California Department of Health Care Services

Medi-Cal Managed Care Quality Strategy

Annual Assessment

October 2017

To comply with Code of Federal Regulations 438.202(a), States that have contracts with managed care organizations must have a written strategy for assessing and improving the quality of managed care services offered by all Medi-Cal managed care health plans.

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EXECUTIVE SUMMARY

California's Medicaid system, Medi-Cal, provides health care services to 13.5 million beneficiaries through two distinct health care delivery systems: managed care and traditional fee-for-service (FFS). Medi-Cal Managed Care has grown tremendously in recent years. In 2013, it served about six million beneficiaries. That number has increased, and Medi-Cal managed care currently provides health care services to about 10.8 million low-income Californians, including children, pregnant women, and Seniors and Persons with Disabilities (SPDs). The California Department of Health Care Services (DHCS or Department) contracts with 23 full-scope Medi-Cal managed care health plans (MCPs) and three specialty health plans (SHPs) to provide health care services to Medi-Cal enrollees in all 58 California counties.

The 2016 *Medi-Cal Managed Care Quality Strategy Comprehensive Review* built on prior years' Managed Care Quality Strategies by evaluating MCP performance, updating progress toward measurable objectives for key indicators, establishing new targets for improvement, assessing past interventions, introducing future interventions and describing changes in service delivery, contractual standards and enhancing oversight and monitoring of Medi-Cal Managed Care.

The current report continues to focus and build on performance in three areas critical for the health of MCP beneficiaries:

- Maternal and child health: timely postpartum care, immunizations of two-year-olds.
- Chronic disease management: hypertension control, diabetes care.
- Prevention: tobacco cessation.

The current report also focuses on two additional areas that are essential to addressing the health of MCP beneficiaries: identifying and reducing health disparities among beneficiaries, and reducing opioid medication misuse and overuse in an attempt to help foster healthier communities. As outlined in the *2016 Medi-Cal Managed Care Quality Strategy*, while these two focus areas are not linked to a specific quality metric, they are essential for MCP beneficiaries to achieve the seven overall DHCS Quality Strategy priorities of improving patient safety; delivering effective, efficient, and affordable care; engaging persons and families in their health; enhancing communication and coordination of care; advancing prevention; fostering healthy communities; and eliminating health disparities.

DHCS uses specific performance measures to monitor the quality and coverage of timely postpartum care, immunizations of two-year-olds, hypertension control, diabetes care, and

tobacco cessation. For each of these measures, DHCS continues to investigate causes for the performance gaps by analyzing aggregated data that MCPs report to the National Committee for Quality Assurance (NCQA), encounter data MCPs report to DHCS, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1] MCP data. DHCS also continues to elicit MCP perspectives on the challenges faced in engaging beneficiaries and providers. In the *2016 Comprehensive Review*, DHCS developed new targets for improvement, having achieved improvement towards the goals originally set in 2014. For the two new focus areas, identifying and reducing health disparities and reducing opioid misuse and overuse, DHCS is engaging in non-measure related interventions with both MCPs and external stakeholders to address these critical areas.

This *Annual Assessment* also describes the program history and structure, defines contractual standards, and outlines oversight and monitoring activities of the Medi-Cal managed care program. This report addresses operational processes and procedures implemented by DHCS that:

- Assess the quality of care delivered through MCP contracts.
- Make improvements, based on assessment, in the quality of care delivered to Medi-Cal beneficiaries through MCP contracts.
- Obtain the input of Medi-Cal beneficiaries and other stakeholders.
- Ensure that contracted MCPs comply with standards established by the State.
- Conduct periodic effectiveness evaluation reviews and update the strategy, as needed.
- Ensure compliance with the new federal managed care regulations released by the Centers for Medicare and Medicaid Services (CMS) in March 2016 known as the “Final Rule.”

This report also describes any significant changes in the Medi-Cal program, defined as changes to the managed care population or within State or federal regulations that necessitate a modification in Medi-Cal managed care policies, benefits, or quality improvement processes and activities carried out within DHCS to support the goal of ensuring that every Californian has access to high-quality health services. The Quality Strategy Report reflects the unique operational contributions that Medi-Cal Managed Care can make in furthering DHCS’ goals. DHCS views this assessment as a living document and tool to focus improvement efforts

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

throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help achieve the Department's mission to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health and substance use disorder services, and long-term services and supports.

A. Maternal and Child Health

In measurement year (MY) 2016, the proportion of women with live births who had timely postpartum care increased by 5 percentage points from MY 2015, from 59 percent to 64 percent, which places California well above the national Medicaid 25th percentile (percentiles being referenced for MY 2016 rates are from the NCQA Quality Compass Healthcare Effectiveness Data and Information Set [HEDIS®][2] 2016 Medicaid HMO percentiles, which reflect MY 2015 data). As Medi-Cal Managed Care continues to grow, over 3,700 more women were due for a postpartum visit in MY 2016 as compared to MY 2015.

Section 3 of this report describes DHCS interventions to improve timely postpartum visits, including a quality improvement collaborative and methods to engage MCPs.

In MY 2016, immunization coverage for two-year-old MCP beneficiaries remained static at 71 percent, leaving about 55,300 two-year-olds without one or more recommended immunizations. Although immunization coverage for two-year-olds did not decrease in MY 2016, as it has in the previous four years, Medi-Cal Managed Care continues to need to improve the rate of immunizations for vaccine-preventable diseases.

Section 3 of this report describes DHCS interventions to improve immunization coverage for two-year-old MCP beneficiaries. To address the performance gap, DHCS is continuing to partner with the California Department of Public Health (CDPH) to increase MCP providers' use of the California Immunization Registry (CAIR), which has been aided by the release of the new, single, statewide immunization registry system, CAIR 2.0, which began October 2016. CDPH is also working with MCPs to offer reports that will assist MCPs to identify which of their provider sites are signed up to use CAIR and which provider sites are actively uploading information to CAIR.

DHCS recently concluded its participation in a National Governors Association (NGA) grant that focused on strategies to improve immunization rates for children. The grant, awarded to DHCS in 2015, focused on three MCPs in Sacramento County where childhood immunization

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA)

rates have been particularly low over the past three years, with the intent of expanding successful interventions to other MCPs statewide. The participating MCPs identified provider groups that all three MCPs contract with and developed joint Plan-Do-Study-Act (PDSA) improvement plans to target these high volume provider groups in a collaborative effort. Both CDPH and the Sacramento County Department of Public Health participated in the grant, as well, assisting the MCPs with interventions and both provider and beneficiary engagement. This represented the first example of a joint MCP collaboration in one county and DHCS is hoping its success will lead to other such MCP collaborations. Despite the conclusion of the grant, the three MCPs have indicated an interest in continued collaboration in Sacramento County on childhood immunizations. Additionally, for any MCP with childhood immunization rates below the Minimum Performance Level (MPL) for HEDIS® 2017, or with rates below the statewide managed care average and a statistically significant decline from HEDIS® 2016, DHCS has required these MCPs to choose childhood immunizations as one of their two Performance Improvement Projects (PIPs). More than half of DHCS' contracted MCPs will do a PIP on childhood immunizations for 2017-2019. DHCS will continue to work with the external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG) to facilitate quarterly discussions with the MCPs to provide quality improvement technical assistance and a forum to discuss barriers and lessons learned in this quality improvement effort. HSAG will also continue to provide individual technical assistance to all MCPs that choose or are obligated to choose immunizations for two-year-olds as the topic for one of their two PIPs.

B. Chronic Disease Management

In MY 2016, MCP performance on key measures for chronic disease management increased by one to nearly 3 percentage points, depending on the indicator. The proportion of diabetic patients who received blood glucose control testing increased by 1 percentage point, and the proportion of diabetic patients with glycosylated hemoglobin (HbA1c) levels above 9 percent (poor diabetes control) decreased by 2 percentage points. At the same time, as a result of continued growth of Medi-Cal managed care, MCPs served 44,000 more beneficiaries living with diabetes in MY 2016 as compared to MY 2015. These patients are at increased risk for poor health outcomes, such as kidney failure, blindness, and lower extremity amputations. As previously reported for MY 2013, MCP performance had shown a decline in key measures of diabetes care; improvement in MYs 2014 through 2016 reflects numerous joint efforts by both DHCS and the MCPs. Section 3 of this report describes DHCS interventions to improve diabetes care, including a quality improvement collaborative and venues to enlist MCP and stakeholder participation.

In MY 2016, MCPs reported Controlling High Blood Pressure in 63 percent of their beneficiaries with hypertension, representing an increase of 2 percentage points from MY

2015. With the growth in Medi-Cal Managed Care, MCPs served 53,000 more beneficiaries living with hypertension in MY 2016 as compared to MY 2015. Section 3 of this report describes DHCS interventions to achieve and sustain these improvements, including continued participation in the CMS Prevention Learning Network to support implementation of the Million Hearts Initiative in Medi-Cal, which includes working with MCPs to set MCP-specific targets for Controlling High Blood Pressure.

C. Tobacco Cessation

Tobacco is the leading cause of preventable death in the U.S. Tobacco cessation services have demonstrated to be clinically effective,[3] with a return on investment of 3:1 for dollars spent on smoking cessation services in Medicaid populations.[4] In the 2013 Medi-Cal Managed Care Adult CAHPS® survey, a median of 18.2 percent of respondents reported smoking currently (range of 10 percent to 27 percent among MCPs). This means that an estimated 413,000 MCP beneficiaries were smokers in 2013. A median of 71 percent (range 58 percent to 80 percent) of smokers indicated they received advice from a health care provider to quit smoking. In the 2016 Adult CAHPS® survey, 17.3 percent of respondents reported smoking currently, every day or some days, representing a 1 percentage point decline from 2013. However, this means that an estimated 906,000 MCP beneficiaries are smokers. Sixty-five percent (65.4%) of smokers indicated they received advice from a health care provider to quit smoking. This leaves an estimated 317,000 smokers who did not recall being counseled to quit in the prior 6 months, which shows that improvements are needed in MCPs tobacco cessation counseling. The percentage of smokers who responded that their providers discussed cessation medications was only 38.3 percent and those who responded that their providers discussed other cessation strategies was 35.1 percent.

The CAHPS® survey will next be conducted in 2019, and DHCS will continue to evaluate progress towards goals of reducing smoking prevalence and increasing the percentage of beneficiaries reporting receiving advice to quit smoking from their health care provider. Additionally, DHCS is exploring opportunities to monitor progress towards tobacco cessation goals by utilizing alternative metrics. Section 3 of this report describes DHCS efforts to expand tobacco cessation interventions such as identifying and tracking tobacco users, as discussed in DHCS' updated tobacco All Plan Letter (APL) 16-014: Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries[5].

[3] Agency for Healthcare Research & Quality, Treating Tobacco Use and Dependence: 2008 Update.
[4] PLOS One by Patrick Richard, Kristina West, Leighton Ku: "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts." January 6, 2012.
[5] CA Department of Healthcare Services. APL 16-014: Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries. November 30, 2016.

D. Health Disparities

Identification and reduction of health disparities or health inequities has been a DHCS priority for the past several years. This report highlights the reduction of health disparities in managed care as a quality strategy focus area because the accurate identification of health inequities and targeted inventions thereof are key to achieving meaningful improvements in other metrics. In prior reports, DHCS has identified wide gaps in MCP performance by race and ethnicity. For example, African-American or Black beneficiaries had a nearly 20 percentage point higher prevalence of hypertension than other race and ethnic groups as reported in MY 2013. Additionally, African-American or Black women with recent births had the lowest postpartum visit rate of any race or ethnic group in MY 2013. In order to more accurately identify and address health inequities, DHCS commissioned its EQRO to perform a health disparities analysis in 2016; the results of this analysis are expected to be available in the fall of 2017. The EQRO has examined External Accountability Set (EAS) measures and stratified the rates by age, gender, race/ethnicity, and language preference for both statewide and individual MCP reporting units. DHCS hopes that the results will enable the MCPs and DHCS to: a) more accurately identify health inequities and b) better target our neediest populations with quality improvement efforts. Section 3 of this report describes other efforts that DHCS is making in order to further reduce health disparities.

E. Fostering Healthy Communities

Fostering healthy communities is one of the seven priority focus areas of the DHCS Quality Strategy and is critical to achieving and maintaining health on an individual and population basis. In an attempt to address this focus area, DHCS has identified opioid overuse as a quality strategy focus area. Opioid misuse and overuse is a national crisis that has received much attention in the past several years. The severity of the crisis is such that it effects not just our beneficiaries and their immediate health care needs, but our beneficiaries' families and their communities. Given this, DHCS has chosen to focus on opioid misuse and overuse, with the hope of promoting healthier communities for our beneficiaries to live, play and work in. DHCS, including managed care, is engaged in several efforts to promote awareness of opioid misuse and to reduce overuse which are described in Section 3 of this report.

F. Overall Performance

In MY 2016, MCP overall performance showed a marked increase from MY 2015. For indicators for which DHCS held MPLs accountable to meet the MPLs, 89 percent of the rates were above the MPLs in MY 2016, as compared to MY 2015, when 78 percent of the rates were above the MPLs. While this increase is encouraging and a tribute to the work of the

MCPs and their partners, DHCS also made changes to its EAS metrics in 2016 for Reporting Year (RY) 2017, which may partially account for some of the increases; these changes are discussed in greater detail in Section 3. There also continues to be variability in MCP performance. In MY 2016, 11 percent of reporting unit indicators were above the High Performance Levels (HPLs). The eight best performing MCPs in MY 2016 (CalOptima, Central California Alliance for Health, Health Plan of San Mateo, Inland Empire Health Plan, Kaiser North, Kaiser South, LA Care, Santa Clara Family Health Plan, and San Francisco Health Plan) performed above the contractually-required MPLs for all their indicators for all reporting units, compared with six MCPs in MY 2015. Four MCPs (Alameda Alliance for Health, Community Health Group, Contra Costa Health Plan, and Kern Health Systems) performed above the contractually-required MPLs for all but one indicator each in MY 2016, as compared with two MCPs in MY 2015. At the other end of the spectrum, one third of reporting unit indicators in two MCPs (Gold Coast Health Plan and Health Plan of San Joaquin) were below DHCS' MCP MPL requirements.

To address these continued challenges in quality improvement performance, DHCS continues its engagement with MCPs, as well as its rapid-cycle quality improvement methods. DHCS is working with high-performing MCPs to define and spread evidence-based strategies and promising practices. MCPs with indicators with rates below the MPLs are required to submit PDSA cycles and continuously evaluate the effectiveness of their interventions. Four of the historically lowest performing MCPs continue under a Corrective Action Plan (CAP) with close DHCS monitoring. Two of these four MCPs have been under a CAP for between two and four years and continue to show dramatic improvements in performance. The other two MCPs have also demonstrated improvement in their rates, although these same two MCPs also saw expansion of their CAPs due to poor performance in other reporting units. Based on the improved performance in MY 2016, no new MCPs triggered a CAP in 2017. DHCS sent Advance Warning Letters to five MCPs whose performance in MY 2016 is at risk of triggering a CAP in MY 2017. This is a new policy, instituted by DHCS in 2016 to identify MCPs at risk of triggering a CAP, based on the DHCS CAP Process triggers, in order to prevent the MCP from falling under a CAP in the following year. MCPs that receive an Advance Warning Letter are required to attend a meeting with DHCS leadership to discuss the MCP's strategies to improve performance and avoid a CAP in the following measurement year. DHCS is also working on other strategies to help low performing MCPs, including the DHCS-HSAG Quality Conference in October 2017 to assist MCPs in quality improvement strategies.

SECTION 1: INTRODUCTION

Each state that enters into contracts with managed care organizations must develop a written quality strategy per Title 42 Code of Federal Regulations (CFR), Section (§) 438.202. CMS released its update to the managed care regulations, known as the Final Rule. In March 2016. The regulations pertaining to Medicaid managed care Quality Strategies can be found at 42 CFR §438.340. Changes resulting from the Final Rule are apparent in this current quality strategy annual assessment to ensure that DHCS is compliant by the implementation date of July 1, 2018. The current report is an annual review and update of the managed care quality strategy, assessing progress and describing changes in DHCS' approach to improving the quality of care and health of beneficiaries in Medi-Cal MCPs.

This document follows the structure of the CMS Quality Strategy Toolkit for states.

A. Managed Care Overview, Goals, Objectives

1. Overview

To meet the needs of MCP beneficiaries with high-quality and appropriate health services, it is important to know their demographics, including age, gender, and race-ethnicity. There were approximately 10,821,000 MCP beneficiaries as of December 1, 2016.[6] This is an increase in membership of almost 4.7 million beneficiaries since the same time in 2013. Of this total, 41 percent (4.4 million) were children under age 18, and 59 percent (6.4 million) were adults. Girls comprised 49 percent of these children under age 18. Women comprised 51 percent of the 18 to 20-year-olds, 57 percent of the 21 to 44-year-olds, and 56 percent of beneficiaries aged 45 years and older. Of all MCP beneficiaries, 46 percent were Hispanic, 21 percent were White, 8 percent were Black, 14 percent were Asian/Pacific Islander, and 12 percent were other/ unknown race-ethnicity. By aid code groups, 11 percent (approximately 1.1 million) were optional targeted low income children (whose parents' income is 138 percent to 266 percent of Federal Poverty Level [FPL], 15 percent (approximately 1.6 million) were SPDs including children, 10 percent (approximately 968,000) were dually eligible for Medi-Cal and Medicare, 39 percent (approximately 4.2 million) were Affordable Care Act (ACA) expansion population, and 35 percent (approximately 3.8 million) were other populations (all other aid codes that do not include seniors and persons with disabilities, those dually eligible for Medicare and Medi-Cal, the ACA population and optional targeted low income children). Detailed information

[6] CA Department of Healthcare Services. Medi-Cal Managed Care Performance Dashboard

regarding the breakdown of membership by MCP can be found in in the Medi-Cal Managed Care Enrollment Reports.[7]

DHCS contracts with 23 full-scope MCPs and three SHPs to provide health care services to Medi-Cal enrollees in all 58 counties. For this report, and in other quality of care reports, DHCS has reported on Kaiser Foundation Health Plan as two entities, Kaiser North and Kaiser South; however, they are considered to be one entity when counting MCPs. DHCS has provisionally entered into a contract with one new MCP that will be operational in early 2018, increasing the number of contracts with full-scope MCPs to 24.

