Coordinated Care Initiative

HEALTH PLAN QUALITY AND COMPLIANCE REPORT

January 2016

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Executive Summary

Welfare and Institutions Code Section 14182.17(e)(1)(C) requires the Department of Health Care Services (DHCS) to submit a written report to the Legislature, effective January 10, 2014 and for each subsequent year of the Duals Demonstration Project, known as Cal MediConnect, which is authorized under Section 14132.275. Cal MediConnect is one component of the Coordinated Care Initiative (CCI), which serves dual-eligible beneficiaries, who are eligible for Medi-Cal and Medicare. Cal MediConnect combines the full continuum of acute, primary, institutional, behavioral health, and home and community-based Medicare and Medi-Cal services into a single benefit package. Cal MediConnect is delivered through an organized service delivery system administered by Medicare-Medicaid managed care health plans (MMPs).

The report is required to describe the degree to which MMPs in counties participating in Cal MediConnect have fulfilled quality requirements as set forth in the health plan contracts (three-way contract). The three-way contract template can be found at: http://www.calduals.org/implementation/cci-documents/cci-fact-sheets/contracts-mous/.

The January 10, 2014 reporting date was based on the initial January 1, 2013 CCI implementation date. Because participating counties and DHCS needed additional time to prepare for enrollment and implementation, the counties had delayed and staggered implementation dates throughout 2014 and early 2015. Due to the delays, as well as to account for a data lag, DHCS had to modify the due date for this report to January 10, 2016. DHCS informed the Legislature of the adjusted timeline in June of 2015.

Background

The Financial Alignment Initiative – Partnerships to Provide Better Care

In July 2011, the Centers for Medicare and Medicaid Services (CMS) announced the opportunity for states and CMS to better coordinate care for Medicare-Medicaid enrollees (Duals) under the Financial Alignment Initiative through two different demonstration models:

1. **Managed fee-for-service** in which a state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

2. **Capitated model** in which a state and CMS contract with health plans (three-way contract) that receive a prospective, blended payment to provide enrolled Duals with coordinated care.

The Financial Alignment Initiative is designed to better align the financial incentives of Medicare and Medicaid to provide Duals with a better health care experience. All state demonstrations under the Financial Alignment Incentive are evaluated to assess their impact on the beneficiary's care experience, quality, coordination, and costs. California is testing the capitated model.

Coordinated Care Initiative

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs), including Duals, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013).

The three major components of the CCI are:

1. A three-year Duals Demonstration Project, (Cal MediConnect - California's Financial Alignment Demonstration), for Duals that combines the full continuum of acute, primary, institutional services, and mild to moderate mental health care, as well as home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs);
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of the Long Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD and other beneficiaries who are eligible for Medi-

Cal only, and for beneficiaries who are Duals and who are not enrolled in Cal MediConnect.

Enrollment in the CCI began on April 1, 2014, as described in the implementation schedule titled, "CCI Enrollment Timeline by Population and County," which can be found at the following link: http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf.

Cal MediConnect

Through Cal MediConnect, Duals have access to better, more coordinated care, in addition to dental, vision, and non-emergency transportation services. The Department of Health Care Services (DHCS) and CMS contract with MMPs that oversee and are accountable for the delivery of covered Medicare and Medicaid services for Duals in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara.

MMPs are responsible for providing a comprehensive assessment of Duals' medical, behavioral health, LTSS, functional, and social needs. Duals and their caregivers work with an interdisciplinary care team (ICT) to develop person-centered, individualized care plans (ICPs). Cal MediConnect is designed to offer opportunities for Duals to self-direct services, be involved in care planning, and live independently in the community. Cal MediConnect includes beneficiary protections that ensure high-quality care is delivered. CMS and DHCS have established a number of quality measures relating to beneficiary overall experience, care coordination, and fostering and supporting community living, among many others.

Memorandum of Understanding and the Three-Way Contract

DHCS executed a Memorandum of Understanding (MOU) with CMS on March 27, 2013. The MOU provides federal authority and outlines the parameters for implementing Cal MediConnect.

