Volume 1 of 5
Medi-Cal Specialty Mental Health Services External Quality Review Technical Report

Contract Year 2024–25

Main Report

California Department of Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Commonly Used Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

- **§**—section
- **AAS**—alternative access standards
- **ADHD**—attention deficit/hyperactivity disorder
- **ANC**—annual network certification
- **BH-CONNECT**—Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
- **BHAS**—Behavioral Health Accountability Set
- **BHIN**—Behavioral Health Information Notice
- **BHT**—Behavioral Health Transformation
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CAP**—corrective action plan
- **CA WIC**—California Welfare and Institutions Code
- **CCPRs**—Cultural Competence Plan Requirements
- **CFR**—Code of Federal Regulations
- **CHIP**—Children's Health Insurance Program
- **CLAS**—culturally and linguistically appropriate services
- **CMS**—Centers for Medicare & Medicaid Services
- **CQS**—Comprehensive Quality Strategy
- **DHCS**—California Department of Health Care Services
- **DMC**—Drug Medi-Cal
- **DMC-ODS**—Drug Medi-Cal Organized Delivery System
- **DNR**—Do Not Report
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **HCAI**—Department of Health Care Access and Information
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HHS**—U.S. Department of Health & Human Services
- **HMO**—health maintenance organization
- **HPL**—high performance level
- **HSAG**—Health Services Advisory Group, Inc.

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

- **Integrated BHP**—Integrated behavioral health plan
- **ISCAT**—Information Systems Capabilities Assessment Tool
- **LOC**—level of care
- **MCE**—managed care entity
- **MCO**—managed care organization
- **MCP**—managed care health plan
- **MHP**—mental health plan
- **MPL**—minimum performance level
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **PAHP**—prepaid ambulatory health plan
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project
- **PMV**—performance measure validation
- **QAPI**—quality assessment and performance improvement
- **SFTP**—secure file transfer protocol
- **SMHS**—specialty mental health services
- **SUD**—substance use disorder

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), or prepaid ambulatory health plan (PAHP) (described in §438.310[c][2]) or their contractors furnish to Medicaid beneficiaries. Each state must comply with §457.1250,[2] and as required by §438.350, each state that contracts with MCOs, PIHPs, or PAHPs must ensure that:

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

The California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), as the EQRO for DHCS' Medicaid (Medi-Cal) Specialty Mental Health Services (SMHS) Program. HSAG meets the qualifications of an EQRO as outlined in §438.354 and performs annual EQRs of DHCS' contracted PIHP entities to evaluate their quality, timeliness, and accessibility of SMHS to eligible Medi-Cal members served by DHCS' contracted mental health plans (MHPs). The Centers for Medicare & Medicaid Services (CMS) designates all MHPs as PIHP entities. In addition to providing an assessment of the quality, timeliness, and accessibility of SMHS the MHPs delivered to eligible Medi-Cal members, HSAG makes recommendations, as applicable, as to how DHCS can use the EQR results in its assessment of and revisions to the DHCS Comprehensive Quality Strategy (CQS).[3]

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[2] 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: Dec 11, 2025.

[3] *Department of Health Care Services Comprehensive Quality Strategy 2025*. Available at: 2025 Comprehensive Quality Strategy.pdf. Accessed on: Jan 13, 2026.

Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS CQS goals as well as whether DHCS needs to revise the CQS 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, or PAHP.
  - 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, or PAHP and validated by an EQRO in accordance with §438.358(b)(1)(ii).
  - Conducting PIPs in addition to those conducted by an MCO, PIHP, or PAHP 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, or PAHPs 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.

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 SMHS provided to eligible Medi-Cal members by MHPs, 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, or PAHP.
- 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's, PIHP's, or PAHP'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, or PAHP, 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, or PAHPs, 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, or PAHP 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.

CMS designates DHCS-contracted MHPs as PIHPs. Section 438.2 defines a PIHP, in part, as an entity that:

- Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

This report provides a summary of MHP EQR activities. Note that beginning January 1, 2025, some MHPs completed early behavioral health administrative integration, voluntarily integrated county functions for SMHS and substance use disorder (SUD) services, and began operating under a restructured contract as an Integrated Behavioral Health Plan (Integrated BHP). DHCS refers to MHPs that began operating under a restructured contract as an MHP with a Drug Medi-Cal Organized Delivery System (DMC-ODS) as MHP/DMC-ODS plans and MHPs that began operating under a restructured contract as an MHP with Drug Medi-Cal (DMC) as MHP/DMC plans. For these MHPs, based on the review period of the activities, performance measure validation (PMV), network adequacy validation (NAV), and compliance reviews were conducted for the MHP entity, and PIP validation was conducted for the Integrated BHP entity. HSAG summarizes DMC-ODS plan EQR activities in the *2024–25 Drug Medi-Cal Organized Delivery System External Quality Review Technical Report*. Except when citing Title 42 CFR, this report refers to DHCS' SMHS PIHPs as MHPs and Integrated BHPs (as applicable) and will sometimes refer to these MHPs and Integrated BHPs as "plans." Note that DHCS does not exempt any plans from EQR.

Quality, Timeliness, and Accessibility

CMS requires that the EQR evaluate the performance of MCOs, PIHPs, or PAHPs 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, or PAHP 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 accessibility, 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 MHPs' and, as applicable, Integrated BHPs' strengths and weaknesses with respect to the quality, timeliness, and accessibility of mental health care services furnished to members. In this report, the term "member" refers to a person who is entitled to Medi-Cal benefits and/or has been determined to be eligible for Medicaid and a person entitled to receive SMHS from an MHP or Integrated BHP. 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 MHP Data Were Aggregated and Analyzed and Conclusions Drawn Related to Quality, Timeliness, and Accessibility

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, or accessibility of care).

In *Volume 2 of 5 (Appendix B)* 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 five volumes that include the following content:

Volume 1—Main Report

- An overview of the county MHP structure.

- A description of the DHCS CQS report.
- An aggregate assessment of MHPs and Integrated BHPs 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—Comparative Plan-Specific PIP Information.
- Appendix B—Plan-Specific EQR Assessments and Recommendations.
  - Plans' self-reported follow-up on the 2023–24 EQR recommendations made by the previous EQRO.
  - HSAG's assessment of plans' EQR strengths, weaknesses, and recommendations based on the activity results included in this EQR technical report.

Volume 3—Comparative MHP-Specific Compliance Review Scoring Results

- Comparative MHP-specific compliance review scoring results.

Volume 4—Validation of Network Adequacy

- Detailed methodology, results, conclusions, and recommendations related to the NAV audits HSAG conducted of the MHPs and DHCS.
- Comparative MHP-specific results for all audited network adequacy indicators.

Volume 5—Alternative Access Standards Reporting

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

County Mental Health Plan Overview

In the State of California, DHCS administers the Medi-Cal SMHS program through its county MHPs. In California, the CHIP population is included in Medi-Cal. DHCS is responsible for

assessing the quality of care delivered to members through its MHPs, making improvements to care and services, and ensuring that MHPs comply with federal and State standards.

At the start of contract year 2024–25, DHCS contracted with 56 MHPs to provide SMHS in 57 counties throughout California.[4] Eligible Medi-Cal members receive SMHS through their county MHP. Following the January 1, 2025, early behavioral health administrative integration, there were 39 MHPs and 17 Integrated BHPs. DHCS aims to achieve statewide behavioral health administrative integration by January 1, 2027. A description of behavioral health administrative integration may be found at Behavioral Health Administrative Integration FAQ.

Table 1.1 shows the full MHP names, full Integrated BHP names, and shortened plan names for EQR activities. MHPs participated in PMV and NAV as MHP entities based on PMV and NAV activities being conducted retrospectively. DHCS conducted compliance review scoring of the MHP entities. MHPs that opted for early behavioral health administrative integration conducted PIPs via the Integrated BHP structure.

Table 1.1—Mental Health Plan Full Plan Names, Full Integrated BHP Names, and Shortened Plan Names for EQR Activities

— Indicates that the MHP has not opted for early behavioral health administrative integration.

* Integrated BHP active as of January 1, 2025.

^ Designated as an MHP/DMC plan.[5]

Full Mental Health Plan Name	Full Integrated Behavioral Health Plan Name	Shortened Name
Alameda County Behavioral Health Care Systems	—	Alameda
Alpine County Behavioral Health Services	—	Alpine
Amador County Behavioral Health	—	Amador
Butte County Department of Behavioral Health Services	—	Butte
Calaveras County Behavioral Health Services	County of Calaveras*^	Calaveras

[4] For contract year 2024–25, SMHS was covered in all 58 counties; however, HSAG only conducted EQRs for the 56 MHPs that maintained contracts with DHCS. During contract year 2024–25, Sutter and Yuba counties held one MHP contract under a joint powers authority, and SMHS in Sierra County was delivered under a memorandum of understanding with Placer County.

[5] Counties in which MHPs integrated with an active DMC State plan operate an SMHS PIHP (i.e., MHP) and a non-managed care DMC program plan.