There are currently six models of Medi-Cal Managed Care:

1) A County Organized Health System (COHS) is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission. A COHS model has been implemented in 22 counties and operates as a single county-operated health plan. Medi-Cal beneficiaries in COHS counties do not have the option of accessing services through traditional Medi-Cal FFS unless authorized by the MCP or DHCS. The COHS model serves about 2.19 million beneficiaries through six health plans in 22 counties; six of those counties were added in 2013.

2) In the Two-Plan Model, beneficiaries may choose between two MCPs; typically, one MCP is a Local Initiative (LI) and the other a commercial plan. DHCS contracts with both MCPs. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The commercial plan is a private insurance plan that also provides care for Medi-Cal beneficiaries. The Two-Plan Model serves about 6.89 million beneficiaries through 12 health plans in 14 counties.

3) In the Geographic Managed Care (GMC) model, DHCS allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county). The GMC model has six health plans that serve more than 1.16 million beneficiaries in Sacramento and San Diego counties. Beginning in early 2018, one new MCP will begin operations under the GMC model in both Sacramento and San Diego counties, bringing the total to seven MCPs.

4) The Regional Model consists of two commercial health plans that provide services to beneficiaries in the rural counties of the State, primarily in northern and eastern

[7] CA Department of Healthcare Services. Medi-Cal Managed Care Enrollment Reports

California. The Regional Model was implemented in November 2013, bringing Medi-Cal Managed Care to counties that historically offered only FFS Medi-Cal. The Regional Model serves more than 300,000 beneficiaries in 18 counties.

5) The Imperial Model operates in Imperial County with two commercial health plans. It serves more than 75,000 Medi-Cal beneficiaries.

6) The San Benito Model operates in San Benito County, and provides services to beneficiaries through a commercial health plan and FFS Medi-Cal. The San Benito Model serves more than 8,000 beneficiaries. San Benito is California's only county where enrollment into managed care is not mandatory.

2. Quality Goals and Priorities

Three linked goals have formed the foundation of the overall DHCS Quality Strategy for the past several years, including the current *2017 DHCS Strategy for Quality Improvement in Health Care.*[8] These goals continue to be the following:

- To improve the health of all Californians.
- To enhance quality, including the patient care experience, in all DHCS programs.
- To reduce DHCS's per-capita health care costs.

The framework for the present report is based on the seven priorities of the overall *2017 DHCS Strategy for Quality Improvement in Health Care*, as well as three commitments from the *DHCS Strategic Plan* 2013–2018[9], as specified under *3. Medi-Cal Managed Care Objectives* below.

3. Medi-Cal Managed Care Objectives

The focus areas of this report were chosen because they reflect DHCS priorities, address large performance gaps, and have interventions readily available to improve the health of significant segments of the Medi-Cal Managed Care population. Using these criteria, DHCS continues with five focus areas that are directly linked to quality metrics and two areas that are not linked to a single quality metric. DHCS continues to focus on two chronic diseases (diabetes and hypertension), two services within maternal/child health (postpartum care and immunization of two-year-olds), and tobacco cessation (a key prevention strategy) as priority focus areas.

[8] CA Department of Healthcare Services. Strategy for Quality Improvement in Health Care. January 2017

[9] CA Department of Health Care Services Strategic Plan 2013-2018, 2015 Update

DHCS also added a focus on reducing health disparities, as well as a focus on fostering healthy communities through the reduction of opioid overuse and misuse.

Below is the framework for the Medi-Cal Managed Care Quality Strategy, 2016-17:

a) Overall DHCS Quality Strategy Priorities

- Deliver effective, efficient, and affordable care.
- Engage persons and families in their health.
- Enhance communication and coordination of care.
- Foster healthy communities.
- Eliminate health disparities.
- Advance prevention.
- Improve patient safety.

b) DHCS Strategic Plan Commitments:

- Treat the whole person by coordinating, integrating services.
- Hold DHCS, MCPs, providers and partners accountable for performance.
- Maintain effective, open communication.

c) DHCS Managed Care Focus Areas

- Maternal and child health:
    - Postpartum care
    - Childhood immunizations.
- Chronic disease:
    - Diabetes care.
    - Control of hypertension.
    - Tobacco cessation.
- Fostering healthy communities through reducing opioid misuse and overuse.
- Reducing health disparities.

d) Three Linked Goals (Triple Aim)

- Improve health.

- Enhance quality of health care services.
- Reduce DHCS per capita health care costs.

4. Metric-Linked Focus Areas – Objectives for Services to be Provided in MY 2018

Listed below are the objectives for services to be provided in MY 2018, for the five quality metric linked focus areas. The targets were set in comparison to the baseline year of MY 2015. This builds upon the targets set in the Managed Care Quality Strategy Report for 2013, some of which were achieved in MY 2014 and sustained in MY 2015, and some of which DHCS and its MCPs are still working to achieve. Interventions listed in Section 3 of this report were either implemented in 2016 and 2017, or will be implemented in 2017 and 2018. See Section 3 of this report for an analysis of the scope of the challenges that must be addressed to reach and sustain these objectives.

1) Postpartum Care.

a. Increase the Medi-Cal weighted average for timely postpartum care to at least 64 percent for MY 2018.

- Target for MY 2018: 64 percent.
- Baseline from MY 2015: 59 percent.
- Target reached in MY 2016: 64 percent, target reached two years ahead of goal. DHCS will continue work to improve upon this performance.
- Source: Reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average.

b. Increase the percentage of Medi-Cal Managed Care reporting units meeting the MPL for timely postpartum care to at least 80 percent for MY 2018.

- Target for MY 2018: 80 percent
- Baseline from MY 2015: 75 percent
- Target reached in MY 2016: 92 percent, target reached and exceeded two years ahead of goal. DHCS will continue work to improve upon this performance.

- Source: Reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average.

2) Immunization of Two-Year-Olds.

a. Increase to at least 80 percent the proportion of MCP beneficiaries with up-to-date immunizations by their second birthday during MY 2018.

- Target for MY 2018: 80 percent
- Baseline from MY 2015: 71 percent
- Progress toward goal: DHCS maintained the rate of 71 percent for MY 2016 and will aggressively work towards improving childhood immunization rates by MY 2018.
- Source: Reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average.

3) Hypertension.

a. Increase to 66 percent the proportion of MCP beneficiaries 18 to 85 years of age with hypertension whose blood pressure is adequately controlled during MY 2018.

- Target for MY 2018: 66 percent
- Baseline from MY 2015: 61 percent
- Progress toward goal: DHCS increased the control of blood pressure rate by 2 percentage points to 63 percent in MY 2016, and will continue to work towards the goal of 66 percent in MY 2018.
- Source: Reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average.

4) Diabetes.

a. Outcome objective: Decrease to 35 percent the proportion of MCP beneficiaries with diabetes who had HbA1c testing greater than 9 percent or unknown in MY 2018.

- Target for MY 2018: 35 percent
- Baseline from MY 2015: 40 percent
- Progress toward goal: DHCS decreased the number of beneficiaries with poor control of blood glucose by 2 percentage points to 38 percent in MY 2016, and will continue to work towards the goal of 35 percent in MY 2018.
- Source: Reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average.

b. Process objective: Increase to 91 percent the proportion of MCP beneficiaries with diabetes who had HbA1c testing during MY 2018.

- Target for MY 2018: 91 percent
- Baseline from MY 2015: 86 percent
- Progress towards goal: DHCS increased the number of beneficiaries with diabetes receiving HgbA1c testing by 1 percentage point to 87 percent in MY 2016, and will continue to work towards the goal of 91percent by MY 2018.
- Source: Reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average.

5) Tobacco Cessation.

a. Prior Target: Increase to 76 percent the median proportion of smokers who report being counseled to quit in the prior six months (as measured during 2016 Adult CAHPS® survey).

- Target for MY 2016: 76 percent
- Baseline from MY 2013: 71 percent
- Target reached in MY 2015 (based on 2016 Adult CAHPS® Survey results): No; 65 percent of smokers reported receiving counseling; the number of Medi-Cal smokers increased two-fold between 2013 and 2016.
- Source: Adult CAHPS® survey

- The current target, for MY 2016, will be maintained for MY 2019, as DHCS did not achieve the target, and feels it is still a realistic and important goal.

b. Prior Target: Increase to 45 percent the median proportion of smokers who report a provider discussed tobacco cessation medications in the prior six months (as measured during 2016 Adult CAHPS® survey).

- Target for MY 2016: 45 percent
- Baseline from MY 2013: 40 percent
- Target reached in MY 2015 (based on 2016 Adult CAHPS® Survey results): No; 38 percent of smokers reported a provider discussed cessation medications; the number of Medi-Cal smokers increased two-fold between 2013 and 2016.
- Source: Adult CAHPS® survey
- The current target, for MY 2016, will be maintained for MY 2019, as DHCS did not achieve the target, and feels it is still a realistic and important goal.

6) Health Disparities.

- Review the first annual analysis of health disparities released by the EQRO that will analyze MY 2015 HEDIS® rates by demographic variables. Utilize the findings from the report to target MCP quality improvement activities, particularly those activities related to HEDIS® measures.
    - Due to a delay in obtaining finalized data as well as methodology adjustments to ensure a robust analysis, DHCS expects to meet this objective by fall 2017. In addition, DHCS will review the second health disparities annual analysis when available, which will analyze MY 2016 HEDIS® indicators by demographic variables.
- Establish first annual Health Disparities MCP Award in 2016.
    - DHCS did not meet this objective due to a delay in the first annual health disparities analysis, but intends to move forward with this award when feasible.
- Establish health disparity focused MCP PIP in 2017.

- DHCS successfully established health disparities as a mandatory PIP topic for all MCPs for 2017 and will monitor progress of these PIPs throughout 2017 and 2018. DHCS will establish a quality improvement collaborative with MCPs related to the health disparity focused PIP.

7) Fostering Healthier Communities.

- Continue to participate in department and statewide workgroups on opioid overuse and misuse with the goal or reducing opioid addiction and increasing access to medication assisted therapy for opioid addiction.
  - DHCS continues its participation in these workgroups.
- Continue to work with MCPs on strategies to support judicious prescribing practices, to improve beneficiary outcomes, to provide alternative therapies for pain, to facilitate patient review and restriction programs, and to promote the use of naloxone.
- DHCS continues to work with MCPs and external partners on promoting safe opioid prescribing, facilitating patient review and restriction programs, and providing alternative therapies for pain.

The objectives above will help DHCS meet its overall Quality Strategy priorities of delivering effective, efficient, and affordable care; engaging persons and families in their health; enhancing communication and coordination of care; eliminating health disparities; fostering healthy communities; and advancing prevention. They also address a number of the Department's commitments to the people it serves. For objectives that DHCS has reached already, DHCS will continue efforts to sustain and surpass this improvement. For objectives that DHCS has not reached, DHCS will continue to work towards achieving the objectives.

5. Additional Objectives

The objectives listed below are additional commitments to MCP beneficiaries and the public from the DHCS Strategic Plan 2013–2018[10] and the overall 2017 DHCS Strategy for Quality Improvement in Health Care.[11] In future years, these will also include measurable targets, but for this report are framed as broad goal statements.

[10] CA Department of Health Care Services. Strategic Plan 2013-2018. 2015 Update
[11] CA Department of Healthcare Services. Strategy for Quality Improvement in Health Care. January 2017

Improve patient safety.

- Treat the whole person by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care.

- Hold ourselves and our providers, health plans, and partners accountable for performance.

- Maintain effective, open communication and engagement with the public, our partners, and other stakeholders.

B. Development and Review of Quality Strategy

This report was developed by staff throughout DHCS, and involved obtaining feedback from MCPs and DHCS advisory groups, including the Medi-Cal Managed Care Advisory Group, related to the focus areas, objectives, and interventions. DHCS will submit this *2017 Medi-Cal Managed Care Quality Strategy* to CMS for approval and make it available to the public via the DHCS website.

DHCS assesses the effectiveness of this strategy annually, and reviews its progress in implementing this strategy quarterly. DHCS has ongoing collaboration with stakeholders on initiatives described in this document through quarterly MCP All-Plan Chief Executive Officer Meetings, quarterly All-Plan Medical Director Meetings, quarterly Managed Care Advisory Group Meetings, and quarterly Stakeholder Advisory Committee meetings.

Every three years, DHCS coordinates a comprehensive review and update of its quality strategy. In October 2016, DHCS submitted a comprehensive *Medi-Cal Managed Care Quality Strategy Report* to CMS. The current report is an annual assessment of that 2016 comprehensive Medi-Cal Managed Care Quality Strategy. The next comprehensive review will occur in 2019.

1. State Standards

Contract provisions established for MCPs incorporate specific standards for the elements outlined in 42 CFR §438.340: access to care, structure and operations, and quality measurement and improvement, for all beneficiaries, including those with special health care needs, such as seniors and persons with disabilities. MCPs are responsible for communicating established standards to network providers, monitoring provider compliance, and enforcing corrective actions, as needed.

As previously noted in this report, CMS released its update to the managed care regulations (“Final Rule”) in March 2016. This is the first update to Medicaid and the Children’s Health

Insurance Program (CHIP) managed care regulations since 2002. There are four key goals of the Final Rule: (1) support state delivery system reform efforts; (2) strengthen the beneficiary experience and key consumer protections; (3) strengthen program integrity by improving accountability and transparency; and (4) align key rules with those of other health coverage programs. The effective date of the Final Rule was July 5, 2016, although the effective dates of various components will be phased in over subsequent years. The Final Rule has broad implications across the Department, with particular impacts on DHCS Contracts and oversight of the MCPs, the county mental health plans, the dental managed care plans, and the county Drug Medi-Cal Organized Delivery Systems. DHCS has been working internally and with its MCPs and stakeholders to ensure compliance with the requirements of the Final Rule within the required timeframes. Because of the impact of the Final Rule on DHCS and its MCPs, this report will highlight several of the more significant requirements. The complete Final Rule is published in the Federal Register. For a full description of the current state standards, see the *2016 Medi-Cal Managed Care Quality Strategy Report.*

2. Final Rule Highlights

a) Mental Health Parity

On March 29, 2016, CMS released a final rule on the application of Mental Health Parity and Addiction Equity Act requirements to coverage offered by Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and CHIPs. A key objective of the rule is to ensure that restrictions or limits on mental health and substance use disorder services are not more substantively applied compared to medical/ surgical services. As such, the rule imposed restrictions or limits on aggregate lifetime and annual dollar limits, financial requirements, and quantitative and non-quantitative treatment limitations. Additionally, the rule added requirements to make certain information pertaining to mental health and substance use disorder benefits available, specifically the criteria for medical necessity determinations and the reason for denial of reimbursement or payment.

Since certain mental health and substance use disorders services are carved-out of the MCPs' benefit structure, the State was responsible for conducting the parity analysis. DHCS collected, analyzed, and evaluated State and local-level information obtained from various sources. DHCS surveyed MCPs, MHPs, and counties providing substance use disorder services through Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS), as well as reviewed State policies within the Medicaid State Plan, waiver programs, State and federal statutes and regulations, All Plan Letters (APL) and County Information Notices, Medi-Cal contracts with the MCPs and MHPs, the Medi-Cal Provider Manual, and the DMC and Specialty Mental Health Services (SMHS) Billing Manual for potential restrictions and/or limitations.

After several months of undertaking the parity analysis, DHCS has identified areas of concern and determined compliance steps. On October 2, 2017, DHCS will submit a compliance plan to CMS and post a summary on its website.

DHCS will issue APLs to MCPs to provide clarification and guidance on parity compliance requirements. Further, DHCS will monitor MCPs, MHPs, DMC counties, and DMC-ODS counties for ongoing parity compliance.

b) Grievances and Appeals

CMS published the Medicaid and CHIP Managed Care Final Rule (81 FR 27497), which stipulated new requirements for the beneficiary Grievance and Appeal System that became effective July 1, 2017. The primary change impacting beneficiaries' rights was the new requirement for beneficiaries to exhaust the MCP-level appeals process prior to requesting a State Fair Hearing. Other key changes included introduction of new terminology ("adverse benefit determination" to replace what was previously known as an "action" or "denial") and the establishment of new timeframes for beneficiaries to file appeals and State Fair Hearings, MCPs to process expedited appeals, and MCPs to authorize or provide services when an adverse benefit determination has been overturned by appeal or State Fair Hearing. DHCS has issued an APL to MCPs to provide clarification and guidance on the new requirements (APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments)[12].

c) Network Adequacy

The Final Rule requires states to develop and implement network adequacy standards for primary and specialty care (adult and pediatric), behavioral health (adult and pediatric), obstetrics/gynecology, pediatric dental, hospitals, pharmacy providers, and long-term services and supports (LTSS) providers that require the beneficiary to travel to the provider. CMS provided states flexibility to develop state-specific standards as long as certain elements outlined by CMS were taken into consideration, including expected enrollment and utilization of services, characteristics and needs of specific populations, numbers and types of network providers, and geographic location of network providers.

