ZIP Code 92310. The smallest median number of impacted members was zero individuals in 60 distinct combinations of MCPs and ZIP Codes associated with seven different MCPs. The largest median number of impacted members was 29,206 individuals for Inland Empire Health Plan and ZIP Code 92201.

Time Frame for Approval or Denial of Requests

For requests submitted during the initial request and decision phase between February 6, 2023, and July 31, 2023, the median number of days to approval or denial across MCPs was 58 days.

For requests submitted during the corrective action plan (CAP) resubmission phase between August 1, 2023, and October 9, 2023, the median number of days to approval or denial was 32 days.[4] This calculation includes only requests where a decision was rendered.

Approved Telehealth Requests

For 2022–23, DHCS approved 33 telehealth requests received from six MCPs. Anthem Blue Cross Partnership Plan received approval for 13 requests, more than any other MCP. The provider types associated with requests were Hematology, Mental Health (non-psychiatry) Outpatient Services, Nephrology, Primary Care Provider (PCP), and Psychiatry. Both adult and pediatric requests were received for all listed provider types except Hematology; only adult requests were received for Hematology. The population served and provider type for which requests were most frequently approved was Pediatric Psychiatry, with six approved requests. Across all approved requests, the percentage of members with in-person access ranged from 87 percent to 99 percent, with a median of 96 percent. The number of full-time equivalent (FTE) providers required by DHCS ranged from 0.25 to 4.00, with a median of 0.50. The number of telehealth providers contracted by the MCP was greater than or equal to the number of providers required by DHCS for all approved requests.

[4] HSAG also calculated the median number of days to approval or denial across all distinct requests with approvals or denials, independent of MCP. Those medians are 81 days for the initial request and decision phase and 27 days for the CAP resubmission phase.

Consumer Complaints

HSAG reviewed DHCS' quarterly grievance reports from State Fiscal Year (SFY) 2021–22 Quarter 3 through SFY 2022–23 Quarter 2 (January 2022 through December 2022) for member complaints related to access to providers. Grievance call frequencies were collected for four categories of complaints: "Timely Access," "Geographic Access," "Out-of-Network," and "Rural Member Denied Out-of-Network Request." Results were stratified by MCP and county. On average, across all categories of complaints, MCPs received 544.7 complaints per county where any complaints were received. The smallest number of complaints for any MCP and county where any complaints were received was one complaint (California Health & Wellness Plan, Kaiser NorCal, and Partnership HealthPlan of California), and the largest number of complaints for an MCP and county was 18,160 complaints (L.A. Care Health Plan). In all, 52,840 complaints were received across the four included categories, with 85.8 percent related to Timely Access, 10.4 percent related to Geographic Access, 3.8 percent related to Out-of-Network provider issues, and less than 0.1 percent related to Rural Member Denied Out-of-Network Request issues.

Contracting Efforts

HSAG reviewed data on MCP contracting efforts and the outcomes of those efforts as documented in alternative access standard requests submitted between February 6, 2023, and October 9, 2023. The following bullet points summarize common themes in the current year's data:

- No contracting efforts required
  - Network provider closer than out-of-network provider
  - Provider location outside of MCP's licensed service area
- Provider outreach in progress
  - Planning to contact provider in near future
  - Contacted or attempted to contact provider by telephone, mail, or email
  - Contracting steps/negotiations in progress[5]
  - Provider already contracted with MCP but not yet credentialed
  - Provider already contracted with MCP but not yet contracted at location
  - Provider affiliated with network contracted with MCP but not yet credentialed or contracted at location
- Provider outreach unsuccessful
  - Provider unreachable due to incorrect or outdated directory information
  - Incorrect directory information regarding provider location, specialty, or population served
  - Provider on extended leave, retired, died, or no longer practices at location

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

  - Members cannot make appointments for care at the location
- Contracting efforts failed
  - Unable to resolve rate dispute with provider
  - Provider lacks capacity to take on new patients/new networks
  - Provider affiliated with closed network that prohibits additional contracts
  - Provider policy against contracting with Medi-Cal or MCPs
  - Provider credentialing failed or other quality of care issue

It is noteworthy that, in instances where contracting efforts failed, MCPs often indicated that individual providers' contractual relationships with other networks played an important role.