Many of the specific requirements are outlined in the three-way contracts between the State, CMS, and the MMPs in each CCI county. These three-way contracts require the MMPs to offer quality, accessible care, and to improve care coordination among medical care, behavioral health, and LTSS to eligible Duals. DHCS and CMS developed a three-way contract for each participating MMP, including a contracting process that ensures a coordinated program operation, enforcement, monitoring, and oversight. The three-way contract includes provisions for CMS and DHCS to evaluate the performance of the primary-contracted MMPs and sub-contracted plans. MMPs are held accountable for ensuring that sub-contracted plans meet all applicable laws and requirements.

The three-way contract and MOU can be found at:
http://www.calduals.org/implementation/cci-documents/cci-fact-sheets/contracts-mous/.

Quality Monitoring and Quality Withholds

Participating MMPs are subject to monitoring and evaluation as part of their participation in Cal MediConnect. CMS and DHCS jointly monitor the MMPs' performance on a broad set of metrics. Each MMP is required to report data for quality metrics selected by CMS and DHCS for ongoing monitoring during the demonstration period. There are 85 metrics listed in the MOU that form the quality monitoring efforts of Cal MediConnect. These metrics are similar to those for other states that have approved MOUs for Dual integration efforts. The quality metrics selected are derived largely from standard measurement sets including the Healthcare Effectiveness Data and Information Set (HEDIS), the Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) as well as measurement sets used to evaluate quality in Special Needs Plans (SNPs). In addition, DHCS identified a selected set of metrics to evaluate LTSS quality.

The Medicare and Medi-Cal programs withhold a certain percentage of estimated capitation rates for each MMP (one, two, and three percent in the first, second, and third years, respectively), which are tied to specific quality withhold measures. If the MMP meets specified performance targets, it will receive quality payments equal to the percentage deducted from the rates for enrolled Duals. All of the metrics selected for the quality withhold are part of the larger set of metrics to be used for ongoing health plan monitoring.

In Year 1 (April 2014 – December 2015), the quality withhold was equal to one percentage point based on ten performance measures. These measures (see Table 1 below) focused on key structure and process measures including submission of complete encounter data for enrolled Duals, the proportion of initial health assessments completed within the specified timeframe, evidence of the establishment of a beneficiary governance board, and evidence of appropriate access to services, among others. Determinations of whether or not MMPs met the threshold for each quality measure including the data associated with them will be released in the second half of 2016..

The quality withholds will increase to two percentage points in Year 2 (January – December 2016) and three percentage points in Year 3 (January – December 2017). These quality withholds will be based on ten different quality measures. These measures (see Table 2 below) are focused more on process and outcomes with a clinical focus. The three-way contract includes more detail about the quality withhold measures, including performance standards.

The MOU states that MMPs meeting quality withhold requirements will be reported for each year of Cal MediConnect.

Table 1: Year One Quality Withhold Measures.

Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Risk assessments	Percent of members with initial assessments completed within 90 days of enrollment	Centers for Medicare & Medicaid Services (CMS)/State defined process measure	X	
Behavioral health shared accountability process measure Phase A (9/1/13 – 12/31/13) Phase B (1/1/14 – 12/31/14)	Phase A: Policies and procedures attached to a memorandum of understanding (an MOU) with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes the signature of the primary behavioral health provider	State defined measure		X
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements	CMS/State defined measure	X	X
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements	CMS/State defined measure	X	X
Customer service	Percent of best possible score the health plan earned on how easy it is to get information and help when needed	Agency for Healthcare Research and Quality (AHRQ) /Consumer Assessment of Healthcare Providers and Systems (CAHPS)	X	X

Access to care	Percent of respondents who always or usually were able to access care quickly when they needed it	AHRQ/CAHPS	X	X
Interaction with care team	Percentage of members who have a care coordinator and at least one care team contact	State defined measure		X
Ensuring physical access to buildings, services and equipment	Documentation of an established work plan and identification of the individual responsible for physical access compliance	State defined measure		X
Documentation of care goals	Number of members with at least one documented discussion of care goals in the individualized care plan	State defined measure		X

Table 2: Years Two and Three Quality Withhold Measures

Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Follow-up after hospitalization for mental illness	Percent of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner	National Committee for Quality Assurance (NCQA)/ Healthcare Effectiveness Data and Information Set (HEDIS)	X	
Screening for clinical depression and follow-up	Percent of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented	Centers for Medicare & Medicaid Services (CMS)	X	
Part D medication adherence for oral diabetes medications	Percent of health plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication	CMS Prescription Drug Event (PDE) data	X	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year	NCQA/HEDIS Health Outcomes Survey (HOS)	X	
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital	NCQA/HEDIS	X	

Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
	stay or for a different reason			
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season	Agency for Healthcare Research and Quality (AHRQ)/ Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data	X	
Behavioral health shared accountability outcome measure	Reduction in emergency room use for seriously mentally ill and substance use disorder enrollees (greater reduction in Demonstration Year Three)	State defined measure		X
Interaction with care team	Percentage of members who have a care coordinator and at least one care team contact	State defined measure		X
Documentation of care goals	Number of members with at least one documented discussion of care goals in the individualized care plan	State defined measure		X

California Evaluation Design Plan

CMS contracted with Research Triangle Institute (RTI) International to monitor the implementation of demonstrations under the Financial Alignment Initiative and to evaluate its impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and state-specific evaluations.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g., people with mental illness and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI International will collect qualitative and quantitative data from the State each quarter, analyze Medicare and Medi-Cal enrollment and claims data, conduct site visits, beneficiary focus groups, and key informant interviews, and incorporate relevant findings from any beneficiary surveys conducted by other entities. Information from monitoring and evaluation activities will be provided to CMS and DHCS in annual

reports, followed by a final evaluation report. The California Evaluation Design Plan can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html.

Cal MediConnect Reporting Requirements

Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and California Specific Reporting Requirements

In November 2013, CMS published the "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements," which contains the quality evaluation measures that all states participating in Financial Alignment Initiative are required to report. These core measures address the full range of services and benefits for Cal MediConnect, including medical, pharmacy, LTSS, and behavioral health, as well as care coordination and consumer satisfaction. The "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements" can be found on the CMS website at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015CoreReportingRequirements121415.pdf.

In addition to these core reporting requirements, there is a separate reporting appendix for state-specific measures that have been developed with much stakeholder input over the course of the planning and implementation phases of Cal MediConnect. This appendix can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015ReportingAppendixCA.pdf.

The core and state-specific measures are included in Table 3 below.

Table 3: Quality Measures under Cal MediConnect

Measure	Description	Measure Steward/ Data Source	CMS Core Measure	State Specified Measure
Antidepressant medication management	Percent of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment	National Committee for Quality Assurance (NCQA)/ Healthcare Effectiveness Information Set (HEDIS)	X	
Initiation and engagement of alcohol and other drug (AOD)	Percent of adolescent and adult members with a new episode of AOD dependence	NCQA/HEDIS	X	

dependence treatment	who received the following: • Initiation of AOD treatment: Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis • Engagement of AOD treatment: Percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit			
Follow-up after hospitalization for mental illness	Percent of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner	NCQA/HEDIS	X	
Screening for clinical depression and follow-up	Percent of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented	Centers for Medicare & Medicaid Services (CMS)	X	
Care transition record transmitted to health care professional	Percent of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	American Medical Association (AMA)-Physician Consortium for Performance Improvement (PCPI)	X	
Medication reconciliation after discharge from inpatient facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented	NCQA/HEDIS	X	
Consumers Assessment of Healthcare Providers and Systems (CAHPS), various settings including health plan plus supplemental items/questions, including: • Experience of Care and Health Outcomes for Behavioral Health (ECHO) • Home health	Depends on survey	Agency for Healthcare Research and Quality (AHRQ)/CAHPS	X	

• Nursing home • People with mobility impairments • Cultural competence • Patient centered medical home				
Part D call center – Pharmacy hold time	Average time spent on hold when pharmacists call the drug plan's pharmacy help desk	CMS Call Center data	X	
Part D call center – Foreign language interpreter and TTY/TDD availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number	CMS Call Center data	X	
Part D appeals auto–forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the drug plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000	IRE	X	
Part D appeals upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal This measure is defined as the percent of IRE confirmations of upholding the drug plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100	IRE	X	
Part D complaints about the drug plan	How many complaints Medicare received about the drug plan For each contract, this rate is calculated as: [(Total number of complaints logged into the Medicare Complaints Tracking Module (CTM) for the drug plan regarding any issues) / (Average contract enrollment)] * 1,000 * 30 / (Number of days in period)	CMS CTM data	X	
Part D beneficiary access and performance problems	To check on whether members are having problems getting access to care and to be sure that drug plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews Medicare gives the drug plan a lower	CMS Administrative data	X	

