Medi-Cal Managed Care Program

QUALITY STRATEGY REPORT

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

Annual Update
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Quality Strategy Report

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EXECUTIVE SUMMARY

This report outlines the managed care quality strategy as mandated by Title 42 Code of Federal Regulations (CFR), Section (§) 438.202. The Department of Health Care Services (DHCS) developed a comprehensive DHCS Quality Strategy based upon the National Quality Strategy. The DHCS Quality Strategy defines 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 more than 8.4 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 over 5-million low-income Californians, including children, pregnant women, seniors, and persons with disabilities. As of April 2013, 21 managed care health plans that are contracted with the State (Plans) to provide health care services to Med-Cal enrollees in 30 of the State's most populous counties. Under current DHCS initiatives, the numbers of beneficiaries served in Medi-Cal Managed Care could increase to nearly 6.5 million persons in all 58 counties.

Each state that enters into one-or-more contracts with managed care organizations, prepaid ambulatory health plans, or prepaid inpatient health plans must develop a written quality strategy per 42 CFR §438.202. This *Quality Strategy Report* describes the program history and structure, defines contractual standards, and outlines oversight and monitoring activities of the Medi-Cal managed care program. This report also addresses operational processes and procedures implemented by DHCS that:

   o   Assess the quality of care delivered through Plan contracts;

   o   Make improvements, based on assessment, in the quality of care delivered to Medi-Cal beneficiaries through Plan contracts;

   o   Obtain the input of Medi-Cal beneficiaries and other stakeholders;

   o   Ensure that contracted Plans comply with standards established by the State; and

   o   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 Strategy Report* reflects the unique operational contributions that Medi-Cal Managed Care can make in furthering DHCS's goals.

This updated *Quality Strategy Report* reflects DHCS's renewed emphasis on quality and outcomes. In November 2010, the Centers for Medicare and Medicaid Services (CMS) approved DHCS's five-year Section 1115 Medicaid waiver, *A Bridge to Reform* (Waiver). Through the Waiver, California has received approximately $10-billion in federal funds to invest in its 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, improve health care outcomes, slow the growth rate of long-term expenditures in the Medi-Cal program, and expand coverage to uninsured Californians. These investments will achieve the State's three linked goals: 1) Improve the health of all Californians, 2) Enhance the quality, including the patient care experience, of all DHCS programs, and 3) Reduce the DHCS's per-capita health care program costs.

SECTION I: INTRODUCTION

Managed Care Goals, Objectives, and Overview

Program Background
The Department of Health Care Services (DHCS) has employed a managed care delivery system for the Medi-Cal program in a variety of forms since 1972. DHCS initially contracted health care services through Medi-Cal managed care plans (Plans) operating under the Prepaid Health Plan (PHP) and Primary Care Case Management (PCCM) models of managed care. 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, who continued to receive specialty care still through the Medi-Cal 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 Plans operating under the County-Organized Health System (COHS) model of managed care, which are organized and operated by individual counties. Medi-Cal beneficiaries in COHS counties do not have the option of accessing 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 of the state's 58 counties (Appendix A).

In 1991, State legislation (Assembly Bill 337) amended various sections of the Welfare and Institutions (W&I) Code to establish the California Managed Care Initiative (Initiative), which expanded Medi-Cal Managed Care by requiring mandatory enrollment into Plans for persons eligible for Medi-Cal under designated aid codes. Pursuant to the Initiative, the State developed several competitive models for the delivery of health care services in targeted counties throughout California. For example, in 1994, the Geographic Managed Care (GMC) Pilot Project established mandatory enrollment into Plans primarily for low-income children and families in Sacramento County. The GMC model allows beneficiaries the option of choosing from multiple commercial Plans. 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 Plans.

The principal model implemented during the expansion of Medi-Cal Managed Care under the Initiative was the Two-Plan Model. Medi-Cal beneficiaries in these counties have the option to select from two Plans, either a locally-operated "local initiative" Plan or a commercial Plan. As in the COHS and GMC models, Two-Plan Model Plans provide services to Medi-Cal beneficiaries in designated aid codes at a capitated reimbursement rate. Currently, GMC model Plans operate in two counties, and Two-Plan Model Plans operate in 14 counties (Appendix A).

