



Medi-Cal Managed Care Program

BASELINE QUALITY REPORT

To comply with CFR 438.202 and 438.204, States that have contracts with managed care organizations must develop a quality strategy.

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Baseline Quality Report

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EXECUTIVE SUMMARY

This report outlines the baseline Managed Care quality strategy as mandated by Code of Federal Regulations 438.202. It has been developed with CMS guidance based on reports developed by other states.

Over the next year, the Department will be developing a comprehensive, DHCS Quality Strategy that is based upon the National Quality Strategy. This DHCS Quality Strategy will define priority areas, baselines, targets, and specific interventions. Because of the nature of quality improvement, the DHCS Quality Strategy will be a living document that is updated on a regular basis to reflect ongoing learning, scientific developments, and stakeholder input.

California's Medicaid system, Medi-Cal, provides health care services to approximately 8 million beneficiaries through two distinct health care delivery systems: the managed care system and the traditional fee-for-service (FFS) system. The Medi-Cal managed care program currently provides health care services to approximately 5 million low-income Californians, including children, pregnant women, seniors, and persons with disabilities. As of April 2012, 21 managed care health plans, contracted by the state, provide health care services to Medi-Cal enrollees in 30 of the most populous counties in California. Under current Department of Health Care Services (DHCS) initiatives, the numbers served in Managed Care could increase to nearly 7 million persons in all 58 counties.

Each state that enters into one or more contracts with managed care organizations, prepaid ambulatory health plans, or pre-paid inpatient health plans must develop a written quality strategy per Code of Federal Regulations 438.202. The *Quality Report* describes the program history and structure, defines contractual standards, and outlines oversight and monitoring activities of the Medi-Cal managed care program. The *Quality Report* also addresses operational processes and procedures implemented by DHCS that:

- Assess the quality of care delivered through managed care health plan contracts;
- Make improvements, based on assessment, in the quality of care delivered to Medi-Cal beneficiaries through managed care health plan contracts;
- Obtain the input of Medi-Cal beneficiaries and other stakeholders;
- Ensure that contracted health plans comply with standards established by the State; and
- Conduct periodic effectiveness evaluation reviews and update the strategy, as needed.

Quality improvement processes and activities carried out within DHCS support the goal of ensuring that every Californian has access to high quality health services. The *Quality Report* reflects the unique operational contributions that Medi-Cal managed care can make in furthering DHCS' goals. Because California is currently facing significant fiscal challenges, while at the same time increasing the size of the Medi-Cal managed care program, having an appropriate quality strategy in place is even more crucial to monitor, assess, and improve the quality of healthcare services provided to our beneficiaries.

The updating of the *Quality Report* is occurring at the time when DHCS is placing a renewed emphasis on quality and outcomes. In November 2010, DHCS' five-year 1115 "Bridge to Reform" Waiver (Waiver) was approved by CMS. Through the Waiver, California will receive approximately \$10 billion in federal funds to invest in our health care delivery system to prepare for national health care reform. This funding will enable California to create more accountable coordinated systems of care, strengthen the health care safety net, reward health care quality

and improve outcomes, slow the long-term expenditure growth rate of the Medi-Cal Program, and expand coverage to uninsured Californians. These investments will achieve the three linked goals of 1) improving the health of all Californians, 2) enhancing the quality, including the patient care experience, in all DHCS programs, and 3) reducing the Department's per capita health care program costs.

I. INTRODUCTION

Legislative and Program History

Managed care has been a part of the DHCS Medi-Cal program in a variety of forms since 1972. DHCS initially contracted Medi-Cal managed care services through Prepaid Health Plans (PHPs) and Primary Care Case Management (PCCM) plans. These plans were largely individual clinic sites or small physician group practices that contracted with the state to provide primary care services to relatively small numbers of Medi-Cal members, with specialty care still being provided through the fee-for-service (FFS) program.

Medicaid Reform legislation (Title XIX, Social Security Act, Section 1115), passed in 1982, allowed the Medi-Cal program to contract with County Organized Health System (COHS) plans which are organized and operated by the county. Medi-Cal beneficiaries in COHS counties do not have the option of getting services through traditional Medi-Cal FFS unless authorized by the plan. Santa Barbara (1983) and San Mateo (1987) were the first counties to have COHS plans in California. Currently six COHS plans are operating in 14 counties (see Appendix A).

In 1991, state legislation (Assembly Bill 337) amended various sections of the Welfare and Institutions Code to establish the California Managed Care Initiative (Initiative) which expanded Medi-Cal managed care by requiring mandatory enrollment into managed care for designated aid codes. The Initiative resulted in the development of several competitive plan models for the delivery of health care services to Medi-Cal managed care beneficiaries in targeted counties throughout California. For example, in 1994, the Geographic Managed Care (GMC) Pilot Project made enrollment into managed care mandatory primarily for low-income children and families in Sacramento County. This plan model allows beneficiaries the option of choosing from among multiple commercial plan alternatives. Expansion of the Medi-Cal managed care program was designed to improve timely access to preventive and primary health care services in a cost-effective manner for Medi-Cal beneficiaries enrolled in managed care health plans.

The principal model implemented during the Medi-Cal managed care expansion under the Initiative was the Two-Plan model. Medi-Cal beneficiaries in these counties have the option to select from two managed care plans, either a locally-operated "Local Initiative" plan or a commercial health plan. As in the COHS and GMC plan models, health plans provide services to Medi-Cal beneficiaries in designated aid codes at a capitated reimbursement rate. Currently, GMC models operate in two counties, and Two-Plan models operate in 14 counties.

Initially, in both the GMC and Two-Plan model counties, seniors and persons with disabilities (SPD) eligible for Medi-Cal benefits under the Supplemental Security Income program had the option to voluntarily enroll in the Medi-Cal managed care program or to enroll in Medi-Cal FFS. The 1115 Waiver, approved by CMS in November 2010, gave DHCS the authority to end voluntary enrollment and mandatorily enroll the SPD population into Medi-Cal managed care. The SPD population was transitioned into managed care over the course of a year, starting in June 2011.

Establishing a Quality Baseline

Health plans contracted with the state to provide services to Medi-Cal beneficiaries must establish a comprehensive, structured quality improvement (QI) program, document monitoring

activities, and maintain systems for performance measurement. DHCS is responsible for developing and implementing a comprehensive quality strategy to address the methods established for oversight, monitoring, quality assessment and performance improvement of the Medi-Cal managed care program, as required by Code of Federal Regulations (CFR), Title 42, Section 438.204(c). Steps for revising the *Quality Report* include:

- DHCS management collaborated to draft a revised *Quality Report*.
- DHCS management collaborated with the DHCS Medical Director to ensure the goals and objectives of the *Quality Report* are consistent with the goals and objectives of the DHCS Quality Strategy.
- During the revision process, DHCS sought public input from various stakeholder groups, including the Medi-Cal Managed Care Advisory Group, health plan CEOs, health plan Medical Directors, and the Quality Improvement Workgroup.
- The final revised *Quality Report* will be shared with stakeholder workgroups for public review and comment.
- The *Quality Report* will be submitted to CMS for approval.
- The *Quality Report* will be made available to the public via the DHCS website.

Currently, the contracted External Quality Review Organization (EQRO) reviews the program objectives identified in the *Quality Report* when developing the annual Program Evaluation Report. DHCS has ongoing collaboration with stakeholders on initiatives identified in the *Quality Report* through quarterly Managed Care All-Plan CEO meetings and Managed Care All-Plan Medical Directors meetings. DHCS is committed to increasing regular opportunities for stakeholders to discuss the status of the *Quality Report*, address current issues, and make recommendations for needed improvement.

Over the next year, the Department will be developing a comprehensive, DHCS Quality Strategy that is based upon the National Quality Strategy. This DHCS Quality Strategy will define priority areas, baselines, targets, and specific interventions. Because of the nature of quality improvement, the DHCS Quality Strategy will be a living document that is updated on a regular basis to reflect ongoing learning, scientific developments, and stakeholder input.

Quality Objectives

Since the expansion of the Medi-Cal managed care program during the mid-1990s, DHCS has made continuous strides in monitoring quality of care and evaluation of service delivery provided to the enrolled populations; initially, mainly low income children and families. As the Medi-Cal managed care population shifts with inclusion of the SPD, Duals, and other populations, DHCS continues to move forward with strategies to ensure appropriate access, program monitoring, and evaluation of services for all Medi-Cal beneficiaries.

Medi-Cal managed care program objectives and quality strategies include:

Medi-Cal Managed Care Program Objectives:

- Increase access to appropriate health care services for all enrolled beneficiaries.
- Establish accountability for quality health care by implementing formal systematic monitoring and evaluation of the quality of care and services provided to all enrolled Medi-Cal beneficiaries including individuals with chronic conditions and special health care needs.

- Improve systems for providing care management and coordination for vulnerable populations, including seniors and persons of all ages with disabilities and special health care needs.
- Improve the quality of care provided to Medi-Cal beneficiaries by contracted health plans.

Medi-Cal Managed Care Quality Improvement Strategies:

- To establish a process by 2013 that ensures all beneficiaries enrolled in Medi-Cal managed care have access to a medical home and to increase access to medical homes through geographic managed care expansion into currently FFS-only counties.
- To implement one or more performance standards and measures for Medi-Cal managed care plans to evaluate and improve beneficiary health outcomes for seniors and persons with disabilities by HEDIS^{®1} measurement year 2013.
- To complete all plan contract revisions requiring enhanced case management and coordination of care services for members identified as high risk and a process for MMCD to monitor plan compliance by October 2012.
- To develop and implement an All Cause Readmissions (ACR) statewide collaborative in 2012 with all plans, in order to reduce hospital readmissions and improve transitions of care for all members including SPDs by 2015.
- To issue the final report of the results of the previous statewide collaborative, intended to reduce the number of avoidable emergency room visits, by 2012.
- To administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS^{®2}) survey in all managed care counties, in reporting year 2013.
- To establish a process by 2012 for timely notification to plans that ensures beneficiaries with a recent MER denial are contacted for care coordination and to address any special needs.
- To establish a formal process by 2013 to engage stakeholders and advocates in policy development.

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

² CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

II. ASSESSMENT

States with Medicaid Managed Care Programs must assess how well the program is meeting its program objectives (CFR 42, Section 438.202 (d)). DHCS is responsible for oversight and monitoring of access to program services, quality of care delivered to enrollees, availability and timeliness of appropriate levels of care, and internal structural systems established by contracted health plans.

Quality and Appropriateness of Care and Services

Contracted plans must implement an effective Quality Improvement System that monitors and evaluates performance measurement and implements strategies to improve the quality of care delivered by health care providers rendering services on its behalf, regardless of setting. Plans are also accountable for demonstrating evidence of an internal QI system that includes governing body participation in QI activities, designated QI committee(s) with oversight and performance responsibility, Medical Director supervision of QI activities, and inclusion of contracting physicians and other healthcare providers in the development and performance review of the QI system.

DHCS has established the following strategies to monitor access, appropriateness and quality of care provided by contracted health plans and their network providers:

■ *Enrollee Race, Ethnicity and Primary Language Data*

Information about the race, ethnicity and primary spoken language of enrollees is collected by eligibility workers at local county social services offices during the Medi-Cal enrollment process. The information is self-reported by the individual, although it is sometimes determined by the eligibility worker. County staff enters the information into Medi-Cal Eligibility Data System (MEDS) along with the individual's enrollment application information. MEDS data reports contain incomplete or invalid responses in the race, ethnicity, and primary language data fields, resulting in about 5 percent of ethnicity codes and 2 percent of language codes not being available. Federal law prohibits *requiring* enrollees to provide this information.

Plans must comply with 42 CFR 438.10 (c) and ensure that all monolingual, non-English-speaking, or limited proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpretation services at all key points of contact, either through interpreters, telephone language services, or any electronic options health plans choose to utilize. Health plans must ensure that lack of interpreter services does not impede or delay timely access to care. Each plan is required to provide translated and culturally appropriate informing materials to all monolingual or LEP members that speak one of the identified threshold or concentration standard languages. Health plans must also provide translated and culturally appropriate informing materials to Medi-Cal beneficiaries who indicate their primary language as other than English, reside in the plan's service area, and meet a numeric threshold of 3,000 or a concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes. Plans must ensure that Medi-Cal beneficiaries receive information in a language and manner they can understand, but translating written information does not always meet this need. DHCS will work with the health plans to address the distinction between spoken and written languages so plans do not spend money translating and printing materials into a language that their members speak, but do not read.

Contracted health plans are further required to use enrollee race, ethnicity, and primary spoken language data, among other relevant information to identify the special healthcare needs of members with limited English proficiency and members from diverse cultural and ethnic backgrounds. This information is used to plan and implement culturally competent and linguistically appropriate services, health education and continuous quality improvement programs and services.