	score (from 0 to 100) when it finds problems The score combines how severe the problems were, how many there were, and how much they affect drug plan members directly. A higher score is better, as it means Medicare found fewer problems			
Part D Medicare Plan Finder (MPF) accuracy	Accuracy of how the MPF data match the Prescription Drug Event (PDE) data	CMS PDE data, MPF Pricing Files, Health Plan Management System-approved formulary extracts, and data from First DataBank and Medispan	X	
Part D high risk medication	Percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices	CMS PDE data	X	
Part D diabetes treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes	CMS PDE data	X	
Part D medication adherence for oral diabetes medications	Percent of drug plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication	CMS PDE data	X	
Part D medication adherence for hypertension (ACEI or ARB)	Percent of drug plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication	CMS PDE data	X	
Part D medication adherence for cholesterol (statins)	Percent of drug plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication	CMS PDE data	X	
Health plan makes timely decisions about appeals	Percent of health plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage	Independent Review Entity (IRE)	X	
Reviewing appeals decisions	How often an independent reviewer agrees with the health plan's decision to	IRE	X	

	deny or say no to a member's appeal			
Call center – Foreign language interpreter and TTY/TDD availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number	CMS call center data	X	
High risk residents with pressure ulcers (long-stay)	Percent of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (three-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s)	National Quality Forum (NQF) endorsed	X	
Risk assessments	Percent of members with initial assessments completed within 90 days of enrollment	CMS/State defined process measure	X	
Individualized care plans	Percent of members with care plans by specified timeframe	CMS/State defined process measure	X	
Risk stratification based on long-term services and supports (LTSS) or other factors	Percent of risk stratifications using behavioral health/LTSS data/indicators	CMS/State defined process measure	X	
Discharge follow-up	Percent of members with specified timeframe between discharge to first follow-up visit	CMS/State defined process measure	X	
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration	CMS/State defined process measure	X	
Care for older adults – Medication review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year	NCQA/ HEDIS	X	
Care for older adults – Functional status assessment	Percent of plan members whose doctor has done a: • Functional status assessment to see how well they are doing • Activities of daily living (such as dressing, eating, and bathing)	NCQA/HEDIS	X	
Care for older adults – Pain screening	Percent of plan members who had a pain screening or pain management plan at least once during the year	NCQA/HEDIS	X	
Diabetes care – Eye exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year	NCQA/HEDIS	X	
Diabetes care – Kidney disease monitoring	Percent of plan members with diabetes who had a kidney function test during the year	NCQA/HEDIS	X	
Diabetes care – Blood sugar controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year	NCQA/HEDIS	X	

	that showed their average blood sugar is under control			
Rheumatoid arthritis management	Percent of plan members with rheumatoid arthritis who got one or more prescription(s) for an anti-rheumatic drug	NCQA/HEDIS	X	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year	NCQA/HEDIS Health Outcomes Survey (HOS)	X	
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason	NCQA/HEDIS	X	
Controlling blood pressure	Percent of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	NCQA/HEDIS	X	
Comprehensive medication review (CMR)	Percent of beneficiaries who received a CMR out of those who were offered a CMR	Pharmacy Quality Alliance (PQA)	X	
Complaints about the health plan	How many complaints Medicare received about the health plan Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (average contract enrollment)] * 1,000 * 30 / (number of days in period)	CMS CTM data	X	
Beneficiary access and performance problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from zero to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems	CMS Beneficiary database	X	
Members choosing to leave health plan	Percent of health plan members who chose to leave health plan in current year	CMS	X	
Getting information from drug plan	Percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost: • In the last six months, how often did your health plan's customer service give you the information or help you needed about	AHRQ/CAHPS	X	

	prescription drugs? • In the last six months, how often did your plan's customer service staff treat you with courtesy and respect when you asked for information or help about prescription drugs? • In the last six months, how often did your health plan give you all the information you needed about the prescription medications are covered? • In the last six months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?			
Rating of drug plan	Percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs • Using any number from zero to ten, where zero is the worst prescription drug plan possible and ten is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS	X	
Getting needed prescription drugs	Percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan • In the last six months, how often was it easy to use your health plan to get the medicines your doctor prescribed? • In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS	X	
Getting needed care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists • In the last six months, how often was it easy to get appointments with specialists? • In the last six months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS	X	
Getting appointments and care quickly	Percent of best possible score the plan earned on how quickly members get appointments and care • In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?	AHRQ/CAHPS	X	