Initially, in counties operating under the GMC and Two-Plan models of managed care, seniors and persons with disabilities (SPDs) eligible for Medi-Cal benefits under the Supplemental Security Income (SSI) program had the option to voluntarily enroll into a Plan or to enroll in Medi-Cal FFS. The Section 1115 Medicaid waiver, "A Bridge to Reform" (Waiver), approved by the Centers for Medicare and Medicaid Services (CMS) in November 2010, authorized DHCS to

end voluntary enrollment and to begin mandatory enrollment of the Medi-Cal-only SPD population into Plans. The SPD population was transitioned into Plans over a 12-month period that began in June 2011.

Medi-Cal Managed Care Program Goals
Since the expansion of the Medi-Cal Managed Care program during the mid-1990s, DHCS has made continuous improvements in monitoring the quality of care and evaluation of service delivery provided to the enrolled populations, which initially consisted primarily of low-income children and families. The population of Plan members continues to expand with the transition of SPDs, dual eligibles (individuals eligible for both Medicare and Medi-Cal services), and other populations, and DHCS continues to move forward with strategies to ensure appropriate access, program monitoring, and evaluation of services for all Medi-Cal beneficiaries. The goals of the Medi-Cal Managed Care program include:

- o Improve health and health outcomes for the Medi-Cal population.

- o Improve the quality of care provided to Medi-Cal beneficiaries by contracted health plans.

- o Increase access to appropriate health care services for all enrolled beneficiaries.

- o Establish accountability for quality health care by implementing formal systematic monitoring and evaluation of the quality of care and services provided to all Medi-Cal beneficiaries including individuals with chronic conditions and special health care needs. The Medi-Cal Managed Care contract (Contract) defines members with special health care needs as "those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional conditions, and who require health or related services of a type or amount beyond that required generally." It requires Plans to implement and maintain a program for members with special health care needs that includes, but is not limited to, the following:

  - Standardized procedures for the identification of members with special health care needs, at enrollment and on a periodic basis thereafter;

  - Methods for ensuring and monitoring timely access to specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a specialist as a primary care provider (PCP), standing referrals, or other methods as defined by Contractor;

  - Methods for ensuring that each member with special health care needs receives a comprehensive assessment of health and related needs, and that all medically necessary follow-up services are documented in the medical record, including needed referrals;

  - A program for case management or care coordination for members with special health care needs, including coordination with other agencies that provide services for people with special health care needs (e.g., mental health, substance abuse, Regional Center, California Children's Services (CCS), local education agency, child welfare agency); and

- Methods for monitoring and improving the quality and appropriateness of care for members with special health care needs.

  o 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.

Quality Management Structure

In March 2011, DHCS's Director created the Office of the Medical Director, which is charged with helping the Department advance the Institute for Healthcare Improvement's "Triple Aim". As part of the Department's blueprint to achieve this goal, the Medi-Cal Managed Care program is included in DHCS's "Strategy for Quality Improvement in Health Care" (Quality Strategy). The Quality Strategy establishes goals, priorities, guiding principles, and a quality improvement initiative throughout DHCS to improve health, patient care, and reduce cost. Consistent with the Triple Aim and the "Three Aims of the National Quality Strategy (NQS)," DHCS's Quality Strategy is anchored by "Three Linked Goals": improve the health of all Californians; enhance quality, including the patient care experience, in all DHCS programs; and reduce DHCS's per-capita health care program costs.

DHCS's Medi-Cal Managed Care Division (MMCD) administers the Medi-Cal Managed Care program. MMCD is responsible for developing a managed care quality strategy that aligns with the DHCS Quality Strategy, but with emphasis on strategies and objectives for the managed care program.