Providers under Contract

The following are the results of HSAG's calculations based on provider data current as of September 2023:

- For all MCPs, the median percentage of contracted providers across counties, populations served, and provider types is 50.3 percent (interquartile range [IQR] 13.6 percent–86.6 percent).[6] This indicates that an MCP typically contracts with roughly half of the providers who are contracted with any MCP in a county.
- The MCPs with the highest median percentage of contracted providers across counties and provider types are CenCal (100.0 percent; IQR 93.0 percent–100.0 percent) and Partnership (100.0 percent; IQR 75.7 percent–100.0 percent). These MCPs typically contract with a higher proportion of providers located within the counties they serve than other MCPs.
- The MCP with the lowest median percentage of contracted providers across counties and provider types is Aetna (11.9 percent; IQR 4.3 percent–33.9 percent). This MCP typically contracts with a lower proportion of providers located within the counties it serves than other MCPs.
- The provider type with the highest median percentage of contracted providers across counties and MCPs is Hospitals (69.2 percent; IQR 46.7 percent–100.0 percent). MCPs typically contract with a higher proportion of providers of this type located within the counties they serve compared to other provider types.
- The provider type with the lowest median percentage of contracted providers across counties and MCPs is Adult Ear, Nose, and Throat (ENT)/Otolaryngology (4.4 percent; IQR 0.0 percent–75.6 percent). MCPs typically contract with a lower proportion of providers of this type located within the counties they serve compared to other provider types.

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

Timeliness

Timely Access Study

The following are summaries of calendar year 2022 Timely Access Study calls and the first two quarters of calendar year 2023 calls. In the *2023–24 Medi-Cal Managed Care External Quality Review Technical Report*, HSAG will include the full calendar year 2023 results and will compare the calendar year 2023 results to the calendar year 2022 results.

Calendar Year 2022—Calls to Providers

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

Table 1 presents calendar year 2022 cumulative results for providers' compliance with non-urgent and urgent in-person appointment wait times, stratified by adult and pediatric member populations. Providers for which HSAG obtained at least one appointment have been included. The rate is determined by the total number of providers with an appointment time obtained for the designated appointment that met the appointment wait time standards.

Table 1—Calendar Year 2022 Timely Access Study Statewide Provider Compliance for In-Person Appointment Wait Time Standards

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

Provider Type	Percentage of First Available In-Person Appointment Meeting Wait Time Standards				Percentage of Available In-Person Appointment Meeting Wait Time Standards		
	Non-Urgent		Urgent		Preventive Care		Non-Urgent Follow-up
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	
PCP	76.6%	81.0%	48.4%	54.8%	—	—	—
Specialist	63.2%	63.5%	40.6%	43.7%	—	—	—
Non-Physician Mental Health Provider	78.5%	75.3%	62.0%	55.2%	—	—	79.0%

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

Calendar Year 2022—Calls to MCMC Plan Call Centers

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

Calendar Year 2022—Calls to MCMC Plan Nurse Triage/Advice Lines

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

Cumulative First Two Quarters of Calendar Year 2023—Calls to Providers

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

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

Table 2—Cumulative First Two Quarters of Calendar Year 2023 Timely Access Study Statewide Provider Compliance for In-Person Appointment Wait Time Standards

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

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

Cumulative First Two Quarters of Calendar Year 2023—Calls to MCMC Plan Call Centers

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

Cumulative First Two Quarters of Calendar Year 2023—Calls to MCMC Plan Nurse Triage/Advice Lines

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

Conclusions—Timely Access Study

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

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

Quality

DHCS Comprehensive Quality Strategy

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

During the review period for the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*, DHCS did not publicly post any formal updates to the Comprehensive Quality Strategy; therefore, HSAG made no recommendations to DHCS regarding the quality strategy.