	• In the last six months, not counting the times when you needed care right away, • How often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?			
Overall rating of health care quality	Percent of best possible score the plan earned from plan members who rated the overall health care received Using any number from zero to ten, where zero is the worst health care possible and ten is the best health care possible, what number would you use to rate all your health care in the last six months?	AHRQ/CAHPS	X	
Overall rating of health plan	Percent of best possible score the plan earned from plan members who rated the overall plan. Using any number from zero to ten, where zero is the worst health plan possible and ten is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS	X	
Breast cancer screening	Percent of female plan members aged 40-69 who had a mammogram during the past two years	NCQA/ HEDIS	X	
Colorectal cancer screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer	NCQA/HEDIS	X	
Cardiovascular care – Cholesterol screening	Percent of plan members with heart disease who have had a test for —bad (LDL) cholesterol within the past year	NCQA/HEDIS	X	
Diabetes care – Cholesterol screening	Percent of plan members with diabetes who have had a test for bad (LDL) cholesterol within the past year	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season	AHRQ/CAHPS Survey data	X	
Improving or maintaining mental health	Percent of all plan members whose mental health was the same or better than expected after two years	CMS HOS	X	
Monitoring physical activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year	HEDIS / HOS	X	
Access to primary care doctor visits	Percent of all plan members who saw their primary care doctor during the year	HEDIS	X	
Access to specialists	Proportion of respondents who report that it is always easy to get appointment with specialists	AHRQ/CAHPS	X	
Getting care quickly	Composite of access to urgent care	AHRQ/CAHPS	X	
Being examined on the examination table	Percent of respondents who report always being examined on the examination table	AHRQ/CAHPS	X	
Help with transportation	Composite of getting needed help with	AHRQ/CAHPS	X	

	transportation			
Health status/function status	Percent of members who report their health as excellent	AHRQ/CAHPS	X	
Behavioral health shared accountability process measure Phase A (9/1/13 – 12/31/13) Phase B (1/1/14 – 12/31/14)	Phase A: Policies and procedures attached to an memorandum of understanding (MOU) with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving a coordinated care plan as indicated by having an individual care plan that includes the evidence of collaboration with the primary behavioral health provider	State defined measures		X
Behavioral health shared accountability outcome measure	Reduction in emergency room (ER) use for seriously mentally ill and substance use disorder enrollees (greater reduction in Demonstration Year Three)	State defined measure		X
The number of critical incident and abuse reports for members receiving LTSS	Enrollee protections	State defined measure		X
Members with an individual care plan completed	Care coordination	CMS/State defined measure	X	X
Low risk members with an ICP within 30 working days after the completion of the Health Risk Assessment (HRA)	Care coordination	CMS/State defined measure	X	X
High risk members with an ICP within 30 days after the completion of the HRA	Care coordination	CMS/State defined measure	X	X
Members with first follow-up visit within 30 days after hospital discharge	Care coordination	CMS/State defined measure	X	X
ER utilization rates	Utilization measure, potentially revised to reflect avoidable ER visits	State defined measure		X
In-Home Supportive Services (IHSS) utilization	Utilization measure	State defined measure		X
Readmissions of short-and long-stay nursing facility residents after hospitalization for diabetes, chronic obstructive pulmonary disease or any medical diagnosis	Utilization measure	State defined measure		X
Unmet need in LTSS	Unmet need in activities of daily living/instrumental activities of daily living and IHSS functional level	State defined measure		X
IHSS Case manager contact with member	Ability to identify case manager or contact case manager DHCS will work with CMS and will publish	State defined measure		X

	details as they become available			
Satisfaction with IHSS case manager, home workers, personal care	Satisfaction with case manager, home workers, personal care	State defined measure		X
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements	CMS/State defined measure	X	X
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements	CMS/State defined measure	X	X
Customer service	Percent of best possible score the plan earned on how easy it is to get information and help when needed	AHRQ/CAHPS	X	X
Access to care	Percent of respondents who always or usually were able to access care quickly when they needed it	AHRQ/CAHPS	X	X