■ *Enrollment*

DHCS uses an enrollment broker to ensure that beneficiaries are enrolled in a managed care health plan no later than 90 days from the date MEDS lists the individual as meeting enrollment criteria contained in 22 CCR 53906(a). DHCS' enrollment broker uses the MEDS' information to generate and send enrollment packets to newly eligible Medi-Cal beneficiaries in Two-Plan and GMC counties. Race, ethnicity, and language information on each new member is transmitted to the appropriate plan within the plans' enrollment files, as required by CFR 438.204 (b)(2).

■ *Threshold Language Determination*

DHCS periodically prepares a threshold language report on all Medi-Cal managed care enrollees to determine whether the threshold languages need to be updated for the Two-Plan and GMC counties. This information is used to determine which languages are needed for translation of enrollment materials in each county and which languages must be available from customer service representatives. DHCS also conducts an annual Linguistic Study of enrollees in Two-Plan and GMC counties, which the enrollment contractor uses to further guide call center staffing and provisions for the on-site representatives in each county.

The health plans use the threshold language criteria specified in plan contracts and periodic policy and/or all-plan letters to determine the threshold languages for their Medi-Cal members in each specific service area. Plans use the criteria to determine the languages into which informing materials must be translated and to arrange for appropriate cultural and linguistics support to members with limited English proficiency.

■ *External Quality Review Organization (EQRO) Technical Report*

DHCS complies with the federal requirement to contract with an External Quality Review Organization (EQRO) to produce annual EQRO Technical Reports as well as several focused reports:

- Annual aggregate report on the External Accountability Set (HEDIS[®]) performance measurement results
- Summary report on the biennial Member Satisfaction Survey (CAHPS[®]) results
- Annual plan specific evaluation reports
- Quarterly Quality Improvement Projects (QIPs) status reports

These EQRO produced reports are released throughout the year on the DHCS website. Each report presents the results of the EQRO's independent evaluation and describes the data collection and analysis methodologies. These reports also present the EQRO's recommendations for effectively integrating its findings into program policy development and ongoing program and plan quality assurance and improvement activities.

Performance Measures and Improvement Projects

All plans must comply with the DHCS requirements for reporting performance measurement results, conducting Quality Improvement Projects (QIPs) and implementing the biennial Consumer Satisfaction Survey as outlined in the annual “Quality and Performance Improvement Program Requirement” DHCS All Plan Letter. The 2012 requirements are in DHCS All Plan Letter 11-021 which is available on the DHCS website at

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.PDF>

■ *External Accountability Set (EAS) HEDIS® Measures*

Plans report audited results annually on all required *Healthcare Effectiveness Data and Information Set (HEDIS®)* measures, which must adhere to the most current HEDIS® reporting year specifications and to DHCS specified timelines. The DHCS-selected EQRO contractor conducts an annual on-site HEDIS® Compliance Audit. HEDIS® rates are calculated and reported at the plan level by county level unless otherwise approved by DHCS. Currently, exceptions to the county level reporting requirement include the two plans (Inland Empire Health Plan and Molina Healthcare) operating in Riverside and San Bernardino counties, the COHS plan (Central California Alliance for Health) operating in Merced, Monterey and Santa Cruz counties, and the COHS plan (Partnership Health Plan) in Marin, Mendocino, Napa, Solano, Sonoma and Yolo counties which report at a multiple county level.

Plans must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required HEDIS® measure. DHCS adjusts the MPL each year to reflect the national Medicaid averages reported in the most current version of NCQA *Audit Means, Percentiles and Ratios*. Currently, the MPL is the 25th percentile of the national Medicaid rates. For each measure that a plan does not meet the established MPL or is reported as “Not Reportable” due to a material bias, a must submit a HEDIS® Improvement Plan (IP) to DHCS within the specified timeframe that describes steps to be taken for improvement during the subsequent year. Plans, with scores below the MPL for the same measure in more than one county, may submit a single HEDIS® IP which must separately address the targeted population(s) in each county. Additionally, plans that historically have multiple HEDIS® measures that fall below the MPL or a measure that falls below the MPL without improvement after two consecutive years are required to submit Corrective Action Plans (CAP) and quarterly status reports. DHCS also establishes a High Performance Level (HPL) for each required EAS measure, which is currently at the 90th percentile of the national Medicaid average. DHCS publically reports audited HEDIS®/EAS results for each contracted health plan as well as the program average for Medi-Cal managed care and national Medicaid and commercial plan averages for each measure.

■ *Under/Over-Utilization Monitoring*

Plans are required to report utilization data for selected HEDIS® Use of Services measures through the contracted EQRO. DHCS medical and nurse consultants facilitate discussions of utilization data monitoring results at the quarterly Medical Directors meetings.

■ *Quality Improvement Projects (QIPs)*

Plans must conduct and/or participate in two QIPs, including the DHCS-led statewide collaborative project and either an internal QIP or a small group collaborative developed and led by two or more plans.

Plans must submit a proposal for all QIPs for approval by DHCS medical and nurse consultants and validation by the EQRO. Both the approval and validation processes focus on ensuring QIPs meet federal requirements and appropriately target the needs of the plan's Medi-Cal members and the DHCS quality goals. DHCS in conjunction with its EQRO continually assesses and modifies its QIP reporting form to support plan compliance with CMS protocols for performance improvement projects.

For each approved and validated QIP, plans must submit an annual status report that includes re-measurement results and any changes to the planned interventions. Most QIPs are in place for three years, allowing for at least two annual re-measurements to determine whether there is sustained improvement over the baseline. Once a QIP is completed, the plan must submit a new QIP proposal within 60 days to remain in compliance with DHCS QIP requirements. DHCS adheres to Title 42, CFR, Section 428.240 (b)(1) in reviewing the significant improvement of QIPs sustained over time in clinical and non-clinical care areas that effect health outcomes and enrollee satisfaction. Please refer to Appendix B for a list of active QIPs.

- o *Previous Statewide Quality Improvement Collaborative*
Reduction in Avoidable Emergency Room Visits (2007-2010)

All full scope managed care contracted plans began a statewide collaborative in July 2007 to reduce avoidable emergency room visits. An avoidable emergency room visit was defined by the collaborative group as "a visit that could have been more appropriately managed and/or referred to a primary care provider in an office or clinic setting." The goal of the project was to reduce avoidable ER visits by 10 percent by the final rate re-measurement in October 2011.

The target population was enrolled Medi-Cal managed care members, 1-19 years of age, with diagnoses of upper respiratory infections (cold/flu), otitis media (ear infection), and pharyngitis (cough/sore throat) identified from evaluation of encounter data. Plans began two statewide interventions in January 2009 -- a member health education campaign and health plan collaboration with local hospital ERs. As part of health education campaign, the collaborative developed an ER poster and brochure for the purpose of increasing communication between the provider and member regarding the appropriate use of the ER.

Re-measurement showed that plans were not successful in reducing the avoidable ER rate for CY 2008 and CY 2009. CY 2010 ER avoidable rates are still under review by DHCS and the EQRO. The final report will be published and released during the Fall 2012 and will indicate if any plans were successful in reducing the avoidable ER rate by 10% over the life of the collaborative.

There were several limitations to the implementation of the interventions that may have confounded the goal of reducing ER avoidable visit rates. The most significant limitation was that plans did not have the financial and staff resources to provide and re-supply the ER posters and brochures to all providers responsible for caring for members ages 1-19 throughout the intervention period. Plans were only required to coordinate with one hospital regarding the exchange of member ER use. Publicity and concern about the H1N1 during the 2009-10 flu season may have driven up the rate of ER visits.

Despite the inability to reduce the avoidable ER rates for CY 2008 and CY 2009, member and provider surveys conducted during CY 2010 and a health plan survey conducted during CY 2011 revealed a perception of benefit and value of the collaborative.

- **Provider Surveys $n=519$** (regarding their use of ER Posters and Brochures)
 - ♦ 50% of patients asked questions about the appropriate use of the ER
 - ♦ 87% of providers initiated discussion about appropriate ER use
 - ♦ 87% indicated the poster was helpful
 - ♦ 88% indicated the brochure was helpful
- **Member Surveys $n=875$** (member responses after talking to their doctor about ER use)
 - ♦ 88% indicated they would be likely to call the doctor when not sure about going to the ER
 - ♦ 90% indicated they would be more likely to call the doctor if worried about their child's earache, sore throat, cough cold or flu
- **Plan Survey $n=18$** (regarding plan perspective about the ER Collaborative Interventions)
 - ♦ 72% of the plans indicated insufficient resources to print the posters; 61% indicated insufficient resources to print the brochure
 - ♦ 61% indicated they would continue to distribute the poster after the collaborative ended; 72% indicated they would continue to distribute the brochures.
 - ♦ 94% of plans indicated success in collaborating with hospitals regarding the exchange of data.
 - ♦ 83% indicated that they would continue to receive data from hospitals after the collaborative ended.
 - ♦ Plans' responses to a question about the overall benefits and value of implementing the ER Collaborative:
 - 78% indicated raised member awareness of avoidable ER use
 - 61% indicated improved communication with providers
 - 56% indicated improved communication and coordination with hospitals
 - 50% indicated raised provider awareness about ER use
- *Current Statewide Quality Improvement Collaborative*
Reducing Hospital Readmissions (2011-2015)

All full scope managed care contracted plans began a statewide collaborative in July 2011 to reduce hospital readmissions. DHCS established the collaborative for several reasons, including a growing interest in hospital readmissions as a potential focus for measuring (and improving) quality and reducing cost. Recent research shows readmissions are often associated with gaps in follow-up medical care and can be reduced with better quality of care and improved coordination of care both before and after patient discharge. In addition, readmissions are expensive (\$9.7 billion for Medi-Cal in 2005-2006), can involve additional difficulties for patients and caregivers, and often can be preventable. While readmission rates are higher for Medi-Cal than private insurance, they are lower in Medi-Cal Managed Care than in Medi-Cal Fee-for-Service. (Source: http://www.oshpd.ca.gov/HID/Products/Health_Facts/HealthFacts_ReAd_WEB.pdf). By focusing efforts on reducing hospital readmissions, DHCS hopes the statewide collaborative will not only lower rates of readmissions, but also improve direct patient care, discharge planning, and case management.

The 1115 Waiver Special Terms and Conditions require DHCS to collect hospital readmission rate data. Using the same data collection for more than one purpose is a more efficient use of resources.

In January 2011, DHCS administered an electronic survey to all contracted managed care plans to solicit suggestions for the next statewide collaborative. Suggestions were discussed at the February 2011 Medical Directors' meeting and the feedback shared with the health plans. The high costs associated with preventable 30-day readmissions prompted DHCS and the health plans to select All-Cause Readmissions (ACR) as the focus for the statewide collaborative.

DHCS, in conjunction with its EQRO, convened a planning workgroup composed of medical directors and quality improvement managers from 21 health plans to identify the project focus, goals, measures, interventions, and evaluation. The EQRO researched if any existing measures of readmission could be adapted to the Medi-Cal population, and then provided technical assistance in the development of a HEDIS[®]-like measure. Plans will report the HEDIS[®]-like All-Cause Readmissions Measure for members 21 years and older with readmissions within 30 days of an acute inpatient discharge. Plans will report the rates on three distinct populations for members enrolled in the plan for each county: 1) Overall readmission rate; 2) SPD readmission rate; and 3) Non-SPD readmission rate. The final measurable goal will be developed after plans submit pre-baseline data in September 2012.

The ACR collaborative is divided into four phases: Study Design, Baseline, Re-measurement 1, and Re-measurement 2. In June 2013, the EQRO will complete an interim report that details the activities of the collaborative during the Study Design phase. Baseline measurement, using data from calendar year (CY) 2012 will occur in September 2013, and the report is scheduled for submission in May 2014. The Re-measurement 1 report, using CY 2013 data, is scheduled for completion in May 2015 and the second and final Re-measurement 2 report, using CY 2014 data, in May 2016.

■ *Consumer Satisfaction Survey*

The EQRO is responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey biennially in compliance with NCQA and AHRQ requirements. The CAHPS[®] surveys a sample of Medi-Cal managed care members in English and Spanish and covers services provided to adults and children. DHCS and the health plans use the consumer survey results to evaluate member satisfaction with the care they received from their providers and plans, to determine the need for further evaluation, and to highlight areas where specific quality improvement interventions by DHCS and/or health plans are needed.

The CAHPS[®] survey was most recently administered in 2010. The report, *Results of the 2010 Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) for Medi-Cal Managed Care Health Plans*, is available on the DHCS website at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Report_s/CAHPS2009-10.pdf. The report includes information about the survey methodology, the demographics of respondents, and results by plan and by Medi-Cal managed care delivery model (i.e., Geographic Managed Care, Two-Plan, and County Organized Health System).