Compliance Reviews

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

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

Performance Measure Results Analyses

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

Managed Care Health Plan Conclusions

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

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

- MCPs show varying levels of opportunities for improvement based on performance measure results, with the percentages of rates worse than the minimum performance levels ranging from 86.67 percent to 6.67 percent.
- While the MCMC weighted average for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure was below the minimum performance level for measurement year 2022, the MCMC weighted average for this measure, as well as the weighted averages for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and both *Follow-Up After Emergency Department Visit for Substance Use* measures, improved significantly from measurement year 2021 to measurement year 2022. These performance measure results show that MCPs are making progress toward ensuring that members with mental health and substance use disorders are seen for follow-up after an emergency department visit. Additionally, this improvement supports DHCS' Comprehensive Quality Strategy Bold Goal to improve follow-up for mental health and substance use disorders by 50 percent at the State level by 2025.[7]
- While the MCMC weighted averages for seven of the 15 performance measure weighted averages that HSAG compared to benchmarks (47 percent) were below the minimum performance levels for measurement year 2022, aggregate performance measure results show that for four of these measures, MCPs collectively made performance improvements that contributed to MCMC weighted averages improving significantly from measurement year 2021 to measurement year 2022:
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

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

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

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

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

Population-Specific Health Plan Conclusions

For performance measure rates that were compared to the DHCS-established high performance levels and minimum performance levels, both PSPs (AIDS Healthcare Foundation and SCAN Health Plan) performed above the high performance levels for all performance measure rates. The PSPs continue to perform above the DHCS-established

minimum performance levels, reflecting the provision of quality, timely, and accessible health care services to their members.

Preventive Services Study

The 2023 Preventive Services Report includes the results from the analysis of 23 indicators that assess the utilization of preventive services by pediatric MCMC members at the statewide and regional levels (i.e., delivery type model, population density, geographic region, and county) as well as by key demographic characteristics (i.e., race/ethnicity, primary language, gender, and age).

HSAG identified the following overall findings for the 2023 Preventive Services Report analyses:

- **Overall Finding 1:** Performance for measurement year 2022 improved from measurement year 2021. However, the majority of indicators that could be compared to national benchmarks did not meet the national benchmarks for measurement year 2022.
- **Overall Finding 2:** Performance is regional.
- **Overall Finding 3:** Statewide performance varies based on race/ethnicity and primary language.
- **Overall Finding 4:** Overall performance across California's six largest counties was high for a majority of indicators, but improvement is needed for well-child visits, childhood immunizations, blood lead screenings, and follow-up after hospitalizations for mental illness.
- **Overall Finding 5:** At least half of younger MCMC children received well-child visits and received immunizations at higher rates than seen nationally.
- **Overall Finding 6:** Adolescent rates for well-care visits are lower than rates for younger children.
- **Overall Finding 7:** Over half of MCMC children received a blood lead screening by their second birthday, but MCMC children received blood lead screenings at lower rates than seen nationally.

Technical Assistance

HSAG provided technical assistance to DHCS and MCMC plans via email, telephone, and Web conferences. HSAG also collaborated with DHCS to host an in-person quality conference in Sacramento, California, to support MCMC plans' quality improvement efforts. The conference focused on how to imbed quality and equity within organizations; build partnerships with community organizations; and integrate quality, health equity, and member experiences to improve whole-person care.