Medi-Cal Managed Care Program Objectives

  o Establish a process by December 2013 to ensure that 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.

  o Implement one-or-more performance standards and measures that would require plans to evaluate and improve SPD health outcomes by Healthcare Effectiveness Data and Information Set (HEDIS®)[1] reporting year 2013. Plans must use the five HEDIS® performance measures that are specifically required for stratification of the SPD and non-SPD populations (see Appendix B for list of required HEDIS® measures and stratification).

  o Complete the COHS Plan contract revisions, and align them with Two-Plan and GMC contracts that require enhanced case management and coordination-of-care services for SPD members identified as high-risk and a process for MMCD to monitor plan compliance by August 2013.

  o Continue a statewide collaboration with Plans through calendar year (CY) 2015 to reduce "All Cause Readmissions" by addressing continuity of care and care transitions for adults 21-years and older, including SPDs and dual eligibles.

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

o Administer the 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] survey to all Plans, with results available in early 2014.

o Establish a process by June 2013 for timely notification of Plans that ensures that Plans contact beneficiaries who have recently received a denial of their Medical Exemption Requests (MERs) for care coordination and to address any special needs.

o Coordinate activities that focus on the collection, analysis, and reporting for 16 of the *Initial Core Set of Adult Health Care Quality Measures for Medicaid-Eligible Adults* as part of the Adult Medicaid Quality Grant (AMQG) (Appendix C).

o Reduce the smoking rate among Medi-Cal managed care Plan members. In line with the DHCS's Quality Strategy, by 2014, the Medi-Cal Managed Care program will make available the full complement of effective tobacco-use treatments, adapt clinical systems to assess all patients for tobacco use, strongly advise those who smoke about the importance of quitting, refer smokers to evidence-based treatments, train Plan providers on evidence-based tobacco use treatment strategies, and strengthen monitoring.

o Continue to consistently review our process to engage stakeholders and advocates in policy development - ongoing.

Development and Review of Quality Strategy

States with Medicaid managed care programs must assess how well the program is meeting its objectives for assessing and improving the quality of managed care services offered by the plans, as required by 42 CFR §438.202. DHCS is responsible for developing and implementing a comprehensive quality strategy to address the methods established for oversight, monitoring, and quality assessment and performance improvement for the Medi-Cal Managed Care program.

Steps for revising the MMCD *Quality Strategy Report* include:

o DHCS managers collaborate with each other to draft a revised MMCD *Quality Strategy Report*.

o DHCS managers collaborate with the DHCS Medical Director to ensure the goals and objectives of the MMCD quality strategy are consistent with the goals and objectives of the DHCS Quality Strategy.

o During the revision process, DHCS seeks input about areas that the Department should focus on related to quality which help guide the revision to the strategy.

o During all subsequent revisions, DHCS will ask Plans to share the report with beneficiaries, requesting their input and comments via a special email inbox.

o DHCS will share the final revised MMCD *Quality Strategy Report* with stakeholder workgroups and post it on the DHCS website for public review and comment.

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

o DHCS will submit the MMCD *Quality Strategy Report* to CMS for approval and make it available to the public via the DHCS website.

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

Frequency of Reporting

DHCS will update its quality strategy annually and when there are significant changes to populations mandatorily enrolled in managed care. Every three years, DHCS will coordinate a comprehensive review and update of its quality strategy. This *Quality Strategy Report* is the annual update for the report submitted to CMS in April 2012. The next comprehensive review and update of the *Quality Strategy Report* will be issued in 2015.

Performance Assessment

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

o Each year, DHCS will review the EQRO's findings and recommendations on the MMCD *Quality Strategy 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.

o The EQRO will report on the results of any action items related to the MMCD *Quality Strategy Report* in the following year's *Technical Report* until such time that the MMCD *Quality Strategy Report* is again updated. *Note:* The next *Technical Report* that covers the State fiscal year (SFY) 2011-12 (July 1 through June 30) is scheduled to be released in the third quarter of SFY 2013-14.

