



**QUARTERLY UPDATE
TO THE LEGISLATURE**

MEDI-CAL MANAGED CARE PROGRAM

**For the Reporting Period
July through September 2012**

**Department of Health Care Services
Medi-Cal Managed Care Division**

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A. PURPOSE OF THE REPORT

This report is a condensed version of previous reports as the expansion effort, with the exception of El Dorado, Imperial, Placer, Lake and San Benito, is complete. The expansion effort into the remaining counties of El Dorado, Imperial, Placer, Lake and San Benito, will continue pursuant to Assembly Bill (AB) 1467 (Committee on Budget, Chapter 23, Statutes of 2012), otherwise known as the Rural County Medi-Cal Managed Care Expansion. DHCS will be required to provide the fiscal and appropriate policy committees of the Legislature with an additional quarterly update, commencing January 1, 2014, and ending January 1, 2016, regarding this rural county expansion effort.

Updates to this report are *italicized* for ease of review.

Assembly Bill (AB) 131 (Committee on Budget, Chapter 80, Statutes of 2005), authorized the Department of Health Care Services (DHCS) to expand the Medi-Cal Managed Care Program into 13 new counties: El Dorado, Imperial, Kings, Lake, Madera, Marin, Merced, Mendocino, Placer, San Benito, San Luis Obispo, Sonoma, and Ventura.

Since January 1, 2006, DHCS has been required to provide quarterly updates to the policy and fiscal committees of the Legislature on DHCS' core activities to improve the Medi-Cal Managed Care Program and to expand into the 13 counties.

Pursuant to AB 131, the quarterly updates shall include, when applicable:

- Progress or key milestones and objectives to implement changes to the existing program;
- Submittal of State Plan Amendments to the Centers for Medicare and Medicaid Services;
- Submittal of any federal waiver documents; and,
- Applicable key functions related to the effort to expand the Medi-Cal Managed Care Program.

This report is not intended to update the ongoing development and implementation of DHCS' Section 1115 Demonstration Waiver (Demonstration Waiver). Updates on the Demonstration Waiver are included in DHCS' semi-annual report to the Legislature titled "Mandatory Enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care." The purpose of this report is to provide quarterly updates to the policy and fiscal committees of the Legislature on DHCS' core activities to improve the Medi-Cal Managed Care Program for the expansion into the 13 counties listed above.

DHCS is currently undertaking or has completed the actions listed below to enhance and improve the Medi-Cal Managed Care Program:

B. AVOIDABLE EMERGENCY ROOM VISITS COLLABORATIVE

For the past four years, DHCS has worked collaboratively with Medi-Cal managed care health plans (MCPs) to reduce avoidable visits to the emergency room (ER). An avoidable ER visit is a visit that is more appropriately managed by and/or referred to a primary care provider (PCP) through an office or clinic setting. MCPs worked collaboratively to implement two statewide interventions: a health education campaign and a health plan collaboration with a selected network hospital.

The ER Collaborative ended in December 2010 and all MCPs submitted their final ER Collaborative reports to the External Quality Review Organization (EQRO). *The EQRO has completed the final report. The final ER Collaborative Report was released on July 17, 2012 and is available on the DHCS website at:*

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Coll_ER_Remeasure_Report.pdf

C. REDUCING HOSPITAL READMISSIONS

In July 2011, DHCS began meeting with MCPs and DHCS' EQRO, Health Services Advisory Group (HSAG), to begin a new Statewide Collaborative Quality Improvement Project (QIP) titled, "Reducing All Cause Hospital Readmissions (ACR)." Two subcommittees, the Guiding Principles Subcommittee and the Measure Specifications Subcommittee, were formed and were composed of staff from the Medi-Cal Managed Care Division (MMCD), MCPs, and the EQRO.

The Guiding Principles Subcommittee developed a set of principles for conducting MCP meetings for the collaborative process. The Measure Specifications Subcommittee developed specifications for customizing the selected Healthcare Effectiveness Data and Information Set (HEDIS) and ACR measures, specific to the Medi-Cal population.

A hospital readmission is a preventable or avoidable hospital admission that occurs within 30 days after discharge from the first or index admission. MCPs submitted Statewide Collaborative QIP proposals on March 30, 2012. All QIP proposals were reviewed by MMCD and validated by HSAG. MCPs submitted QIP study design phase data on September 28, 2012. All QIP study design phase data will be reviewed by HSAG. *MCPs are now conducting a barrier analysis and designing interventions to be implemented in January 2013.*

Over the next three years, the QIP goals for the Reducing Hospital Readmissions Collaborative are to: 1) understand the reasons why Medi-Cal members 21 years of age and older are readmitted to the hospital, and 2) identify and implement effective strategies to reduce hospital readmission rates.

D. ASSEMBLY BILL 1422 GROSS PREMIUMS TAX SUNSET EXTENSION

AB 1422 (Bass, Chapter 157, Statutes of 2009) added MCPs to the list of entities subject to California's gross premiums tax, or Managed Care Organization (MCO) tax, a 2.35 percent tax on total operating revenue. The proceeds from this tax are appropriated to DHCS for the Medi-Cal Managed Care Program and to the Managed Risk Medical Insurance Board for the Healthy Families program (HFP). The bill increases premiums paid by HFP enrollees, and allows the California Children and Families Commission to transfer monies among its various funds.