DHCS management reviewed and assessed the 2010 survey results; however due to competing priorities and resource challenges, DHCS is still following-up on the survey

findings, including reviewing aggregate results with contracted plans as a group, convening individual meetings with plans with particularly poor results, and determining the best process for improving the performance of any plans determined not to be meeting minimum access standard in accordance with contract requirements.

The next CAHPS® survey is scheduled for 2013, and will also focus on capturing the managed care experiences of the Seniors and Persons with Disabilities population.

Clinical Practice Guidelines

Plans provide or arrange for all medically necessary covered Medi-Cal services and other services covered under the DHCS contract, which includes all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury (Title 22, CCR, Section 51303). DHCS clinical staff develops healthcare policy, contract language, and provide consultation for the program's standards for the covered scope of services. Registered nurses in DHCS review plans' scope of services policies and procedures, Evidence of Coverage deliverables, provider manuals, educational material, Memoranda of Understanding (MOUs) with public health agencies for compliance with contract requirements and adherence to acceptable practice standards. DHCS has established clinical guidelines as contract requirements, including, but not limited to, the following guidelines:

- American Academy of Pediatrics (AAP)
- Advisory Committee on Immunization Practices (ACIP)
- American College of Obstetricians and Gynecologists (ACOG)
- Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF)

DHCS oversight, to assure appropriate use of clinical guidelines by plans, is accomplished by on-site provider medical record reviews by DHCS nurse evaluators, and in some cases, by plan performance on select HEDIS® measures.

Regulatory Requirements and Contract Compliance

Contract provisions established for Medi-Cal managed care health plans incorporate specific standards for the elements outlined in 42 CFR 438.204: access to care, structure and operations, and quality measurement and improvement. Plans are responsible for communicating established standards to network providers, monitoring provider compliance and enforcing corrective actions as needed.

Access to Care

Standards for access to care include availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services as required by 42 CFR 438.206. Medi-Cal managed care program standards promote early intervention at the appropriate level of care, and ensure that preventive and primary care services are available and accessible to enrollees. Plans must establish accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and 1300.67.2.2 to ensure that each member has a primary care provider (PCP) and access to specialists for medically necessary services.

Access standards must address availability of routine appointments and medically necessary specialty care services, appointment follow-up procedures and missed appointments, first prenatal visit, waiting times in provider offices, telephone medical advice, urgent care, and after-hours calls availability for physicians or appropriate licensed professional under their supervision (Appendix C). Access standards ensure that members are offered appointments for covered health care services within a time period appropriate for their condition. If a plan's network is unable to provide medically necessary services to a member, the plan must timely and adequately cover these services out-of-network for the member, and for as long as the plan's network is unable to provide them. The plan must coordinate with out-of-network providers with respect to payment. The plan must ensure that cost to the member is no greater than it would be if the services were furnished within the plan's network and that appropriate medical care is provided.

The following activities and reports document DHCS and plan-specific endeavors to monitor access to care and status of available services:

■ *Provider Network Report*

At startup, plans must submit a provider network report to DHCS to provide evidence of the required covered services for members in their service areas. For example, documented evidence must demonstrate that provider networks are continuously in compliance with the established provider to member ratios (including primary care physicians, total physicians, and non-physician medical practitioners), meet the established time and distance standards, and have adequate numbers and types of certified (or eligible for certification) specialists available within the network to accommodate the specialty care needs of members. Plans submit quarterly *Change in Provider Network Reports* to DHCS, including a summary of provider network changes, the resulting impact of those changes, and information such as percentage of traditional and safety net providers, number of members assigned to each PCP, and network providers who are not accepting new patients.

A site review is also required as part of the credentialing process when either a facility and/or a provider are added to the plan's provider network. If a provider is added to the plan's provider network and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or re-credentialing.

As SPDs were transitioned into managed care, DHCS began extensive monitoring of six plans identified by CMS as possibly having limited access for specific types of medical specialists. Monitoring for the six plans consists of several reports, including: a health plan transfer summary, grievance calls received by DHCS Office of the Ombudsman, grievances reported by each health plan, monthly specialist report and an outbound call survey. The monitoring is analyzed by DHCS and summarized for each report. Since June 2011, when DHCS began this additional monitoring to ensure access to specialists exists, DHCS has concluded that each of the six plans are free of outstanding issues that would warrant concern regarding their ability to ensure access to specialists.

■ *Expansion*

Before all expansions and when any new population is brought into managed care, (e.g. mandatory enrollment of SPDs), the State establishes and monitors initial and ongoing network adequacy to serve the newly enrolled members to ensure compliance with 42 CFR 438 and the Knox Keene Act. This includes such items as: specialist to beneficiary ratios; geo-mapping of FFS providers versus network providers; minimum standards regarding access to specialty providers and their capacity to serve individuals; physical and

programmatic accessibility of the plan (including completion of facility site reviews before readiness) or other strategies to ensure adequate network resources to meet the needs of the individuals to be served.

■ *Geographic Mapping Reports*

Plans submit geographic mapping of their current provider network to DHCS quarterly using Geographic Information Software (GIS) maps to display and analyze the composition of their provider networks. Geographical mapping of provider networks provides verification of the availability and location of primary care providers and specialists in relation to the needs of plan members. DHCS standards requires plans to meet the provider-to-member ratios of at least one full-time equivalent primary care physician to 2,000 enrollees and one full-time equivalent for total physicians to 1,200 enrollees. Plans monitor provider caseloads quarterly to ensure that providers remain within established provider/beneficiary ratios and capacity limits. Plans provide a copy of the provider caseload report to DHCS upon request. DHCS contract managers review submissions from plans and verify that plans are meeting their contractual obligations.

■ *Care Coordination/Case Management*

Plans must maintain procedures for monitoring the coordination of care, determining whether targeted case management services are needed, establishing referral processes, initiating and maintaining disease management services and processing authorizations for members receiving out-of-plan services. Plans must ensure that all members receive either basic or complex case management services, including but not limited to all medically necessary services. The plan and each member's primary care provider, who serves as the patient's medical home, are responsible for the coordination of case management services.

In 2011, complex case management services expanded to include Person-Centered Planning for SPD beneficiaries to ensure members and/or their family or designated caregiver have comprehensive knowledge and choice regarding treatment options. Additionally, plans are now required to stratify SPDs into higher risk and lower risk groups, and to perform a Health Risk Assessment within specified timeframes for each group. At a minimum, an annual reassessment of SPD health risk is required. The assessments inform the development of a person centered care plan for each high risk member.

DHCS works collaboratively with contracted plans to meet requirements in 42 CFR 438.208 for care coordination for individuals with special health care needs. To assist plans in identifying the SPDs transitioning into managed care who require complex case management, DHCS provided FFS utilization data when available. DHCS also implemented the Health Information Form (HIF), a tool for members to self-identify acute healthcare needs. The HIF information is sent to the plan with the enrollment file and used as part of the health risk assessment process.

To ensure a seamless transition into managed care, SPDs were given an extended continuity of care by allowing access to their current out-of-network Medi-Cal FFS provider for up to 12 months after initial enrollment into managed care.

DHCS will assess plans' compliance with case management/coordination of care requirements by means of medical record review reporting, an annual survey of plan case management/coordination of care activities and operations, grievance monitoring, reporting of risk stratification and health risk assessment results, and by means of on-site verification by DHCS clinical staff auditors.

■ *Materials/Alternative Formats/Enrollment*

Plans must make materials available in alternative formats (e.g. large print, Braille, or audio) when requested by a member (Senate Bill 208). County-specific inserts with additional information about managed care and the plan choices in each county were developed for the SPD enrollment packets. The inserts were translated into the appropriate threshold languages and are available on the DHCS web page.

■ *Community Advisory Committee(s)*

Plans must form local committees to maintain community partnerships with consumers, community advocates and traditional and Safety-Net providers. Plans must include and involve the Community Advisory Committee in policy decisions related to educational, operational and cultural competence issues.

■ *Emergency Department Protocols*

Plans must develop and maintain protocols that describe communication and interaction processes and distribute them to emergency departments. A health professional from the plan or a contracting physician must be available 24 hours per day, seven days per week to coordinate transfer of care in emergent care situations, authorize medically necessary post-stabilization services and communicate with emergency room personnel. Written protocols must include plan telephone triage and advice systems, contact person responsible for coordinating services who can be contacted 24 hours per day, instruction and referral procedures, and procedures ensuring continuity of care and handling in cases where an assessment determines the beneficiary to have a non-emergent condition.

■ *Provider Directory*

Each plan issues, and periodically updates, a Provider Directory to inform members of primary care providers, Medi-Cal services, policies and procedures, statutes, regulations, telephone access and other special services. Plans submit revised provider directories to DHCS every six months for review and approval. To insure that Provider Directory submissions are current and accurate, DHCS conducts random phone calls to approximately 10 percent of the listed providers to validate the information (i.e., address, phone number, office hours, languages spoken, and accessibility). DHCS staff reports errors to the health plans for corrections.

■ *Site Review Reports*

Plans must conduct site reviews on all primary care provider sites in accordance with DHCS Policy Letter 02-02. The Facility Site Review (FSR) is a system-wide process to assess the structure and capacity of sites to provide primary care services. Plan nurse reviewers conduct the initial and tri-annual full scope reviews. Plan reviewers use the DHCS Full Scope Site Review Survey and Medical Record Review Survey forms to ensure that all contracting plans and subcontracting entities use DHCS survey standards, review criteria and scoring methodology.

Site reviews ensure that all primary care sites within health plan provider networks meet established quality standards in areas such as: physical plant accessibility and safety; health care personnel training and qualifications; office management systems; clinical services (lab, pharmacy, radiology); preventive services (equipment and health education materials); and infection control. In addition, the site's medical records are reviewed to ensure proper format and documentation regarding continuity and coordination of care, specialist care and carve-out entities; and that pediatric, adult, and OB/GYN preventive services are performed

according to the American Academy of Pediatrics, the United States Preventive Services Task Force, and the American Congress of Obstetricians and Gynecologists.

Plans submit FSR scores electronically to DHCS at least every six months (January and July) for review and evaluation. DHCS nurse evaluators analyze scoring data and monitor for trends that may require implementing system-wide quality improvement strategies, including corrective actions and technical assistance.

Structure and Operations

DHCS has established contractual standards and processes for evaluating the operational structure and procedures plans use for internal and external communication, monitoring and the provision of consultation and technical assistance as required by 42 CFR 438.207. Structural operations also include the plan's internal operational systems and processes for monitoring and communicating with DHCS and network providers. Plans must comply with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and report any breach of member Protected Health Information (PHI) to DHCS immediately. Secure data portals are used by the plans and DHCS for data and information exchange containing PHI. In addition, DHCS employees attend an annual training to identify and understand procedures surrounding PHI. Contractual requirements include standards for provider selection, enrollment, disenrollment, grievance systems, and subcontracted and delegated relationships. DHCS and the plans use the following documentary evidence to demonstrate the establishment and monitoring of structural operations:

■ *Evidence of Coverage Member Handbook*

All contracted plans must submit an Evidence of Coverage (EOC) Member Handbook annually for approval prior to distribution to members. The EOC must meet state regulations regarding print size, readability, understandability of text and describe the full scope of Medi-Cal managed care covered benefits, all available services, procedures for accessing services and address/phone number for each service location. EOC Handbooks are reviewed by DHCS contract managers, nurses and staff from the Member Rights/ Program Integrity Unit.

■ *Member Rights/Program Integrity Monitoring Reviews*

DHCS conducts routine member rights and program integrity monitoring reviews of each Medi-Cal managed care health plan on a biennial basis to evaluate plan compliance with state and federal statutes and regulations, contract requirements, and DHCS all-plan and policy letters. Monitoring reviews include verification that plans meet the requirement for conducting cultural awareness and sensitivity training, specifically regarding SPD members, as specified in the 1115 waiver.

Monitoring reviews include evaluation of plan operational policies and procedures and interviews with appropriate plan staff in the following areas: member grievances, prior authorization notification, cultural and linguistic services, marketing, and program integrity (fraud, waste, and abuse). Monitoring reviews also include on-site reviews of member grievance and prior authorization notification case files, as well as visits to selected provider offices to verify that cultural and linguistic services requirements are being met. At the conclusion of the monitoring review, DHCS provides the plan with a formal report of findings and observations and provides technical assistance where needed to ensure plan compliance.

■ *Facility Site Review Oversight*

DHCS oversees and monitors plans to ensure that primary care site review processes are consistent with the DHCS contract. DHCS nurse evaluators also provide ongoing technical assistance and education to plan nurse reviewers. Plans conduct Facility Site and Medical Record reviews on all primary care provider sites in accordance with DHCS Policy Letter 02-02 and Title 22, CCR, Section 53913.