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:

o Plans' annual HEDIS® scores, Quality Improvement Project (QIP) proposals, and annual status reports

o Baseline and re-measurement reports for the statewide collaborative

o Plans' CAHPS® survey results

o Other Quality Improvement (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)

- o Plan audit reports (conducted jointly by DHCS and the Department of Managed Health Care [DMHC])

- o DHCS Office of the Ombudsman calls, cases, and State Fair Hearing request statistics

- o Plans' quarterly grievance reports

- o Results of Facility Site Review (FSR) and Medical Record Reviews conducted by Plans and DHCS

- o Other relevant documentation

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

SECTION II: ASSESSMENT

Health plans contracted with the State to provide services to Medi-Cal beneficiaries must establish a comprehensive, structured QI program, document monitoring activities, and maintain systems for performance measurement. DHCS is responsible for the:

- o Oversight and monitoring of Plan member access to program services,
- o Quality of care delivered to Plan members,
- o Availability and timeliness of appropriate levels of care, and
- o Internal structural systems established by Plans as required by 42 CFR §438.204.

Quality and Appropriateness of Care

Plans must implement an effective QI system that monitors and evaluates performance measurement and implements strategies to improve the quality of care delivered to all enrolled Medi-Cal beneficiaries, including individuals with chronic conditions and special health care needs, by health care providers rendering services on its behalf, regardless of setting as required in 42 CFR §438.204(b)(1). "Individuals with special health care needs" is defined in all Plan contracts as "those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional condition, and who also require health or related services of a type or amount beyond that required generally." Plans must also demonstrate evidence that they:

- o Operate internal QI systems that require their governing bodies to participate in quality-improvement activities,

- o Establish QI committee(s) with oversight and performance responsibility,

- o Require their Medical Directors to supervise QI activities, and

- o Include contracting physicians and other healthcare providers in the development and performance review of the QI system.

Enrollment
DHCS contracts with an enrollment broker to ensure that Medi-Cal beneficiaries are enrolled into a Plan no later than 90 days from the date the beneficiary is shown on the Medi-Cal Eligibility Data System (MEDS) to meet the enrollment criteria contained in Title 22, California Code of Regulations (CCR), Section (§) 53906(a). DHCS's enrollment broker uses MEDS information to generate and send enrollment packets to newly eligible Medi-Cal beneficiaries in Two-Plan and GMC counties. For all counties, race, ethnicity, and language information on each new member is transmitted to the appropriate Plan within the Plans' enrollment files, as required by 42 CFR §438.204(b)(2).

Enrollee Race, Ethnicity and Primary Language Data
Eligibility workers at local county social services offices collect information on the race, ethnicity, and primary spoken language of each Medi-Cal enrollee during the Medi-Cal enrollment process. Counties are required to ask applicants in which language they prefer to receive oral and written communication; counties must document these responses in each applicant's file. Only the applicant should report his or her language, race, and ethnicity;

providing this information is voluntary. County staff enter the information into MEDS along with the individual's enrollment application information. MEDS data reports may contain incomplete or invalid responses in its fields for race, ethnicity, and primary language data; subsequently, a small percent of ethnicity codes and language codes are not available. Federal law prohibits states from *requiring* Medicaid enrollees to provide this information.

Plans must comply with 42 CFR §438.10(c) and ensure that all monolingual, non-English-speaking, or limited-English-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 Plans choose to employ. 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. They 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. DHCS works with Plans to address the distinction between spoken and written languages so Plans only translate and print materials into languages that their members read. Pursuant to the Affordable Care Act (ACA), the State is developing a new application that will use data standards mandated by the Office of Management and Budget (OMB) and include questions about primary language and whether spoken or written communication is desired.

Plans are also required to use enrollee race, ethnicity, and primary spoken language data, and other relevant information, to identify the special healthcare needs of LEP members 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.

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. DHCS analyzes this information to determine the languages into which enrollment and informing materials in each county must be translated and which languages must be available to interpret conversations between Plan members and Plan customer service representatives. DHCS also conducts an annual Linguistic Study of enrollees in all counties. The enrollment broker uses this information to further guide Two-Plan and GMC Plans in how to staff and train their call-center staffs and their onsite representatives.

The Plans use the threshold language criteria specified in their Contracts with DHCS and the periodic Policy Letters and All-Plan Letters DHCS issues to determine which threshold languages they must make available for their members in each part of their specific service

areas. Plans use the threshold language criteria to determine the languages into which informing materials must be translated and to arrange for appropriate cultural and linguistic support to LEP members.