In response to the Final Rule, in July 2017 DHCS released its network standards in the Network Adequacy Proposal. Additionally, DHCS established a list of 15 core specialists to which network adequacy standards must apply. Following the proposal's release, legislation was established to codify the standards. Legislation also established the categorization of

[12] CA Department of Healthcare Services. APL 17-006: Grievances and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments. May 9, 2017

counties by population density. MCPs not able to meet the network adequacy standards may request an alternative access standard from DHCS.

DHCS will submit an assurance of compliance with the network adequacy standards to CMS through the submission of the annual network certification. Upon implementation, geo-access software will be used to monitor these standards. DHCS will continue to provide technical assistance and hold the plans accountable to comply with the network standards, including enforcement of corrective action if plans fail to meet them. The Final Rule network adequacy requirements are effective in the July 1, 2018 health plan contract year.

d) Drug Utilization

The Final Rule includes a new requirement that MCPs that provide coverage of outpatient drugs also operate a Drug Utilization Review (DUR) program that assures that prescriptions are appropriate; medically necessary; and are not likely to result in adverse medical effects. The Final Rule requires that MCPs' DUR programs include a prospective DUR process, a retrospective DUR process, the establishment of a DUR Board that meets the requirements of §1927(g) of the Social Security Act (SSA), and education programs and resources designed to improve the ability of physicians and pharmacists to identify patterns and reduce the frequency of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. Ultimately, the objective of the DUR program is to help ensure the appropriate prescribing of medications and an improved quality of care for beneficiaries. Finally, it includes a requirement that MCPs provide a detailed description of their DUR program activities to DHCS on an annual basis, allowing DHCS to compile and submit a single, annual Medi-Cal DUR report to CMS.

CMS requires DHCS to monitor and provide approval of the MCPs' Medi-Cal DUR program activities, and ensure that MCPs are compliant with §1927(g) of the SSA. Accordingly, DHCS has determined that the complexities of the federal DUR requirements necessitate that MCPs utilize the established Medi-Cal State DUR Board and educational components of the Medi-Cal DUR program. Effective July 1, 2017, in collaboration with DHCS' FFS Program for covered outpatient drugs, MCPs began participating in a global Medi-Cal DUR program. However, MCPs will maintain their current proprietary claims processing procedures and protocols and MCPs will individually administer the systematic components related to the prospective and retrospective DUR processes. As is the case with the FFS program, MCPs are not required to implement all Medi-Cal DUR Board recommended actions, nor are they required to mirror the Medi-Cal DUR activities.

e) Managed Long-Term Services and Supports (MLTSS)

Per the Final Rule, DHCS must implement mechanisms to identify persons who need LTSS, and each MCP must implement mechanisms to comprehensively assess each beneficiary

identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. DHCS must also ensure through its contracts with MCPs that there are mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan, if applicable.

For the LTSS component of the CCI, all Medi-Cal members, including Duals, are required to join an MCP to receive Medi-Cal benefits, including LTSS and Medicare wrap-around benefits. MCPs are required to provide care coordination for these members. This includes risk-stratifying the population, conducting Health Risk Assessments (HRAs), when applicable or requested by the member, developing Individual Care Plans for high-risk members, and establishing Interdisciplinary Care Teams, when appropriate, or requested by the member.

MCPs are required to establish a risk-stratification mechanism or algorithm for the following populations: 1) Full benefit Duals who opt-out of Cal MediConnect; 2) Full-benefit Duals who are excluded from Cal MediConnect; and 3) Partial benefit Duals. The risk-stratification mechanism should be designed to stratify newly enrolled members into high or low-risk groups. For purposes of this risk-stratification, an individual may be deemed high-risk if the individual has been authorized to receive In-Home Supportive Services greater than or equal to 195 hours per month, Community Based Adult Services (CBAS), and/or Multipurpose Senior Services Program (MSSP) Services. Medi-Cal Only Seniors and Persons with Disabilities MCPs are also required to follow risk-stratification requirements for newly enrolled Medi-Cal only SPD members. The HRA must include specific LTSS referral questions. These questions are intended to assist MCPs in identifying members who may qualify for and benefit from LTSS services (refer to APL 17-013 titled, “Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities.”[13]).

f) Beneficiary Support System (BSS)

Per the Final Rule, DHCS must provide for its contracted MCPs a template or model Member Handbook or Evidence of Coverage (EOC), which outlines the information that all beneficiaries are entitled to, as required by the Final Rule. The purpose of the template Member EOC is to assist MCPs with compliance regarding the new Final Rule regulations. The DHCS model EOC has been completed and will be released later this year. Similarly, the MCPs are required to routinely update and maintain accurate Provider Directories, as per directives in the Final

[13] CA Department of Healthcare Services. APL 17-013: Requirements of Health Care Assessment of Medi-Cal Seniors and Persons with Disabilities. July 11, 2017

Rule. This project continues along a similar timeline to ensure compliance with the new Final Rule regulations.

As part of the Final Rule requirement, DHCS has a developed a BSS website[14] that links beneficiaries to health plans operating in each county. The BBS website links provide access to member handbooks, provider directories, and formularies for each MCP. The BSS will also assist existing and future beneficiaries understand the enrollment process and navigate their MCP options. Components of the BSS include: choice counseling to provide enrollment assistance to beneficiaries when selecting a plan, assistance for beneficiaries in understanding managed care, such as help with choosing a provider and navigating the system, and assistance for those who use LTSS.

g) Transition of Care

Per the Final Rule, DHCS must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to managed care or from one managed care entity to another, when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The transition of care policy must include the following provisions, among others: the beneficiary has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the managed care network; the beneficiary is referred to appropriate providers of services that are in the network; the State, in the case of FFS, or the managed care plan that was previously serving the beneficiary, fully and timely complies with requests for historical utilization data from the new managed care plan; the beneficiary's new provider(s) are able to obtain copies of the beneficiary's medical records, as appropriate. DHCS, through its Medical Exemption Request process as well as through APL 15-019: Continuity of Care for Medi-Cal Beneficiaries that Transition into Medi-Cal Managed Care, and block transfer provisions under the Knox Keene Act (Health and Safety Code §1373.65 and 28 CCR §1300.67.1.3) are fully compliant with this Final Rule transition of care requirement. These policies and procedures help to ensure that transitioning Medi-Cal managed care beneficiaries do not suffer any lapses or gaps in care that MCP beneficiaries are offered.

[14] BSS website can be found at this location: https://www.healthcareoptions.dhcs.ca.gov/

SECTION 2: ASSESSMENT

A. National Performance Measures

Each year, DHCS requires the MCPs with which it contracts to report on a set of quality metrics known as the EAS. The EAS consists primarily of HEDIS® measures developed by the NCQA. For MY 2016 MCPs reported performance on 17 measures consisting of 30 individual indicators (See Appendix A, which indicates that 21 of the 30 measures are in the CMS Adult and Child Core Sets). DHCS regularly re-evaluates the EAS measures' feasibility and usability, applicability to the Medi-Cal population, alignment with Department, State and National priorities, opportunities for quality improvement, specific measure changes, and changes in practice standards that may affect measure selection. Evaluation of the EAS is a lengthy process involving extensive stakeholder and MCP feedback. The EAS was evaluated in 2016, for MYs 2016 and 2017 (RYs 2017 and 2018), and three new metrics were added, including DHCS's first EAS behavioral health measure (see Appendix A). Additionally, one metric was modified by the NCQA such that it qualified as a new metric (Immunizations for Adolescents, with the addition of human papillomavirus vaccination for girls and boys).

For MY 2016, DHCS held MCPs accountable for performing at least as well as the national Medicaid 25th percentile, or the MPL, on 18 of 30 indicators. DHCS defines the HPL as performing as well as the national Medicaid 90th percentile. For MY 2017, DHCS will hold the MCPs accountable to the MPL for 21 of the 30 indicators; this is because in MY 2016, four metrics were new and DHCS does not hold the MCPs to the MPL in the first year of reporting a new metric. For MY 2017, DHCS will hold the MCPs to the MPL on the two metrics that have a national benchmark; the other two metrics do not yet have a national benchmark.

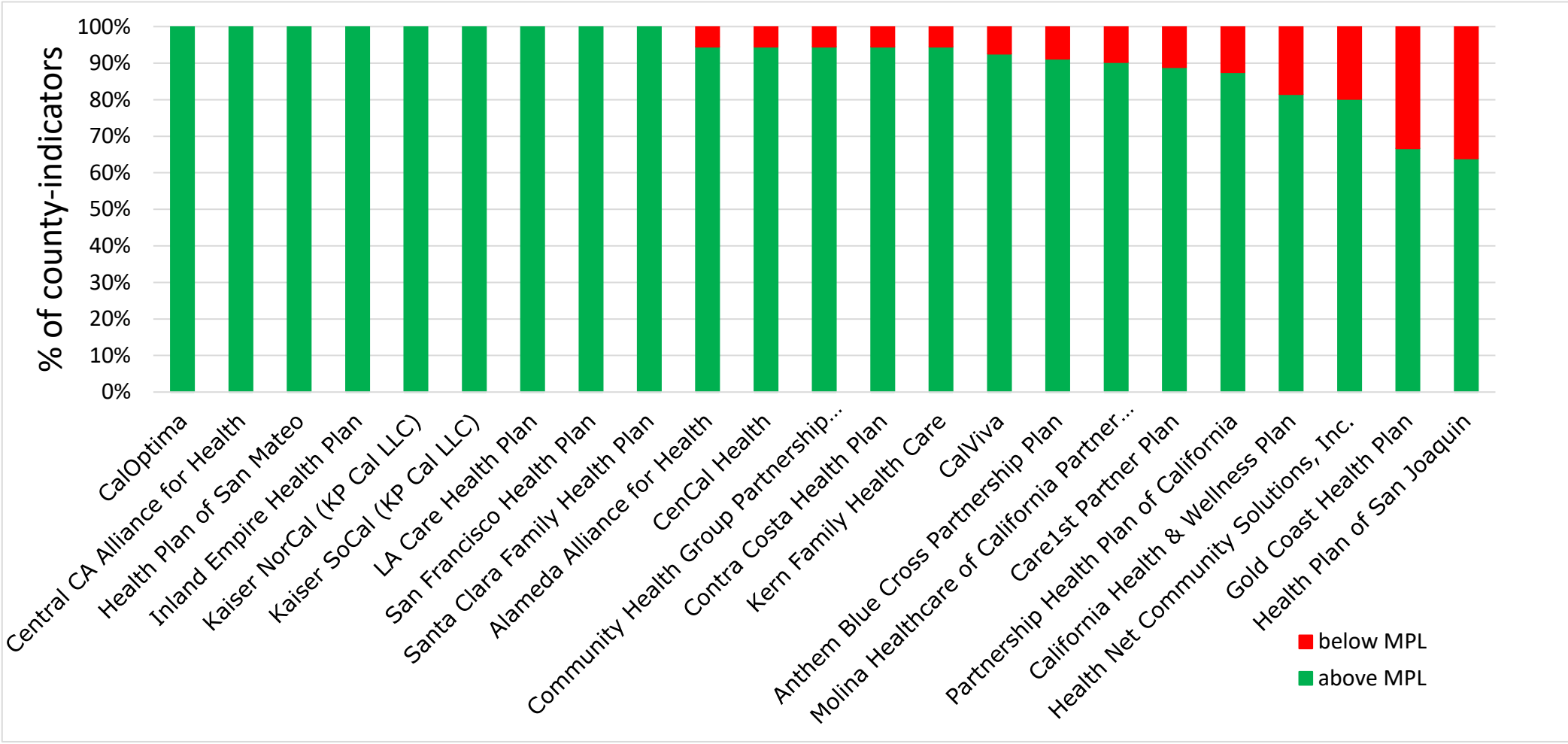
For health care services provided in MY 2015, the MCPs exceeded the MPLs for 78 percent of the indicators. This left 22 percent of indicators falling below the MPLs. For the same MY, MCPs exceeded the HPLs for 11 percent of the indicators. For health care services provided in MY 2016, for indicators for which DHCS held MCPs accountable to meet the MPLs, 89 percent of the rates were above the MPLs, demonstrating an 11 percentage point increase from the prior year. Note that the number of indicators to which DHCS held MCPs to the MPLs decreased in MY 2016 due to four of the indicators being first year indicators on the EAS. Additionally in MY 2016, the MCPs exceeded the HPLs for 11 percent of the indicators.[15]

[15] For MY 2014, one of the 23 MCPs operating was new. Additionally, nine of the reporting units for MY 2014 were considered new. New health plans and new reporting units are not held to the MPL until their second full year of operation. For MY 2015, there were no new MCPs or reporting units, so all MCPs and all reporting units were held to the MPL.

Figure 2-1 shows the variability in MCP performance on these 18 indicators in MY 2016 (RY 2017). Eight MCPs fully met their contractual requirements across all their counties of operation; they had no indicators with rates below the minimum performance levels (CalOptima, Central California Alliance for Health, Health Plan of San Mateo, Inland Empire Health Plan, Kaiser North, Kaiser South, LA Care, Santa Clara Family Health Plan, and San Francisco Health Plan). Four MCPs (Alameda Alliance for Health, Community Health Group, Contra Costa Health Plan, and Kern Health Systems) performed above the contractually-required MPLs for all but one indicator in MY 2016. The lowest performing MCP was Health Plan of San Joaquin, with 36 percent of its indicators having rates below the MPLs; however, that is an improvement over MY 2015 when 50 percent of metrics were below the MPL. The next lowest performing MCPs are Gold Coast Health Plan and Health Net with 33 percent and 20 percent of indicators with rates below the MPLs, respectively.

Performance on key maternal/child health, chronic disease, and tobacco cessation indicators are discussed in detail in Section 3 of this report.

Figure 2-1. MCP Performance by County Indicators Above and Below Minimum Performance Levels* for Measurement Year 2016 (RY 2017)



***** The DHCS MPLs are set as the national Medicaid 25th percentile (except for CDC-H9 where a lower rate is better and the MPL is the national Medicaid 75th percentile). MCPs are not held to the MPL in a new county until their second full year of operations. See Appendix A for the measures included.

B. Monitoring and Compliance

1. Rapid Cycle Quality Improvement

In an effort to raise MCP performance, DHCS continued the following approaches for MCPs not meeting minimum contractual performance standards for one or more indicators in MY 2016 (RY 2017):

- To ensure time for intervention, DHCS continues to work to reduce time lags in identifying and addressing poor performance. In July 2017, DHCS identified poor performing MCPs, as soon as MCPs submitted their final, audited rates to NCQA.

- In 2014, DHCS initiated a new approach to quality improvement projects (QIPs) that focuses on rapid cycle quality improvement. Based on lessons learned from the process, DHCS has determined that a focus on rapid-cycle improvement and implementation of PDSA cycles can increase the potential for improved outcomes. As a result, DHCS will continue to focus on rapid cycle quality improvement methods for MCPs with indicators with rates below the minimum performance levels in 2017 and 2018.

- DHCS continues to use instructions and a template for developing objectives using interim outcomes to facilitate use of PDSA methods. DHCS also modified the instructions and template for 2016-2017 after obtaining MCP input.

- DHCS continues to require MCPs with substandard performance to conduct triannual evaluations of their PDSA cycles, with DHCS engagement throughout the year to monitor progress, provide technical assistance, and share lessons learned across MCPs.

- Throughout 2016 and the first two quarters of 2017, DHCS continued to hold quarterly collaborative discussions on the four DHCS-priority topics (i.e., diabetes, hypertension, postpartum care, and immunizations of two-year-olds), which provide a forum for MCPs to receive technical assistance, learn about additional tools and resources, and share evidence-based strategies. With the new PIP topics for 2017-2018, DHCS will continue with the collaborative discussions but modify the content as appropriate to the PIP topics.

- In July 2017, DHCS conducted the first of what will be annual surveys of the MCPs on their experience of the PDSA process for the prior year in order to better tailor technical

assistance, and provide better resources and support to the MCPs on their rapid cycle improvement projects.

- In 2017, DHCS released its first two EAS Highlights, one page snapshots of EAS indicators highlighting promising practices from MCP PDSA or PIP projects in an effort to promote the sharing of promising practices. The first two highlights focused on cervical cancer screening and childhood immunizations. The third and fourth highlights will be released in the fall and winter of 2017.

Rapid cycle quality improvement methods were also implemented and will continue to be utilized in PIPs.

2. Performance Improvement Projects

DHCS requires MCPs to conduct and/or participate in two PIPs annually. In September 2015, MCPs embarked on a new PIP process. The new process places a greater emphasis on improving outcomes using quality improvement science. The new approach guides MCPs through the process using rapid-cycle improvement methods to pilot small changes, which also aligns with the PDSA process MCPs engage in for quality indicators below the MPL. The EQRO developed a series of five modules, which follow a framework that represents a modified version of The Institute for Healthcare Improvement's Model for Improvement, and which have been approved by CMS. The EQRO provides technical assistance throughout the PIP process with frequent contact and feedback. In 2015, MCPs selected their first PIP topic, which was one of four DHCS pre-selected topics that align with the priority focus areas of timeliness of postpartum care, diabetes, hypertension, and childhood immunizations. Of the 23 full-scope MCPs that participated in the first round of PIPs, five selected the topic of improving childhood immunization rates, eight selected the topic of timely postpartum visit care, eight selected the topic of diabetes care, and two selected the topic of controlling high blood pressure. Of the three SHPs, one selected diabetes care, one selected controlling high blood pressure, and one selected a separate topic due to the preselected topics not being appropriate for the SHP's specialized population.