The 1115 waiver requires DHCS to assess the level of physical accessibility of primary care provider sites and provider sites that serve a high volume of SPDs. DHCS created a physical accessibility review tool and in January 2011, plans were required to submit documentation on the benchmarks and methodology they were going to use to identify high volume providers in accordance with DHCS Policy Letter 10-016 and W&I Code 14182(b)(9). Plans are required to update this information annually.

○ *On-site Primary Care Provider Monitoring Visits*

Plans must complete initial full scope Facility Site Reviews (FSR) on all primary care provider sites not previously reviewed and then every three years thereafter. DHCS performs oversight monitoring by conducting on-site reviews of randomly chosen Medi-Cal primary care provider sites. DHCS also conducts Readiness Review FSRs for the primary care sites of plans which are expanding into a new Medi-Cal managed care county. The purpose of oversight reviews is to validate the health plan's FSR processes and to monitor services provided by the health plans. DHCS gives proactive technical assistance and educational consultation to plans and providers at the review and during the follow-up corrective action plan process. A FSR is also required as part of the credentialing process when both the facility/site and the provider are added to the health plan's provider network. If a new provider joins a site that has a current passing FSR score, a site survey need not be repeated for provider credentialing or re-credentialing.

○ *Master Trainer and Reviewer Certification*

Each plan has one or two certified FSR nurse reviewer Master Trainers who oversee their plan's site review process; train and certify new reviewers; and facilitate local collaboration with other plans and review programs. DHCS nurse evaluators certify each plan's Master Trainer by conducting a side-by-side FSR to ensure the Master Trainer candidate's mastery of the FSR process.

○ *DHCS Review of FSR Data Submissions*

Plans are required to electronically submit data to DHCS for every primary care FSR conducted via a dedicated DHCS web portal. DHCS nurse evaluators monitor this data and communicate with Master Trainers regarding any issues related to the submissions, corrective action plan closures, or other related problems.

○ *Ongoing Technical Support*

DHCS nurse evaluators provide ongoing and frequent telephone and email support to plan Master Trainers throughout the year on many issues related to the interpretation and application of the FSR process and DHCS policies. The implementation of the new 2012 FSR tool and guidelines has increased the level of DHCS consultation provided to the plans.

- *Review of Plan FSR Policies and Procedures*
DHCS nurse evaluators review and approve each plan's FSR policies which are required to be submitted to DHCS as deliverables during the contract implementation phase and anytime there are contract revisions.

- *Audit and Investigations Medical Audit Reviews*
The DHCS Audits and Investigations Medical Review Branch (A&I) is tasked with conducting annual medical reviews of all Medi-Cal managed care contracted health plans and is developing an internal work plan to carry out this requirement. A&I medical review audits include evaluation of health plan compliance in the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administration and organizational capacity. DHCS requires health plans to prepare Corrective Action Plans (CAP) for findings of non-compliance. MMCD will then review and approve the health plan's CAP.

- *Department of Managed Health Care Medical Loss Ratio Examinations*
The Department of Managed Health Care (DMHC) performs Medical Loss Ratio (MLR) examinations of managed care contracted health plans in conjunction with DHCS. MLR examinations are performed through a combination of desk top reviews conducted at DMHC and on-site visits at the offices of managed care contracted health plans. DMHC also conducts financial audits, administration expense ratio examinations, quarterly network adequacy assessments, and medical surveys.

- *DMHC Medical Surveys for Seniors and Persons with Disabilities*
DMHC conducts health plan medical surveys in order to effectively assess the overall performance of health plans participating in the 1115 waiver in providing health care benefits and meeting the health care needs of SPDs every three (3) years.

- *Fraud and Abuse Detection and Prevention*
DHCS requires contracted health plans to have policies and procedures in place to prevent, detect, and adequately report instances of suspected fraud and abuse to DHCS. Member and provider complaints and suspected fraud cases submitted by plans are reviewed by DHCS staff and forwarded to the DHCS Audits and Investigations Division (A&I) for further investigation. DHCS works collaboratively with A&I and the Department of Justice (DOJ) to provide technical assistance, to conduct educational trainings for plans about the prevention, detection, reporting and investigation of fraud and abuse and to facilitate opportunities for sharing best practices.

- *Grievance Logs*
DHCS requires plans to establish and communicate to contracting and non-contracting providers a formal process for acknowledging, accepting, and resolving member grievances. Plans submit aggregated grievance data logs to MMCD quarterly for analysis. DHCS also conducts biennial on-site monitoring reviews with plans to verify compliance with state and federal requirements for member rights and program integrity. Monitoring reviews focus on the plans' processes for grievances and prior authorization notifications. Although corrective action plans are not required for these review report findings, plans must correct findings within 30 days of receipt of report. Findings determined to be serious during the initial review will be followed up in six months on a subsequent review.

■ *Joint Medical Reviews*

Health plans undergo an on-site medical audit every three years conducted jointly by DHCS Audits and Investigations (A&I) and the DMHC. DHCS reviews the results, monitors and approves corrective action plans submitted by plans for audit deficiencies, makes on-site visits to plan and provider sites as needed to ensure compliance, and provides training or technical assistance to plan, A&I and DMHC staff.

■ *Medical Exemptions from Managed Care Enrollment*

Title 22 CCR, Section 53887 allows Medi-Cal beneficiaries in Two-Plan Model counties who are already receiving treatment from a FFS Medi-Cal provider for specific medical conditions (e.g. a scheduled surgery or late stage pregnancy) to be temporarily exempted from enrollment in a Medi-Cal managed care plan until the patient's condition is stable. Medical exemptions may help prevent an interruption in the treatment of specific medical conditions when requested by the treating physician and verified by DHCS enrollment and clinical staff.

Due to the mandatory enrollment of previously voluntary populations (e.g. SPDs), the number of requests for medical exemption from managed care rose sharply in 2011 and continues at a high rate. This has created an opportunity for DHCS to review applicable statute and regulations and to improve its review processes and consistency of decision making. Interventions to educate beneficiaries and providers about existing continuity of care standards for managed care enrollees that provide alternatives to the exemption process are underway.

■ *Disenrollment*

Disenrollments are tightly regulated in the GMC and Two- Plan Models and happen rarely in the COHS model of care. DHCS, or the enrollment broker, reviews and processes all requests for disenrollment and notifies the plan and the member of the decision. Only members with voluntary aid codes, in need of long term care or an organ transplant may be dis-enrolled into FFS. The plan shall continue to cover and ensure that all medically necessary services are provided to members who dis-enroll and receive Skilled Nursing Facility Long Term Care or organ transplant services through the Medi-Cal FFS program until the date of disenrollment is effective. Members are enrolled back into the plan when they no longer need the services mentioned above.

■ *Office of the Ombudsman*

The DHCS Office of the Ombudsman has administrative responsibility for member complaint resolution and coordinating all State hearing requests submitted by Medi-Cal beneficiaries enrolled in managed care plans. The Office of the Ombudsman uses a contracted translation service to serve the needs of non-English speaking members and has bilingual-Spanish employees on staff. Monitoring of contract requirements include:

○ *Member Complaint Investigation*

The Office of the Ombudsman investigates, consults with DHCS clinical staff, and works to resolve complaints made by enrolled plan members about Medi-Cal managed care health plans. Plan members may make complaints directly to the Office of the Ombudsman through a toll-free line (1-888-452-8609) and through a designated website at www.dhs.ca.gov/mcs/mcmcd/htm/OfficeoftheOmbudsman.htm. The Office of the Ombudsman serves as a resource for members in various ways, such as assisting with resolution of issues members have with their health plan, conducting impartial investigations of member complaints, assisting with urgent enrollment and disenrollment

processes, providing education about effective navigation through the Medi-Cal managed care system, and offering referrals.

With expansion of managed care into new counties, mandatory enrollment for previously voluntary populations (e.g. SPDs), and changes in optional Medi-Cal benefits, the number of calls to the Ombudsman has greatly increased. In 2008, the average number of calls per month was 4,431; by 2011, the average number had increased to 11,446 per month.

- *State Hearing Request Coordination*

The Office of the Ombudsman coordinates and processes all state hearing requests submitted by Medi-Cal managed care beneficiaries. Staff compiles medical and pharmacy information with assistance from DHCS medical consultants and assists the California Department of Social Services (CDSS) administrative law judges with understanding critical member issues.

Expansion and mandatory enrollment has also increased the number of Ombudsman supported State Hearings from 75 per month in 2008 to 193 per month in 2011.

- *Utilization Management Reports*

Plans must develop, implement, continuously update and improve their Utilization Management (UM) program to ensure that they consistently use appropriate processes to review and approve the provision of medically necessary covered services. Responsibilities include ensuring established criteria are used for authorization of services, that only health care professionals make denial decisions, and there is separation of medical decisions from fiscal and administrative management.

Annually, plans must report rates for under/over utilization monitoring based on selected HEDIS[®] Use of Services measures selected by DHCS and submit to an audit of these rates by the contracted EQRO.

Plans must have internal mechanisms to track and monitor prior authorization, timeliness of determination and a process to integrate reports on review of number and types of appeals, denials, deferrals and modifications.

Quality Measurement and Improvement

Plan contracts require an ongoing program for quality assessment and performance improvement of the services provided to enrollees as required in 42 CFR 438.240. Quality measurement and improvement standards include clinical practice guidelines, quality assessment and performance improvement program, and health information systems. The clinical practice guidelines used by plans and providers are nationally recognized and accepted, based on valid and reliable clinical evidence and applicable to the populations served within the Medi-Cal managed care program. Quality improvement projects are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

- *Clinical Practice Guidelines*

For all health services delivery areas where DHCS has not specified standards of practice guidelines, health plans may adopt nationally recognized standards, best practices guidelines and/or recommendations from appropriate professional organizations of proven methods that

are time-tested, research supported and accepted by peer professionals as reasonable practices. Plans must establish Memorandum of Understanding agreements with local county public health programs, such as Women, Infants and Children (WIC), Comprehensive Perinatal Services Program (CPSP), and California Children's Services (CCS) to address practice and quality of care issues, referral and communication systems, and ongoing collaborative processes. Health plan nurse reviewers assess content elements of clinical practice guidelines for preventive and primary care every three years as part of the Site Medical Record Review.

■ *HEDIS[®] External Accountability Set*

To assess the quality of care provided to Medi-Cal managed care plan members, as federally required, DHCS requires contracted plans to annually report the results of selected Healthcare Effectiveness Data and Information Set (HEDIS[®]) performance measures – referred to as the “External Accountability Set” (EAS). HEDIS[®] measures are established by the National Committee for Quality Assurance and are used nationally to assess the quality of care provided by commercial, Medicaid and Medicare plans.

The HEDIS[®] measures that make up the EAS for Medi-Cal managed care plans currently focus on access to care provided to women and children, ambulatory care services provided to members of all ages, immunizations for adolescents, monitoring for patients on persistent medications, weight assessment and nutritional and physical activity counseling, avoidance of inappropriate antibiotic use, screening for diseases such as cervical cancer, and care provided to members with chronic diseases such as diabetes and asthma. Plans submit data annually for the EAS. Any plan that scores below the Department-established Minimum Performance Level (MPL) on any required EAS measure must submit an Improvement Plan indicating how they will work to improve plan performance in the measures below the MPL. (See Appendix D for list of required HEDIS[®] measures since 2010.)

DHCS shares plan-specific and aggregate results with the plans and publicly releases them on an annual basis. DHCS also incorporates plan results into the *Consumer Guides* provided to potential enrollees, both mandatory and voluntary, in the GMC and Two-Plan model counties. These *Consumer Guides* are designed to encourage members to choose a Plan based on the quality of care provided in areas particularly relevant to each member -- such as prenatal care, timely childhood immunizations, treatment for chronic conditions, -- and the plan's customer service. DHCS also uses HEDIS[®] scores for six selected measures in the Auto Assignment Performance Incentive Program, which awards more defaulted enrollment to plans with higher scores in these measures. HEDIS[®] scores for 15 HEDIS[®] indicators will be used to determine the allocation of the five-percent “Quality Factor”.

Plans indicate that the public release of HEDIS[®] scores, both in the annual summary report and the *Consumer Guides*, is a strong incentive for plans to improve quality particularly because these materials are reviewed not only by members, but also by legislators, advocates and other potential purchasers.