Let's Get Healthy California

In 2012, Governor Jerry Brown and the California Health and Human Services (CHHS) Agency brought together a Task Force comprised of California's leaders in health and health care to develop a framework to improve the health of all Californians. The *Let's Get Healthy California Task Force Final Report* is available on the CHHS website: http://www.chhs.ca.gov/Documents/Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf. The Task Force was charged with envisioning what California should look like in ten years if the State commits to becoming the healthiest state in the nation.

The Task Force identified three areas of focus that most profoundly affect the health and health care landscape: redesigning the health care delivery system, creating healthy communities and neighborhoods, and lowering the cost of care. The Task Force acknowledged the unprecedented increase in chronic disease and noted that racial and ethnic disparities continue to widen across many health outcomes. The report makes clear that eliminating health disparities is an over-arching goal and that health equity is vital to achieving improvements in health.

The report's recommendations build on work that California has begun: to build a healthier state by being an early implementer of the ACA, and through innovative, evidence-based projects and practices.

Office of Health Equity

To eliminate disparities, a priority of the DHCS Quality Strategy, DHCS is developing a report using available metrics to begin to characterize identifiable health disparities in the populations it serves. Once identified, DHCS will work with stakeholders and partners to develop aggressive intervention plans to eliminate addressable disparities. As part of the partnership, DHCS will develop an interagency agreement with the Office of Health Equity within the California Department of Public Health (CDPH) to optimize effectiveness and efficiency in shared efforts to eliminate health disparities.

National Performance Measures

California is currently measuring the core performance measures that have been developed for children and adults in Medicaid and the Children's Health Insurance Program (CHIP). With respect to the core performance measures for children, California has been monitoring five of these measures in the Healthy Families Program (HFP). This program is currently transitioning into the Medi-Cal Managed Care program. In Medi-Cal Managed Care, Plans have been reporting seven of the core measures. DHCS will continue to monitor a subset of the core performance measures for children as part of the Medi-Cal Managed Care program.

With respect to the core performance measures for adults, Plans currently report six of the measures to DHCS. California has received the AMQG, which will be used to increase the number of core measures tracked in California and will support evaluation of the measures. DHCS will focus on the quality of care in three major areas that are responsible for significant morbidity, mortality, and health care costs: diabetes management, maternal health and birth outcome, and mental health medication management. Tables of the core performance measures for children and adults are shown in Appendices C and D, and the measures monitored for each of the programs is indicated.

Monitoring and Compliance

In accordance with 42 CFR §438.204(b)(3), DHCS has established regular and ongoing monitoring activities that are conducted by MMCD staff, and in collaboration with other DHCS and State entities and a contracted EQRO.

MMCD works closely with other divisions in DHCS, primarily Audits and Investigations (A&I), and with other State agencies such as DMHC, to monitor plan compliance. In accordance with 42 CFR §438.204(d) and 42 CFR Subpart E §438.310 – §438.370, DHCS contracts with a qualified EQRO to perform several external quality review activities. Results from those activities allow the EQRO to evaluate the care plans provided to Medi-Cal managed care beneficiaries in the areas of quality, access, and timeliness. Health Services Advisory Group, Inc. (HSAG), the current EQRO, has been contracted with DHCS for those services since 2008. The current contract with HSAG runs through June 30, 2015, with two optional one-year extensions. If exercised, the extensions would take the Contract through June 30, 2017.

MMCD clinical staff monitor the FSR processes and plan compliance with established performance levels for the required HEDIS® measures. They also provide technical assistance on plans efforts to improve performance, when needed. MMCD staff also monitor and provide technical assistance on areas such as reported grievances and programs utilizing member incentives to improve HEDIS® scores and health outcomes for their members.

Audits & Investigations

A&I's Medical Review Branch conducts annual medical reviews of all Plans and has developed an internal work plan to carry out this requirement. A&I medical review audits include evaluation of Plan compliance with Contract requirements and with State and federal regulations in the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administration and organizational capacity.