The technical assistance activities resulted in:

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

Network Adequacy

Skilled Nursing Facility (SNF)/Intermediate Care Facility (ICF) Experience and Distance Reporting

Based on the results of the 2022–23 SNF Experience and SNF/ICF Distance analyses, HSAG developed the following conclusions:

- For the SNF Experience analysis, the percentage of residents experiencing no events for the *Adverse Events* and *Behavioral Health* composite measures decreased from calendar year 2021 to calendar year 2022, indicating worse performance in calendar year 2022. Performance for the *Physical Health* composite measure generally stayed the same from calendar year 2021 to calendar year 2022.
  - The increase in behavioral health events was primarily driven by an increase in the *Percent of Residents Who Have Depressive Symptoms* measure rate (by 1.48 percentage points).
- For the SNF Experience analysis, rates for the long-stay quality measures have stabilized after the COVID-19 public health emergency in calendar years 2020 and 2021.
  - However, the *Percent of Residents Who Have Depressive Symptoms* rate for long-stay SNF residents has not yet stabilized. In calendar year 2019 (i.e., prior to the impacts of COVID-19), this rate was 1.07 percent. In calendar year 2020, this rate increased to 4.50 percent, and it continued to increase in calendar year 2021 to 5.08 percent and in calendar year 2022 to 6.56 percent.
- Long-stay SNF residents had a longer average driving distance from their place of residence to a facility than short-stay residents for calendar year 2022. Additionally, both long- and short-stay SNF residents who had a psychiatric diagnosis other than Alzheimer's disease, who had intellectual disability or developmental disability indicated, or who entered the facility from a psychiatric hospital had longer than average driving distances from their place of residence to a facility. As expected, short- and long-stay SNF residents who

resided in rural areas had a longer average driving distance (26.79 and 38.96 miles, respectively) from their place of residence to a facility than SNF residents who resided in urban areas (11.38 and 15.42 miles, respectively).

- Long-stay ICF residents had a longer average driving distance from their place of residence to a facility than short-stay ICF residents for calendar year 2022. As expected, short- and long-stay ICF residents who resided in rural areas had a longer average driving distance (31.06 and 30.99 miles, respectively) from their place of residence to a facility than ICF residents who resided in urban areas (12.45 and 21.19 miles, respectively). Additionally, the average driving distances for short- and long-stay ICF residents increased by 3.48 and 2.57 miles, respectively, from calendar year 2021 to calendar year 2022.

Member Perceptions of Care

During contract year 2022–23, DHCS contracted with HSAG to administer and report the results of the following Consumer Assessment of Healthcare Providers and Systems[8] (CAHPS®) surveys:

- CAHPS 5.1 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set[9] (HEDIS®) and Children with Chronic Conditions (CCC) measurement sets to meet CMS' Children's Health Insurance Program Reauthorization Act requirements.
- CAHPS 5.1 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set (i.e., CAHPS 5.1H Adult and Child Medicaid Health Plan Surveys) for the adult and child Medicaid populations for the 24 MCPs and Medi-Cal fee-for-service (FFS).

Children's Health Insurance Program Survey

HSAG mailed 6,680 child surveys to a sample of Children's Health Insurance Program (CHIP) members selected for surveying. Of these, 979 child surveys were completed for the CHIP sample.

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

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

- The general child population scored below the 2022 National Committee for Quality Assurance (NCQA) child Medicaid national 50th percentiles for all reportable measures, which included:

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

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

  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
  - Composite Measures:
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
- The CCC population scored below the 2022 NCQA CCC Medicaid national 50th percentiles for all reportable measures, except the *Access to Prescription Medicines* CCC item. These measures included:
  - Global Ratings:
    - *Rating of Health Plan*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Specialist Seen Most Often*
  - Composite Measures:
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
  - CCC Composite Measures and Items:
    - *Family-Centered Care (FCC): Personal Doctor Who Knows Child*
    - *FCC: Getting Needed Information*
- The 2023 score for the *Rating of All Health Care* global rating was statistically significantly lower than the 2021 score for the general child population.