Full Mental Health Plan Name	Full Integrated Behavioral Health Plan Name	Shortened Name
Colusa County Department of Behavioral Health	—	Colusa
Contra Costa County Mental Health	—	Contra Costa
Del Norte County Department of Health and Human Services	—	Del Norte
El Dorado County Health & Human Services Agency	—	El Dorado
Fresno County Department of Behavioral Health	County of Fresno*	Fresno
Glenn County Behavioral Health	—	Glenn
Humboldt County Health and Human Services	—	Humboldt
Imperial County Behavioral Health Services	—	Imperial
Inyo County Health & Human Services Behavioral Health	—	Inyo
Kern County Behavioral Health and Recovery Services	—	Kern
Kings County Behavioral Health	—	Kings
Lake County Behavioral Health Services Department	County of Lake*	Lake
Lassen County Health and Social Services	—	Lassen
Los Angeles County Department of Mental Health	—	Los Angeles
Madera County Behavioral Health Services	County of Madera*^	Madera
Marin County Behavioral Health and Recovery Services	County of Marin*	Marin
Mariposa County Human Services, Behavioral Health & Recovery Services Division	—	Mariposa
Mendocino County Mental Health	—	Mendocino

Full Mental Health Plan Name	Full Integrated Behavioral Health Plan Name	Shortened Name
Merced County Behavioral Health and Recovery Services	—	Merced
Modoc County Behavioral Health Services	—	Modoc
Mono County Behavioral Health	—	Mono
Monterey County Behavioral Health	—	Monterey
Napa County Health and Human Services Agency	—	Napa
Nevada County Behavioral Health	County of Nevada*	Nevada
Orange County Behavioral Health Services	County of Orange*	Orange
County of Placer, Department of Health and Human Services	—	Placer
Plumas County Mental Health Services	County of Plumas*^	Plumas
Riverside County Mental Health Services	County of Riverside*	Riverside
Sacramento County Behavioral Health Services	County of Sacramento*	Sacramento
San Benito County Behavioral Health	—	San Benito
San Bernardino County Department of Behavioral Health	—	San Bernardino
San Diego County Behavioral Health Division	—	San Diego
San Francisco Community Behavioral Health Services	—	San Francisco
San Joaquin Behavioral Health Services	County of San Joaquin*	San Joaquin
San Luis Obispo County Behavioral Health Department	County of San Luis Obispo*	San Luis Obispo
San Mateo County Behavioral Health and Recovery Services	—	San Mateo
Santa Barbara Department of Behavioral Wellness	County of Santa Barbara*	Santa Barbara

Full Mental Health Plan Name	Full Integrated Behavioral Health Plan Name	Shortened Name
Santa Clara County Behavioral Health Services Department	—	Santa Clara
County of Santa Cruz Health Services Agency	—	Santa Cruz
Shasta County Behavioral Health	—	Shasta
Siskiyou Behavioral Health Division	—	Siskiyou
Solano County Health & Social Services	—	Solano
County of Sonoma	—	Sonoma
Stanislaus County Behavioral Health & Recovery Services	County of Stanislaus*	Stanislaus
Sutter-Yuba Behavioral Health Services	—	Sutter/Yuba
Tehama County Health Services Agency	—	Tehama
Trinity County Behavioral Health Services	—	Trinity
Tulare County Health & Human Services Agency	County of Tulare*	Tulare
Tuolumne County Behavioral Health Department	County of Tuolumne*^	Tuolumne
Ventura County Behavioral Health	County of Ventura*	Ventura
Yolo County Health & Human Services Agency	—	Yolo

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 must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, or PAHP. 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 July 2025, DHCS released the updated draft of the 2025 DHCS CQS for public comment. The public comment period was open through August 13, 2025. On December 30, 2025, DHCS submitted the final draft of the DHCS 2025 CQS to CMS and posted the document on the DHCS CQS webpage. The 2025 CQS reflects lessons learned, stakeholder feedback, and DHCS policy changes to advance quality and health equity for all Medi-Cal beneficiaries. DHCS' CQS webpage summarizes that the 2025 CQS:[6]

- Outlines DHCS' comprehensive approach to developing, implementing, and maintaining a quality strategy that encompasses all Medi-Cal delivery systems—managed care, fee-for-service, behavioral health, dental, and other DHCS programs.
- Defines measurable goals, emphasizes the use of CMS Core Set measures, and tracks improvement while adhering to federal and State requirements.
- Reinforces DHCS' commitment to reducing health disparities and advancing health equity in every aspect of program design and delivery.
- Describes DHCS' quality improvement infrastructure; the development and review process for the CQS; managed care standards and evaluation requirements; continuous program quality improvement; and the State's plan to identify, evaluate, and reduce health disparities.
- Defines "significant change" and highlights additional quality improvement efforts in programs outside of managed care.
- Highlights DHCS' ongoing delivery system reform efforts, including California Advancing and Innovating Medi-Cal (CalAIM), Behavioral Health Transformation, and new initiatives such as the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration. These efforts focus on reducing variation and complexity, managing member risk through population health strategies, and improving quality outcomes through value-based initiatives and payment reform.

Through the 2025 CQS, DHCS emphasizes its commitment to advancing its vision for a more coordinated, person-centered, and equitable health system in the face of many federal and State policy changes.

[6] California Department of Health Care Services. DHCS Comprehensive Quality Strategy Website. Available at: DHCS Comprehensive Quality Strategy. Accessed on: Jan 13, 2026.

Comprehensive Quality Strategy Development

DHCS' process for reviewing and updating its CQS included:

- Addressing feedback received from CMS on the updated draft of the CQS.
- Convening an interdisciplinary team to review all relevant materials and update the CQS.
- Posting the draft DHCS CQS for public review, presenting the draft document at stakeholder meetings, consulting with tribal organizations about the quality strategy, and incorporating stakeholder feedback into the final draft version.
- Reviewing the effectiveness of the *2022 Comprehensive Quality Strategy*.
- Reviewing all recent EQRO reports, addressing EQRO recommendations, and incorporating overarching themes into the 2025 CQS.

After completing all updates, DHCS posted the final draft of the DHCS 2025 CQS on DHCS' CQS website.

Vision, Goals, and Guiding Principles

DHCS' CQS indicates that DHCS' vision for the Medi-Cal program is for those served by the program to have longer, healthier, and happier lives. The CQS describes a whole-system, person-centered, and population health approach to health and social care in which health care services are only one of many elements needed to support improved health for Medi-Cal members.

The population health management (PHM) framework serves as the cornerstone of CalAIM and the foundation for the CQS goals and guiding principles, which reflect DHCS' commitment to improving health outcomes and addressing health disparities, member involvement, and DHCS' accountability in all of its programs and initiatives, and for all populations. The 2025 CQS goals are a continuation of the 2022 CQS goals as part of DHCS' currently approved 1915b and 1115 waivers.

Comprehensive Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and patient-centered chronic disease management
- Providing whole person care for high-risk populations, addressing drivers of health

Comprehensive Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability, and member involvement

Clinical Focus Areas and Bold Goals

In the CQS, DHCS identified the following three key clinical focus areas:

- Children's preventive care
- Maternity outcomes and birth equity
- Behavioral health integration

The three key clinical focus areas serve as the foundation of DHCS' Bold Goals 50x2025 initiative, which includes achieving the following by December 31, 2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50 percent.
- Close maternity care disparities for Black and Native American persons by 50 percent.
- Improve maternal and adolescent depression screening by 50 percent.
- Improve follow-up for mental health and substance use disorder by 50 percent.
- Ensure all MCPs exceed the 50th percentile for all children's preventive care measures.

DHCS notes in the 2025 CQS that while it has made progress toward achieving its Bold Goals and 2022 CQS priorities, the 2025 CQS aims to build on previously initiated efforts to ensure successful achievement of the Bold Goals.

Managed Care Performance Monitoring and Accountability

DHCS selects performance measures to drive continuous quality improvement. DHCS leads a cross-divisional Quality Metric Workgroup that evaluates metrics for all program areas and makes recommendations about which metrics to include for monitoring and accountability. DHCS also coordinates with its public purchaser partners, Covered California and the California Public Employees Retirement System (CalPERS), to help increase alignment, especially for health plans and provider networks that serve multiple populations.

DHCS evaluates performance metrics based on the CQS guiding principles. Additionally, the metrics must be:

- Clinically meaningful.
- Have high population impact.
- Align with other national and State priority areas and initiatives as well as other public purchasers.
- Have an availability of standardized measures and data.
- Be evidence based.
- Promote health equity.

DHCS holds plans accountable to meet minimum performance levels (MPLs) for key high-priority performance measures that have existing national benchmarks. Plans that do not meet the MPLs by exceeding the national 50th percentile or having at least a 5 percentage point increase from the prior year baseline are subject to corrective action plans (CAPs) and/or enforcement actions. DHCS indicated in the CQS that based on the 2025 CQS covering measurement years 2026, 2027, and 2028, DHCS will maintain consistency in its required performance measures through measurement year 2028.

The most up-to-date information on the DHCS CQS is located at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx. Information regarding CalAIM is located at https://www.dhcs.ca.gov/calaim.

Conclusions

DHCS' 2025 CQS vision, goals, and guiding principles support improvement across all DHCS programs and delivery systems. The CQS provides detailed descriptions of the strategies and processes DHCS will use to collaborate with and include all relevant entities and people to implement the continuous quality improvement processes DHCS outlines throughout the document.

In the 2025 CQS, DHCS assesses the 2022 CQS and describes changes and enhancements it made to the updated CQS to address federal and State policy changes and the changing health care environment. DHCS notes gains toward achieving the CQS as well as opportunities for improvement. DHCS describes progress made on the Bold Goals, indicating that it is on track to achieve Bold Goals 1, 2, and 3 by measurement year 2025. DHCS indicates that data issues resulted in challenges for achieving progress on Bold Goal 4 and that Bold Goal 5 demonstrates the most opportunity for improvement.