Department of Managed Health Care

DHCS entered into an interagency agreement with DMHC to perform 1115 Waiver Plan Surveys of Medi-Cal managed care health plans. These surveys include evaluation of Plan compliance with contract requirements and with State and federal regulations. DMHC performs a financial audit at least once every three years and a network adequacy assessment on a quarterly basis of all Plans.

DHCS requires Plans to prepare a Corrective Action Plan (CAP) for both A&I and DMHC findings of non-compliance with terms of the Contract; the CAP must be approved by MMCD. DHCS also provides technical assistance to Plans to help them address findings of non-compliance as deemed necessary.

Plans undergo an onsite medical survey every three years conducted jointly by A&I and DMHC. DHCS reviews the results, monitors and approves CAPs submitted by plans for audit deficiencies, makes onsite visits to plan and provider sites as needed to ensure compliance, and provides training or technical assistance to plan, A&I and DMHC staff.

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 PCP sites in accordance with DHCS Policy Letter 02-02 and 22 CCR §56230.

DHCS performs oversight monitoring by conducting onsite reviews of randomly chosen Medi-Cal PCP 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 to validate the Plan's FSR processes and to monitor services provided by the Plans. DHCS gives proactive technical assistance and educational consultation to Plans and providers during the FSR and the follow-up CAP process.

An FSR is also required as part of the credentialing process when the facility/site and the provider are added to the Plan's provider network. Plans electronically submit data for every primary care FSR conducted, which is monitored by DHCS nurse evaluators.

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.

The Master Trainers and Certified Reviewers from each Plan and DHCS 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 accordance with the Waiver, Plans must also assess the level of physical accessibility of all PCP sites and provider sites that serve a high volume of SPDs. DHCS issued a physical accessibility review tool, and Plans are required to annually submit documentation on the benchmarks and method they use to identify high-volume providers, in accordance with DHCS Policy Letter 10-016 and W&I Code §14182(b)(9).

External Accountability Set (EAS) HEDIS® Measures

To assess the quality of care provided to Plan members, as is federally required, DHCS requires Plans to annually report audited results for all required HEDIS® performance measures, referred to as the EAS (see Appendix B for list of required 2013 HEDIS® measures). HEDIS® measures are established by the NCQA and are used nationally to assess the quality of care provided by commercial, Medicaid, and Medicare plans.

The DHCS contracted EQRO conducts annual onsite HEDIS® Compliance Audits. Plans are required to report HEDIS® rates at the county level unless otherwise approved by DHCS. Currently, exceptions to the county-level reporting requirement include Inland Empire Health Plan and Molina Healthcare for their Riverside and San Bernardino counties; Central California Alliance for Health for its Monterey and Santa Cruz counties; and Partnership Health Plan for its Napa, Solano, and Yolo counties; which all report at a combined county level. Some of these Plans report separate rates for other counties.

As described earlier, Plans are required to meet or exceed the DHCS-established Minimum Performance Level (MPL) for each measure or they must submit a HEDIS® IP. Additionally, DHCS 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 Plan and the program average for Medi-Cal Managed Care and national Medicaid and commercial plan averages for each measure.

The HEDIS® measures that make up the EAS for Plans currently focus on access to care provided to women, children, and adolescents; ambulatory care services provided to members of all ages; immunizations for children and adolescents; monitoring for patients on persistent medications; weight assessment and nutritional and physical activity counseling; avoidance of inappropriate antibiotic use and imaging studies for lower back pain; screening for diseases such as cervical cancer; and care provided to members with high blood pressure and chronic diseases such as diabetes and asthma.

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 it provides 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 selected measures in the Auto-Assignment Performance Incentive Program, which awards more defaulted enrollment to Plans that earn higher scores in these measures. DHCS will use HEDIS® scores for 15 HEDIS® indicators to determine a single quality rating for each Plan that will be included in the dashboard and may be used for other quality-withhold purposes, as yet to be determined.