■ *Quality Improvement Projects*

All individual QIP proposals submitted by plans are reviewed and approved by DHCS clinical staff prior to implementation by plans. DHCS medical and/or nurse consultants approve QIP topics and serve as project leads for the statewide collaborative quality improvement and for some small group collaborative projects. The EQRO contractor validates submitted proposals and subsequent status reports for all QIPs. DHCS and EQRO reviewers use the *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans* to ensure

compliance with federal requirements (42 CFR 438.240). The Guide can be found on the MMCD website:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/QIA_Assessment_Guide_November_2010.pdf

■ *Health Information Systems*

DHCS has determined minimum Management Information System (MIS) requirements it expects of its contracted managed care health plans and periodically reviews documentation from the plans to ensure that these minimum requirements are met. The MIS shall have the capability to capture, edit, and utilize various data elements for internal management use as well as to meet the data quality and timeliness requirements of DHCS's encounter data submission. The MIS shall provide, at a minimum, for the health plan's capability to record, update, and extract:

- All Medi-Cal eligibility data
- Information on members enrolled in the plan
- Provider claims status and payment data
- Health care services delivery encounter data
- Provider network information
- Other financial information

On execution of new or renewed contracts, the plan must submit a baseline assessment of its MIS as well as policies and procedures to DHCS. This provides DHCS with a high-level understanding of how the plan collects and maintains claims/encounters, enrollment information and data on ancillary services such as prescription drugs and whether the system has sufficient capacity to accommodate all activities associated with the anticipated enrollment level.

■ *Encounter Data*

DHCS maintains managed care data element dictionaries, which specify the form and manner in which the contracted health plans must submit encounter data on a monthly basis. Health plans, including their respective subcontractors, must have in place mechanisms, including edits and reporting systems sufficient to assure encounter data is complete and accurate prior to submission to DHCS. The submitted encounter data undergoes rigorous quality control checks, which are continually enhanced to catch data problems early in the process before data is entered into DHCS's Management Information Systems/Decision Support System (MIS/DSS) database. Should encounter data be found insufficient or inaccurate, DHCS has established timeframes for the submission of corrected data.

Multiple reports generated during the processing of submitted encounter data enable DHCS to monitor the plans' level of compliance with contract requirements and the quality, accuracy and timeliness of the data. Key performance indicators related to plan performance are tracked and reported to DHCS quarterly to allow for comparison from plan to plan and with national benchmarks.

Additionally, the Section 1115 Waiver requires DHCS to establish encounter data quality standards and sanctions. DHCS created a workgroup comprised of plan representatives, stakeholders, and subject matter experts to determine the most efficient process for meeting the Waiver requirements. As a result of the workgroup's findings and recommendations, DHCS is amending health plan contract language to reflect specific quality, accuracy, and

timeliness requirements. If plans fail to comply with these requirements, they will be required to develop and complete corrective action plans and may face monetary sanctions.

■ *SPD Member-Specific Data*

In June 2011, DHCS began providing plans with information about their newly enrolled SPD members to support the transition of the SPD population from FFS to the Managed Care program. Each month plans are able to access data that provides 12 months of FFS claims as well as Treatment Authorization Request (TAR) data for each new transitioning SPD member enrolled in their plan. This data is to help ensure better coordination of care for the SPDs.

■ *Stakeholder Input*

DHCS has organized various on-going collaborative workgroups to ensure that stakeholders have ample opportunity to advise, provide input, and make recommendations regarding program services, operational issues and areas for quality improvement. DHCS currently conducts the following Stakeholder Workgroups:

- *Medi-Cal Managed Care Advisory Group*
DHCS facilitates quarterly meetings that include health plan representatives and consumer advocacy representatives, promoting bi-directional communication between DHCS and stakeholders, on issues that affect Medi-Cal beneficiaries,
- *DHCS/DMHC Medical Audits Committee*
DHCS organizes quarterly multi-agency in-person meetings to plan and discuss issues related to collaborative joint audits of health plans.
- *Site Review Workgroup (SRWG)*
The Master Trainers and Certified Reviewers from each plan and DHCS RN staff meet in person at least twice a year at Site Review Workgroup (SRWG) meetings to address FSR issues, such as policy revisions, inter-rater reliability methods for medical record and physical site review scoring, problem-solving strategies related to oversight and monitoring and reviewer training and certification needs. In 2008, SRWG formed a subcommittee, the FSR Policy Revision Task Force, which was composed of plan Master Trainers, medical directors and DHCS nurse evaluators and nurse consultants. The Task Force held teleconferences to update the FSR policy, review tools, and review guidelines. These meetings led to the development of the revised FSR tool and guidelines, which was released in February 2012, along with the updated Frequently Asked Questions document.

Plans must complete initial full scope site reviews on all primary care provider sites that have not been previously reviewed and then every three years on an ongoing basis. Nurses serving as FSR Master Trainers from each plan and DHCS meet in person quarterly to address FSR issues, such as policy revision, inter-rater reliability methods for medical record and physical site scoring, problem solving strategies related to oversight and monitoring, and reviewer training and certification needs. The Certified Reviewers do not attend the quarterly meetings.

- *Annual Inter-Rater Review Training Day*
DHCS nurse evaluators collaborate with plan Master Trainers to implement annual statewide inter-rater review (IRR) training days and other mandatory trainings for all plan Master Trainers and site reviewers.

- *Health Education and Cultural Linguistics Workgroup (HECLW)*
Directors/managers of health education and cultural and linguistic services (C&L) from each plan meet quarterly in Sacramento to discuss and address issues related to health education, C&L, behavioral risk assessments, group needs assessment, and other topics related to improving the quality of health education and C&L services provided to enrolled members. The HECLW provided input and participated in the development of the following DHCS policy/all plan letters: non-monetary member incentives, group needs assessment, and readability and suitability of health education materials. The workgroup has also provided input on revision to the Staying Healthy Assessment (SHA) and will be participating in the pilot study of the revised SHA age specific questionnaires in Spring 2012.
- *Medical Directors Workgroup*
Plan medical directors are responsible for overseeing and rendering decisions related to clinical services, provision of medical care, and healthcare quality improvement. Medical directors meet quarterly with DHCS's Medical Director and other staff to address and problem solve a wide range of health care topics including clinical services, specific health conditions, program benefits, coordination of services, provider issues, health care policy and legislation, and budgetary constraints. These meetings have included presentations by representatives from various state and private programs and agencies including the California Department of Public Health; the Medi-Cal Fee-for-Service program; the California Children's Services; the Women, Infant and Children's Supplemental Food Program; researchers and clinicians from learning institutions; the California Medical Association; and plan medical directors.
- *Pharmacy Directors Workgroup*
Plan pharmacy directors meet quarterly with the DHCS pharmacy consultants, medical consultants and other staff to discuss pharmacy issues relevant to Medi-Cal Managed Care. One responsibility of plan pharmacy directors is oversight of plan formularies to assure medication access meets all medically necessary needs of Medi-Cal managed care members and that access is comparable to and consistent with the Medi-Cal FFS pharmacy services benefit.
- *Quality Improvement Workgroup*
Managers in the areas of quality improvement and performance measurement and medical directors from Medi-Cal managed care plans participate in periodic teleconferences, generally held quarterly. Participants, including DHCS staff, discuss issues specifically related to current and future quality improvement strategies, required and proposed performance measures, plan-specific and collaborative QIPs, and other activities related to quality improvement within the Medi-Cal managed care program.
- *State Hearings Quality Circle*
DHCS and the California Department of Social Services (CDSS) hold quarterly meetings to promote improvement in the quality and efficiency of the state hearing process.

Health Information Technology

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.

Adoption of Electronic Health Records

In September 2011, DHCS submitted California State Medi-Cal Health Information Technology Plan (HIT Plan) to CMS outlining the state's plan for widespread provider adoption and meaningful use of certified Electronic Health Records (EHRs).

The vision elements defined in the HIT Plan are ambitious and set an aggressive agenda for successful achievement of meaningful use criteria by Medi-Cal providers. These vision elements are:

- By 2011, the state will ensure that Medi-Cal beneficiaries, on request, have access to their Health Information Exchange (HIE) disclosures.
- By 2011, California will establish policies that balance protection of patient privacy with the appropriate sharing of health information.
- By 2013, statewide provider performance standards are used to improve health outcomes.
- By 2013, patient and population health data from EHRs will be shared bi-directionally between providers. California's Departments of Health Care Services and Public Health, OSHPD and other approved institutions to support the essential functions of public health for effective quality, access, and cost of care.
- By 2015, 90% of Medi-Cal providers eligible for Incentive Payments will have adopted certified EHRs for meaningful use in their practices and a secure and interoperable manner.
- By 2015, 90% of Medi-Cal providers will have implemented clinical decision support tools with their EHRs.
- By 2015, all Medi-Cal beneficiaries of providers with EHRs will have access to their Personal Health Record and self-management tools.
- Upon EHR adoption, Medi-Cal providers and beneficiaries will be able to use available electronic health information from the beneficiaries' other providers employing EHRs to make informative health care decisions at the point of care.

Over the coming years, California will continue to leverage extensive relationships with stakeholders throughout the state to advance the use of EHRs, establish routine health information exchange practices and improve patient and population health. In the future, the accepted standard of care will include the use of EHRs in all practice settings that have the capacity to exchange health information to improve patient care. EHRs will be integrated with government systems through bi-directional data exchange that enables quality assurance, program evaluation and improved population and public health assessments that improve the health and well-being of Californians.

III. IMPROVEMENT

The *Quality Report* not only serves as a descriptive guide for current quality improvement activities, but also as a roadmap for planning and initiating meaningful future strategies. Although California is experiencing a difficult budget crisis, updating the *Quality Report* will help focus DHCS on how best to use available resources to advance DHCS' mission and respond to the healthcare needs of Californians. Future quality improvement strategies include collaboration with both state and private agencies, ensuring access to the appropriate level of care and evaluating the utilization and effectiveness of care and medical services. In this section, the interventions describe how DHCS will meet strategic objectives and the initial and/or ongoing steps it has taken to foster improvement.

Interventions, Meeting Objectives, Steps to Improvement

■ *Sanctions*

Sanctions may be imposed on Plans upon failure to meet reporting requirements. Sanctions may also be imposed when timelines and activities for the corrected action are not met. Sanctions are written into the contracts and are used when other interventions have failed and until DHCS determines that the Plan is again in compliance. Types of sanctions that may be used include, but are not limited to:

- Stopping default enrollments
- The ceasing of activities
- Denial of payments
- Appointment of temporary management if the Plan has repeatedly failed to meet the contractual requirements
- Require Plan to temporarily suspend or terminate personnel or subcontractors
- Take other appropriate action as determined necessary by DHCS

■ *Collaboration with California HealthCare Foundation*

DHCS continues to collaborate with the California HealthCare Foundation (CHCF) to evaluate the Section 1115 waiver implementation. CHCF is completing a project to evaluate how DHCS implemented the Section 1115 waiver and determine if DHCS adopted the recommendations from CHCF's 2005 report.

■ *Medical Home*

One of the key goals identified in the 2008-2009 DHCS *Strategic Plan* was to organize care to promote improved health outcomes. In this goal, the primary objective is to ensure that every Medi-Cal beneficiary has a medical home. Managed Care has a major role in meeting this DHCS goal. The following strategies are currently underway within DHCS:

○ *Medical Home Workgroup*

A Medical Home Workgroup met in 2009 to establish the definition of Medical Home as it applies to Medi-Cal managed care and the result was a definition based on The Joint Principals that Define a Medical Home as developed by the Patient Centered Primary Care Collaborative (AAP, AFP, ACP, and AQA). Contracts have been amended to include this definition, to require that all members are assigned to a medical home, and to clarify that basic and complex case management and person centered planning are functions of the medical home.

- *Geographic Expansion*
Geographic expansion of the Medi-Cal managed care program increases access to a medical home for Medi-Cal enrollees. Between 1994 and 2001, three new COHS plans began providing services in six counties, while Geographic Managed Care and Two-Plan Models started in 14 counties. Since 2008, six more counties have COHS plans and the Two-Plan Model has expanded into two additional counties (See Appendix A).
- *Member Evaluation Tool (Health Information Form – HIF)*
DHCS initiated the Member Evaluation Tool (MET) project in 2007 to develop an initial health evaluation tool for newly enrolled members in response to the California Healthcare Foundation's (CHCF) recommendations in the November 2005 report, *Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Disabilities*. DHCS began using the MET, now called the Health Information Form (HIF), in June 2011 to coincide with the transition of SPDs to managed care. The HIF allows members to self-report certain conditions and treatments that may need expedited appointments with their primary care physicians or other health care providers to initiate care or avoid disruption of services. The HIF is required to be used in the plans' health risk stratification algorithm and health risk assessment.
- *Policy Development and Contract Revision*
DHCS reviews, updates, and revises existing policy letters and contract language and develops new clinical policy letters as needed. Clinical policy and all plan letters clarify contractual and regulatory requirements, and provide a standard that allows plans and DHCS to establish monitoring and quality improvement activities. The following policy letters are currently under development or undergoing revision by DHCS:
 - *Individual Health Education Behavioral Assessment*
Providers and health plans have expressed interest in updating the DHCS-developed "Staying Healthy Assessment" (SHA) tool, which may be used to meet contractual requirement to complete an Individual Health Education Behavioral Assessment (IHEBA) for all members within 120 days of enrollment. DHCS has worked with the HECLW and a statewide SHA Committee to revise the SHA's age specific questionnaires. A final draft of the SHA questionnaires will be pilot-tested during the spring of 2012. The revised SHA questionnaires and policy letter are targeted for release in July 2012.
 - *Non-Monetary Member Incentives*
With the passage of AB 915 in October 2007, DHCS began development of policy guidelines for non-monetary member incentives used by Medi-Cal managed care plans. In March 2009, DHCS issued the Policy Letter 09-005, "Non-Monetary Member Incentive Guidelines," available on the DHCS website at <http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx>. To better monitor the Plans' use of member incentives, DHCS is revising this policy letter to require Plans to submit evaluations at the end of each member incentive program; and annual updates for ongoing programs.