Additionally, as a way to assess progress toward achieving the four CQS goals, for each required performance measure with a performance target, DHCS designated the associated CQS goals. Associating the CQS goals with the performance measures will help DHCS to determine which performance measures are contributing to achievement of the CQS goals and

the measures on which strategies need to be focused to improve performance and better support goal achievement.

Recommendation

DHCS' 2025 CQS vision, goals, and guiding principles support improvement across all DHCS programs and delivery systems. The CQS provides a comprehensive roadmap for bringing all relevant entities and people into the continuous quality improvement processes that are outlined throughout the CQS. Based on the extensive details and planned activities described, HSAG has no recommendations for how DHCS can target the CQS vision, goals, and guiding principles to better support improvement to the quality, timeliness, and accessibility of care for all Medi-Cal 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, and PAHPs 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 MHPs and Integrated BHPs. 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 MHPs, Integrated BHPs, 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.[7]

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.
  - 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.

[7] 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: Dec 11, 2025.

    - 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 MHPs and Integrated BHPs 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 July 2025. The plans submitted one form for each required PIP for each annual submission. The July 2025 submissions included information about the PIP design.

Requirements

DHCS requires that each MHP and Integrated BHP conduct a minimum of two DHCS-approved PIPs—one clinical PIP and one nonclinical PIP.

In alignment with DHCS' CQS Bold Goals,[8] DHCS required the following for the PIP topics:

[8] *Department of Health Care Services Comprehensive Quality Strategy 2025*. Available at: 2025 Comprehensive Quality Strategy.pdf. Accessed on: Jan 13, 2026.

Mental Health Plans

- Clinical PIP—DHCS required MHPs to select a topic that focuses on improving the rate for one of the following Healthcare Effectiveness Data and Information Set (HEDIS®)[9] measures:
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Emergency Department Visit for Mental Illness*
    - MHPs must at least report the 30-day follow-up indicator but may choose to also report the 7-day indicator.
- Nonclinical PIP—DHCS required MHPs to select one of the following topics:
  - Increase the percentage of members who receive at least one peer support service.
  - Improve timely access from first contact from any referral source to first offered appointment for any SMHS.

Integrated Behavioral Health Plans

- Clinical PIP—DHCS required Integrated BHPs to select a topic that focuses on improving the rate for one of the following measures:
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Emergency Department Visit for Mental Illness*
    - Integrated BHPs must at least report the 30-day follow-up indicator but may choose to also report the 7-day indicator.
  - *Follow-Up After Emergency Department Visit for Substance Use*
    - Integrated BHPs must at least report the 30-day follow-up indicator but may choose to also report the 7-day indicator.
  - *Pharmacotherapy for Opioid Use Disorder*
- Nonclinical PIP—DHCS required Integrated BHPs to select one of the following topics:
  - Increase the percentage of members who receive at least one peer support service.
  - Improve timely access from first contact from any referral source to first offered appointment for any SUD service or SMHS.

Note the following regarding the Integrated BHP PIP topics:

- For integrated DMC-ODS counties, the PIPs may pertain to SMHS, DMC-ODS, or both.
- For integrated DMC counties, both PIPs must pertain to SMHS, potentially including special attention to members with co-occurring SUD needs.

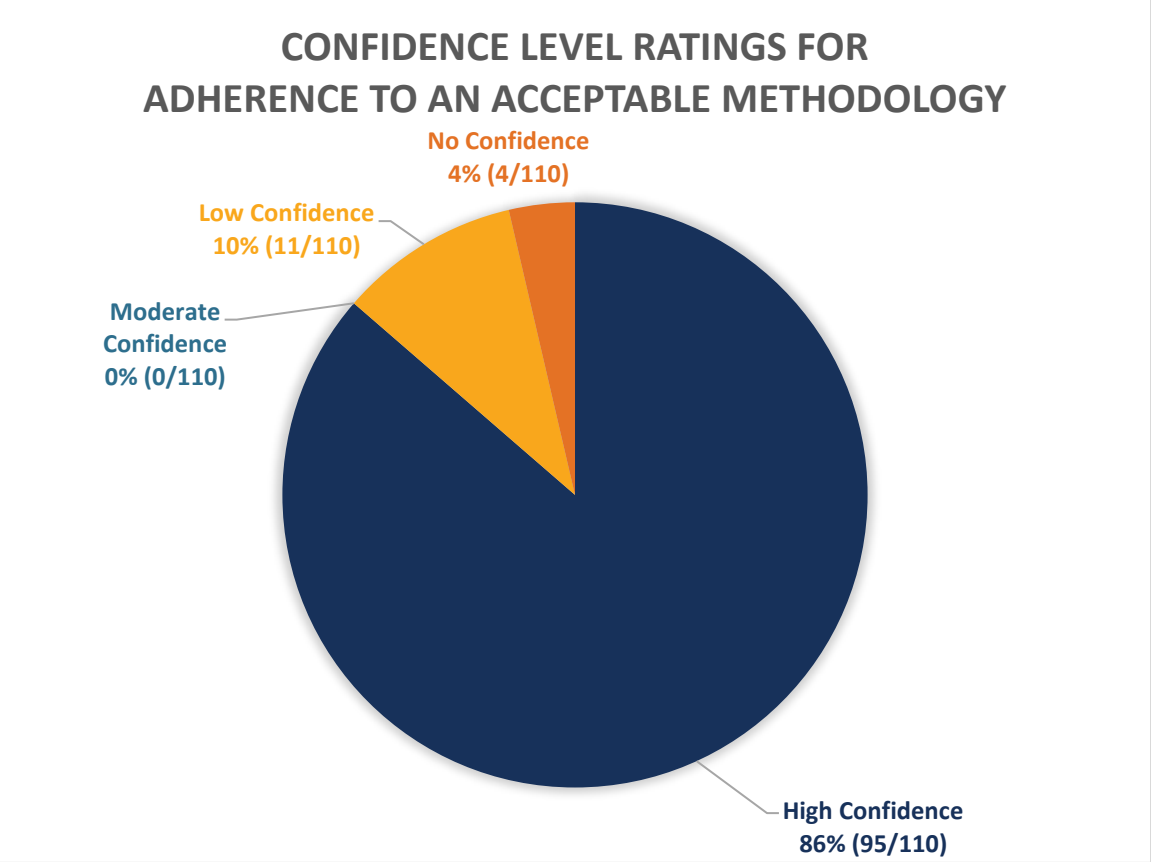
[9] HEDIS® is a registered trademark of NCQA.

Results

HSAG validated the 2025 annual PIP submissions received from the MHPs and Integrated BHPs. Note that HSAG conducted no PIP validation for Alpine. This MHP serves a very small mountain community with no hospital, urgent care, or primary care providers/clinics, and has no available data for review and analysis. Due to these challenges, HSAG, DHCS, and Alpine continue to have discussions regarding viable, meaningful clinical and nonclinical PIP topics. HSAG anticipates that both clinical and nonclinical PIP topics will be determined and that Alpine will submit both PIPs for validation in 2026. Validation findings for Alpine's PIPs will be reported in the 2025–26 EQR technical report.

In its PIP validation, HSAG assigned evaluation element scores and determined confidence levels for the overall confidence of MHPs' and Integrated BHPs' adherence to an acceptable PIP methodology. Figure 3.1 depicts the distribution of the confidence level ratings for the 110 PIPs that HSAG validated in 2025 (76 PIPs submitted by MHPs and 34 PIPs submitted by Integrated BHPs).

Figure 3.1—October 2025 Performance Improvement Project Submission Confidence Levels for Adherence to an Acceptable Methodology



In *Volume 2 of 5 (Appendix A)* of this EQR technical report, HSAG includes plan-specific PIP validation findings. Note that the July 2025 PIP submissions covered the PIP Design stage only; therefore, the plans' PIPs did not progress to the point of implementing interventions. HSAG will include PIP intervention information in the *2025–26 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report*.

Conclusions

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

MHPs and Integrated BHPs successfully submitted their 2025 annual submissions for their clinical and nonclinical PIPs, and HSAG assessed the validity and reliability of each PIP submission. Of the 110 PIPs validated in 2025, HSAG assigned 95 PIPs (86 percent) *High Confidence* levels for adherence to an acceptable PIP methodology. HSAG found no significant difference between the validation results of MHPs and Integrated BHPs. These PIP validation findings indicate that most plans built a robust foundation in the Design stage of their PIPs.

HSAG's 2025 PIP validations determined that for PIPs which received *Low Confidence* and *No Confidence* level ratings for adherence to an acceptable methodology, MHPs and Integrated BHPs did not include all required details about their PIP processes in the PIP submissions. While HSAG conducts PIP trainings and provides plan-specific technical assistance to ensure MHPs and Integrated BHPs have a thorough understanding of the PIP submission requirements and validation criteria, plans should review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure the plans include all required information in the 2026 annual PIP submissions. HSAG will provide ongoing technical assistance to plans, as requested, throughout the life of the PIPs.

In *Volume 2 of 5 (Appendix B)* 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, and PAHPs 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, and PAHP performance measures (as required by the state) or MCO, PIHP, and PAHP 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 for each MHP in alignment with the CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 2).[10] During each audit, HSAG assesses the validity of each plan's performance measure data in accordance with this protocol. 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 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 PMV audits and analyzes performance measure results to:

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

Note: MHPs must calculate and report DHCS' required performance measure rates annually for a measurement year (January through December) at the contractor (i.e., plan) level.

[10] 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: Dec 11, 2025.

Technical Methods of Data Collection and Analysis

HSAG adheres to the CMS EQR Protocol 2, 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.