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

Healthcare Effectiveness Data and Information Set (HEDIS®) Improvement Plans

Plans have a contractual obligation to meet or exceed the DHCS-established 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 National Committee for Quality Assurance (NCQA) *Audit Means, Percentiles and Ratios*. Currently, DHCS's MPL is the 25th percentile of the national Medicaid rates (except for reverse measures where a lower score is better). For each measure that a Plan does not meet the established MPL or is reported as "Not Reportable" due to a material bias, it must submit a HEDIS® Improvement Plan (IP) to DHCS within the specified timeframe that describes the steps it will take to improve its performance during the subsequent year. DHCS is considering how to change the requirement for "Not Reportable." Plans with scores below the MPL for the same measure in more than one county may submit a single HEDIS® IP that must separately address the targeted population(s) in each county.

Effective 2013, DHCS modified the HEDIS® IP process, requiring Plans to provide a more rigorous analysis of barriers and targeted interventions. DHCS has begun to track previous IPs to assess whether the Plans' analyses and interventions are evolving to produce better quality-improvement outcomes. DHCS may require Plans with HEDIS® measures that continue to fall below the MPL to complete a formal CAP.

Under/Over-Utilization Monitoring

Plans are required to report utilization data for selected HEDIS® Utilization and Relative Resource Use measures through the contracted EQRO. For the 2013 reporting year, all non-specialty Plans are required to submit unaudited HEDIS® rates for measurement year 2012. The results for these measures are reported to the EQRO consistent with HEDIS® technical specifications and in a format designed by DHCS. However, these measures are not included in the EQRO's audit process. The measures for the 2013 reporting year are listed below.

The *Frequency of Selected Procedures* measure summarizes the number and rate of various frequently performed procedures. Plans report the absolute number of procedures and the number of procedures per 1,000 member months by age and sex for their Medi-Cal members. They report on four indicators: back surgery; bariatric weight loss surgery, lumpectomy; and mastectomy.

The *Inpatient Utilization: General Hospital/Acute Care* measure summarizes utilization of acute inpatient services for total inpatient, medicine, surgery, and maternity. The plans report the following data for each of the categories: discharges; discharges/1,000 member months; days; days/1,000 member months; and average length of stay.

The HEDIS® Utilization and Relative Resource Use data is then used to produce reports that disclose the data by Plan, model type, and total for the Medi-Cal Managed Care program. Finally, DHCS medical and nurse consultants facilitate discussions of utilization data reports results at Medical Directors meetings, as needed. This is also covered annually during the HEDIS® selection process.

Corrective Action Plan Development

Plans that have numerous or sustained rates of performance below the MPL or rates that have fallen precipitously from the previous year, may be required to complete a CAP, additional QIPs, and other actions, as appropriate.

In July 2011, DHCS initiated a CAP with one of its contracted Plans due to ongoing poor HEDIS® performance, resulting in numerous External Accountability Set (EAS) measures scored below the MPL. This CAP is effective through 2015 and, on a quarterly basis, the Plan submits status updates to DHCS for review. In 2013, DHCS worked internally to revise the CAP process so that the Plan's quarterly status update form could be analyzed in association with its IPs. Both the CAP and IP requirements are imposed on a Plan as a result of poor HEDIS® performance, and a significant amount of overlap is expected between the two QI efforts. By associating the CAP quarterly status update form with the IPs, DHCS will be able to continuously monitor this Plan's targeted interventions and provide constructive feedback. This will enhance DHCS's oversight of the Plan's QI activities with the overall goal of fostering significant improvement in the Plan's HEDIS® performance.

Quality Improvement Projects (QIPs)

Plans must conduct and/or participate in two QIPs annually. One is the DHCS-led statewide collaborative project and the other can be either an internal QIP or a small-group collaborative QIP developed and led by two-or-more Plans. Prior approval is required by DHCS to participate in a small-group collaborative QIP.

Plans must submit proposals for QIP approval by DHCS medical and/or nurse consultants, whose determinations are subsequently validated by the EQRO. Both the approval and validation processes focus on ensuring that QIPs meet federal requirements and appropriately target the needs of the Plan's members and DHCS's 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 its 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, statistically significant improvement, or a decline in performance. Once a QIP is completed, the Plan must submit a new QIP topic proposal within 60 days to remain in compliance with DHCS's QIP requirements. DHCS adheres to 42 CFR §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 (see Appendix E for a list of current QIPs).