The following policy letters were recently released by DHCS:

- *Group Needs Assessment*
Plans are required to conduct a Group Needs Assessment (GNA) every five years to identify members' needs, available health education, cultural and linguistic programs and resources, and gaps in services. The GNA findings are used to plan and implement

culturally competent and linguistically appropriate services, health education, and continuous quality improvement programs. A new GNA policy letter, developed with input from the HECLW, provides a new GNA Report format with specific instructions on what to include in the report. The revised DHCS Policy Letter 10-012 was released November 10, 2010 and is available on the DHCS web site at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2010/PL10-012.pdf>.

- *Member-Specific Data Files for New Medi-Cal Only SPD Members*
DHCS provided Plans with FFS claims data and Treatment Authorization Requests (TARs) files for Medi-Cal only SPDs who were being transitioned from FFS to mandatory enrollment in managed care. The data will assist Plans with risk stratification and assessment of these members, the development of care coordination plans for high-risk members, and the initiation of other care management activities necessary to assure timely access to appropriate care for this new population. Policy Letter 11-003 was released February 10, 2011 and is available on the DHCS web site at:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-003.Rev2.pdf>
- *Health Risk Assessment Requirements for Seniors and Persons with Disabilities*
DHCS clarified the definition for “higher risk” beneficiaries for the risk stratification process. Plans are required to apply a health risk stratification mechanism or algorithm and perform a health risk assessment survey upon mandatory enrollment of each Medi-Cal only SPD. Plan contract language was added to include these new requirements. The revised DHCS Policy Letter 11-007 was released February 25, 2011 and is available on the DHCS web site at:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-007.PDF>
- *Competency and Sensitivity Training*
Plans are required to conduct cultural awareness and sensitivity training required to meet the needs of SPDs. DHCS requires plans to provide SPD Medi-Cal beneficiaries with access to quality health care that is delivered in a culturally competent manner. All appropriate health plan and provider staff must be trained using a DHCS developed sensitivity training curriculum. DHCS provided Plans with web-based training modules and the tools necessary to conduct the training in January 2011. Plans are required to provide refresher courses as necessary, train new Plan staff and new network providers, and maintain documentation of training conducted and current training schedules. DHCS Policy Letter 11-010 is available on the DHCS web site at:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-010.PDF>
- *Facility Site Review Tool*
Plans are required to implement a new Facility Site Review (FSR) Tool to assess the physical accessibility of provider sites, including specialist and ancillary service providers that serve a high volume of SPDs. Plans must make the results of this FSR available to members through their web sites and provider directories. This will assist the new SPD members in selecting provider sites that are accessible. The revised DHCS Policy Letter 11-013 is available on the DHCS web site at:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdf>.

- *Readability and Suitability of Health Education Materials*
DHCS recently developed an All Plan Letter (APL) pertaining to the readability and suitability of written health education materials that includes a new Readability and Suitability Checklist. The new APL provides health plans with a standardized process for reviewing and approving health education materials they intend to use with their Medi-Cal managed care members. DHCS All Plan Letter 11-018 was released August 19, 2011 and is available on the DHCS website at:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-018.pdf>.

- *Quality and Performance Improvement Program Requirements for 2012*
Plans are required to report annual performance measurement results, participate in a consumer satisfaction survey, and conduct ongoing quality improvement projects (QIPS). DHCS releases an All Plan Letter every year clarifying the quality and performance improvement program requirements. The 2012 requirements are included in DHCS All Plan Letter 11-021 released September 21, 2011. It is available on the DHCS web site at:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.PDF>

IV. REVIEW OF QUALITY REPORT

Performance Assessment

DHCS has established the following process to assure timely release of *Quality Report* updates whenever appropriate:

- Each year DHCS will review the EQRO's findings and recommendations on the *Quality Report*, presented in its annual *Technical Report*. Any action items that result from this will be shared with the EQRO and tracked by DHCS staff.
- The EQRO will report on the results of any action items related to the *Quality Report* in the following year's *Technical Report* until such time that the *Quality Report* is again updated. *Note:* The next *Technical Report* that covers the 2011 to 2012 year is scheduled to be released in early 2013.

Frequency of Reporting

Every three years DHCS will coordinate a comprehensive review and update of its quality strategy. The next *Quality Report* will be updated three years from the time this one receives CMS approval or sooner if DHCS makes significant changes to populations mandatorily enrolled in managed care.

Effectiveness

In preparing the annual *Technical Report*, which includes an evaluation of DHCS's implementation of its most recent quality strategy, the EQRO considers the following documentation:

- Plans' annual HEDIS[®] scores
- Plans' QIP proposals and annual status reports
- Baseline and re-measurement reports for the statewide collaborative
- Plans' CAHPS[®] survey results
- Other QI activities conducted by DHCS throughout each year (e.g. annual Quality Conference and quarterly meetings of the plan Medical Directors and the QI Workgroup)
- Plan audit reports (conducted jointly by DHCS and DMHC)
- DHCS Office of the Ombudsman calls, cases, and State Fair Hearing request statistics
- Plans' quarterly grievance reports
- Results of Facility Site Review and Medical Record Reviews conducted by plans and DHCS
- Other relevant documentation

These documents and activities each have specific schedules and performance targets, which are discussed throughout this document.

V. ACHIEVEMENTS AND OPPORTUNITIES

Successes and Challenges

Since Medi-Cal managed care's major expansion began in the mid-1990s, the program has achieved many successes. DHCS has conducted extensive activities in areas such as community education, public informing, testing systems, meeting with stakeholders, identifying practice standards and performance measures, negotiating contracts, developing policies to clarify contract requirements, and writing and reviewing contract deliverables, informing and educational materials, and policies and procedures. As a result of these ongoing activities, a successful, well-organized program has been established, maintained, and further expanded.

Another major success has been a greater degree of transparency for the public release of quality improvement and performance measurement reports on the DHCS website. These reports are used by members, plans, legislators, advocacy groups and other stakeholders, researchers, other state Medicaid programs and government entities. Publicly sharing quality improvement and performance information not only promotes a more comprehensive presentation of the Medi-Cal managed care program, but also encourages more informed dialogue among stakeholders.

- *Transition of the Seniors and Persons with Disabilities Population into Managed Care*
The 1115 "Bridge to Reform" Waiver allowed the transition of the SPD population into managed care. This allows DHCS to achieve care coordination, better manage chronic conditions, and improve health outcomes for the SPD population. In June 2011, DHCS commenced enrolling the SPD population into managed care in 16 counties. The transition of the SPD population from FFS to managed care will be completed with May 2012 enrollment. Because of the higher needs of the SPD population, the Department must work closely with plans to ensure that appropriate services are provided on an ongoing basis with continued refinement of complex care management and coordination.

DHCS believes the SPD transition has been successful, although there are valuable lessons to be learned, specifically in the areas of beneficiary outreach and education, provider engagement, continuity of care, and data sharing. A phone survey of 463 SPDs yielded positive results:

- 87% said their ability to make appointments has improved.
- 90% of those who received services through their plan are satisfied with the services.
- 81% of those who received services say they are more satisfied now than they were with their previous FFS experience.

DHCS believes the lessons learned from the challenges during the SPD transition, will help with the Duals Integration Demonstration (described on page 34), including:

- Greater education of beneficiaries and providers to ensure the demonstration guarantees continuity of care.
- Educating providers on the MER process to limit denials and incompletes, and ensure that continuity of care provisions are understood.
- Enhance processes and procedures for engaging and educating beneficiaries, beyond mail and phone calls.
- Develop better processes and protocols for data sharing, to ensure plans receive accurate FFS data in a timely manner and plans transmit assessment data to providers in a timely manner.

■ *Community-Based Adult Services*

DHCS has amended the Special Terms and Conditions (STCs) of the 1115 Waiver to provide: an additional benefit to SPDs who are enrolled in managed care under the terms of the demonstration project, and those who are dually-eligible for Medicaid and Medicare (dual-eligibles); and a FFS benefit for individuals in those counties that have not yet implemented managed care, and individuals who do not qualify for, or received exemptions from, managed care.

The amendment provides Community-Based Adult Services (CBAS) to individuals who are Medi-Cal eligible, meet specified medical necessity criteria, and:

- Meet “Nursing Facility Level of Care A” (NF-A) or above; or
- Have a moderate to severe cognitive impairment, including moderate to severe Alzheimer’s Disease or other dementia; or
- Have a developmental disability; or
- Have a mild to moderate cognitive disability, including Alzheimer’s or dementia, and need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
- Have a chronic mental illness or a brain injury, and need assistance or supervision with either:
 - Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
 - One need from the above list and one of the following: money management, accessing resources, meal preparation, or transportation.

Many of these individuals had been receiving Adult Day Health Care (ADHC) services under the State Plan. However, that service was eliminated from the State Plan, effective March 31, 2011. This Amendment provides Enhanced Case Management (ECM) for members of the Settlement class who are not eligible for CBAS. ECM will be provided to eligible individuals through managed care for those enrolled in managed care and through FFS for those not enrolled in managed care.

Comprehensive best practices have greatly contributed to program success and include:

- Program activities emphasize access to comprehensive health services and prevention-oriented health care that promotes health, well-being and individual choice.
- Consistent collaboration with stakeholder workgroups has enabled DHCS to identify key program issues and to plan meaningful improvement strategies.
- Access issues are addressed by DHCS both with plans and other stakeholders to assure ongoing basic access to the appropriate level of health care services for both current and future enrollee populations.
- Public sharing of quality improvement and performance measurement results supports both program transparency and better informed dialogue among stakeholders.

California is currently facing significant fiscal challenges, which have required difficult policy and programmatic decisions about service levels and staff resources. In addition, other limiting trends that threaten access to care for vulnerable populations include a continuing undersupply of nurses, declining numbers of physicians opting to practice adult medicine and family practice, declining provider participation in the Medi-Cal program in both managed care and FFS, and increasing hospital and emergency room closures.

Recommendations

During these times of limited budgetary resources, it is especially important that the DHCS have a quality strategy focused on the best use of available resources to advance the quality of health care and services provided to the low-income families, children, pregnant women, seniors and persons with disabilities enrolled in the Medi-Cal managed care program. Improving the quality and efficiency of health care and preserving and improving every enrollee's health status are the desired outcomes of the program.

Quality improvement activities recommended in the future for the Medi-Cal managed care program will emphasize the following:

- Providing person-centered care tailored to meet the needs of the individual for ALL Medi-Cal managed care beneficiaries. In 2011, DHCS began providing person-centered planning for SPDs. Providing this service to all beneficiaries is a DHCS priority, but it has been delayed due to staffing and budget issues.
- Eliminating unnecessary barriers in accessing health care from appropriate professional and institutional networks, with consideration for improved reimbursement for providers and efficient business processes such as provider enrollment, treatment authorization and claims processing.
- Reducing and eliminating disparities in health outcomes from selected populations and groups.

■ *Strategies Recommended by Stakeholders*

In developing this *Quality Report* for Medi-Cal managed care, DHCS solicited input and strategic recommendations from the Medi-Cal managed care Advisory Group, which includes advocates, medical directors, and quality improvement managers from the plans. In general, the majority of recommendations from these stakeholders were addressed by one or more current or proposed activities in the updated *Quality Report*. In addition, this *Quality Report* will be posted on the DHCS web site for public comment, at which time DHCS will solicit input from enrolled members.

The following list represents an overview of recommendations received from stakeholders during the development process of this updated *Quality Report*:

■ *Recommendations included in Quality Report*

- Evaluate the successes/relevance of the current quality strategy before identifying and designing new strategies.
- Revise contract language and coordinate efforts with DHCS Audits and Investigations to assure that plans are audited to appropriate standards.
- Expand the core goals to go beyond quality of care and to make improvements in quality of service and patient safety.