The second PIP topic was selected by the MCPs in January 2016. Under the guidance of DHCS and the EQRO, MCPs provided information supporting their choice of topic and were encouraged to select an area where they had a demonstrated need for improvement. Many of the MCPs chose another of the four DHCS pre-selected topics that align with the priority focus areas of timeliness of postpartum care, diabetes, hypertension and childhood immunizations, but others chose topics related to other areas in need of improvement such as cervical cancer screening, the medication management of people with asthma, and increasing developmental

screenings in children. These first two PIPs concluded in June 2017. Results of the PIPs will be included in the 2017-2018 annual EQRO Technical Report.

Currently, MCPs are in the process of selecting new PIP topics for 2017-2018. DHCS has required that each MCP participate in a PIP focused on a statistically significant health disparity (e.g., race, ethnicity, language spoken, gender, geographical location, provider, etc.) for their first PIP topic. The health disparity identified by the MCP may be related or unrelated to any of the current EAS metrics, but each MCP or SHP is encouraged to choose a health disparity related to an EAS metric on which the MCP or SHP is not performing well, when possible. For their second PIP topic, MCPs must follow the following algorithm:

a) Childhood Immunizations (CIS-3) is a required topic for those MCPs that performed below the MPL, or below the statewide Medi-Cal managed care average with declining performance on CIS-3 in RY 2017.

   If not required to choose CIS-3 as a topic based on the criteria in "a", the second PIP topic must focus on:

b) Controlling High Blood Pressure, Comprehensive Diabetes Care, or Prenatal and Postpartum Care for those MCPs that performed below the MPL on any of these measures in RY 2017. If an MCP is performing below the MPL for more than one of these measures, the MCP should choose the measure for which it has performed below the MPL for consecutive years or a measure for which the MCP's performance has been significantly declining for consecutive years.

   OR

c) If an MCP performed above the MPL and Medi-Cal managed care average for CIS-3, and above the MPLs for Controlling High Blood Pressure, Comprehensive Diabetes Care, and Postpartum Care in RY 2017, the MCP may choose a PIP topic for any area in need of improvement.

Once DHCS and HSAG have approved the MCPs' new PIP topics for 2017-2018, the MCPs will begin work on those topics.

3. Corrective Action Plans

DHCS updated the Quality of Care Corrective Action Plan (CAP) process in September 2015 and shared the process with MCPs. A CAP is triggered if an MCP meets any of the following criteria:

1) Three or more of the same EAS indicators for which MCPs are held to the MPL, are below the MPL in the same reporting unit for the last three or more consecutive years; or
2) More than 50% of the total number of EAS indicators for which MCPs are held to the

MPL, for any reporting unit, are below the MPL in the most recent measurement year; or

3) DHCS determines that the imposition of a CAP is necessary because the MCP is out of compliance with EAS requirements as set forth in its DHCS/MCP contract and/or the most recent DHCS Quality Improvement All Plan Letter (APL), or DHCS identifies a serious quality improvement trend or issue that needs to corrected with the MCP.

DHCS reserves the right to impose sanctions for MCPs under a CAP that do not meet established milestones, which may include financial penalties.

In September 2014, DHCS re-initiated a CAP with one of its lowest performing MCPs due to persistent substandard performance across many of its counties of operation. This CAP is effective through 2017 and, on a quarterly basis, the MCP submits status updates to DHCS for review. This MCP has continued to achieve all DHCS required CAP milestones and has seen improvement in quality performance.

In September 2015, DHCS initiated new CAPs with three additional MCPs, two due to persistent substandard performance across three or more indicators for three or more years in the same reporting unit, and one to address encounter data collection and reporting difficulties experienced by MCPs. These CAPs are effective through 2020. The MCP with the CAP related to encounter data successfully met its milestones and its CAP was closed in November 2016. DHCS continues to meet with the other two MCPs on a quarterly basis for status updates, and DHCS nurse consultants and EQRO staff continue to meet telephonically with the MCPs on a monthly basis to provide technical assistance on QIPs. Both MCPs continue to see improvement in quality performance.

In August 2016, DHCS initiated a new CAP with one additional MCP for persistent substandard performance across three or more indicators for three or more years in the same reporting unit. That MCP has also seen improvement in performance from MY 2015 to MY 2016. No new quality CAPs were triggered based on MY 2016 performance results.

In 2016, DHCS initiated a new policy of issuing Advance Warning Letters to MCPs that do not meet CAP criteria for the current reporting year, but who, based on the CAP triggers outlined above, are at risk of triggering a CAP in the next reporting year. For MCPs with three or more indicators below the MPL for two years in a row in the same reporting unit, or for MCPs with 40 percent or more of all EAS indicators below the MPL in the same reporting unit, or for MCPs where DHCS identifies a concerning quality improvement trend or issue that needs to be addressed with the MCP, DHCS will issue an Advance Warning Letter notifying the MCP of the potential CAP and the DHCS CAP triggers. The letter requires the MCP leadership staff to have a meeting with DHCS executive leadership staff to discuss the implications of the letter

and the MCP's plan to improve for the following year. DHCS sent Advance Warning Letters to two MCPs in August of 2016 and will send letters to five MCPs in 2017.

4. Public Reporting of Performance Results

DHCS publically reports audited performance results for each MCP on its website and in frequent presentations to stakeholders. DHCS continues to report MCP performance results on the Medi-Cal Managed Care Performance Dashboard (Dashboard). This Dashboard displays data pertaining to enrollment and demographics, financial strength of care plans, health care service utilization, grievances, and State Fair Hearings, Continuity of Care and Medical Exemption Requests, and MCP HEDIS® and CAHPS® rates. The Dashboard is continuing to evolve based on the program needs and input from MCPs and stakeholders.

DHCS has also taken other steps to increase public reporting of data. In March 2015, DHCS joined the California Health and Human Services (CHHS) Open Data Portal, which facilitates public access to non-confidential health and human services data. The goal is to make publishable state data open and freely available in accessible formats for the public to reuse and redistribute. DHCS is dedicated in publishing high quality data with comprehensive metadata and documentation to foster interoperability and maximize public understanding of the data. DHCS has provided unprecedented user-friendly access to publicly available data on Medi-Cal and other DHCS programs and continues to add data on a quarterly basis.

5. Monitoring Network Adequacy

DHCS monitors and analyzes network adequacy data on a quarterly basis. The data is categorized into areas such as geographic access to Primary Care Providers (PCP's) and specialists, out-of-network requests/referrals/denials, provider ratio, provider capacity, physical accessibility, access related grievances, and areas of quality concern. DHCS dialogues with the MCPs to ensure that all identified network concerns are appropriately addressed and corrected. If findings in a particular area continue to occur and remain unresolved, DHCS may impose a CAP.

In 2016, DHCS began work on the Access Assessment Project, authorized under the Medi-Cal 2020 waiver section 1115a Medicaid demonstration, which requires DHCS to conduct an Access Assessment to evaluate primary, core specialty and facility access to care for Medi-Cal managed care beneficiaries based on requirements set forth in the Knox Keene Health Plan Service Act of 1975 and DHCS and MCP contracts as applicable. The Assessment will consider State Fair Hearing and Independent Medical Review decisions, and grievance and appeals/complaints data. DHCS has amended its contract with its EQRO to conduct the Assessment. As a part of the Assessment process, DHCS selected 18 committee members in

2016 to participate in an advisory committee tasked with providing feedback on the overall design and final report. The Access Assessment Advisory Committee (AAAC) has met on three separate occasions to review and offer suggestions on the continued development of the Access design. In 2018, the AAAC will meet initially to review the assessment results and then meet a second time to review the final report and recommendations.

6. Consumer Assessment of Healthcare Providers and Systems

DHCS has been using the results of the tobacco questions from the 2013 Adult CAHPS® survey to inform tobacco cessation interventions and monitoring, and will continue to do so with the results of the 2016 Adult CAHPS® survey. DHCS also uses the CAHPS® surveys to assess beneficiary experience of care, and publishes results in the Consumer Guide to help inform beneficiaries' decisions on choosing an MCP. Recently, CMS conducted its first-ever nationwide adult Medicaid (NAM) CAHPS survey. NAM CAHPS surveyed a representative sample of adult beneficiaries age 18 and older who were not residing in an institutional setting and were continuously enrolled in Medicaid from October 2013 through December 2013, prior to the state Medicaid expansions that occurred on or after Jan 1, 2014. The NAM CAHPS is a CAHPS-like survey built on the CAHPS health plan survey, with additional questions added. The goal of the survey was to obtain national and state estimates of adult Medicaid beneficiaries' experience of care, including access to and utilization of services, across different financing and delivery models and population groups. DHCS will use these results, as it does with its own CAHPS surveys, to inform tobacco cessation interventions, as well as to improve upon beneficiary experience of care.

C. Quality and Appropriateness of Care

1. Enrollee Race, Ethnicity, and Primary Language Data

DHCS contracts with an enrollment broker to enroll beneficiaries into an MCP. The DHCS enrollment broker uses Medi-Cal Eligibility Data System information to generate and send enrollment packets to newly eligible Medi-Cal beneficiaries in Two-Plan Model, Regional, Imperial, San Benito, and GMC model counties. Self-reported race, ethnicity, and language information for each new beneficiary is transmitted to the appropriate MCP based on MCP enrollment files, as required by 42 CFR §438.204(b)(2). DHCS has identified 12 threshold languages, including English, based on the Medi-Cal population with mandatory aid codes in each county. DHCS uses the threshold language data to determine which languages to translate enrollment and informing materials into for each county Interpreters must be available to interpret conversations between Medi-Cal enrollees/beneficiaries and enrollment customer service representatives. In addition, MCPs must use the threshold language criteria to determine the languages into which informing materials must be translated. MCPs must

also arrange for appropriate cultural and linguistic support to limited English proficient beneficiaries, including interpreter services in provider offices.

2. External Quality Review

The most recent EQRO recommendations for DHCS (from the 2015-16 EQRO Technical Report) are listed below, along with DHCS responses:

1) ***EQRO recommendation:*** Consider adding strategies related to ensuring that female beneficiaries ages 21 to 64 are screened for cervical cancer in the appropriate time frames.

   DHCS response: DHCS continues to work with MCPs that are doing PDSAs on cervical cancer screening (CCS) through technical assistance teleconferences. DHCS has also started sharing promising quality improvement practices with the MCPs via one page snapshots of EAS indicators highlighting PDSA or PIP projects; the first highlight released in early 2017 was on CCS.

2) ***EQRO recommendation:*** Consider adding improvement strategies not already included in the MCMC quality strategy and related to the following measures for which MCPs showed statistically significant declining performance from RY 2015 to RY 2016:

   - Prenatal and Postpartum Care—Timeliness of Prenatal Care
   - Use of Imaging Studies for Low Back Pain
   - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W-34)

   DHCS response: DHCS will consider the addition of new quality strategy focus areas when it next re-evaluates the quality strategy in 2018.

3) ***EQRO recommendation:*** Evaluate annually the focus of and need for the collaborative discussions based on any changes in DHCS-priority focus areas, MCPs' and SHPs' feedback, and MCP/SHP performance measure results.

   DHCS response: DHCS continues to obtain feedback from the MCPs after each collaborative discussion, and is currently re-evaluating the topics for the 2017-2018 collaboratives with the advent of the new PIP topics. DHCS will continue to solicit MCP feedback in this process. DHCS is also in the process of analyzing the MCP and SHP feedback obtained from a survey that the MCPs/SHPs completed for Quality Improvement.

4) **EQRO *Recommendation:*** Using the skills and lessons learned from HSAG's on-site technical assistance, develop a plan for spreading and expanding the use of quality

improvement science tools and techniques to other existing DHCS projects, future DHCS projects, and new DHCS staff orientation sessions.

DHCS response: DHCS continues to utilize the skills and lessons learned from HSAG's on-site technical Assistance as it works with MCPs as well as refines its own internal processes.

SECTION 3: IMPROVEMENT and INTERVENTIONS

A. DHCS Initiatives and Interventions to Improve Quality of Care

1. DHCS Initiatives to Improve the Quality of Care

This section describes initiatives to improve the quality of health care services provided to MCP beneficiaries in the following areas:

- Maternal and child health (postpartum care, immunizations)
- Chronic disease management (diabetes care, control of hypertension)
- Prevention (tobacco cessation)
- Reducing Health Disparities
- Fostering Healthy Communities through Reducing Opioid Misuse and Overuse

These initiatives respond to important gaps in care that have large consequences on individual and population health, as well as on the Medi-Cal budget. These areas are a subset of all the health needs of MCP beneficiaries. Focusing on these five areas for the next three years should strengthen organizational structures and capacity to enable DHCS and its contracted MCPs to make improvements in the overall quality of health care services.

In Table 3-1, the health interventions for the three measure linked areas are listed in descending order by the estimated number of beneficiaries impacted.

Table 3-1. Estimated Impact of MCP Performance: Beneficiaries Documented to have Received Appropriate Care ("Served") vs. Not "Served," MY 2016 (RY 2017)

Performance Measure	Growth in Number of Beneficiaries Impacted from MY2015 to MY 2016	Number of Beneficiaries Impacted MY 2016	Percentage of Beneficiaries "served"	Number of Beneficiaries Not Documented to Receive Appropriate Care
Controlling High Blood Pressure	52,859 more adults with hypertension (HTN)	460,770 adults with HTN	63% with controlled HTN	171.961 HTN patients with blood pressure not controlled
Diabetes Care: HbA1c testing	44,339 more adults with diabetes	394,840 adults with diabetes	86.82% tested in past year	52,049 diabetes patients with no HbA1c test results
Diabetes Care: Blood Glucose	44,339 more adults with diabetes	394,840 adults with diabetes	62.25% whose last HbA1c was ≤9%**	149,066 diabetes patients whose HbA1c was >9% (not controlled) or unknown
Immunization Coverage	3,061 fewer two-year-olds	188,672 two-year-olds	71% up-to date on immunizations	55,282 two-year-olds incompletely immunized
Postpartum Care	3,724 more woman who gave birth	118,283 women who gave birth	64% had timely postpartum visit**	42,850 mothers without a timely postpartum visit
Tobacco Cessation^: Advised to quit	493,000 more adults who smoke*	906,000 adults who smoke	65.4% recalled being counseled to quit	317,000 smokers not recalling being counseled to quit
Tobacco Cessation^: Discussed medication to quit	493,000 more adults who smoke*	906,000 adults who smoke	38.3% recalled discussing cessation medications	562,000 smokers not recalling discussing medication to quit

* Growth in number of beneficiaries between MY 2013 and MY 2015, as the CAHPS® Survey is run only every three years.

** This table uses the inverse of the HEDIS® CDC-H9 rate (i.e., 1 minus .37.75). To qualify for the numerator for this rate, a beneficiary would either have a HbA1c test value greater than nine or a test value unknown.

^ No change in this data as the CAHPS® survey is conducted every three years, most recently

in 2016.

Note: numbers rounded to nearest 1,000.

Note: For the Tobacco Cessation (advised to quit) row, percentages are based on the respondent numbers for the 2016 CAHPS® survey. Impacted population is estimated by applying the percentages to the total adult sample frame for the 2016 CAHPS® Survey. For the remainder of the rows: proportions are statewide weighted averages derived from the rates MCPs submit to NCQA. The source for column two is the total population eligible for the HEDIS® rate calculation, as reported by MCPs to NCQA. These are minimum estimates, since NCQA specifications exclude certain patients (such as those not continuously enrolled in the MCP for 12 months).

The populations served and not served both continued to grow, though not as significantly as in recent years. In fact, 3,000 fewer children required immunizations in MY 2016 as compared to MY 2015. The growth in membership through the expansion of Medi-Cal can be seen most in adult beneficiaries with chronic diseases such as diabetes or hypertension. DHCS saw improvement in a number of key areas in MY 2016. The Medi-Cal statewide average for Controlling High Blood Pressure, Diabetes HbA1c testing, Diabetes HbA1c >9, and Postpartum Care have all improved from MY 2015 to 2016; the improvement is quite dramatic for postpartum care with a statistically significant increase of 5 percentage points between MY 2015 and MY 2016 in the provision of timely postpartum care. The statewide weighted average for Controlling High Blood Pressure and Diabetes HbA1c >9 increased by 2 percentage points each between MY 2015 and MY 2016, both of which were statistically significant increases. Additionally, the statewide weighted average for Diabetes HbA1c testing increased by 1 percentage points between MY 2015 and MY 2016.

DHCS has struggled with the childhood immunization rate for several years; between MY 2012 and MY 2015, the Medi-Cal statewide weighted average for immunizations of two-year-olds declined from 77 percent to 71 percent. In MY 2016, the statewide weighted average for immunization of two-year-olds remained the same at 71 percent. While this does not represent improvement, DHCS is encouraged by the lack of further decline and hopes that next year will demonstrate an actual increase in the rate. DHCS implemented or plans to implement the following interventions to address the causes of poor performance and to reach or surpass improvement objectives for MY 2015 and MY 2016 that are listed in Section 1 of this report.

2. DHCS Interventions from State Fiscal Year (SFY) 2015–16 and SFY 2016–17

DHCS employed numerous interventions from SFY 2015-16 and SFY 2016-17:

a) Intensify engagement with targeted MCPs.