Performance Measure Validation Activities

The PMV audit process involved three phases: pre-virtual audit validation activities, virtual audit validation activities, and post-virtual audit validation activities. The following provides a summary of HSAG's activities with MHPs 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.

To reduce the burden on the MHPs, HSAG conducted combined PMV and NAV virtual reviews. This section describes the PMV-related activities, and NAV activities are described in Section 7 of this report (**Validation of Network Adequacy**) and in *Volume 4 of 5* of this EQR technical report.

Pre-Virtual Audit Validation Activities (October 2024 through April 2025)

- Distributed a combined document request packet to the MHPs that included the list of DHCS-required performance measures, the Information Systems Capabilities Assessment Tool (ISCAT), a timeline for each of the required audit tasks, and guidance on the process requirements.
- Communicated frequently with the MHPs throughout the audit season about important audit items, including reminders of upcoming deadlines, required processes, DHCS reporting requirements, and performance measure clarifications.
- Scheduled combined PMV and NAV virtual audit reviews with MHPs.
- Completed initial reviews of ISCATs and corresponding documentation.
- Hosted individual pre-virtual review audit kick-off calls and provided MHPs with virtual audit agendas for combined PMV and NAV virtual reviews.
- Conducted a review of programming code used for measure calculation or a review of manual processes used for measure calculation.

- Conducted a 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.

Virtual Audit Validation Activities (February 2025 through May 2025)

- Conducted combined PMV and NAV virtual audit reviews with each MHP.
- Conducted primary source verification on a sample of the records included in each performance measure to ensure the data matched source data systems and adhered to measure specifications.
- Provided preliminary audit findings.

Post-Virtual Audit Validation Activities (February 2025 through September 2025)

- Distributed post-virtual audit review follow-up items to the MHPs.
- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided each MHP with a final information systems standard tracking report that documented the resolution of each item.
- Conducted final rate review, worked with MHPs as needed on rate corrections, and provided approval on final rates.
- Produced and provided final, plan-specific PMV audit reports to MHPs and DHCS.

Description of Data Obtained

DHCS contracted with HSAG to conduct an independent audit for both measurement year 2023 and measurement year 2024 for MHPs.

Through the audit methodology, HSAG obtained a number of different information sources to conduct the measurement year 2023 and measurement year 2024 PMV audits. These included:

- The ISCAT.
- Source code, computer programming, and query language (if applicable) used to calculate the required performance measure rates.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.

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.

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 MHP performance measure results and conclusions are included in Section 5 of this report ("**Mental Health Plan Performance Measures**").

Results

For contract year 2024–25, HSAG conducted PMV audits for measurement years 2023 and 2024 for 56 MHPs. The 56 audits resulted in 112 separate data submissions for performance rates at the plan level (56 for measurement year 2023 and 56 for measurement year 2024). Each PMV audit included preparation for the virtual audit review, ISCAT review, information systems review, supplemental data validation if applicable, source code review, a virtual audit review meeting, primary source verification, preliminary and final plan-level rate review, and final audit reports production.

Based on the MHPs not having access to all data needed to fully follow the performance measure specifications, HSAG assigned a *Do Not Report* (*DNR*) designation for all 56 MHPs for all measurement year 2023 and measurement year 2024 performance measure results, meaning that the rates were materially biased to an unknown degree and should therefore not be reported.

Conclusions

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

The following contributed to all MHPs not being able to produce valid plan-level performance measure rates for all required Behavioral Health Accountability Set (BHAS) measures and HSAG auditors assigning a *DNR* designation for all measures:

- HSAG determined an unknown volume of missing data related to the overall population inclusive of all Medi-Cal members assigned to each plan. HSAG's assessment of the measurement year 2023 and measurement year 2024 rates submitted during the PMV

audit process concluded that the submitted rates captured the active population (i.e., members who received or are receiving services from the specific plan) rather than a true representation of the overall population of all Medi-Cal members for whom the plan is responsible. HSAG was unable to quantify the volume of missing data, resulting in an unknown degree of bias and the *DNR* designation.

- HSAG observed that MHPs' interpretation of DHCS' various communications regarding the PMV reporting requirements was inconsistent. HSAG's assessment during the PMV audit process concluded that plans thought that using the DHCS plan data feed as an integrated data source for performance measure rate calculations was optional, and there was a lack of clear communication about the data sources required by DHCS for performance measure rate calculation. HSAG determined some plans were unable to report accurate rates for performance measures in scope of review without integrating the optional plan data feed files.

It is important that DHCS provide clear and direct communication to the MHPs on the performance measure reporting requirements inclusive of the identified required data sources. Additionally, it is important that MHPs have data sharing agreements with managed care health plans (MCPs) in the county to integrate these data sources for performance measure rate calculations. HSAG also observed that MHPs have opportunities to investigate methods to incorporate additional supplemental data sources for applicable BHAS performance measures.

During the audit process, HSAG stressed the importance of MHPs using all plan data feed files that DHCS made available to them for performance measure reporting. HSAG also emphasized to MHPs that it is essential they identify the various data sources needed for reporting and monitor the rates frequently to ensure that the plans resolve any potential issues prior to reporting final rates.

HSAG auditors identified MHP-specific challenges and opportunities for improvement; provided feedback to each MHP, as applicable, during the audit process; and included detailed feedback in each plan's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report.

Recommendation

HSAG recommends that DHCS provide timely, detailed communication to the MHPs regarding all BHAS requirements, including required data sources, specifically about the eligible population each MHP should use for performance measure reporting, and expectations for vendor oversight and monitoring.

In *Volume 2 of 5 (Appendix B)* of this EQR technical report, HSAG includes an assessment of each MHP'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. Mental Health Plan Performance Measures

Objective

The primary objective related to MHP performance measures is for HSAG to assess MHPs' 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 MHPs during the PMV activities described in Section 4 of this report ("**Validation of Performance Measures**") and from National Committee for Quality Assurance (NCQA) via NCQA's Quality Compass®.[11]

Description of Data Obtained

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

- Performance measure data submitted by the MHPs, which included numerators, denominators, and calculated rates.
- NCQA's HEDIS 2023 and HEDIS 2024 Medicaid health maintenance organization (HMO) benchmarks (50th percentiles and 90th percentiles).

Requirements

To comply with 42 CFR §438.330, DHCS selects a set of performance measures to evaluate the quality of care MHPs deliver to their members. DHCS refers to this DHCS-required performance measure set as the BHAS. As outlined in the DHCS CQS, DHCS' Quality and Population Health Management program's Quality Metric Workgroup evaluates metrics for all program areas and makes recommendations about which measures should be required for monitoring and accountability. The workgroup also ensures that all required measures are aligned with the CQS and its key objectives.[12] The performance measure requirements support the advancement of DHCS' CQS goals as well as DHCS' *Medi-Cal's Strategy to Support*

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

[12] *Department of Health Care Services Comprehensive Quality Strategy 2025*. Available at: 2025 Comprehensive Quality Strategy.pdf. Accessed on: Jan 13, 2026.

Health and Opportunity for Children and Families, which is a forward-looking policy agenda for children and families enrolled in Medi-Cal.[13]

DHCS consults with HSAG and reviews feedback from MHPs and stakeholders to determine which measures DHCS will include in the BHAS. MHPs must report contractor-level rates.

Behavioral Health Accountability Set

DHCS' measurement year 2023 and measurement year 2024[14] BHAS included five HEDIS measures. Three of the required measures have more than one indicator. In this report, HSAG uses "performance measure" or "measure" (rather than indicator) to reference required BHAS measures. Collectively, performance measure results reflect the quality, timeliness, and accessibility of care MHPs provide to their members.

Table 5.1 lists the measurement year 2023 and measurement year 2024 BHAS measures and their descriptions.

Note:

- NCQA provided DHCS with an exemption from NCQA Measure Certification[SM,15] for measurement year 2023 and measurement year 2024 BHAS reporting, resulting in MHPs not being required to use an NCQA Certified vendor for performance measure reporting.
- All BHAS performance measures are reported using the administrative reporting method, which requires that MHPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MHPs derive the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. MHPs may not use medical records to retrieve information. When using the administrative method, MHPs use the entire eligible population as the denominator.

Table 5.1—Measurement Year 2023 and Measurement Year 2024 Behavioral Health Accountability Set Measures

^ NCQA requires race and ethnicity stratifications for this measure.

[13] *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: Dec 11, 2025.

[14] The measurement year is the calendar year for which MHPs report the rates. Measurement year 2023 represents data from January 1, 2023, through December 31, 2023, and measurement year 2024 represents data from January 1, 2024, through December 31, 2024.

[15] NCQA Measure Certification[SM] is a service mark of NCQA.

Measure
Measures Held to MPLs
Adherence to Antipsychotic Medications for Individuals with Schizophrenia The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
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*—The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ♦ *Effective Continuation Phase Treatment*—The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
*Follow-Up After Emergency Department Visit for Mental Illness—Follow-Up Within 30 Days^* 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).
*Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days^* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Measures Not Held to MPLs
*Follow-Up After Emergency Department Visit for Mental Illness—Follow-Up Within 7 Days^* 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).
*Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days^* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days after discharge.

DHCS-Established Performance Levels

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

To establish the HPLs and MPLs for the measurement year 2023 BHAS HEDIS measures, DHCS used NCQA's Quality Compass HEDIS 2023 Medicaid HMO benchmarks, which reflect the previous year's benchmark percentiles (measurement year 2022). 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 HPLs and MPLs for the measurement year 2024 BHAS HEDIS measures, DHCS used NCQA's Quality Compass HEDIS 2024 Medicaid HMO benchmarks, which reflect the previous year's benchmark percentiles (measurement year 2023). DHCS based the HPLs on NCQA's Quality Compass HEDIS 2024 Medicaid HMO 90th percentiles and the MPLs on the Medicaid HMO 50th percentiles.