■ *Recommendations for future consideration*

- Investigate the feasibility of "deeming" (accepting) audits conducted by other regulatory agencies, especially for plans that have gone above and beyond contractual requirements by achieving National Committee for Quality Assurance (NCQA) accreditation.
- Keep measurement strategies in line with current HEDIS® measures and NCQA standards. Assessing health outcomes via chart review requires extensive resources currently unavailable to most plans and providers. (DHCS currently consults each year

- with plan medical directors and staff involved in HEDIS[®] reporting regarding the impact on plan resources of any proposed changes to required HEDIS[®] measures.
- Make developing and implementing programs to reduce racial disparities a priority, with a closer look at ethnicity, language, and cultural issues. Plans are required to conduct a GNA (Policy Letter 10-012) to identify cultural and linguistic needs of members, as well as, gaps in services. Plans must then use the GNA findings to plan and implement culturally competent and linguistically appropriate services, health education, and continuous quality improvement programs and services. Work with plans to (1) urge NCQA to develop HEDIS[®] measures appropriate to the disabled population, especially those who are cognitively impaired; (2) develop quality projects that address the needs of these members; and (3) work with NCQA to develop measures that assess the results of these efforts.
 - Support statewide adoption of a fully interoperable Health Information Technology system (such as electronic medical records and e-prescribing) that would allow comprehensive management of medical information and secure exchange between members, providers, and plans. For example, the capacity could be developed to accept CHDP PM 160 forms electronically, provide aggregate feedback to plans, and accept proxy formats generated by electronic medical records.
 - Work with agencies such as the California Department of Social Services or county human services agencies to explore how more accurate information on beneficiaries' race, ethnicity and language can be provided to health plans.
 - Work with the California Department of Public Health to expand upon efforts already initiated by DHCS to address such issues as childhood obesity, diabetes education and prevention, pregnancy/prenatal care of young women, and breastfeeding informing materials.
- *Expansion of Medi-Cal Managed Care Statewide*
California's proposed 2012-13 budget proposes to expand Medi-Cal managed care statewide starting in June 2013. The proposal combines strong beneficiary protections with centralized responsibility for the broader continuum of care. This combination will promote accountability and coordination, align financial incentives and improve care continuity across medical services, long-term services, and behavioral health services.
- *Duals Integration Demonstration*
DHCS is developing a pilot program to test innovative payment and person-centered delivery models that integrate the full range of acute, behavioral health, and long-term supports and services for members that are dually eligible for Medicare and Medi-Cal. DHCS will pursue newly available federal funding to support this work through the federal Coordinated Health Care Office. The pilot goals are to 1) coordinate Medicare and Medi-Cal benefits across care settings, 2) maximize the ability of dually eligible individuals to remain in their homes and communities with appropriate services and supports in lieu of institutional care, and 3) minimize or eliminate cost-shifting between Medicare and Medicaid. DHCS aims to achieve significant efficiencies and improved care for members that are dually eligible by enrolling these individuals into Managed Care Plans in four counties: Los Angeles, Orange, San Diego, and San Mateo. The three-year demonstration will begin in January 2013. Pending further state and federal authority, DHCS will expand the pilot program in up to six additional counties: Alameda, Contra Costa, Riverside, Sacramento, San Bernardino, and Santa Clara.
- *Shifting the Healthy Families Program into Medi-Cal Managed Care*
DHCS has proposed shifting the Healthy Families Program (HFP), California's version of the Children's Health Insurance Program (CHIP) to Medi-Cal Managed Care. DHCS would

require Medi-Cal Managed Care Plans into which the HFP enrollees would transition, to meet specified performance standards and comply with all existing performance standards and measurements set forth in the law prior to the transition of any children. Shifting the HFP to Medi-Cal Managed Care would create a more consumer friendly approach to coverage for children with a more streamlined enrollment and reenrollment process and expanded benefits including retroactive coverage, more comprehensive mental health services, better access to immunizations, and lower cost sharing. This proposal would provide a more consistent health plan contracting process, while increasing plan accountability for providing high quality services to children.

■ *California Children's Services Pilots*

DHCS will demonstrate improved care coordination for children with special health care needs under the 1115 Waiver using four proposed pilot models:

- Existing Managed Care Plans;
- Enhanced Primary Care Case Management;
- Specialty Health Care Plan; and
- Provider-Based Accountable Care Organizations.

Improved care coordination for this vulnerable population will result in improved health outcomes, improved cost-effectiveness, creating clearer accountability, improved satisfaction with care, and will promote timely access to care and family-centered care. All pilots eliminate the current Medi-Cal Managed Care Carve-out for CCS children. The contractors will manage all patient care to provide improved coordination of care, to align incentives and to optimize health outcomes.

■ *Health Homes Assessment*

Section 2703 of the Affordable Care Act (ACA) provides a State option to provide care through Health Homes for individuals with chronic conditions. The ACA supports the implementation of this program by providing states an enhanced Federal Medical Assistance Percentage (FMAP) equal to 90 percent of a State's payments made to designated providers for coordinated health care provided to individuals with two chronic conditions; one chronic condition and risk of a second; or a serious and persistent mental health condition. In order to implement section 2703, it is necessary to identify the eligible beneficiary population. This requires an analysis of the current data system to verify the most robust method to track the portion of the population eligible for the 90 percent FMAP. It is likely that a substantial portion of the 400,000 SPDs who are currently being transitioned from FFS to Medi-Cal Managed Care would be eligible to participate in a Health Home program.

VI. APPENDICES

- A. Medi-Cal Managed Care Health Plan Demographics (as of March 2012)
- B. Internal Quality Improvement Projects (as of April 2012)
- C. Access to Care Contract Requirements
- D. HEDIS[®] External Accountability Set (EAS) Measures: 2010-2013

APPENDIX A: HEALTH PLAN DEMOGRAPHICS (as of March 2012)

Medi-Cal Managed Care Enrollment Report - March 2012				
Plan Type	County	Plan Name	Totals	
Two-Plan Model Local Initiative Plans and Commercial Plans (Two-Plan)	Alameda	Alameda Alliance for Health (1996)	121,822	
		Anthem Blue Cross (1996)	34,827	
	Contra Costa	Contra Costa Health Plan (1997)	74,159	
		Anthem Blue Cross (1996)	12,448	
	Fresno	CalViva Health (2011) formerly Health Net (1997)	151,951	
		Anthem Blue Cross (1996)	75,231	
	Kern	Kern Family Health (1996)	115,444	
		Heath Net (2004)	40,879	
	Kings	CalViva Health (2011)	13,533	
		Anthem Blue Cross (2011)	10,592	
	Los Angeles	LA Care (1997)	978,439	
		Health Net (1997)	482,605	
	Madera	CalViva Health (2011)	18,672	
		Anthem Blue Cross (2011)	11,019	
	Riverside	Inland Empire Health Plan (1996)	226,578	
		Molina Healthcare (1997)	41,018	
	San Bernardino	Inland Empire Health Plan (1996)	257,397	
		Molina Healthcare (1997)	56,598	
	San Francisco	San Francisco Health Plan (1997)	53,877	
		Anthem Blue Cross (1996)	13,946	
	San Joaquin	Heath Plan of San Joaquin (1996)	96,447	
		Anthem Blue Cross (1997)	28,363	
	Santa Clara	Santa Clara Family Health (1997)	115,123	
		Anthem Blue Cross (1996)	34,926	
	Stanislaus	Anthem Blue Cross (1997)	54,974	
		Health Net (2005)	27,288	
	Tulare	Anthem Blue Cross (1997)	70,693	
		Health Net (1999)	46,305	
	Total Two-Plan Enrollment			3,265,154

APPENDIX A: HEALTH PLAN DEMOGRAPHICS (as of March 2012)

Medi-Cal Managed Care Enrollment Report - March 2012				
Plan Type	County	Plan Name	Totals	
Geographic Managed Care Plans (GMC)	Sacramento	Anthem Blue Cross (1994)	95,928	
		Health Net (1994)	64,178	
		Kaiser Foundation (1994)	27,964	
		Molina Healthcare (2000)	34,682	
	San Diego	Care 1st Health Plan (2006)	27,195	
		Community Health Group (1998)	118,534	
		Health Net (1998)	36,386	
		Kaiser (1998)	13,683	
			Molina Healthcare (2008)	69,136
		Total GMC Enrollment		487,686
County Operated Health Systems (COHS)	Marin (2011)	Partnership Health Plan of CA	17,547	
	Mendocino (2011)		20,746	
	Napa (1998)		14,628	
	Solano (1994)		62,144	
	Sonoma (2009)		54,418	
	Yolo (2001)		27,722	
	Merced (2009)	Central California Alliance for Health	75,089	
	Monterey (1996)		76,414	
	Santa Cruz (1996)		35,414	
	Santa Barbara (1983)	CenCal	64,969	
	San Luis Obispo (2008)		29,303	
	Orange (1995)	CalOptima	383,956	
	San Mateo (1987)	Health Plan of San Mateo	63,114	
	Ventura (2011)	Gold Coast Health Plan	104,851	
	Total COHS Enrollment		1,030,315	
Total for Two-Plan, GMC and COHS			4,783,155	

Source: DHCS CAPMAN Capitation Report

APPENDIX B: CURRENT INTERNAL & SMALL GROUP COLLABORATIVE QUALITY IMPROVEMENT PROJECTS
(as of April 2012)

Health Plan	Internal QIP Title	Objective	Current Phase
AHF Healthcare Centers	Advance Care Directives	Increasing the number of advance care directives by providing an environment which fosters the initiation of this conversation. PHC's goal is to reintroduce this topic to its members and do so as part of their on-going primary care.	Re-measurement 1
AHF Healthcare Centers	CD4 and Viral Load Testing	Increasing CD4 and Viral Load Testing	Re-measurement 2
Alameda Alliance for Health	Improving Hypertension Diagnosis and Anti-Hypertensive Medication Fills among Members with Hypertension	Improve identification and coding of hypertension among practitioners. Increase the percentage of hypertensive members filling at least 4 anti-hypertensive medications of any kind during the re-measurement year.	Proposal
Anthem Blue Cross Partnership Plan (Alameda, Contra Costa, San Francisco, San Joaquin, Santa Clara, Fresno, Sacramento, Stanislaus, Tulare)	Improving HEDIS® Postpartum Care Rates	Improve the rate of postpartum care visits for Medi-Cal members including individuals with special health care needs.	Re-measurement 2
Anthem Blue Cross Partnership Plan (Kings, Madera)	TBD	TBD	Proposal Due 6/12
CalViva	Retinal Eye Exams	Improving Comprehensive Diabetes Care by Increasing the Number of Retinal Eye Exams among Members with Diabetes in the Medi-Cal population from 18 through 75 years of age	Proposal
CalOptima	Improving the Rates of Cervical Cancer Screening Among Women	Improving the Rates of Cervical Cancer Screening Among Women 21-64	Re-measurement 2
Care 1st Partner Plan	Comprehensive Diabetic Care	The Quality Improvement Project (QIP) focus is the evaluation of Care 1st Health Plan's member's access, accessibility, and timeliness of care beginning with the primary care provider and collaboration with specialist to increase the likelihood of desired health outcomes of enrollees.	Baseline
CenCal Health	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/ Adolescents	Increase BMI documentation for child/adolescent members (ages 3-17) and referrals or counseling for nutrition education and physical activity.	SLO: Re-measurement 2 SB: Re-measurement 3
Central California Alliance for Health	Improving Asthma Health Outcomes	A primary diagnosis of asthma accounted for 11% of all admissions for members ages 1-9 and asthma related costs for those members was 31% of total asthma costs. In terms of ER utilization, asthma is in the top ten diagnoses for children ages 1-19 with annual ER costs close to half a million dollars. Acute care utilization shows that there still is a lot of opportunity for improvement.	Baseline
Community Health Group Partnership Plan	Increasing Follow-up to Positive Post-Partum Screens	Increase percentage of members with a live birth who receive a post-partum visit within 6 months of delivery & percentage of members screened for post-partum depression using a screening tool.	Re-measurement 4

APPENDIX B: CURRENT INTERNAL & SMALL GROUP COLLABORATIVE QUALITY IMPROVEMENT PROJECTS
(as of April 2012)