Medi-Cal Survey

HSAG determined the sample sizes for the 2023 CAHPS Survey with the goal of obtaining 411 completed surveys at the MCP level. While the sample sizes were determined based on these goals, some measures at the MCP level and every measure except *Rating of Health Plan* at the FFS level had fewer than 100 responses for the adult and child populations. According to NCQA HEDIS Specifications for Survey Measures, if a measure has fewer than 100 responses, the measure is not reportable.[10]

HSAG calculated State weighted scores for the adult and child Medi-Cal populations. Overall, the differences between the State weighted scores and the NCQA Medicaid national 50th percentiles ranged from -9.5 percentage points to -1.3 percentage points, with an average of

[10] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2022.

- 5.5 percentage points for the adult population and from -8.0 percentage points to -0.4 percentage points, with an average of -4.3 percentage points for the child population.

The following MCPs showed the greatest level of performance by scoring statistically significantly above the 2022 NCQA Medicaid national 50th percentiles for the following reportable measures:

- California Health & Wellness Plan—*Getting Needed Care* (adult population only)
- California Health & Wellness Plan and Kaiser SoCal—*How Well Doctors Communicate* (adult population only)
- California Health & Wellness Plan—*Customer Service* (child population only)
- Central California Alliance for Health—*Customer Service* (child population only)
- Health Plan of San Joaquin—*Rating of Specialist Seen Most Often* (child population only)
- Health Plan of San Mateo—*Rating of Specialist Seen Most Often* (adult population only)
- Kaiser SoCal—*Rating of Health Plan* and *Rating of Personal Doctor* (child population only)

Aetna showed the greatest opportunity for improvement for the adult population, and CalViva Health and Health Net Community Solutions, Inc. showed the greatest opportunity for improvement for the child population, with these MCPs having the most reportable measures demonstrating statistically significantly lower performance than the 2022 NCQA Medicaid national 50th percentiles. Scores statistically significantly below the 50th percentiles were seen across all measures for the adult and child populations.

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

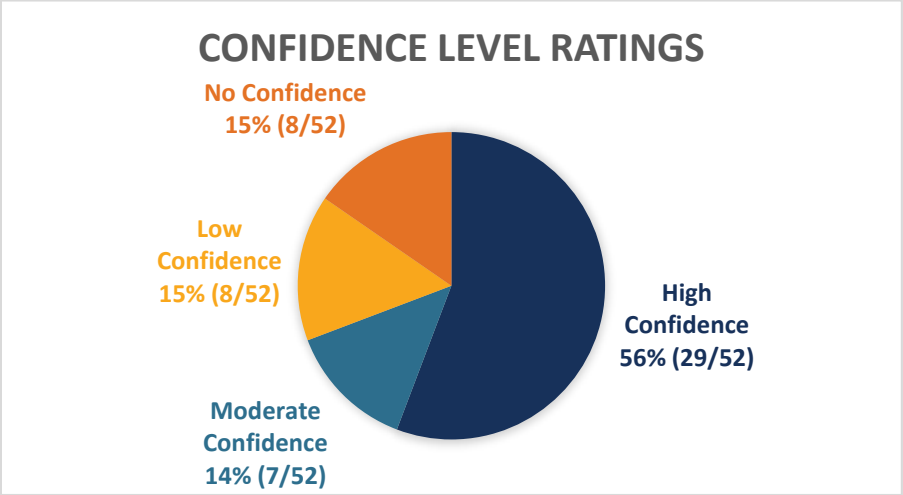
Based on 2023 CAHPS performance, the MCPs have opportunities to improve members' experience with care and services. The *Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly* measures show the greatest opportunities for improvement for the adult population, and the *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate* measures show the greatest opportunities for improvement for the child population, since these measures had the most MCPs with scores lower than the 50th percentiles. Low performance in these areas may point to issues with access to and timeliness and quality of care.