HSAG includes in Table 5.2 the HPL and MPL benchmark values that DHCS established for the measurement year 2023 BHAS measures for which DHCS determined to hold MHPs accountable to meet the MPLs.[16] Note that according to DHCS' license agreement with NCQA, HSAG includes the NCQA Quality Compass benchmarks.

[16] 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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HSAG includes in Table 5.3 the HPL and MPL benchmark values that DHCS established for the measurement year 2024 BHAS measures for which DHCS determined to hold MHPs accountable to meet the MPLs.[17] Note that according to DHCS' license agreement with NCQA, HSAG includes the NCQA Quality Compass benchmarks.

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

Measurement year 2023 HPL and MPL 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.

Measure	Measurement Year 2023 High Performance Level	Measurement Year 2023 Minimum Performance Level
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	72.61%	61.39%
Antidepressant Medication Management—Effective Acute Phase Treatment	74.16%	60.79%
Antidepressant Medication Management—Effective Continuation Phase Treatment	58.06%	43.28%

[17] The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the data") is Quality Compass® 2024 and is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on the data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

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Measure	Measurement Year 2023 High Performance Level	Measurement Year 2023 Minimum Performance Level
Follow-Up After Emergency Department Visit for Mental Illness—Follow-Up Within 30 Days	73.26%	54.87%
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days	72.29%	57.69%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	73.87%	60.22%

Table 5.3—High Performance Level and Minimum Performance Level Benchmark Values for Measurement Year 2024

Measurement year 2024 HPL and MPL benchmark values represent NCQA's Quality Compass HEDIS 2024 Medicaid HMO 90th and 50th percentiles, respectively, reflecting the measurement year from January 1, 2023, through December 31, 2023.

Measure	Measurement Year 2024 High Performance Level	Measurement Year 2024 Minimum Performance Level
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	74.83%	62.56%
Antidepressant Medication Management—Effective Acute Phase Treatment	76.76%	62.43%
Antidepressant Medication Management—Effective Continuation Phase Treatment	61.06%	44.25%
Follow-Up After Emergency Department Visit for Mental Illness—Follow-Up Within 30 Days	73.12%	53.82%
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days	75.56%	59.85%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	74.14%	60.22%

Quality Enforcement Actions

California Welfare and Institutions Code (CA WIC) §14197.7(e)[18] and the MHP contracts authorize DHCS to impose enforcement actions on MHPs that fail to meet the required MPLs for any of the applicable BHAS measures. Enforcement actions may include corrective action plans (CAPs) and monetary and non-monetary sanctions. The enforcement action level and type depend on the number of deficiencies and the severity of the quality issues identified.

Enforcement Tiers

DHCS establishes accountability requirements based on enforcement tiers. MHPs not meeting the MPLs or that do not achieve at least a 5 percent increase over baseline from prior measurement year performance will be placed in an enforcement tier.

Following are the criteria for each tier:

- Tier 1—The MHP has one performance measure rate below the MPL and does not achieve at least a 5 percent increase over baseline (measurement year 2023)
- Tier 2—The MHP has two or more performance measure rates below the MPLs, and each measure does not achieve at least a 5 percent increase over baseline (measurement year 2023)

Monetary Sanctions

DHCS will determine whether to impose a monetary sanction based on the enforcement tier in which the MHP is placed. DHCS will only impose monetary sanctions on MHPs that fall within Tier 2. DHCS will not impose monetary sanctions on MHPs that fall within Tier 1 or that do not trigger a tier rating. MHPs may be subject to additional enforcement actions if they are unable to accurately report measure rates. Note that measurement year 2024 was the first year that MHPs were subjected to sanctioning by DHCS for performance on BHAS measures.

Sanction amount calculations will be based on the population not served and incorporate various factors related to the out-of-compliance performance measure by taking into account the following factors:

- Population Not Served—The number of affected members who did not receive the service based on the numerator and denominator data the MHP submitted during the BHAS PMV process.
- Severity—The percentage point difference between the MHP's performance measure rate and the MPL.
- Trending—The percentage point difference between the MHP's current measurement year performance measure rate and the previous measurement year performance measure rate.

[18] Cal. WIC §14197.7. Available at: Law section (ca.gov). Accessed on: Dec 11, 2025.

- Healthy Places Index[19] Impact—DHCS will reduce the sanction amount for MHPs 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 Behavioral Health Information Notice (BHIN) 24-044.[20]

Results

Based on the MHPs not having access to all data needed to fully follow the performance measure specifications, HSAG assigned a *DNR* designation for all 56 MHPs for all measurement year 2023 and measurement year 2024 performance measure results, meaning that the rates were materially biased to an unknown degree and should therefore not be reported.

Comparison Across All Mental Health Plans

All MHPs received a *DNR* designation for all measurement year 2023 and measurement year 2024 performance measure results. Across all plans, the reason for the designation was because the plans did not have access to all data needed to fully follow the performance measure specifications.

Conclusions

As indicated under the Conclusions heading in Section 4 of this report ("**Validation of Performance Measures**"), based on all MHPs receiving a *DNR* designation for all measurement year 2023 and measurement year 2024 performance measure results, HSAG concluded that it is important that DHCS provide clear and direct communication to the MHPs on the performance measure reporting requirements inclusive of the identified required data sources. Additionally, it is important that MHPs have data sharing agreements with MCPs in the county to integrate these data sources for performance measure rate calculations. HSAG also observed that MHPs have opportunities to investigate methods to incorporate additional supplemental data sources for applicable BHAS performance measures.

[19] Public Health Alliance of Southern California. The California Healthy Places Index. Available at: https://www.healthyplacesindex.org/. Accessed on: Dec 11, 2025.

[20] California Department of Health Care Services. Behavioral Health Information Notice No: 24-044. Available at: BHIN-24-044-Monetary-Sanctions-Fail-to-Meet-Exceed. Accessed on: Dec 11, 2025.

In *Volume 2 of 5 (Appendix B)* of this EQR technical report, HSAG includes an assessment of each MHP'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.

6. 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, or PAHP'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 MHPs, rather than contracting with the EQRO to conduct reviews on its behalf. Transparency and accountability are important aspects of the DHCS CQS, 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.[21]

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 enrollee rights requirements described in §438.100, and the QAPI requirements described in §438.330. Note that DHCS excludes the following two standards from its reviews in accordance with the CMS-approved CalAIM 1915(b) Waiver:
  - §438.56—Disenrollment: Requirements and Limitations
  - §438.114—Emergency and Poststabilization Services

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.

[21] *Department of Health Care Services Comprehensive Quality Strategy 2025*. Available at: 2025 Comprehensive Quality Strategy.pdf. Accessed on: Jan 13, 2026.

Technical Methods of Data Collection and Analysis

DHCS collected the data for the MHP compliance reviews through the triennial DHCS Audits & Investigations Division Behavioral Health Audits and from the results of other activities, including annual network certification (ANC) 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).

Timeliness of Compliance Reviews

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

Results

DHCS completed the compliance review scoring for all required CFR standards for 29 MHPs in October 2025. DHCS will inform assessed MHPs of their individual plan scoring results prior to DHCS publicly posting this 2024–25 EQR technical report.

Compliance review scores across all assessed MHPs show that all 29 plans were fully compliant with the Confidentiality CFR standard (§438.224).

Most assessed MHPs were fully compliant with the following eight CFR standards:

- §438.208—Coordination and Continuity of Care
- §438.210—Coverage and Authorization of Services
- §438.214—Provider Selection

- §438.228—Grievance and Appeal Systems
- §438.230—Subcontractual Relationships and Delegation
- §438.236—Practice Guidelines
- §438.242—Health Information Systems
- §438.330—Quality Assessment and Performance Improvement Program

All assessed MHPs had findings within at least one CFR standard. Most MHPs had findings within the Enrollee Rights CFR standard (§438.100), and all MHPs had findings within the following two CFR standards:

- §438.206—Availability of Services
- §438.207—Assurance of Adequate Capacity and Services

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

Note that DHCS indicated that it conducted compliance reviews for the following MHPs in November 2024, and the compliance review results were included in the previous EQRO's 2023–24 SMHS EQR technical report:

- Alameda
- Alpine
- Butte
- El Dorado
- Glenn
- Humboldt
- Imperial
- Kern
- Kings
- Los Angeles
- Marin
- Mariposa
- Mendocino
- Nevada
- Orange
- Plumas
- Riverside
- San Benito
- San Bernardino
- San Francisco
- San Mateo

- Santa Barbara
- Shasta
- Siskiyou
- Sonoma
- Stanislaus
- Tuolumne

Comparative, plan-specific compliance review results for reviews not previously reported on are included in *Volume 3 of 5* 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 MHPs and determined that DHCS conducted the reviews for all applicable MHPs within the previous three-year period.

The CMS *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023, indicates that plans must understand the definition of "full compliance" before the review.[22] DHCS conducting the compliance review scoring prior to notifying the MHPs of the scoring methodology is not consistent with Protocol 3. Based on DHCS notifying the plans of its scoring methodology prior to DHCS publicly posting this 2024–25 EQR technical report, DHCS will meet this requirement moving forward.

DHCS' compliance review scores reflect that all assessed MHPs were fully compliant with one CFR standard and most MHPs were fully compliant with eight CFR standards. 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 5 (Appendix B)* 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.