Health Plan	Internal QIP Title	Objective	Current Phase
Community Health Group Partnership Plan	Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD)	Improve treatment of COPD patients 40 years and older by increasing Spirometry testing for assessment and diagnosis, decreasing acute inpatient hospitalizations and emergency department visits, and increasing the appropriate use of asthma medications.	Re-measurement 4
Contra Costa Health Plan	Reducing Health Disparities in Pediatric Obesity	Reduce health disparities in childhood obesity age 3-11 for African Americans, Hispanics & Whites.	Re-measurement 2
Family Mosaic	Increase Rate of School Attendance	Increase the rate of school attendance for all capitated members.	Re-measurement 1
Family Mosaic	Reducing Out-of-Home Placements	Reduce the rate of children and adolescents discharged to out-of-home placements (foster care, group home, and residential treatment facilities).	Re-measurement 2
Gold Coast Health Plan	TBD	TBD	Proposal Due 10/12
Health Net Community Solutions	Improve Cervical Cancer Screening among Seniors and Persons with Disabilities	Improve Cervical Cancer Screening (CCS) among Seniors and Persons with Disabilities (SPD) 21 through 64 years of age	Re-measurement 2
Health Plan of San Joaquin	Improving HbA1c testing rates (Diabetes)	Improve the rate of HbA1c testing in Diabetic membership population age 18 to 75 years	Re-measurement 2
Health Plan of San Mateo	Increasing Timeliness of Prenatal Care	Increase the rate of prenatal visits during the first trimester of pregnancy. This study's data is based on the HEDIS® methodology and eligible population for timeliness into prenatal care measure. It does not exclude members with special health care needs.	Re-measurement 2
Inland Empire Health Plan	Attention Deficit Hyperactivity Disorder (ADHD) Management	Provide more appropriate ADHD management for ADHD-identified child members (ages 6-12 years).	Re-measurement 2
Kaiser Permanente: North	Child/Adolescent Obesity	Increase prevention and management of overweight child and adolescent members (ages 3-17).	Re-measurement 2
Kaiser Permanente: South	Children and Adolescents Access to Primary Care Practitioners	To improve the HEDIS® measure "Children and Adolescents Access to Primary Care Practitioners" with emphasis on the 25 month thru six years of age. To improve, access, patient satisfaction, and potentially overall health for the young members.	Proposal
Kern Family Health Care	Comprehensive Diabetic Quality Improvement Plan	Improve diabetes/case management of members (18-75 years) by increasing the percentage of members receiving an HbA1c test, LDL-C screening, and retinal exams. There was no exclusion criterion for members with special health care needs for any of the study indicators.	Proposal
L A Care Health Plan	Improving HbA1c and Diabetic Retinal Exam Screening Rates	Improving care and reducing complications for diabetic members (18-75) by increasing the percentage of members who receive screening with HbA1c testing and retinal exams.	Re-measurement 2
Molina Healthcare of CA	Improving Hypertension Control	Increase percentages of controlled blood pressure (Systolic Blood Pressure of <140 mm Hg and Diastolic Blood Pressure of < 90 mm Hg) for hypertensive members ages 18 to 85 including members with special health care needs.	Re-measurement 2

APPENDIX B: CURRENT INTERNAL & SMALL GROUP COLLABORATIVE QUALITY IMPROVEMENT PROJECTS
(as of April 2012)

Health Plan	Internal QIP Title	Objective	Current Phase
Partnership Health Plan	Improving Care and Reducing Acute Readmissions for People with COPD	Improving Care and Reducing Acute Readmissions for People with COPD. The study topic represents the entire eligible population of Medicaid members who meet the study criteria residing in Solano, Napa, and Yolo counties. As a COHS, PHC has financial responsibility for most of the Medi-Cal aid codes including the SPD population. The cohort for the QIP, patients with COPD, is a population with special health care needs.	Re-measurement 3
San Francisco Health Plan	Improving the Patient Experience	Improving communication to improve the patient experience with care.	Re-measurement 1
Santa Clara Family Health Plan	Childhood Obesity Partnership and Education (COPE)	To increase the percentage of members, 2 to 18 years of age, with at least one body mass index (BMI) \geq 95th percentile calculated and documented by a primary care practitioner (PCP) and identified through claims and encounter data as ICD-9-CM diagnosis code V85.54, who enrolled and attended at least one session of a nutritional program during the measurement year.	Baseline
SCAN Health Plan	Care for Older Adults	To improve functional status assessment, pain screening, advance care planning, medication reconciliation, and dementia screening for SCAN's Medicaid Enrollees: measured by HEDIS [®] Technical Specifications for Care for Older Adults (measure for Special Needs Plans)	Baseline

APPENDIX C: ACCESS TO CARE CONTRACT REQUIREMENTS

Domain	Contract Requirements	Compliance Documentation, Monitoring and Evaluation
Provider Network	Plans are required to provide access to the following services: <ul style="list-style-type: none"> ◆ Adequate Capacity Primary Care Network ◆ Board certified or eligible Specialists ◆ Non-physician medical practitioners (e.g., midwives, nurse practitioners) ◆ Federally Qualified Health Center services ◆ Traditional and Safety-Net Providers 	<ul style="list-style-type: none"> <input type="checkbox"/> Change in Provider Network Quarterly Report <input type="checkbox"/> Geographic Mapping Reports <input type="checkbox"/> Joint Medical Reviews <input type="checkbox"/> Plan Subcontractors Quarterly Report <input type="checkbox"/> Provider Directory (updated annually) <input type="checkbox"/> Subcontractors' Agreements/Records
Access and Availability	Plans communicate, enforce and monitor provider compliance with the following standards: <ul style="list-style-type: none"> ◆ Appointments (per contract criteria) ◆ Emergency Services facility within service area with at least one physician and one nurse on duty at all times ◆ Urgent care within 24 hours ◆ After Hours Calls ◆ Linguistic/Interpreter Services available 24 hours/7days/week ◆ Access for Disabled Members ◆ Services with Special Arrangements (e.g., family planning) ◆ Community Advisory Committee(s) 	<ul style="list-style-type: none"> <input type="checkbox"/> Consumer Satisfaction Survey <input type="checkbox"/> Emergency Department Protocols <input type="checkbox"/> Evidence of Coverage Member Handbook <input type="checkbox"/> Inpatient Days Information <input type="checkbox"/> Joint Medical Reviews <input type="checkbox"/> Policies and Procedures <input type="checkbox"/> Quality Improvement Projects
Care Coordination	Plans and contracted provider provide the following care coordination services: <ul style="list-style-type: none"> ◆ Comprehensive Medical Case Management ◆ Targeted Case Management ◆ Disease Management Services ◆ Out-of-Plan Case Management and Coordination of Care ◆ Children with Special Health Care Needs services ◆ California Children's Services ◆ Services to Persons with Developmental Disabilities ◆ Plan health professional or contracted physician available 24 hours/7 days/week to coordinate transfers, authorizations 	<ul style="list-style-type: none"> <input type="checkbox"/> Consumer Satisfaction Survey <input type="checkbox"/> Memorandums of Understanding with Local Health Departments <input type="checkbox"/> Policies and Procedures
Providers	Plans monitor provider compliance in the following areas: <ul style="list-style-type: none"> ◆ Preoperational and periodic Facility Site Reviews (FSR) ◆ Full-time equivalent Provider to Member ratios ◆ Regulatory physician supervision ratios for non-physician medical practitioners ◆ Time and distance standard 	<ul style="list-style-type: none"> <input type="checkbox"/> Geographic Mapping Reports <input type="checkbox"/> FSR Master Trainer and Reviewer Certification <input type="checkbox"/> FSR Oversight by Medical Monitoring Unit <input type="checkbox"/> Joint Medical Reviews <input type="checkbox"/> Site Review Reports
Scope of Services	Plans assure that the following services are provided: <ul style="list-style-type: none"> ◆ Medically Necessary Covered Services ◆ Initial Health Assessment ◆ CHDP Preventive and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services ◆ Adult Preventive, diagnostic and treatment ◆ Comprehensive Perinatal Services ◆ Pediatric and Adult Immunizations ◆ Vision Care ◆ Pharmaceutical Services ◆ Health Education ◆ Hospice Care 	<ul style="list-style-type: none"> <input type="checkbox"/> Consumer Satisfaction Survey <input type="checkbox"/> HEDIS® External Accountability Set <input type="checkbox"/> Joint Medical Reviews <input type="checkbox"/> Over/Under Utilization Monitoring <input type="checkbox"/> Quality Improvement Projects
Member Services	Plans and providers must comply with standards re: <ul style="list-style-type: none"> ◆ Member Rights/Responsibilities ◆ Rights to Advance Directives ◆ Notification of Changes to Access to Covered Service ◆ Primary Care Provider Selection/Assignment ◆ Member Grievance System ◆ Expedited State Hearings 	<ul style="list-style-type: none"> <input type="checkbox"/> Call Center Reports Quarterly <input type="checkbox"/> Consumer Satisfaction Survey <input type="checkbox"/> Grievance Log <input type="checkbox"/> Joint Medical Reviews <input type="checkbox"/> Member Services Guide <input type="checkbox"/> Oversight by Member Rights/Program Integrity <input type="checkbox"/> Policies and Procedures <input type="checkbox"/> Quality Improvement Projects <input type="checkbox"/> Quarterly Grievance Report

APPENDIX D: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: 2011-2013

	HEDIS® Reporting year 2011 ³	HEDIS® Reporting Year 2012 ⁴	Proposed: HEDIS® Reporting Year 2013 ⁵	Notes
1.	Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Years of Life	Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Years of Life	Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Years of Life	Hybrid measure; Used for Auto Assignment
2.	Adolescent Well-Care Visits	Adolescent Well-Care Visits	Deleted	Hybrid measure; Used for Auto Assignment
3.	Childhood Immunization Status – Combo 3	Childhood Immunization Status – Combo 3	Childhood Immunization Status – Combo 3	Hybrid measure; Used for Auto Assignment
4.	Appropriate Treatment for Children with Upper Respiratory Infection	Deleted		Admin measure
5.	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Hybrid measure; Prenatal indicator used for Auto Assignment
6.	Use of Imaging Studies for Low Back Pain – 1 st year	Use of Imaging Studies for Low Back Pain – 2 nd year	Use of Imaging Studies for Low Back Pain	Admin measure
7.	Breast Cancer Screening	Deleted		Admin measure
8.	Cervical Cancer Screening	Cervical Cancer Screening	Cervical Cancer Screening	Hybrid measure; Used for Auto Assignment
9.	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents – 1 st year	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents – 2 nd year	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	Hybrid measure
10.	Comprehensive Diabetes Care (8 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/Dl) • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attn. for Nephropathy • Blood pressure control (<140/90 mm Hg)	Comprehensive Diabetes Care (8 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/Dl) • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attn. for Nephropathy • Blood pressure control (<140/90 mm Hg)	Comprehensive Diabetes Care (8 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/Dl) • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attn. for Nephropathy • Blood pressure control (<140/90 mm Hg)	Hybrid measure; HbA1c Testing indicator used for Auto Assignment
11.	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Admin measure

³ Uses data from January 1, 2010, through December 31, 2010, measurement year.

⁴ Uses data from January 1, 2011, through December 31, 2011, measurement year.

⁵ Uses data from January 1, 2012, through December 31, 2012, measurement year.

APPENDIX D: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: 2011-2013

	HEDIS® Reporting year 2011 ⁶	HEDIS® Reporting Year 2012 ⁷	Proposed: HEDIS® Reporting Year 2013 ⁸	Notes
12.		Children & Adolescents' Access to Primary Care Practitioners – 1 st year	Children & Adolescents' Access to Primary Care Practitioners – 2 nd year	Admin measure
13.		Immunizations for Adolescents 1 st year	Immunizations for Adolescents 2 nd year	Hybrid measure
14.		Annual Monitoring for Patients on Persistent Medications (w/out anticonvulsant indicator) 1 st year	Annual Monitoring for Patients on Persistent Medications (w/out anticonvulsant indicator) 2 nd year	Admin measure; Addresses members 18 years & older
15.		Ambulatory care: <ul style="list-style-type: none"> • Outpatient visits • Emergency Department visits 1 st year	Ambulatory care: <ul style="list-style-type: none"> • Outpatient visits • Emergency Department visits 2 nd year	Admin measure; Addresses members <1 year through 85+ years
16.		All-Cause Readmissions – Statewide Collaborative QIP measure 1 st year	All-Cause Readmissions – Statewide Collaborative QIP measure 2 nd year	Admin measure; Modified HEDIS® measure for Medi-Cal
17.			NEW FOR 2013 Controlling High Blood Pressure (CBP)	Hybrid measure
18.			NEW FOR 2013 Medication Management for People with Asthma (MMA)	Admin measure
	7 Hybrid & 4 Admin measures	8 Hybrid & 6 Admin measures	8 Hybrid & 7 Admin measures	

¹ Uses data from January 1, 2010, through December 31, 2010, measurement year.

² Uses data from January 1, 2011, through December 31, 2011, measurement year.

³ Uses data from January 1, 2012, through December 31, 2012, measurement year.