Performance Improvement Projects

Validation of Performance Improvement Projects

During the review period, MCMC plans completed the 2020–22 rapid-cycle PIPs. HSAG validated 52 PIP Module 4s that the MCMC plans submitted. In its PIP validation, HSAG assessed the validity and reliability of the PIP results to determine whether DHCS and key stakeholders can have confidence in the reported PIP findings. Figure 1 depicts the distribution of the confidence level ratings for all 52 PIPs that HSAG validated:

Figure 1—2020–22 Performance Improvement Project Confidence Level Ratings



Performance Improvement Project Interventions

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

- For cancer screening PIP topics, such as breast cancer screening and cervical cancer screening, MCMC plans tested member outreach and care coordination interventions. Additionally, some MCMC plans hosted mobile mammography events.
- For chronic disease management PIP topics, such as controlling high blood pressure and diabetes control, MCMC plans tested member outreach to provide more individualized care management, such as conducting medication reconciliation and ensuring members have 90-day medication supplies. MCMC plans also tested interventions that supported members in managing their chronic diseases at home, such as providing blood pressure reading and recording education and diabetes home care kits.

- For postpartum care PIP topics, MCMC plans tested ways to identify pregnant members with whom they could conduct health education about the importance of postpartum care and ensure that these members scheduled timely postpartum care visits.
- For childhood immunization PIP topics, MCMC plans tested hosting vaccination day events, as well as outreaching to members' parents/guardians to provide vaccination reminders, education, and scheduling assistance. The MCMC plans also worked with the California Immunization Registry for data exchange and reconciliation.
- For children and adolescent well-care visit PIP topics, MCMC plans conducted outreach to members' parents/guardians to remind them of upcoming or missed well-care visits for their children and provide appointment scheduling assistance. Some MCMC plans offered incentives upon completion of well-care visits, while other MCMC plans worked with providers to enhance data exchange processes to improve the quality and timeliness of the data.

Conclusions

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

Information Systems

Encounter Data Validation—Medical Record Review

For the 2022–23 Encounter Data Validation (EDV) study, HSAG evaluated MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2021, and December 31, 2021. Table 3 displays the statewide results for each study indicator. Of note, for the medical record omission rate and encounter data omission rate, lower values indicate better performance.

Table 3—Statewide Results for Study Indicators

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

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

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

Key Data Elements	Medical Record Omission Rate	Encounter Data Omission Rate	Element Accuracy Rate
EDV Study Standards	Less than 10 percent	Less than 10 percent	More than 90 percent for each data element or 80 percent for all-element accuracy rate
Date of Service	8.6%+	3.7%+	—
Diagnosis Code	11.5%	2.1%+	99.5%+
Procedure Code	19.4%	8.5%+	98.7%+
Procedure Code Modifier	28.3%	5.0%+	99.7%+
Rendering Provider Name	9.1%+	3.6%+	63.6%
All-Element Accuracy	—	—	45.2%
All-Element Accuracy Excluding Rendering Provider Name*	—	—	69.1%

When comparing the 2022–23 results to the 2021–22 EDV study, the number of statewide rates meeting the EDV study standards increased by three, likely due to the higher medical record procurement rate and more complete rendering provider names in DHCS' encounter data.

Potential Concerns

Addressing External Quality Review Recommendations

The *CMS External Quality Review (EQR) Protocols, February 2023* indicate that, in the EQR technical report, the EQRO should include recommendations about how the state can target its quality strategy goals and objectives to support improvements in quality of care.[11]

In the *2021–22 Medi-Cal Managed Care Technical Report* and *2022–23 Medi-Cal Managed Care Technical Report*, HSAG made no recommendations to DHCS as part of the EQR; however, HSAG presents considerations and makes recommendations to DHCS as part of the analytic activities it conducts for DHCS. In conversations with HSAG about completed and new analytic activities, DHCS has indicated to HSAG that it reviews and takes HSAG's recommendations into account when planning future analytic activities, making policy changes, and determining guidance to provide to MCMC plans for their quality improvement efforts.

[11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 14, 2024.