[22] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 11, 2025.

7. 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 Indians in the MCOs, PIHPs, or PAHPs, in accordance with §438.14(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 MHPs.
- 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 MHPs, 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.[23]

[23] 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: Dec 11, 2025.

Description of Data Obtained

HSAG obtained the following data from MHPs and DHCS to conduct the NAV audits for the Fiscal Year 2023–24 reporting period:

- Information systems data from the 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 4 of 5* of this EQR technical report. HSAG also includes in this volume the comparative plan-specific NAV audit results.

Additionally, in *Volume 2 of 5 (Appendix B)* of this EQR technical report, HSAG includes an assessment of each MHP'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.

8. Alternative Access Standards Reporting

To assist DHCS with assessing and monitoring network adequacy across contracted plans as described in the DHCS CQS,[24] DHCS contracted with HSAG to conduct AAS reporting analyses.

Objective

The objective for the AAS reporting analyses is to meet the requirements set forth in CA WIC §14197.05,[25] which requires DHCS' annual EQR technical report to present information related to MHPs' AAS requests.

Technical Methods of Data Collection and Analysis

DHCS provided data to HSAG via a SFTP site and email. HSAG submitted to DHCS the required DHCS Data Release Form and detailed data request instructions to ensure all needed data were submitted for the AAS reporting analyses.

Description of Data Obtained

The data types HSAG obtained for the AAS reporting analyses included:

- AAS request
- AAS administrative
- ANC documentation
- Grievances and appeals
- Provider
- Telehealth request

[24] *Department of Health Care Services Comprehensive Quality Strategy 2025*. Available at: 2025 Comprehensive Quality Strategy.pdf. Accessed on: Jan 13, 2026.

[25] Cal. WIC §14197.05. Available at https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05. Accessed on: Dec 11, 2025.

Time or Distance Alternative Access Standards Reporting

DHCS is responsible for the ongoing monitoring and oversight of its contracted MHPs, including the assurance that MHPs' provider networks are adequate to deliver services to Medi-Cal members. If an MHP is unable to meet provider network time or distance standards set by the State, the MHP may request that DHCS allow an AAS for specified provider scenarios (e.g., provider type, geographic area). The DHCS BHIN 24-020[26] provides DHCS' clarifying guidance regarding network certification requirements, including AAS requests. Additionally, as indicated previously, CA WIC §14197.05[27] requires DHCS' annual EQR technical report to present information related to MHPs' AAS requests. As such, DHCS contracted with HSAG to process and report on data related to AAS for provider networks.

For State Fiscal Year 2024–25, the measurement period for this study begins with the initial annual network adequacy certification data and documentation submission on August 1, 2024, and must end by June 30, 2025.

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

[26] California Department of Health Care Services. Behavioral Health Information Notice 24-020. Available at: BHIN 2024 Network Certification Requirements for County Mental Health Plans and Drug Medi-Cal Organized Delivery Systems. Accessed on: Dec 11, 2025.

[27] Cal. WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05. Accessed on: Dec 11, 2025.

9. Secret Shopper Survey

DHCS requested that HSAG conduct a pilot secret shopper survey among outpatient behavioral health providers contracted with one or more DMC-ODS plans or MHPs to ensure members have appropriate access to provider information and to assess appointment availability. DHCS requested that HSAG include a limited number of DMC-ODS plans and MHPs in the pilot survey rather than including all DMC-ODS plans and MHPs.

In this EQR technical report, HSAG only reports information regarding the results of the MHP provider surveys. HSAG includes the results of the DMC-ODS plan provider surveys in the *2024–25 Drug Medi-Cal Organized Delivery System External Quality Review Technical Report*.

Objectives

The goal of the survey was to evaluate the MHPs' network of behavioral health locations. Specific survey objectives include the following:

- Determine if the contact information reported by the MHPs (i.e., phone number, address) is accurate for contracted behavioral health providers.
- Determine whether behavioral health service locations offer the requested services.
- Determine whether behavioral health service locations accept patients enrolled with a DMC-ODS plan or MHP.
- Determine whether behavioral health service locations accept new patients.
- Determine appointment availability with the sampled behavioral health service locations for an outpatient SUD or outpatient SMHS visit.

Technical Methods of Data Collection and Analysis

HSAG obtained data from DHCS via a SFTP site to conduct the secret shopper surveys and collected the data from behavioral health service locations associated with behavioral health providers who were actively contracted with an MHP at the time DHCS created the data file, to serve individuals enrolled in the Medi-Cal program.

Description of Data Obtained

The data types HSAG obtained for the secret shopper survey analyses included:

- Adult and child mock member IDs
- Provider
- Survey response

Methodology

HSAG included the following MHPs in the pilot survey:

- El Dorado County Health & Human Services Agency
- Fresno County Department of Behavioral Health
- Madera County Behavioral Health Services
- San Diego County Behavioral Health Division
- Santa Clara County Behavioral Health Services Department

HSAG used the following process for survey administration:

- Based on the goals and survey objectives, HSAG developed a standardized survey script for DHCS' review and approval.
- HSAG used a random sampling approach to generate a list of service locations to include in the survey.
- Survey callers collected survey responses using the standardized script to request appointment availability for the sampled locations only.
- Survey callers did not leave voicemail messages or schedule appointments.
- Survey callers made up to three attempts to contact each survey case and made calls during standard business hours (i.e., 9:00 a.m.–5:00 p.m. Pacific Time).[28]

Callers who were put on hold at any point during the call waited on hold for 10 minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made additional attempts on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

[28] HSAG did not consider a call attempted when the caller reached an office outside of the office's usual business hours. For example, if the caller reached a recording stating that the office is closed for lunch, the call attempt did not count toward the three attempts to reach the office. The caller attempted to contact the office up to three times outside of the known lunch hour.

- A disconnected/invalid telephone number (e.g., the telephone number connected to a fax line or a message that the number is no longer in service).
- The telephone number connected to an individual or business unrelated to a medical practice or facility.
- The interviewer was unable to speak with office personnel during the call attempts (e.g., the call went to voicemail or a call center that prevented the interviewer from speaking with office staff).

Secret shopper callers underwent project-specific training with a dedicated HSAG analytics manager to standardize how calls were placed and how data collected during the calls were recorded in a web-based data collection tool. To aid in abstraction from the survey, the data collection tool controlled skip logic between survey elements.

Results

HSAG provided DHCS with a written report and data analytics file with the survey results for DHCS' internal use only. DHCS will use the results to determine the scope of future secret shopper surveys.

10. Foster Care Analysis

Objective

The objective of the contract year 2024–25 Foster Care Analysis was for HSAG to conduct an analysis of SMHS provided to Medi-Cal foster care members in accordance with CA WIC §14717.5.[29]

Technical Methods of Data Collection and Analysis

HSAG obtained the data for the 2024–25 Foster Care Analysis from DHCS, public dashboards, and MHPs. 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 analysis. DHCS submitted the data to HSAG via a SFTP site. HSAG accessed public data via website platforms and obtained the data from MHPs via email.

Description of Data Obtained

The data types HSAG obtained for the 2024–25 Foster Care Analysis are listed below:

- Foster care member counts
- Performance Outcome System back-end data
- Annual network adequacy and access assurances reports
- SMHS penetration rates
- Publicly posted HEDIS measure calculations for select measures
- Foster care member utilization of SMHS
- Interpretation and translation services

[29] California Legislative Information. WIC 14717.5. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14717.5.&nodeTreePath=16.6.24&lawCode=WIC. Accessed on: Dec 11, 2025.

Foster Care Analysis Summary

The Foster Care Analysis reported on the following data elements related to SMHS provided to Medi-Cal eligible minors and non-minor dependents in foster care, consistent with CA WIC §14717.5:

- Number of foster care members served annually.
- Specialty mental health preventive and treatment services covered by MHPs, including screenings, assessments, home-based services, outpatient services, day treatment or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Access to mental health services assessed through DHCS' network adequacy standards and MHPs' network adequacy assessment results.
- Available translation and interpretation services.
- Measure rates reflecting SMHS quality and utilization.

The analyses included the following DHCS-calculated measure indicators to meet the CA WIC §14717.5 requirements:

- *Availability of Interpretation and Translation Services (Language Capacity)*
- *Description of Specialty Mental Health Preventive and Treatment Services Covered by MHPs for Foster Care Members*
- *Follow-Up After Hospitalization for Mental Illness, Ages 6–17—7-Day Follow-Up*
- *Follow-Up After Hospitalization for Mental Illness, Ages 6–17—30-Day Follow-Up*
- *Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase*
- *Foster Care Member Utilization of SMHS*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics*
- *Number of Foster Care Members Served by Medi-Cal Annually*
- *SMHS Penetration Rates*
- *Summary of SMHS Network Adequacy*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*

The *2024–25 Mental Health Plan Foster Care Analysis Report* includes the detailed methodology, results, conclusions, and recommendations. The report may be found at BH EQR Annual Technical Reports - DMC-ODS & MH Services.

11. Technical Assistance

At the State's direction, the EQRO may provide technical assistance to groups of MCOs, PIHPs, or PAHPs 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 CQS goals and vision, improving the health care services provided to Medi-Cal members, and achieving health equity.[30]

DHCS contracts with HSAG to provide technical assistance to DHCS and its Medi-Cal managed care entities (MCEs) to help them fully understand the EQR activity requirements and provide support for their implementation of quality improvement activities. MCEs include all Medi-Cal managed care behavioral, dental, and physical health plans.