DHCS has worked to understand and address the causes of lower performance, current MCP activities, successes and challenges, lessons learned, and technical assistance needs. For each indicator, DHCS focused on:

- MCPs with the largest numbers of beneficiaries not served (where interventions are needed to raise the statewide weighted average).
- MCPs with substandard performance (to ensure minimum quality of care in all counties) and the use of rapid cycle Quality Improvement methods.
- MCPs with the largest number of beneficiaries in underserved race-ethnic groups (to address health inequities).

b) Convene Statewide Quality Improvement Collaboratives.

In 2016, DHCS and its EQRO worked together to modify and launch four quarterly quality improvement collaborative discussions based on the four measures linked to DHCS quality strategy focus areas: postpartum care, immunizations of two-year-olds, hypertension and diabetes. These four quarterly collaborative discussions built on the prior year's collaboratives and met throughout 2016 and 2017.

The quarterly collaborative discussions, which involve MCP quality improvement and health education staff, DHCS staff, and EQRO staff, provide a forum for MCPs to identify and resolve barriers, receive and provide technical assistance, and hear from one another on PIPs focused on the four collaborative discussion topics. MCPs are asked to share their quality improvement experiences and expertise as it relates to their PDSA improvement projects and PIPs. MCPs that have a PIP and/or CAP in the corresponding collaborative discussion topic must participate in that collaborative discussion. However, all MCPs are encouraged to participate in each collaborative discussion and participation at each collaborative to date has included nearly every MCP. At each collaborative discussion DHCS shares updates regarding ongoing and potential future collaborations with external partners, as well as other relevant information. This, and the MCP presentations and discussion that occur during the meeting, are then shared with all the MCPs in the form of minutes, further increasing the sharing of best practices. With the start of new PIP topics in 2017, DHCS will be continuing the collaborative discussions; however, the topic content of the collaboratives may change to better suit the new PIP topics. DHCS has found the collaboratives to be a great opportunity to share evidence based strategies and best practices and to support statewide improvement, and improvements have been seen in each of these areas based on the statewide Medi-Cal weighted average for key quality indicators in these areas.

c) Optimize provider education, feedback, incentives for quality improvement.

DHCS continues to work to define strategies used by the most successful MCPs to engage their provider groups for performance feedback and peer comparison, patient registries and population management, care management and patient outreach in order for DHCS to establish and implement standards of practice.

DHCS has continued to work with Integrated Healthcare Association (IHA) to identify successful elements and means to scale them up from its survey of MCP Pay-for-Performance programs and Medi-Cal MCP Pilot project (and Web Reporting Platform). The IHA is a non-profit comprised of diverse stakeholders, including physician organizations, hospitals and health systems, health plans, purchasers and consumers committed to high-value integrated care that improves quality and affordability for patients and has been working on a value based Pay-for-Performance program in California for many years.

DHCS has continued to meet with IHA to learn from their survey of MCP Pay-for- Performance programs and their Medi-Cal MCP Pilot project (and Web Reporting Platform). IHA continues to work on a statewide Pay-for-Performance program that aligns with the DHCS EAS as well as Covered California, in order to reduce the quality metric reporting burden on providers. DHCS continues to be a part of those discussions with IHA. DHCS continues to gather evidence based strategies and best practices from MCPs with successful Pay-for-Performance programs and successful provider report card programs.

d) Optimize beneficiary engagement.

DHCS continues to assess barriers to beneficiary engagement and determine that can most effectively be addressed by MCPs.

This is an ongoing topic during all the Quality Improvement collaborative discussions. DHCS continues to support MCPs learning from each other about barriers that have the greatest effect and thus the highest opportunity for impact. The National Governor's Association grant, which DHCS was awarded in 2015 is an example of this. DHCS, CDPH, the Sacramento County Public Health Department and three MCPs in Sacramento County worked together to improve childhood immunization rates through a joint PDSA project. The MCPs targeted high volume provider groups that they all contract with and shared beneficiary engagement strategies, such as countering cultural barriers to parents obtaining immunizations for their children. The grant ended in 2016; however, the three MCPs involved in the project have indicated a desire to continue working with one another on childhood immunization rates in Sacramento because they found the collaboration useful. One of the MCPs demonstrated increases in their CIS-3 rates that they attribute directly to the collaborative grant work. DHCS hopes that the success of this MCP collaborative leads to other such opportunities amongst the MCPs.

DHCS continues to monitor MCP beneficiary education, outreach, and incentives programs.

DHCS has determined that the majority of MCPs use beneficiary or member incentive programs to encourage healthy behaviors, such as screening for cervical cancer, establishing healthy eating habits or exercising, and obtaining prenatal and/or postpartum care. Providing gift cards to members with diabetes who complete their HbA1c testing is an example of how member incentives are used. Some member incentive programs are ongoing, allowing the MCP to track the impact of the program over time. In the first seven months of 2017, five MCPs started new diabetes incentive programs, three started new immunization incentive programs, and seven started new prenatal and/or postpartum care incentive programs. MCPs have member incentive programs on a myriad of topics, including chronic disease management, well-child care, immunizations, and cervical cancer screening. Including new and ongoing member incentive programs, currently eight MCPs have programs for cervical cancer screening, well-child care, immunizations, postpartum care, and completing the HbA1c test. Seven MCPs have a member incentive program for diabetes disease management, and six MCPs have programs for prenatal care and hypertension. DHCS continues to monitor and approve member incentive programs developed by the MCPs. DCHS updated the beneficiary or member incentive program process for MCPs, and now reviews and monitors MCP use of incentives for focus groups and beneficiary surveys.

MCPs have conducted focus groups and surveys on access to care, immunization, behavioral healthcare satisfaction, postpartum care, and dental services. MCPs are able to gather information directly from beneficiaries through focus groups and surveys, and then use this information to develop strategies to improve quality of care.

e) Share evidence-based strategies and promising practices.

DHCS continues to explore avenues to increase opportunities to share evidence based strategies and best practices among MCPs. In addition to Quality Improvement collaborative discussions, Medical Director Meetings, and Health Education and Cultural and Linguistic Workgroup meetings, DHCS instituted a new avenue to share evidence based strategies and best practices in 2015 and 2016. DHCS gives Quality Awards to high performing MCPs and MCPs that show the greatest improvement in performance. In 2015, DHCS instituted a new Quality Award for Innovation. This award is given to the MCP with the most innovative project or pilot project aimed at improving quality of care. MCPs submit nominations to DHCS and then DHCS and the MCPs vote on the nominations to select the winner. The nomination and voting process for the award provides an opportunity for MCPs to share evidence based strategies and best practices. DHCS complies a booklet with a description of each nominated project, as well as the winner. The booklet provides another opportunity for MCPs to review both the program that won as well as all programs that were nominated. In 2017, DHCS

received 18 nominations for the Innovation Award from 12 MCPs. The winner of the award, based on voting by the MCPs and DHCS, was Inland Empire Health Plan with a Behavioral Health Integration & Complex Care Initiative (BHICCI). The BHICCI aims to engage provider teams to test and implement fundamental practice changes in order to develop an array of "health homes" and integrated complex care management teams within local health organizations. Through the BHICCI, IEHP provides funding to 12 healthcare organizations with 30 participating clinics to develop integrated, multidisciplinary care teams to care for the most complex patients served by these primary care, behavioral health, and specialty clinics. The complex care team manages and cares for a caseload of people with complex needs including co-occurring chronic medical, mental health, and/or substance use conditions, who also may be frequent utilizers of emergency room or inpatient services.

A runner up award was given to Kern Health Systems for a Medical Respite: Rest and Recovery Program. Medical respite is short-term post-acute medical and residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. Kern Health Systems supported an eight bed Medical Respite Program for individuals who are homeless or lack a physical address at the time of discharge from an acute care, inpatient facility. Like other transition of care services, safe and thorough discharge arrangements can assist in preventing readmissions. Intensive case management services are provided to these members during their stay, including all follow up medical, dental, behavioral health and social service appointments. Kern estimates that the Rest & Recovery program will serve up to 365 individuals annually.

In 2017, DHCS developed another avenue by which to share promising practices. DHCS released its first three EAS Highlights, one page snapshots of EAS indicators highlighting promising practices from MCP PDSA or PIP projects in an effort to promote the sharing of better practices by the MCPs. The Highlights also include external resources pertinent to the particular indicators in the Highlight. The first two highlights focused on cervical cancer screening and childhood immunizations. The fourth highlight will be released in the winter of 2017.

DHCS and its EQRO hosted a day long quality conference in October 2017 entitled, "Building Excellence in Quality Improvement: Leadership, Culture, Competence." The conference involved both MCP presentations as well as EQRO didactic presentations focused on promoting a culture of quality throughout the MCP organization.

DHCS continues to engage key MCPs to institutionalize Text4baby enrollment for perinatal beneficiaries. Several MCPs have developed collaborations with CDPH's Black Infant Health (BIH) Program, which aims to improve the health of African American mothers and infants and to reduce disparities by empowering pregnant and mothering African American women to

make healthy choices. One MCP makes weekly referrals to the BIH, while simultaneously notifying its beneficiaries that are eligible for the program; the MCP averaged 20 referrals per week between September 2016 and February 2017. Another MCP attends their local BIH program's quarterly 'baby showers' to educate eligible beneficiaries about the MCP's services and benefits, and in particular, about the Postpartum Incentive Program for beneficiaries. A third MCP is coordinating a home visitation program for the postpartum visit, collaborating with BIH and another local agency. DHCS continues to engage key MCPs to collaborate with BIH the BIH program to improve timely postpartum visit rates. As well as identify evidence-based strategies and best practices within MCP networks for timely notifications of pregnancies and deliveries.

DHCS continues to support efforts for MCPs to increase timely notifications of pregnancies and deliveries, and has utilized the Postpartum Quality Improvement Collaborative to further these discussions. In 2016 DHCS added a second pregnancy data field (the first field specifying if the beneficiary is pregnant) on the daily and monthly enrollment file that is shared by DHCS with the MCPs, which will help the MCPs to identify pregnant beneficiaries. This data field contains the Expected Delivery Date.

One MCP has developed a software program with a supplemental data file that contains identifying information from various data sources such as claims for prenatal vitamins, laboratory test results such as pregnancy tests, in-patient admission requests for a pregnancy/delivery, and faxed pregnancy notification forms and postpartum assessment forms submitted by the provider. The MCP staff often will perform chart abstraction based on these data feeds to gather additional information, including beneficiary contact information. Other MCPs have noted success with Notification of Pregnancy forms submitted by providers.

f) Improve and analyze encounter data to drive program improvement.

DHCS elicited MCP input on data that would be most actionable for their quality improvement efforts. DHCS has determined that timely birth data would enable MCPs to take better action in improving postpartum visit rates. DHCS is continuing to explore avenues to support MCPs efforts to improve timeliness of birth data and recently added a new field to the monthly eligibility file, which provides the estimated date of delivery for identified pregnant beneficiaries.

Additionally, MCPs have identified the need for more timely data regarding services provided to beneficiaries outside of the MCP to ensure successful care coordination efforts and integration of services. DHCS has been providing several types of data to MCPs, including, but not limited to, SPD and CCI historical claims and CCI Medicare Parts A, B, and D claims. In October 2015, DHCS added to that list by providing data on carved out medications that are covered outside of the MCPs, such as anti-psychotic medications, substance use disorder

treatment medications, and medications to treat Human Immunodeficiency Virus. Recently, DHCS further expanded its data sharing efforts to include four new data types, including outpatient specialty mental health, California Children's Services, MCP encounter data, and fee-for-service claims Reports for these services are now being provided to the MCPs on a monthly basis. The reports provide information for the previous 12 months to ensure data is as timely as possible while still providing opportunity to ensure data completeness over time due to expected data lags. MCPs have identified these new reports as a necessary resource to improve the quality of care beneficiaries receive, particularly the coordination of that care.

DHCS has taken steps to evaluate the utilization of encounter data to calculate additional quality indicators. DHCS will continue to determine which measures could be calculated internally using encounter data related to the CMS Core Child and Adult quality measures.

DHCS plans to utilize Focused Studies completed by the EQRO to determine if the methodology used for such measures is valid and if the degree of completeness and accuracy of data is such that DHCS can publicly report such measures with confidence. DHCS is currently reviewing such a focused study on developmental screening to ascertain whether or not the *Developmental Screening in the First Three Years of Life* measure can be accurately reported via encounter data.

DHCS continues the Encounter Data Improvement Project, and is identifying other means to support MCPs to improve data collection and use. DHCS continues to investigate discrepancies in denominators from encounter data compared to other data sources such as the audited, aggregate data MCPs report to NCQA.

g) Measure, report and use MCP performance.

DHCS continues to work towards prompt public reporting. DHCS instituted new guidelines regarding the safe release of data to ensure that beneficiary identification is protected. These new guidelines led to some delays in public reports during 2015. However, as this process continues to be utilized and improved, DHCS will work to ensure delays do not occur.

DHCS continues to present information to stakeholders through a number of venues. In addition to the Dashboard and reports published online, DHCS presents information to the Medi-Cal Managed Care Advisory Group and other large stakeholder meetings.

DHCS continues to inform beneficiaries' choice of MCPs via the Consumer Guide rankings, developed by the Office of Public Advocate.

DHCS continues to include six EAS measures in the auto-assignment algorithm (*Controlling Blood Pressure*, *Cervical Cancer Screening*, *Childhood Immunization Status*, *Timeliness of*

Prenatal Care, *W-34*, *and Comprehensive Diabetes Care*: *HbA1c Testing*), where MCPs with higher performance than other(s) operating in the same county are rewarded by receiving new beneficiaries who do not actively choose to enroll in a particular MCP. This helps to ensure that MCPs with higher quality performance on key areas are rewarded.

DHCS continues to monitor tobacco cessation indicators. An APL, as a follow-up to Policy Letter 14-006, was released in November 2016. APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, provided additional guidance for MCPs and providers on existing provisions, and added two additional provisions regarding the identification of tobacco users and the tracking of treatment utilization activities for tobacco users.

In June 2017, a follow-up survey from October 2015 was sent to the MCPs to gauge their tobacco cessation implementation efforts. Survey results were variable, indicating improvements in some areas such as promotion of tobacco cessation to providers by MCPs, while other areas such as the MCPs' ability to determine if providers were asking beneficiaries about tobacco usage needed improvement. This survey will help to identify best practices in tobacco cessation promotion as well as how to better assist the MCPs with their efforts.

h) Collaborate with CDPH.

DHCS has promoted partnerships between MCPs with local Maternal, Adolescent and Child Health (MCAH) programs. This has included providing a crosswalk for MCPs to access services and provider training from local MCAH programs through the Postpartum Quality Improvement Collaborative. The MCAH programs have agreed to partner with MCPs and county Comprehensive Perinatal Services Program (CPSP) coordinators to build relationships between the coordinators and the MCPs.

DHCS also continues to meet with staff from CDPH's Coordinated Chronic Disease Branch and to share relevant information with the MCPs at the Hypertension and Diabetes Quality Improvement Collaboratives.

DHCS continues to collaborate with CDPH on immunization efforts. While the NGA grant discussed earlier in this report has concluded, DHCS continues to work with the MCPs and CDPH to find ways to increase provider enrollment and utilization of CAIR. CDPH has agreed to run reports for MCPs of their network provider sites to determine if the sites are enrolled and utilizing the registry. MCPs can then use this information to target provider groups not utilizing the registry to provide education and technical assistance. Further, DHCS and CDPH are also collaborating on the newly modified Immunizations for Adolescents quality metric on the EAS, which now includes human papilloma virus (HPV) vaccination for both girls and boys. Finally, in 2016 DHCS added immunizations for adults as a pharmacy benefit. Both DHCS and CDPH

have worked together to promote this benefit to the MCPs and beneficiaries thereby increasing access for medically necessary vaccines (APL 16-009: Adult Immunizations as a Pharmacy Benefit).

Each subsection below describes the importance of the health problem to MCP beneficiaries, the scope, and nature of the performance gap, and its causes. These analyses provided the basis for selection of the interventions listed above as continued priority areas for improvement.

B. DHCS Managed Care Focus Areas

1. Postpartum Care

Timely postpartum visits are important for support of breastfeeding, screening for postpartum depression; follow up of conditions such as diabetes and hypertension, and family planning. The postpartum visit is a critical window for preconception health counseling and reproductive life planning to achieve optimal birth spacing and improve future pregnancy-related outcomes. DHCS contracts require MCPs to implement a comprehensive risk assessment tool comparable to American Congress of Obstetricians and Gynecologists and CPSP standards, administered at key pregnancy milestones including the postpartum visit.[16] Postpartum care is measured by the percentage of women with live births who had timely postpartum care. The NCQA defines a timely postpartum visit as a visit to an obstetrics and gynecology practitioner or midwife, family practitioner or other primary care provider on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts, and abdomen.
- Notation of postpartum care.

NCQA specifies that the eligible population for this measure is women continuously enrolled in a plan from 43 days prior through 56 days after delivery.[17]

***MCP performance: audited, aggregate reporting*.** In MY 2016, the Medi-Cal Managed Care weighted average, a rate which is validated by the EQRO, increased to 64 percent, which is above the 25th percentile for Medicaid. This represents great improvement as compared to

[16] CA Department of Healthcare Services. Medi-Cal Managed Care Boilerplate Contracts
[17] NCQA guidelines do not specify whether continuous enrollment refers to continuous enrollment in a Managed Care
Plan, or continuous enrollment in Medicaid. For all data presented in this report, "continuous enrollment" refers to continuous enrollment in a single Managed Care plan.