Similar to the quality withhold reporting, the MMPs have been reporting on the metrics listed in Table 3; a subset of these reporting metrics are included in a recently released Cal MediConnect Performance Dashboard which can be found at http://www.calduals.org/enrollment-information/enrollment-data/cal-mediconnect-performance-dashboard/. This dashboard will be released quarterly with additional measures being added as data become available and based on stakeholder feedback. Throughout the implementation phase of Cal MediConnect, CMS and DHCS collectively have been monitoring this data and providing clarifying and technical guidance to the MMPs, as necessary, to ensure that all MMPs are interpreting the reporting requirements correctly and reporting consistently.

In addition to the metrics in Table 3, per section 2.16.4.1.3.1 of the three-way contract, MMPs are also required to submit all HEDIS, HOS, and CAHPS data, as well as all other measures listed in Table 3. HEDIS, HOS and CAHPS data must be reported consistent with Medicare requirements. All existing Medicare Part D metrics will be collected as well. DHCS will provide additional details, including technical specifications, in annual guidance for the upcoming reporting year.

Quality Improvement Project Requirements and Activities

Quality Improvement Project (QIP) requirements can be found in section 2.16.4.3 of the three-way contract. In addition, sections 2.16.4.8 and 2.16.4.3.1.2.1 specify that MMPs are required to conduct a “Chronic Care Improvement Program” (CCIP) as well as a QIP following the Plan-Do-Study-Act (PDSA) methodology. The MMPs are following all of the Medicare requirements for both of these efforts.

The Health Plan Management System CCIP Module serves as the means for MMPs to submit and report on their CCIPs to CMS and the State. The CCIP and QIP modules

allow MMPs to report on the CCIP and QIP throughout the entire life cycle of the CCIP and QIP as defined below:

- **Plan**: Describes the processes, specifications, and outcome objectives used to establish the CCIP. The Plan section of the CCIP is only submitted once (in the fall of the MMP's first operational year). Once approved by both CMS and the State, MMPs begin implementation of the CCIP, including collecting data that will subsequently be used in the Annual Update which includes the "Do, Study, and Act" sections;

- **Annual Update** consists of the Do, Study, and Act sections and is completed annually, beginning the first year of CCIP implementation and each year thereafter for the duration of the project:

    - **Do**: Describes how the CCIP is conducted, the progress of the implementation, and the data collection plan;

    - **Study**: Describes and analyzes findings against the benchmark(s) or goal(s), as determined by the MMP, and identifies trends over several PDSA cycles that can be considered for the "Act" stage;

    - **Act**: Summarizes the action plan(s) based on findings and describes the differences between the established benchmarks and the actual outcomes, providing information regarding any changes based on actions performed to improve processes and outcomes, including a short description of actions performed.

The topic for the CCIP is "Decreasing Cardiovascular Disease" and the topic for the QIP is "Reducing All-Cause Hospital Readmissions." The CCIP and QIP requirements can be found here:
http://www.thescanfoundation.org/sites/default/files/field_research_medicare_medical_polling_results_2_12-7-15.pdf.

In early 2015, all of the MMPs that had enrollment in 2014 were required to submit their planning documents for both of these projects. These deliverables were template documents that each MMP was required to complete to describe the specific clinical foci and expected outcomes, relevance to the MMP's population, anticipated outcomes, the population identification process, evidence-based medicine protocols referenced, the MMP's care coordination approach, outcome measures and interventions, and communication sources including the ICT and patients. CMS and DHCS collectively reviewed these deliverables and after several resubmissions, all deliverables were approved.

Since the planning documents were submitted in early 2015, the MMPs have been conducting the Do-Study-Act portions of the methodology, by testing their interventions, studying the results, and making changes to interventions, when appropriate, to better

achieve their expected outcomes. In late 2015, the MMPs submitted their annual updates to their initial planning documents, describing the actions taken throughout the year and what modifications, if any, were implemented to meet their expected outcomes. CMS and DHCS are currently in the process of reviewing these annual updates and anticipate completion of this round of reviews in early 2016.

In addition to the CCIP and QIP, DHCS is anticipating beginning the statewide collaborative (also called Performance Improvement Projects) in 2016 on the topic of care coordination, following the three-way contract requirements. Additional details will be provided in the 2017 update of this report.