Through this technical assistance, HSAG supports DHCS and the MCEs in various areas related to quality improvement that are outside the scope of the EQR-specific activities. As a result of the technical assistance HSAG provides, DHCS and MCEs may identify opportunities for improving the quality, timeliness, and accessibility of care for Medi-Cal members, which may help to improve MCE-specific and statewide performance measure rates.

MCEs' Quality Improvement

Following are examples of technical assistance activities HSAG may conduct with DHCS and the MCEs, at their request, to support quality improvement efforts:

- 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 MCEs related to DHCS' quality monitoring and enforcement actions and CAP processes.
- Provide technical assistance to MCEs 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 the DHCS Managed Care Accountability Set and BHAS.

[30] *Department of Health Care Services Comprehensive Quality Strategy 2025*. Available at: 2025 Comprehensive Quality Strategy.pdf. Accessed on: Jan 13, 2026.

- Respond to requests from DHCS for input on a variety of quality improvement-related issues and topics.
- Respond to requests from MCEs for additional guidance regarding expectations and requirements across the EQR activities.

Objective—MCEs' Quality Improvement

The objective of Technical Assistance for MCEs' 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—MCEs' 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—MCEs' Quality Improvement—MHP Technical Assistance

Following is a high-level summary of the notable technical assistance HSAG provided to DHCS and MHPs 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.
  - NCQA and CMS performance measure specifications.
  - HSAG's PMV audit process.
  - Performance measure reporting methodologies.
  - Future performance measure requirements.
- Provided to DHCS:
  - Information about PMV audit source code review requirements.

- A detailed summary of the process for mapping state-specific codes for performance measure reporting, including the process HSAG used for mapping State codes to mental health providers with MHPs and their measure vendors during the PMV audit process.
- The definition of the *DNR* audit designation to support DHCS' understanding of the instances for which an auditor would apply this designation.

Other Technical Assistance

- 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 DHCS' SMHS program.
- 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 detailed information to DHCS regarding the CMS EQR Protocol 3 compliance review requirements to support DHCS in meeting these requirements for the MHPs.
- Provided to the DHCS Behavioral Health Team historical information regarding the activities HSAG conducts for the physical health plans that DHCS may want HSAG to conduct for the MHPs.
- Provided information to MHPs about HSAG's approach to the EQR and clarification about EQR activity requirements.

Conclusions—MCEs' Quality Improvement—MHP Technical Assistance

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

Quality Conference

DHCS contracted with HSAG to jointly host and facilitate the 2025 Medi-Cal Managed Care Quality Conference. This in-person conference was held in Sacramento, California, on November 13, 2025.

The conference focused on the advancement of the three DHCS Clinical Focus Areas: Children's Preventive Care, Behavioral Health Integration, and Maternity Outcomes & Birth Equity. These topics are part of DHCS' CQS and aim to support quality improvement across the Medi-Cal system. Health equity was a central theme of the conference, woven throughout all sessions to highlight the shared commitment to delivering fair and inclusive care for all Medi-Cal members.

The primary audience for the conference included behavioral health plan and MCP staff members who lead or contribute to quality improvement, strategy, and implementation efforts aligned with DHCS' CQS. This included (1) behavioral health directors, ethnic services managers, and quality improvement coordinators for behavioral health; and (2) chief medical officers, chief health equity officers, and chief quality directors for physical health.

Note that planning for this conference began during contract year 2024–25; however, the conference took place and HSAG submitted the conference evaluation report to DHCS in contract year 2025–26. While the conference occurred and HSAG submitted the report in contract year 2025–26, HSAG includes a summary of the 2025 Quality Conference because the information was available at the time this EQR technical report was produced.

Objective—Quality Conference

The objective of the Technical Assistance—Quality Conference activity is to provide physical and behavioral health plans the opportunity to learn up-to-date information regarding health care equity and quality improvement and to network with other health plans to identify opportunities for collaboration and partnership.

Methodology—Quality Conference

DHCS and HSAG began logistical planning for the conference in February 2025, which continued up to the event in November 2025. DHCS identified the conference content to provide DHCS' new CQS information behavioral health plans and MCPs to support quality improvement across the Medi-Cal system.

DHCS identified panelists and presenters for the conference sessions and provided guidance to these individuals regarding the content DHCS envisioned them to share. The structure of the conference was discussion-focused rather than the panelists and presenters conducting formal presentations. DHCS staff members moderated the discussions to foster collaboration among the panelists and conference participants. HSAG facilitated all logistics for the conference.

Quality Conference Content

Following is a high-level summary of the conference agenda, including organizations represented for each session:

- DHCS Welcome and Presentation on the DHCS CQS
- Fireside Chat—DHCS' Three Clinical Focus Areas (Children's Preventive Care, Behavioral Health Integration, and Maternity Outcomes & Birth Equity) and How Health Equity Intersects Across All Areas
  - CenCal Health
  - Fresno County
  - Kern Health Systems
  - San Mateo County Behavioral Health
- Fireside Chat—Medi-Cal Managed Care Health Plan and Behavioral Health Plan Partnership to Drive Care Coordination and Continuity of Care for Members
  - Gold Coast Health Plan
  - Health Plan of San Mateo
  - Inland Empire Health Plan
  - Riverside County Health
  - San Mateo County Behavioral Health
  - Ventura County
- Breakout Sessions
  - Advancing Collaboration—Data Exchange Between Medi-Cal Managed Care Health Plans and Behavioral Health Plans
    - Gold Coast Health Plan
  - Advancing Collaboration—Caring for Pregnant and Postpartum Members with Behavioral Health Needs
    - County of Fresno Department of Behavioral Health
    - Solano County Department of Health
    - Los Angeles County Department of Public Health
  - Advancing Value-Based Payment—Leveraging Lean Times to Innovate on Improving Quality and Equity
    - L.A. Care Health Plan
    - Los Angeles County Department of Public Health
  - Advancing Health Equity—Leveraging Member Empowerment and Engagement to Advance Health Equity Initiatives
    - Fresno County Department of Behavioral Health
    - Health Plan of San Joaquin
- Award Presentations
- DHCS Closing Remarks

Awards Presentations

DHCS announced the following awards during the conference:

- MCP Outstanding Performance for Measurement Year 2024
  - CenCal Health
  - Central California Alliance for Health
  - Contra Costa Health Plan
  - Health Plan of San Mateo
- MCP Outstanding Performance in Children's Health Domain for Measurement Year 2024
  - CalOptima
  - CenCal Health
  - Central California Alliance for Health
  - Community Health Group Partnership Plan
  - Contra Costa Health Plan
  - Gold Coast Health Plan
  - Health Plan of San Mateo
  - San Francisco Health Plan
  - Santa Clara Family Health Plan
- Specialty MHP Outstanding Performance for Measurement Year 2024
  - Nevada County Behavioral Health
  - San Luis Obispo County Behavioral Health Department
  - Tuolumne County Behavioral Health Department
- DMC-ODS Outstanding Performance for Measurement Year 2024
  - Contra Costa County
  - San Luis Obispo County
  - Siskiyou County

Evaluation Methodology

Conference participants were asked to complete an evaluation at the end of the day and were provided a QR code to access the electronic survey. HSAG also sent the evaluation survey link via email a few days following the conference.

Participants were asked to evaluate the overall conference, opening presentation, fireside chats, and breakout sessions. The evaluation form provided respondents with a Likert scale to rank each statement. The scale included the following choices:

- Very Unhelpful
- Unhelpful
- Neither Helpful nor Unhelpful
- Helpful
- Very Helpful

Participants were also given the opportunity to provide open-ended comments related to the conference content, topics for future quality conferences, and general comments about their quality conference experience.

Results—Quality Conference

The conference drew 194 attendees, of which 71 represented behavioral health plans, 68 represented MCPs, 46 represented DHCS, and nine represented other partner organizations.

Of the 194 conference participants, 29 completed a conference evaluation. Note that of the 29 participants who completed the conference evaluation, 17 were behavioral health plan staff members, eight were MCP plan staff members, and four were DHCS staff members.

Conclusions—Quality Conference

Overall, the feedback from respondents about the 2025 Quality Conference was positive. Most evaluation respondents indicated that they found the conference to be helpful or very helpful. Respondents also indicated that the opening presentation regarding DHCS' CQS and the two fireside chats—one related to DHCS' three clinical focus areas and one related to MCP and behavioral health plan partnerships to drive care coordination and continuity of care for members—were helpful or very helpful.

Feedback regarding the four breakout sessions was mixed, with most respondents indicating that options 1 and 3 (Advancing Collaboration—Data Exchange Between Medi-Cal Managed Care Health Plans and Behavioral Health Plans and Advancing Value-Based Payment—Leveraging Lean Times to Innovate on Improving Quality and Equity, respectively) were helpful or very helpful, and an equal number of respondents indicating that options 2 and 4 (Advancing Collaboration—Caring for Pregnant and Postpartum Members with Behavioral Health Needs and Advancing Health Equity—Leveraging Member Empowerment and Engagement to Advance Health Equity Initiatives, respectively) were very unhelpful or neither helpful nor unhelpful versus helpful or very helpful.

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

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

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

External Quality Review Recommendations for DHCS

This is the first EQR HSAG has conducted for the SMHS program; therefore, HSAG obtained the previous EQRO's recommendations to DHCS from the 2023–24 EQR technical report and requested that DHCS summarize actions DHCS took to address those recommendations. Table 12.1 provides the EQR recommendations from the previous EQRO's 2023–24 SMHS EQR technical report, along with DHCS' self-reported actions taken to address the EQR recommendations. Please note that HSAG made minimal edits to Table 12.1 to preserve the accuracy of DHCS' self-reported actions.