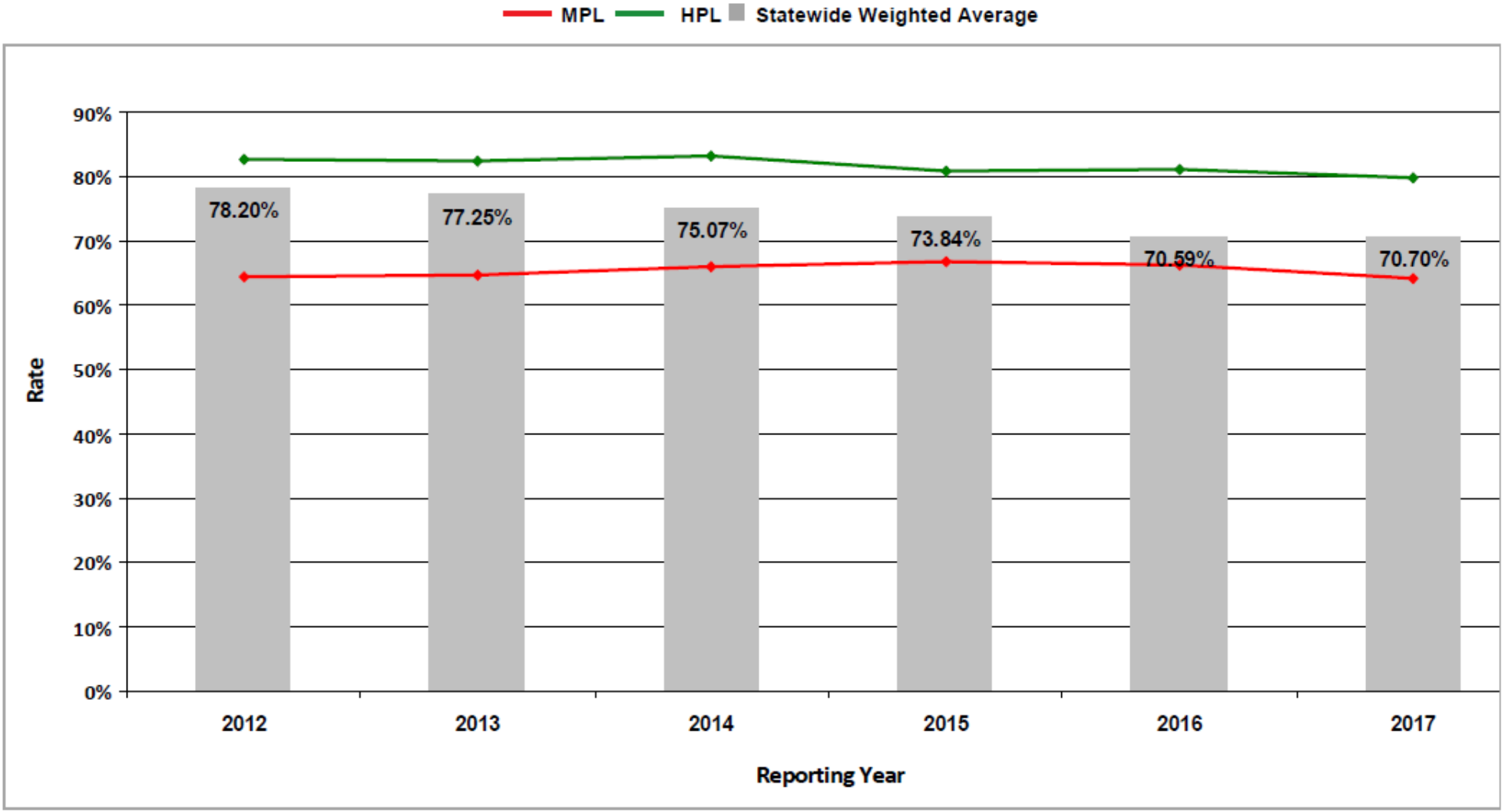
MY 2015, but DHCS wants to continue this increase so that all eligible women receive timely postpartum care.

2. Immunization Status of Two-Year-Olds

In MY 2015, immunization coverage of 192,000 two-year-old MCP beneficiaries fell for a fourth consecutive year to 71 percent. This means 56,000 two-year-olds lacked one or more recommended immunizations, which leaves them vulnerable to measles, pertussis, and other vaccine-preventable diseases that have been increasing in California in recent years.

In MY 2016, immunization coverage of 189,000 two-year-old MCP beneficiaries remained unchanged (Figure 3-2 below) at 71 percent, leaving 55,000 two-year-olds with incomplete immunizations. Variation among MCP performance remained high. In MY 2015, two MCPs exceeded the HPL; in MY 2016, four MCPs exceeded the HPL by immunizing at least 80 percent of their two-year-old beneficiaries. In MY 2015 18 reporting units (operated by eight MCPs) fell below the minimum performance level; in MY 2016, ten reporting units (operated by five MCPs) were below the MPL of 64 percent. See Figure 3-2. Proportion of two-year olds up-to-date on Immunizations below:

Figure 3.2. Childhood Immunizations Status – Combination 3
Medi-Cal Managed Care Statewide Weighted Average, MYs 2011-2016 (RY 2012-2017)



3. Controlling High Blood Pressure

In 2010, heart disease and stroke were the first and third leading causes of death among Californians, respectively, accounting for 24.9 percent and 5.8 percent of deaths.[18] In MY 2015, there were 408,000 MCP beneficiaries identified with hypertension, and more than half of the MCP beneficiaries diagnosed with hypertension were represented by four MCPs. In MY 2016, the number of beneficiaries identified with hypertension grew to 461,000 and about half of the MCP beneficiaries diagnosed with hypertension were represented by four MCPs (Table 3). In MY 2016, MCPs reported controlling blood pressure in 63 percent of their beneficiaries with hypertension, representing an increase of 2 percentage points from MY 2015.

Table 3-1. Four MCPs Serve Approximately Half of Medi-Cal Managed Care Beneficiaries Diagnosed with Hypertension, MY 2015 (RY 2016)[19]

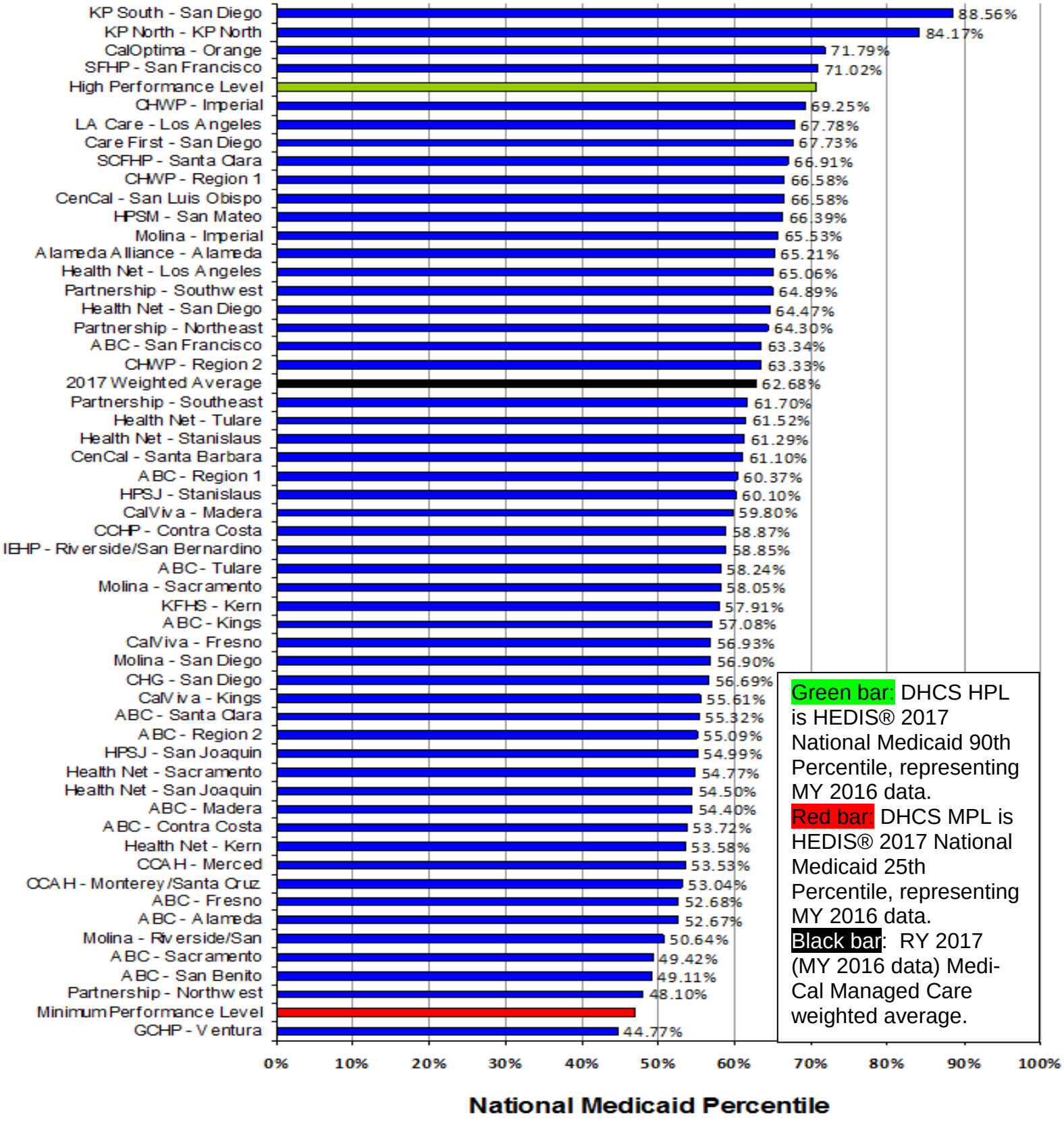
Medi-Cal Managed Care Beneficiaries with Hypertension According to MCP Audited Data (n =460,770)

MCP – Reporting Unit(s)	Number	Percentage
L. A. Care – Los Angeles	85,636	18.6%
Health Net – Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare	50,965	11.1%
Inland Empire – San Bernardino/Riverside	50,052	10.9%
Anthem Blue Cross Partnership Plan – Alameda, Contra Costa, Fresno, Kings, Madera, Region 1, Region 2, Sacramento, San Benito, San Francisco, Santa Clara, Tulare	33,777	7.0%
Sub-Total	220,430	44.5%

The *Controlling High Blood Pressure* measure is used to assess the percentage of beneficiaries 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the MY.

[18] CA Department of Public Health. "Thirteen Leading Causes of Death by Race/Ethnic Group and Sex, California 2010."
[19] 2014 HEDIS® Rates with Extra Data: Total Population validated EQRO.

Figure 3-3. Medi-Cal Managed Care Performance: *Controlling High Blood Pressure* by MCP Reporting Unit, MY 2016 (RY 2017)



4. Diabetes

One in seven adult Californians has diabetes.[20] The prevalence of diabetes increases with age. One out of every six adult Californians aged 65 and over has Type II diabetes. Diabetes rates are also higher among ethnic/racial minorities. Compared with non-Hispanic Whites, Hispanics, and African Americans have twice the prevalence of Type II diabetes and are twice as likely to die from their disease.[21]

Measurement of MCP performance. The HbA1c blood test is the standard biomarker for the adequacy of glycemic management; it reflects average blood glucose levels over the prior two to three months. The test plays a critical role in the management of people with diabetes, since high HbA1c predicts both microvascular and, to a lesser extent, macrovascular complications. Increasing rates of HbA1c testing among those with diabetes is key to better disease management and to improving outcomes.

MCP performance: audited, aggregate reporting. In MY 2015, 350,501 MCP beneficiaries met the HEDIS® specifications to comprise the denominator for the diabetes measures reported to NCQA. This is a minimum estimate of the number of adult MCP beneficiaries with diagnosed diabetes. That number rose to 394,840 MCP beneficiaries in MY 2016. Of these 394,840 beneficiaries with diabetes, 87percent were reported to have an HbA1c test in MY 2016, a 1 percentage point increase over the prior year.

In MY 2015, five MCPs (fifteen reporting units) tested only 73 percent – 83 percent of their diabetes patients' HbA1c levels, placing them in the national Medicaid 25th percentile: Anthem in four counties (Contra Costa, Sacramento, San Benito and Region 1); CalViva in two counties (Madera and Kings) Health Net in five counties (Kern, San Joaquin, Sacramento, San Diego and Stanislaus); Health Plan of San Joaquin in two counties (San Joaquin and Stanislaus) and Molina Healthcare in two counties (Imperial and Sacramento). In MY 2016, only three MCPs (in eight reporting units) fell below the national Medicaid 25th percentile or MPL: Anthem in four counties, Health Net in three counties and Health Plan of San Joaquin in one county.

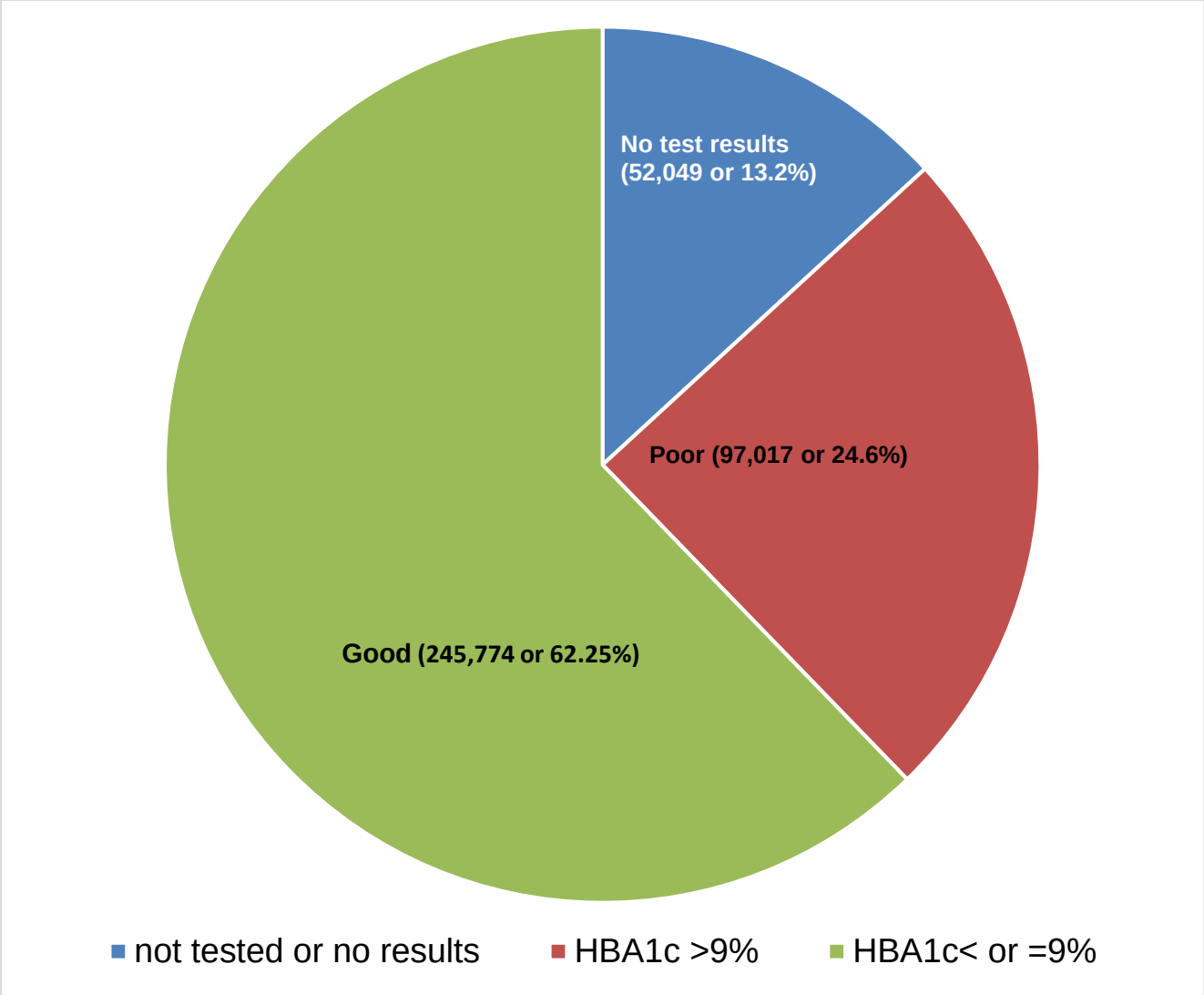
Once HbA1c test results are available, individuals with diabetes can be treated to maintain or improve blood glucose control. In MY 2016(Figure 3-4) the statewide Medi-Cal Managed Care weighted average for poor glycemic control improved to 38 percent (lower rate is better), but that still left 149,000 diabetic patients with either poor control or without documented poor control. (Note that the NCQA indicator called CDC-H9 is comprised of patients with HbA1c > 9

[20] California Diabetes Program. 2012 California Diabetes Program Fact Sheet, Technical Notes.pdf

[21] CA Department of Public Health, Chronic Control Branch, Burden of Diabetes in California, September 2014.

percent plus those who had no test result). These patients are at increased risk of blindness, lower extremity amputations, and renal failure.

Figure 3-4. Blood Glucose Control in MCP Beneficiaries with Diabetes MY 2016 (RY 2017)



Controlling high blood pressure in individuals with diabetes is critical to reducing the risk of heart attack and stroke. In MY 2015, 61 percent of MCP beneficiaries with diabetes had adequate blood pressure control. In MY 2016, this proportion increased to 63 percent, similar to MY 2014 rates. This means more than 1 in 3 beneficiaries with diabetes have uncontrolled blood pressure, which places them at high-risk for cardiovascular complications.