The bill took effect retroactively to January 1, 2009, and was scheduled to sunset on January 1, 2011. SB 208 (Steinberg, Chapter 714, Statutes of 2010) extended the sunset date of AB 1422 to June 30, 2011. State Budget Health Trailer Bill ABX1 21 (Blumenfield, Chapter 11, Statutes of 2011) extended the sunset date again from June 30, 2011 to June 30, 2012. *DHCS proposed trailer bill language to extend the tax; however, the bill did not pass. DHCS intends to pursue legislative authority to extend the MCO tax.*

E. RISK-ADJUSTED CAPITATION RATES

For rate years beginning in State Fiscal Year 2009-10, DHCS implemented maternity supplemental payments and risk-adjusted capitation rates for MCPs contracting in counties that provide health care under the Two-Plan Model (TPM) and Geographic Managed Care (GMC) model of managed care. The maternity supplemental payments to MCPs were in addition to monthly capitation payments and were based on MCP reports of delivery events.

Capitation rates were risk-adjusted to match each MCP's projected costs to their capitated payments more effectively. To calculate the final capitation rates, the final risk-adjusted scores were applied to the developed county average capitation rates. For the first and second years, risk-adjustments were phased in using a rate comprised of 20 percent risk-adjusted county average rates and 80 percent plan-specific rates. For the third year, risk-adjustments are being phased in using a rate comprised of 25 percent risk-adjusted county average rates and 75 percent plan-specific rates. For the fourth year, risk-adjustments will be phased in using a rate comprised of 35 percent risk-adjusted county average rates and 65 percent plan-specific rates.

Nothing new to report for the July through September quarter.

F. COMMUNITY BASED ADULT SERVICES

AB 97 (Committee on Budget, Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services as an optional Medi-Cal benefit. DHCS became the defendant in a lawsuit (*Darling v. Douglas*) to halt the elimination of ADHC. DHCS entered into a settlement agreement with the plaintiffs to establish a new program called Community Based Adult Services (CBAS) that offers some of the same services as ADHC and

allows beneficiaries in danger of institutionalization to remain in their communities; however, CBAS has stricter eligibility requirements to achieve cost savings.

ADHC ended on February 29, 2012, and fee-for-service (FFS) CBAS began on March 1, 2012. The MCPs operating in County Organized Health System (COHS) counties *began* covering CBAS July 1, 2012, with the exception of the Gold Coast Health Plan (GCHP) in Ventura County. The TPM and GMC MCPs, along with GCHP, will begin covering CBAS on October 1, 2012.

MCPs have contracted with former ADHC centers that have been certified as CBAS providers. MCPs assume two responsibilities in relation to CBAS: 1) the assessment process to determine eligibility for CBAS, and 2) the reassessment process to ensure that CBAS members continue to receive the level of CBAS services needed or to determine if CBAS is still necessary. DHCS has executed contract amendments outlining MCP responsibilities in managing CBAS that included rates to cover the daily provision of CBAS services.

G. HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS®)

In December 2011, DHCS released the 2011 HEDIS aggregate report for the Medi-Cal Managed Care Program. In accordance with federal requirements, this report presents the annual plan-specific and program results for HEDIS performance measures used by DHCS to assess and evaluate the quality and appropriateness of care and services provided to MCP members. The 2011 report prepared by the EQRO noted that the Medi-Cal Managed Care Program as a whole demonstrated average performance for most measures with strengths in some areas and room for improvement in others.

The Medi-Cal Managed Care Program performed near the national 75th percentile in the Childhood Immunization Status, and Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life Measures. Some MCPs demonstrated high performance (above the national 90th percentile) in many of the required measures. MCPs that scored below DHCS' minimum performance level (below the national 25th percentile) were required to submit corrective action plans. The aggregate report acknowledged the Medi-Cal Managed Care Program's commitment to monitor and improve quality of care and to have a variety of mechanisms to support improvement efforts of MCPs. The report is available on the DHCS website at:

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>

DHCS is in the process of finalizing the annual update to the Quality and Performance Improvement Program requirements for 2013, and anticipates release by the end of October 2012.

Attachment A

Abbreviations and Acronyms

| | |
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| AB | Assembly Bill |
| ACR | All Cause Hospital Readmissions |
| ADHC | Adult Day Health Care |
| CBAS | Community Based Adult Services |
| COHS | County Organized Health System |
| Demonstration Waiver | DHCS' Section 1115 Demonstration Waiver titled, "California's Bridge to Reform." |
| DHCS | Department of Health Care Services |
| EQRO | External Quality Review Organization |
| ER | Emergency Room |
| FFS | Fee-For-Service |
| GCHP | Gold Coast Health Plan |
| GMC | Geographic Managed Care |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HFP | Healthy Families Program |
| HSAG | Health Services Advisory Group |
| MCO | Managed Care Organization |
| MCP | Medi-Cal Managed Care Plan |
| MMCD | Medi-Cal Managed Care Division |
| PCP | Primary Care Provider |
| QIP | Quality Improvement Project |
| SB | Senate Bill |
| TPM | Two-Plan Model |