Table 12.1—DHCS' Self-Reported Follow-Up on External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 SMHS EQR Technical Report

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations	Actions Taken by DHCS to Address the External Quality Review Recommendation
1. Include statewide underserved populations in DHCS' revised Cultural Competence Plan Requirements (CCPRs) and ensure that local consideration of underserved populations is also addressed. The Hispanic/Latino population is almost always included in the CCPRs, but consideration should also be given to Native Americans and Asian/Pacific Islanders in particular. Even though these populations are often rather small in counties, they warrant more attention to culturally relevant outreach, engagement, and services. Including statewide underserved populations in DHCS' revised CCPRs should occur in addition to locally defined areas of focus and align with the DHCS CQS focus on equity.	DHCS is working internally and with interest holders to explore opportunities to integrate culturally and linguistically appropriate services (CLAS) standard measures in the Behavioral Health Transformation (BHT) Initiative where health equity requirements overlap. BHT is an initiative to expand and reform California's behavioral health system and includes creating pathways to ensure equitable access to care by advancing equity and reducing disparities for individuals with behavioral health needs. Integrating CLAS standards into BHT health equity measures will help to streamline reporting and reduce administrative burden while also strengthening accountability by using data to identify health disparities.

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations	Actions Taken by DHCS to Address the External Quality Review Recommendation
2. Continue to support statewide initiatives that strengthen the behavioral health workforce. State-level leadership that encourages the expansion of master's programs and other certification programs at California colleges is necessary to increase the number of professionals trained to work for MHPs and in the behavioral health field in general.	In July 2025, DHCS, in partnership with the Department of Health Care Access and Information (HCAI) launched the first two of five behavioral health workforce programs under the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative. The Medi-Cal Behavioral Health Student Loan Repayment Program provides loan repayment assistance to behavioral health providers working in Medi-Cal safety net settings. The Medi-Cal Behavioral Health Residency Training Program offers funding to support new or expanded residency slots for eligible residents who commit to serving in Medi-Cal safety net settings. In early 2026, HCAI and DHCS will launch two additional programs focused on providing scholarships to students pursuing relevant behavioral health degrees and a program focused on training for community-based providers. The last BH-CONNECT workforce program will launch in mid-2026 and will focus primarily on recruitment and retention efforts. Collectively, these initiatives are designed to expand the number of behavioral health professionals entering and remaining in the field, and providing care to underserved Medi-Cal communities. Individual recipients of BH-CONNECT workforce awards must complete a two- to four-year service commitment in a Medi-Cal behavioral health setting.

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations	Actions Taken by DHCS to Address the External Quality Review Recommendation
3. Evaluate whether payment reform has created an unintended consequence of more services being provided in clinics rather than in the community and other more accessible field-based locations. While intended to be accounted for in the payment methodology, according to review discussions, the lack of separate transportation billing seems to be impacting whether MHPs (county and contract providers) are disincentivized to deliver SMHS services to complex populations in the community as opposed to a clinic site. This issue could severely limit member engagement and outcomes for members who are most severely impacted by their mental health.	DHCS entered into a contract with the California Mental Health Services Authority to begin analyzing administrative claims data, including changes in service utilization after payment reform. This analysis may attempt to determine changes in office- and field-based services based on the place of service code included in the electronic claim.
4. Consider identifying the criteria for defining a "new" MHP member to better gauge comparable performance across MHPs. These can include factors such as the last date of service, last type of service, and/or date of the most recent case closure. Similarly, create a more specific operational definition for urgent service needs to identify individuals who are not in crisis but have urgent needs. This is especially important for those MHPs that have longer initial wait times. Adding an urgency determination protocol to the CalAIM Screening Tool may assist with this task.	DHCS published adult and youth screening tools in 2023. For both tools, the first question asks, "Is this an emergency or crisis situation?" If the member responds yes, then the person administering the screening tool is instructed to "not finish the screening and handle according to existing emergency or crisis protocols." DHCS, in collaboration with the County Behavioral Health Directors Association of California, is actively working on developing a statewide definition of a "new" member within MHPs and exploring how this information can be collected from the MHPs. Additionally, DHCS acknowledges the importance of a clear operational definition for urgent service needs, particularly for members who are not in crisis but face delays due to longer initial wait times and will engage the relevant stakeholders in determining whether

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations	Actions Taken by DHCS to Address the External Quality Review Recommendation
	specific criteria can be established to define an urgent service.
5. Work with the MHPs that have excessively long wait times for psychiatric services to identify mechanisms to improve access.	DHCS has taken targeted actions to address excessively long psychiatric wait times among MHPs, which include: ♦ Identifying non-compliant MHPs via Timely Access Data Tool reviews. ♦ Providing technical assistance to assess barriers such as workforce shortages and scheduling issues. ♦ Requiring CAPs to implement solutions like telepsychiatry and provider recruitment. ♦ Collaborating with key stakeholders to address systemic challenges and support sustained improvements. DHCS will also publicize opportunities for workforce investments, such as the Behavioral Health Recruitment and Retention and Student Loan Repayment Programs within BH-CONNECT, that MHPs could leverage to help recruit and retain psychiatrists.
6. Encourage monitoring timely access to care beyond initial access. Many MHPs have improved their initial access processes only to have significant bottlenecks elsewhere in service delivery.	DHCS now requires MHPs to monitor timely access beyond initial appointments, recognizing that many plans face delays in follow-up and ongoing services. DHCS took steps to integrate broader access measures into its ANC, with expansion to follow-up monitoring beginning with Fiscal Year 2024–25. DHCS has also worked to provide guidance on addressing service bottlenecks and promoted data-exchange and data-driven strategies to identify and resolve gaps in care delivery.
7. As DHCS increases its monitoring of and assistance to MHPs, as described in the DHCS CQS, identify opportunities to create model tools that will not only assist MHPs in consistently meeting	This year, DHCS is publishing and implementing a quality improvement policy based on BHAS performance, which applies accountability requirements to MHPs performing below the MPLs for three or more

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations	Actions Taken by DHCS to Address the External Quality Review Recommendation
statewide mandates (e.g., medication monitoring, foster care HEDIS measures, but that also could be used flexibly if MHPs want to include additional elements. Tools developed by State staff members with subject matter expertise would be especially useful for small MHPs that have difficulty retaining psychiatric and nursing staff and are unable to develop tools locally as a result.	BHAS measures. MHPs that trigger this requirement must undertake additional quality improvement projects and submit reports, also known as the Quality and Health Equity Workplan, to DHCS. This will involve designing and executing a comprehensive quality improvement project and reporting progress on an A3 Lean Process Template. This tool is versatile and can be used for a wide variety of improvement efforts.
8. Work with MHPs to develop a universal level of care (LOC) tool for adults that could be implemented statewide. Many MHPs are tackling this task independently. A statewide model could launch the work for many, reduce duplicative efforts, and create some uniformity in the approach across plans.	According to the CMS-approved Special Terms and Conditions of BH-CONNECT Section 1115 Demonstration, DHCS is required to implement a LOC tool for psychiatric facilities that are participating in the Institutions for Mental Disease Federal Financial Participation Program. DHCS is actively researching the feasibility of expanding this requirement statewide for all MHPs.
9. Identify a mechanism for MHPs to receive detailed service data associated with inpatient care that are billed through the State's vendor so that a comprehensive view of inpatient utilization is more readily achievable.	The Monthly Plan Data Feed exchange serves as a vital resource for providing information regarding inpatient medical services rendered to members and billed through the State's fiscal intermediary (fee-for-service). This exchange facilitates the delivery of standardized and historical utilization data to MCPs and county MHPs monthly. It is important to note that the data included encompass only paid claims and approved encounters, ensuring that the information shared accurately reflects finalized and validated service activity. DHCS will monitor future EQRO findings. If the issue persists, DHCS will request that the EQRO findings specify the identified gaps.

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations	Actions Taken by DHCS to Address the External Quality Review Recommendation
10. Clarify for MHPs whether the foster care HEDIS measure monitoring in accordance with CA WIC §14717.5 continues to be required, as this is not elucidated in the DHCS CQS or in other DHCS communications regarding quality monitoring.	Collection of foster care-specific data, including CMS' Child Core Set measures and HEDIS measures, continues to be required under CA WIC §14717.5. The EQRO is specifically mandated to report annually on foster care-related data as part of the EQRO's MHP review and validation activities. The data and information are used to describe adequacy and appropriateness of mental health care to minor and non-minor dependents in foster care. After analysis and validation, the EQRO provides county and State recommendations to improve access, timeliness, quality, and outcomes of mental health services. More information may be found at the following publication: Quality of Care Measures in Foster Care

Assessment of DHCS' Self-Reported Actions

HSAG reviewed Table 12.1 in which DHCS summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that DHCS adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to DHCS related to DHCS' CQS and mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which DHCS addresses these recommendations.

External Quality Review Recommendations for MHPs

HSAG provided each MHP an opportunity to summarize actions taken to address recommendations the previous EQRO made in the 2023–24 SMHS EQR technical report. In *Volume 2 of 5* (*Appendix B)* of this EQR technical report, HSAG includes each MHP's self-reported follow-up on the 2023–24 EQR recommendations as well as HSAG's assessment of the self-reported actions. HSAG also includes in *Appendix B* its recommendations for each MHP based on the 2024–25 EQR.