Other essential components of diabetes care are examinations for retinal (eye) and renal (kidney) disease. In MY 2014, only 53 percent of beneficiaries with diabetes were documented to have a retinal exam. This improved to 55 percent in MY 2015 and continued to improve in MY 2016 to 57 percent. The proportion of diabetes patients with an evaluation for kidney disease decreased by 1 percent from 91 percent in MY 2015 to 90 percent in MY 2016.

Barriers and challenges articulated by MCPs. The most common barriers to diabetes care identified by MCPs were poor data quality (such as missing laboratory reports), beneficiary lack of disease knowledge, difficulty adhering to medication or lifestyle changes, and lack of provider awareness or systems for tracking beneficiaries needing services.

5. Tobacco Use

Tobacco is the leading cause of preventable death in the U.S. Tobacco cessation services have been demonstrated to be clinically cost-effective,[22] with a return on investment of 3:1 for dollars spent on smoking cessation services in Medicaid populations.[23] In the 2013 Medi-Cal Managed Care Adult CAHPS® survey, a median of 18.2 percent of respondents reported current smoking (range of 10 percent to 27 percent among MCPs). In the 2016 Medi-Cal Managed Care Adult CAHPS® survey, 17.3 percent of respondents reported smoking currently, every day or some days. A median of 71 percent (range 58 percent to 80 percent) of smokers indicated they received advice from a health care provider to quit smoking in the 2013 CAHPS® survey, but only 65.4 percent of survey respondents indicated as such in the 2016 CAHPS® survey. The percentage of smokers who responded that their provider discussed cessation medications was 38.3 percent in 2016 as compared to a median of 40 percent in 2013. The percentage of smokers who responded that their provider discussed cessation methods and strategies was 35.1 percent in 2016 as compared to a median of 37 percent in 2013.[24]

6. Reducing Health Disparities

The *Let's Get Healthy California Task Force Final Report* (LGHCTF)[25] noted that racial and ethnic disparities continue to widen across many health outcomes. The report makes clear that eliminating health disparities is an over-arching goal and that health equity is vital to achieving improvements in health. In prior reports, DHCS has identified among their beneficiary

[22] Agency for Healthcare Research and Quality. Treating Tobacco Use and Dependence: 2008 Update.
[23] PLOS One. Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts. January 6, 2012.
[24] These results are limited to those with >100 respondents in the denominator.
[25] California Health & Human Services Agency. Let's Get Healthy California Task Force Final Report. December 19, 2012.

populations, wide gaps in MCP performance by race and ethnicity. For example, African-American or Black beneficiaries had a nearly 20 percentage points higher prevalence of hypertension than other race and ethnic groups as reported in MY 2013. Additionally, African-American or Black women with recent births had the lowest postpartum visit rate of any race or ethnic group in MY 2013. In order to more accurately identify and address health inequities, DHCS commissioned its EQRO to perform a health disparities analysis in 2016. Due to a delay in obtaining finalized data as well as analysis methodology adjustments to ensure a robust analysis, DHCS expects to have the final results by fall 2017. In addition, DHCS will review the second annual health disparities analysis when available. The EQRO analyzed EAS measures, and stratified by age, gender, race/ethnicity and language preference both statewide and for individual reporting units.

As previously described in this report, CMS requires that all state Medicaid health plans participate in two PIPs per year. DHCS directed the MCPs to choose from one of four priority focus areas for their first PIP. For their second PIP topic, MCPs selected a topic of their choice in an area that needed improvement. The topic was reviewed and approved by DHCS in collaboration with the EQRO. For the next round of PIPs, starting in 2017, one of the PIPs chosen by the MCPs will have to focus on a statistically significant health disparity. The PIP intervention testing phase will focus on reducing the identified health inequity.

In order to further the spotlight on health disparities, DHCS will also include a Health Disparities Award as part of its annual improvement awards given to the MCPs. Currently, DHCS gives out awards annually for the best overall performance on HEDIS® measures, the most improved performance on HEDIS® measures, and an Innovation Award. When feasible based on data availability, DHCS will give out an award to a MCP that has developed a quality improvement project focused on an identified area of health inequity, designed to improve on that disparity. The award methodology will be developed once DHCS has enough data from the health disparities analyses performed by the EQRO.

Eliminating disparities is also a priority of the DHCS Quality Strategy. In 2013, DHCS developed a series of fact sheets, titled Health Disparities in the Medi-Cal Population[26]. The fact sheets, which reflect the same indicators used by the LGHCTF, characterize identifiable health disparities in the Medi-Cal population. In State Fiscal Year (SFY) 2014–15, DHCS worked with stakeholders and partners to develop aggressive intervention plans to eliminate addressable disparities and inequities and will continue these collaborations in the future. In 2015, DHCS developed a second set of fact sheets based on the quality indicators from the Centers from Medicaid and Medicare Adult Medicaid Quality Grant[27]. As part of the

[26] CA Department of Healthcare Services. Health Disparities in the Medi-Cal Population. 2013.
[27] CA Department of Healthcare Services. Health Disparities in the Medi-Cal Population. 2015.

partnership, DHCS maintains an interagency agreement with the Office of Health Equity within CDPH to optimize effectiveness and efficiency in shared efforts to eliminate health disparities and inequities. The work on these health disparities fact sheets continues and numerous topics have been added, such as tobacco cessation and opioid use.

7. Fostering Healthy Communities

Opioid misuse and overuse is a national crisis that has received much attention in the past several years. The severity of the crisis is such that it effects not only our beneficiaries and their immediate health care needs, but our beneficiaries' families and their communities. Data shows that while the opioid epidemic is an issue for all demographic groups, Medicaid beneficiaries are prescribed opioids twice as often as individuals who have private health insurance. Further, opioid addiction is estimated to be 10 times as high in the Medicaid population as compared to commercial populations. Given this, DHCS has chosen to focus on opioid misuse and overuse as one of its managed care priority areas, with the hopes of promoting and establishing healthy communities in which our beneficiaries live, play and work .

DHCS has formed an Opioid Abuse Prevention and Misuse Workgroup that is composed of clinical and policy staff from various DHCS divisions. The goals of the workgroup are to increase the number of buprenorphine providers in the State, increase the number of beneficiaries receiving buprenorphine for whom it would be appropriate, increase the number of Medi-Cal claims for Naloxone and see a decrease in opioid related overdose mortality. The workgroup is engaged in academic detailing through a partnership with the California Health Care Foundation (CHCF) to increase the number of buprenorphine providers in the State, particularly in the rural counties. DHCS continues to promote the use of buprenorphine, by removing all prior authorization requirements for this medication. The workgroup is also exploring methods to increase availability of naloxone to first responders and family members of beneficiaries on high dose opioid medications, as well as to increase the availability of narcotic treatment programs that provide medication assisted therapy.

DHCS participates in a statewide Prescription Opioid Misuse and Overdose Prevention

Workgroup that also includes CDPH, the Department of Justice, CHCF, and numerous local health departments. DHCS is part of several taskforces, which comprise the workgroup and is working to disseminate health care practices and policies that promote the sharing of best practices to the MCPs.

In 2016 the CHCF released a report that highlights the role of health plans in curbing the opioid epidemic. The report outlined the areas where health plans can have the most impact, such as safe prescribing practices through formulary changes and provider education, decreasing new starts for long-term opioid prescriptions, focusing on beneficiaries on high doses of opioid

medications and those taking high-risk medication combinations, and promoting the use of naloxone and medication assisted treatment. CHCF is currently supporting sixteen opioid safety coalitions in twenty-four California counties most of which have at least one health plan participant. Safety coalitions bring together medical societies, health plans, public health departments, physicians, pharmacists, law enforcement, community advocates, and patients to form a plan to make a difference in opioid overdose rates.

DHCS continues to work with MCPs that are interested in implementing patient review and restriction (PRR) or "lock-in" programs, and to expand access to non-opioid treatment for pain. PRR programs are evidence based interventions that allow health plans to designate one or more health care providers to supply all of the controlled substance prescriptions for those patients who are identified as high-risk. Further, to promote alternatives to opioid therapy, as of July 1, 2016, DHCS restored acupuncture services as an optional benefit for all eligible beneficiaries, similar to physical therapy. MCPs must provide coverage and reimbursement for acupuncture services, to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. DHCS continues to investigate other alternative therapies, as well.

C. Health Information

DHCS recognizes the role that health information technology (HIT) plays in improving the quality of health care provided to beneficiaries, preventing medical errors, reducing health care costs, increasing administrative efficiencies, decreasing paperwork, and expanding access to affordable health care.

D. Encounter Data Validation and Improvement

Over the past few years, DHCS has focused on improving encounter data received from the MCPs. DHCS recognizes the importance of this data to be able to assess utilization, outcomes, disparities, and quality both by DHCS and CMS.

In 2015, DHCS successfully transitioned MCPs to national standard formats and moved to a new Post Adjudicated Claims and Encounters System to receive and process the data. Through this change, DHCS was able to standardize data reporting, enhance the dataset, and improve data management. DHCS also imposed data quality requirements on MCPs and established the Quality Measures for Encounter Data. DHCS has created mechanisms to measure, track, and report on encounter data quality and continues to enhance its monitoring processes. In addition, DHCS has heightened its technical assistance efforts to MCPs to provide multiple venues for collaboration and support.

In 2015, DHCS also signed a new three-year contract with its EQRO to continue conducting annual Encounter Data Validation (EDV) studies. For State Fiscal Year (SFY) 2015-16, the EDV study focused on providing technical assistance to MCPs on implementing quality initiatives to address the findings reported in the medical record review performed during the SFY 2013-14 EDV study. The results of the technical assistance activity will assist the MCPs and DHCS in further improving MCP processes for encounter data collection and reporting to DHCS. Through this recent study, we observed that some of the data quality issues, originally identified in the medical record review, have been resolved due to the DHCS's transition to national standard formats for encounter data reporting.

E. Adoption of Electronic Health Records (EHR)

To support advancements of HIT in the clinical care environment experienced by Medi-Cal beneficiaries, DHCS has implemented the Medicaid EHR Incentive Program in 2011. This program, administered by the Office of Health Information Technology (OHIT), provides financial incentives to providers serving Medi-Cal beneficiaries when the providers adopt a certified EHR and use it in a meaningful way, as specified in CMS regulations. By the end of 2016, OHIT had provided over $1.5 billion in EHR Incentive funds to over 25,000 Medi-Cal professionals and 450 hospitals.

OHIT is working with managed care on the following HIT projects:

- As a component of demonstrating meaningful use of EHRs, providers must submit data on clinical quality measures (CQMs) to the Medi-Cal EHR Incentive Program. OHIT has collaborated with the Managed Care Quality and Monitoring Division (MCQMD) to promote the reporting of an important CQM addressing diabetes treatment, increasing the reporting rate in 2012 of 23 percent to 35 percent in 2015.
- OHIT has tabulated the CQM data for providers from each MCP to provide this to each plan for use in designing and targeting clinical quality improvement activities.
- OHIT is working with a MCP and a community Health Information Exchange (HIE) to incorporate the Staying Healthy Assessment (SHA) into EHRs. The SHA is a behavioral risk questionnaire that managed care providers are required to use with all patients, but which is currently only available in a printed format. Incorporating this questionnaire into EHRs will allow providers improved access to the information for each patient's clinical needs, and the health plan and county authorities will be better able monitor community-wide health behaviors and risk factors. This project may serve as a model for the incorporation of other required printed forms into EHRs.

- Through the EHR Incentive Program, DHCS has received federal funding to support the upgrade of the State's immunization registry (CAIR) to CAIR 2.0. This will enable the bi-directional exchange of information with providers and will support DHCS efforts to increase immunization rates among the Medi-Cal population.

The Medi-Cal EHR Incentive Program plans to work with MCQMD on additional projects to improve the quality and efficiency of patient care. One major area will be improving the resources for health information exchange. Although certified EHRs are designed to exchange information with each other and with HIE organizations, health information exchange remains a largely unrealized objective. DHCS will continue to work with managed care organizations as they further work with health information exchange organizations to support care coordination goals for Medi-Cal members.

F. Patient Safety

DHCS requires MCPs to report on several indicators each year that shed light on patient safety Metrics that address imaging studies for low back pain, avoidance of antibiotics in adults with acute bronchitis, monitoring of renal function in patients receiving diuretics and other drugs, as well as breast cancer screening and cervical cancer screening aim to improve the quality and safety of care. This is achieved by reducing unnecessary back surgery and radiation exposure, antibiotic resistance, adverse medication effects, and increasing rates of preventative screenings.

DHCS has also partnered with the California Maternal Quality Care Collaborative, where objectives include reducing early elective delivery and unnecessary cesarean sections.

As part of its continued commitment to patient safety and maternal quality, DHCS is administering The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program as part of the Federal 1115 Waiver. Activities supported by the PRIME program are designed to accelerate efforts by participating public hospitals to change care delivery to maximize health care value and strengthen their ability to successfully perform under risk-based alternative payment models (APMs) with MCPs in the long term, consistent with CMS and Medi-Cal 2020 goals. The PRIME program includes QIPs undertaken by Public Hospitals highlighting the following patient safety goals:

- Ensure that abnormal test results are conveyed to the ordering clinician and that appropriate follow-up is implemented.
- Ensure annual monitoring being done for patients on persistent medications.

- Increase rates of cancer screening and completion of follow-up across targeted prevention services.
- Decrease statewide cesarean section rate, and decrease variability in cesarean section rates in hospitals throughout California.
- Improve maternal morbidity and mortality statewide.
- Improve communication and coordination between inpatient and outpatient care teams to ensure continuity of health care as patients move from the hospital to the ambulatory care setting.
- Improve medication management and reconciliation to facilitate the appropriate coordinated delivery of health care services.
- Reduce avoidable acute care utilization such as emergency department visits, hospital admissions, and readmissions.
- Develop safe and effective prescribing practices, improve the use of multi-modal pain management strategies, improve the effective use of non-opioid medications, and increase access to naloxone for providers caring for patients with chronic pain.
- Improve the appropriate use of antimicrobials by reducing broad-spectrum antibiotic use and decreasing inappropriate use of antibiotics across health care systems.
- Reduce hospital associated Clostridium difficile infections.
- Reduce inappropriate utilization of and improve the use of cost-effective, evidence-based high-cost imaging, pharmaceutical therapies, and blood products.

DHCS has also developed an internal Collaborative aimed at reducing preventable deaths due to opioid overdose and reduce opioid misuse as well as joining an interagency collaborative with similar goals. DHCS works to increase access to buprenorphine treatment for addiction and naloxone treatment to reverse overdose. DHCS continues to discuss opioid misuse with MCPs and assist MCPs with sharing innovative strategies.

G. Intermediate Sanctions

See Section 2 under Monitoring and Compliance.

SECTION 4: DELIVERY SYSTEM REFORMS

One of the Department's commitments is to design delivery systems and payment strategies to drive improved quality and outcomes (Strategy 4.1 in the DHCS Strategic Plan, 2013–2017).

Below are updates on the most recent delivery system reforms implemented by DHCS.

A. Health Homes

Section 2703 of the ACA gives states the option to provide comprehensive care coordination through health homes for eligible individuals with complex conditions. The ACA supports the implementation of this program by providing states an enhanced Federal Medical Assistance Percentage equal to 90 percent of a state's payments for two years with no deadline to apply or implement the activity.

DHCS is continuing its development of a State Plan Amendment to begin implementing the first wave of county-based, managed care plan-delivered Health Homes Programs (HHP) in July 2018. HHP will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. The HHP provides six core services: comprehensive care management, care coordination (physical health, behavioral health, and community-based LTSS), health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. DHCS is working with the three managed care plans that will implement the HHP in eleven counties in this first wave. DHCS has posted a revised implementation schedule on the HHP webpage[28]. If you wish to be added to the HHP stakeholder list, please email your request to HHP@dhcs.ca.gov.

B. Whole Person Care

The Whole Person Care (WPC) pilot program is a five year, up to $1.5 billion federally funded pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC pilot entities will identify target populations, share data between systems, coordinate care and evaluate individual and population progress — all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes. As of July 1, 2017, there are twenty-five approved pilots operating in various

[28] CA Department of Healthcare Services. Health Home for Patients with Complex Needs

counties throughout California. For more information about the WPC pilot program, please visit the DHCS website[29].

C. Statewide Expansion of Medi-Cal Managed Care

California's SFY 2012–13 budget called for the expansion of Medi-Cal Managed Care statewide starting in September 2013.

To ensure a smooth transition, DHCS set up performance metrics and monitoring activities that focused on how MCPs are meeting the needs of the transitioned beneficiary population. DHCS reviewed collected data and analyzed it to ensure that beneficiaries in all areas, including the regional expansion areas, had access to providers and continuity of care. MCPs reported and continue to report the following information:

- ***Health Plan Grievances/Appeals Related to Access to Care*** – This information includes grievances made to both the Department of Managed Health Care and/or to DHCS.
- ***Continuity-of-Care Requests and Outcomes*** – MCPs report this information to DHCS on a monthly basis; it is used to monitor each MCP's ability to continue to provide services without disruption of care.
- ***Time and Distance Requirements for PCPs (Geo Access)*** – This information is used as a component of each MCP's provider network adequacy review.

In addition to the monitoring reports, DHCS also monitors the following measures for their potential effects on beneficiary transitions into MCPs:

- Network adequacy for MCPs
- Primary care assignments for MCP providers
- Ombudsman inquiries for MCPs
- Beneficiary/Provider call-center inquiries for health services
- Continuity-of-care referrals and outcomes

[29] CA Department of Healthcare Services. Whole Person Care Pilots

- Grievances and appeals
- Beneficiary satisfaction phone survey
- Telemedicine utilization

The data collection, reports, and analysis ensure that DHCS is sufficiently monitoring the expansion of managed care and that MCPs are meeting the needs of the transitioned beneficiary population.

D. Cal MediConnect Program

The Coordinated Care Initiative (CCI), implemented in 2012 through SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012), is a delivery system transformation designed to better serve the state's low-income seniors and persons with disabilities by integrating delivery of medical, behavioral, and long-term care services. The three major components of the CCI are: 1) A three-year Duals Demonstration Project (Cal MediConnect) for individuals dually eligible for Medicare and Medicaid ("duals") that combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through an organized service delivery system; 2) Mandatory Medi-Cal managed care enrollment for Duals; and 3) The inclusion of LTSS as a Medi-Cal managed care benefit for SPD members who are eligible for Medi-Cal only, and for SPD Duals. CCI was implemented in eight counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) and passive enrollment began in April 2014. Enrollment was phased in on a monthly basis according to an implementation schedule. As of December 1, 2016, there were approximately 113,600 beneficiaries enrolled in Cal MediConnect. The most recent enrollment information can be found at: Cal MediConnect Enrollment Dashboard as of December 1, 2016. DHCS mandatorily enrolled nearly all beneficiaries who are enrolled in Medi-Cal into an MCP in CCI counties. Most Medi-Cal only beneficiaries were already enrolled in MCPs, but now they receive their LTSS through the same MCP. LTSS includes skilled nursing and Home Community Based Services, CBAS, and MSSP services.

For dual eligibles who chose not to enroll in a Cal MediConnect health plan, the State requires enrollment in an MCP for all Medi-Cal services, including LTSS. For dual eligible beneficiaries, enrolling in an MCP does not change their Medicare benefits. They can still receive health care services from their Medicare hospitals and providers.

E. Public Hospital Redesign and Incentives in Medi-Cal

Authorized by California's 1115 Medicaid waiver, Medi-Cal 2020, PRIME is a five year, $3.7 billion federally funded program that continues and expands the California delivery system reform initiative that provides incentives for improving the way care is delivered in California's public safety net in order to maximize health care value. PRIME directs designated public hospitals and associated health systems, along with district and municipal hospitals (collectively referred to as "PRIME Entities") to use evidence-based quality improvement methods to achieve ambitious, year-over-year performance targets. All federal funding for this program is contingent on meeting these targets. The PRIME program is considered the successor to the 2010 Bridge to Reform waiver's Delivery System Reform Incentive Program (DSRIP), a Pay-for-Performance program that improved care delivery to prepare California's designated public hospitals for an influx of newly covered patients through the implementation of the ACA.

Efforts within DSRIP included expanding primary care capacity, enrolling individuals into medical homes, and reducing hospital infections. PRIME builds on the DSRIP's success, with a greater focus on clinical outcomes and improved health for patients.

PRIME entities from across the state submitted five-year plans to DHCS in April 2016. The selected PRIME entities will implement various health care improvement projects across three domains: (1) Outpatient Delivery System Transformation and Prevention; (2) Targeted High-Risk or High-Cost Populations; and (3) Resource Utilization Efficiency, and with minimum project requirements for all PRIME entities. In June 2016, DHCS approved plans from 54 PRIME entities (17 DPHs and 37 DMPHs).

In September 2016, entities submitted Demonstration Year (DY) 11 Year-End reports including baseline data and infrastructure activities. In March 2017, they also submitted DY 12 Mid-Year reports to report outcomes for six months of quality improvement activities. To date, entities have earned approximately $1.1 billion in federal PRIME incentive funds.

PRIME is also preparing California's designated public hospitals and associated health systems to move towards sustainable delivery system reform through the increasing use of alternative payment models, which endanger the quantity and quality of services provided to Medi-Cal managed care enrollees that are assigned to public health care systems for their care. In an effort to demonstrate that PRIME improvements can be sustained beyond Medi-Cal 2020, the waiver requires that, by January 2018, 50 percent of the state's Medi-Cal managed care beneficiaries who are assigned to a designated public hospital system receive all or a portion of their care under a contracted APM. Under the waiver, this number must increase by at least 5 percent each year, with the goal of reaching 60 percent by the end of 2020. The

adoption of APMs is intended to ensure that public hospitals shift their focus from volume to value-based payments by providing incentives to clinicians and promoting accountability across the health system.

F. Substance Use Disorder Division Updates

In addition to DMC-ODS waiver, a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder (SUD), DHCS is further expanding efforts to curb opioid-related death and addiction in California through a two-year federal grant from the Substance Abuse and Mental Health Services Administration. DHCS will use a large portion of the grant to expand Californians' access to medication-assisted treatment (MAT), particularly using buprenorphine. Unlike methadone, the most popular form of MAT, buprenorphine is available in primary care, mental health, and other outpatient settings. It may be dispensed by community pharmacies and has less abuse potential than methadone. The pilot will focus on populations that have the highest rates of opioid-related overdose deaths and limited MAT access, including rural areas, and American Indian and Native Alaskan tribal communities. The goals of the project are to implement the 'Hub and Spoke' model in various areas throughout California, which will improve access to Narcotic Treatment Programs and Medication Units in counties with the highest overdose rates. The MAT Expansion Project will also increase the availability of buprenorphine statewide and increase MAT utilization for tribal communities. DHCS also will use the grant to fund additional approaches to reduce opioid misuse, such as opioid misuse prevention efforts; wider distribution of naloxone, which can reverse the toxic effects of an opioid overdose; coordination of local coalitions to reduce opioid abuse; and education and training to help reduce the stigma associated with addiction.

G. Integration of Mental Health and Alcohol Use Disorder Services

Pursuant to the passage of Senate Bill 1 of the First Extraordinary Session (Hernandez, Chapter 4, Statutes of 2013), which added §14132.03 and §14189 to the Welfare and Institutions Code, and as a result of a series of forums with a variety of stakeholders, MCQMD in collaboration with the Mental Health Services Division developed and implemented an expanded outpatient mental health services program to beneficiaries of all ages. Effective January 1, 2014, MCPs are responsible to cover and pay for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition defined by the current Diagnostic and Statistical Manual of Mental Disorders. These

services, described in APL 13-021, are provided by the mental health professionals in the MCPs' networks (outside of the primary care physician's scope of practice) and include:

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and
- Psychiatric consultation.

An update to this APL will be forthcoming in 2017 to reflect changes driven by mental health parity as required by the Final Rule. The eligibility for SMHS provided by county MHPs has not changed pursuant to this new policy. MCPs are required to enter into a Memoranda of Understanding (MOUs) with the county mental health plans (MHPs) that provide SMHS to ensure care coordination as beneficiaries are referred between the two systems (described in APL 13-018), which are all complete. DHCS has also organized a collaborative meeting in conjunction with the California Association of Health Plans (CAHP), between the MCPs and the MHPs, which meets quarterly. Agenda items are driven by the MHP and MCP participants and focus on access, coordination of care, the sharing of data and challenges posed by privacy restrictions, and management of complex diagnoses, such as eating disorders. DHCS also has a dispute resolution process at the state level when issues cannot be resolved at the local level between MCPs and MHPs. Additional information can be found in APL 15-007[30].

In addition to the expanded mental health services, DHCS implemented an alcohol screening benefit effective January 1, 2014 (described in APL 14-004[31]) for beneficiaries ages 18 and older, known as Screening Brief Intervention, and Referral to Treatment (SBIRT), or Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care (most recent United States Preventive Services Task Force terminology). Each beneficiary is eligible for one expanded screening per year (using the Alcohol Use Disorder Identification Test, the Alcohol Use Disorder Identification Test—Consumption or another validated tool) and three brief intervention sessions per year (which can be combined) to address risky alcohol use. The expanded screening is longer than the initial, brief screening in the SHA. Providers who offer SBIRT services must refer MCP beneficiaries who may have an alcohol use disorder to the

[30] CA Department of Healthcare Services. APL 15-007: Dispute Resolution Process for Mental Health Services. April 1, 2015
[31] CA Department of Healthcare Services. APL 14-004: Screening, Brief Intervention, and Referral to Treatment for Misuse of Alcohol. February 10, 2014

county or other community services for further evaluation and treatment. An update to this APL will be forthcoming in 2017 to reflect changes driven my mental health parity as required by the Final Rule. Expanded Substance Use Disorder benefits will continue to be provided through the current delivery systems: Medi-Cal FFS or county administered Drug Medi-Cal, depending on the benefit.

H. Coordination of Dental Health Services

DHCS divisions responsible for Medi-Cal Managed Care and dental services are coordinating efforts to assess and improve oral health of MCP beneficiaries, starting with children. DHCS has also developed policies to guide MCPs on the appropriate use of general anesthesia for dental procedures and provided additional information regarding how to best coordinate these requests with dental procedure approval from dental services. MCPs are required to provide recommended dental screenings for children in accordance with American Academy of Pediatrics, Bright Futures recommendations. MCP also must coordinate with dental providers for services. Additionally, application of dental fluoride varnish in the primary care setting has been a benefit in the Medi-Cal program since 2006.

SECTION 5: CONCLUSIONS and OPPORTUNITIES

DHCS programs now serve over 13 million Californians. One in three people in the State receives health care services financed or organized by DHCS, making the department the largest health care purchaser in California. DHCS invests almost $100 billion in public funds to provide health care services for low-income families, children, pregnant women, and seniors and persons with disabilities, while helping to maintain the health care delivery safety net.

The Department has seen a significant increase in Medi-Cal enrollment and responsibility for coverage. As of December 1, 2016, the number of enrollees in Medi-Cal Managed Care increased to 10.2 million, or 80 percent of all Medi-Cal beneficiaries. Medi-Cal Managed Care has expanded to all 58 counties, enrolled new beneficiaries (including childless adults) and added new benefits (including behavioral health therapy).

This annual report - with its focus on three critical and specific areas of beneficiary health, and two areas of broader beneficiary well-being - reflects the continued emphasis by DHCS on quality and outcomes. This report also reflects the DHCS commitment to the three linked goals of the Department's overall Quality Strategy: improve the health of all Californians, enhance the quality health care delivered (including the patient experience), and reduce per-capita health care costs.

Developing this report required DHCS to collaborate with stakeholders to set priorities and measurable objectives, assess the causes of suboptimal performance, and identify interventions to address these challenges. This process has created a living document and tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help achieve the Department's mission to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long-term services and supports.

Appendix A: DHCS Managed Care EAS Measures for Measurement Year 2017 (Reporting Year 2018)

Full-Scope Managed Care Health Plans – EAS measures for measurement year MY 2017 (to be reported in 2018)

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
1.	ACR*	All-Cause Readmissions	Administrative (non-NCQA), defined by ACR	Yes	No
2.	AMB-OP* AMB-ED*	Ambulatory Care: • Outpatient visits • Emergency Department visits **(Children)***** • Emergency Department visits **(Adults)**	Administrative	Yes	No
3.	MPM-ACE MPM-DIU	Annual Monitoring for Patients on Persistent Medications (2 indicators): • ACE inhibitors or ARBs	Administrative	Yes	No
4.	AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative	No	No
5.	BCS	Breast cancer screening	Administrative	No	No
6.	CCS	Cervical Cancer Screening	Hybrid	No	Yes
7.	CIS-3	Childhood Immunization Status – Combo 3	Hybrid	No	Yes
8.	CAP-1224* CAP-256* CAP-711* CAP-1219*	Children & Adolescents' Access to Primary Care Practitioners (4 indicators): • 12-24 Months • 25 Months – 6 Years • 7-11 Years • 12-19 Years	Administrative	Yes	No

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
9.	CDC-E CDC-HT CDC-H9 CDC-H8 CDC-N CDC-BP	Comprehensive Diabetes Care (6 indicators): • Eye Exam (Retinal) Performed • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attention for Nephropathy Blood pressure control (<140/90 mm Hg)	Hybrid	No	Yes, for *HbA1c Testing* **only**

Appendix A *(continued from previous page)*

Full-Scope Managed Care Health Plans – EAS measures for measurement year (MY) 2016 (to be reported in 2017) and MY 2017 (to be reported in 2018)

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
10.	CBP	Controlling High Blood Pressure < 140/90 mm Hg (except < 150/90 mm Hg for ages 60-85 without diabetes)	Hybrid	No	Yes
11.	IMA-2^	Immunizations for Adolescents: (meningococcal, Tdap and HPV)	Hybrid	No	No
12.	AMR	Asthma Medication Ratio	Administrative	No	No
13.	PPC-Pre PPC-Pst	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Hybrid	No	Yes, for *Prenatal* ***only***
14.	DSF*	Depression Screening and Follow-Up for Adolescents and Adults	Electronic Clinical Data Systems	No	No

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm ****
15.	LBP	Use of Imaging Studies for Low Back Pain	Administrative	No	No
16.	WCC-N WCC-PA	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents • Counseling for nutrition • Counseling for physical activity	Hybrid	No	No
17.	W-34	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	Hybrid	No	Yes

Total Number of Measures = 9 Hybrid + 8 Admin measures (29 indicators total)

^ MCPs will be held to a benchmark for HEDIS® 2018 pending the availability of the benchmark from the National Committee on Quality Assurance will for measures marked with '^'.

* MCPs will not be held to a MPL for measures marked with "*".

** SPD

*** Same age bands that Plans already report to NCQA

**** Data from measurement year 2017 will be used in 2018 auto assignment algorithm. Subsequent years to be determined.

Appendix A *(continued from previous page)*

Performance Measures for Managed Care Specialty Health Plans – EAS for MY 2017 (to be reported in 2018)

AIDS Healthcare Foundation Healthcare Centers

- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure

Family Mosaic Project

- Promotion of Positive Pro-social Activity: Measure specifics to be determined with the EQRO.
- School Attendance: The number of capitated Medi-Cal managed care beneficiaries enrolled in Family Mosaic with a 2 or 3 in school attendance on both the initial and most recent Child and Adolescent Needs and Strengths (CANS) outcomes/assessment tool during the measurement period.

SCAN

- Colorectal Cancer Screening (COL)
- Osteoporosis Management in Women Who Had a Fracture (OMW)

Performance Measures for Managed Long-Term Services and Supports Plans (MLTSSP) EAS for MY 2017 (to be reported in 2018)

Managed Long-Term Services and Supports

- Ambulatory Care (AMB-OP and AMB-ED)
- Medication Reconciliation Post-Discharge (MRP)

Appendix B: Acronyms

AAAC	Access Assessment Advisory Committee
ACA	Affordable Care Act
ACR	All-Cause Readmissions
APL	All Plan Letter
APM	Alternative Payment Models
BIH	Black Infant Health
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAIR	California Immunization Registry
CAP	Corrective Action Plan
CBAS	Community Based Adult Services
CCI	Coordinated Care Initiative
CCS	Cervical Cancer Screening
CCSP	Community Care Settings Pilot
CDPH	California Department of Public Health
CFR	Code of Federal Regulations
CHCF	California Health Care Foundation
CHHS	California Health and Human Services Agency
CIS3	Childhood Immunization Status – Combination 3
CMS	Centers for Medicare & Medicaid Services
COHS	County Organized Health Systems
CPSP	Comprehensive Perinatal Services Program
CQM	Clinical Quality Measures
DY	Demonstration Year
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DUR	Drug Utilization Review
EAS	External Accountability Set
EDV	Encounter Data Validation

Appendix B: Acronyms (continued)

EHR	Electronic Health Record
EOC	Evidence of Coverage
EQRO	External Quality Review Organization
FFS	Fee-for-Service Medi-Cal
FPL	Federal Poverty Level
GMC	Geographic Managed Care
HbA1c	Glycosylated Hemoglobin
HEDIS®	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIT	Health Information Technology
HPL	High Performance Level
HPV	Human Papillomavirus
HRA	Health Risk Assessment
HSAG	Health Services Advisory Group
HTN	Hypertension
IHA	Integrated Healthcare Association
LGHCTF	Let's Get Healthy California Task Force Final Report
LI	Local Initiative
LTSS	Long-Term Support Services
MAT	Medication-Assisted Treatment
MCAH	Maternal, Adolescent and Child Health
MCP	Medi-Cal Managed Care Health Plan
MCQMD	Managed Care Quality and Monitoring Division
MLTSS	Managed Long-Term Services and Supports
MHP	Mental Health Plans
MOU	Memorandum of Understanding
MPL	Minimum Performance Level
MSSP	Multipurpose Senior Services Program
MY	Measurement Year

Appendix B: Acronyms (continued)

NA	Not Applicable
NCQA	National Committee for Quality Assurance
NGA	National Governors Association
OHIT	Office of Health Information Technology
PCP	Primary Care Provider
PDSA	Plan-Do-Study-Act
PIP	Performance Improvement Project
PRIME	Public Hospital Redesign and Incentives in Medi-Cal
PRR	Patient Review and Restriction
QIP	Quality Improvement Projects
RY	Reporting Year
§	Section
SBIRT	Screening Brief Intervention and Referral to Treatment
SFY	State Fiscal Year
SHA	Staying Healthy Assessment
SHP	Specialty Health Plan
SMHS	Specialty Mental Health Services
SPD	Seniors and Persons with Disabilities
SSA	Social Security Act
SUD	Substance Use Disorder