DHCS and EQRO reviewers utilize the *Quality Improvement Assessment (QIA) Guide for Medi-Cal Managed Care Plans* to ensure compliance with 42 CFR §438.240. The Guide can be found on the DHCS website at:
http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Statewide Collaborative – All Cause Readmissions (ACR)

The Statewide Collaborative QIP began in July 2011 and focused on reducing hospital readmissions for all causes within 30 days of discharge. DHCS worked with the Plans and the EQRO to develop guiding principles, a HEDIS®-like measure specific to the Medi-Cal population, and a collaborative evaluation plan. All Plans have submitted QIP proposals containing study-design data, which have been validated by the EQRO. Additionally, Plans conducted barrier analyses and developed interventions to address the identified barriers.

During the first quarter of 2013, the Plans' submitted documentation of the barrier analyses and interventions to DHCS and the EQRO for review. DHCS and the EQRO conducted individual technical assistance calls with all of the Plans and provided feedback on their improvement strategies. Six Plans must resubmit their barrier analyses and interventions for additional review after incorporating changes based on the feedback they received during their technical assistance call. In January 2013, Plans began to implement their interventions. The status of the collaborative, including the Plans' interventions, will be published in an interim report by the EQRO during the summer of 2013.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The EQRO is responsible for administrating the CAHPS® survey biennially in compliance with NCQA and Agency for Healthcare Research and Quality (AHRQ) requirements for DHCS. The CAHPS® surveys a sample of Plan members in English and Spanish, and covers services provided to adults and children. DHCS and Plans use the consumer survey results to evaluate member satisfaction with the care they receive 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 Plans are needed.

The 2013 CAHPS® survey includes supplemental DHCS questions that focus on capturing the managed care experiences of the SPD population. This will allow comparative analysis of beneficiary satisfaction between SPDs and the Medi-Cal managed care population as a whole. In January 2013, the survey sample frame was randomly selected, and in February, 73,260 survey questionnaires and cover letters were mailed to adult members and parents or caretakers of child members. Follow-up postcard reminders were distributed to non-respondents, and computer-assisted telephone interviews were conducted until the close of the survey in May. The survey final report is scheduled for publication in January 2014.

Survey questions include member responses to questions about rating their Plan, all health care, their personal doctor, and a specialist seen most often. Additionally, the results of five composite measures reflect member experiences with getting needed care, getting care quickly, how well doctors communicate, customer service, and shared decision-making.

Encounter Data

In 2012, DHCS signed a three-year contract (with two optional one-year extensions) with its EQRO to conduct an annual Encounter Data Validation (EDV) study. The goal of the study is to examine the extent to which encounter data submitted by plans to DHCS are complete and accurate. The EQRO will compare the administrative records in the Plans' claims-processing systems to the claim/encounter records in the DHCS Management Information

System/Decision Support System (MIS/DSS) database. In addition to the comparative analyses of administrative data, the EQRO will review the Plans' information systems and processes pertaining to claim processing and encounter-data submission to assess the Plans' capabilities to collect and submit accurate and complete encounter data. The EQRO will provide DHCS with annual Plan-specific audit reports and an aggregated report to present comparative analysis findings of each Plan under study and statewide average results.

DHCS has also engaged in an initiative to strengthen encounter data for the Medi-Cal Managed Care program overall – the Encounter Data Improvement Project (EDIP). The project is focused on ensuring the data's completeness, accuracy, reasonableness, and timeliness. EDIP is improving both Plan reporting of data and DHCS processes for inputting and uploading the data into the MIS/DSS data warehouse. Ultimately, DHCS will establish compliance-measurement reporting requirements for the Plans that will measure these four areas.

Finally, DHCS has entered into discussions with A&I to add encounter data to the annual medical audits that it conducts of the health plans and will review data reporting compliance at the plan provider level.

Grievance/Appeal Logs

DHCS requires Plans to establish and communicate to contracting and non-contracting providers a formal process for acknowledging, accepting, and resolving member grievances and appeals. Plans submit aggregated grievance/appeal data logs to MMCD quarterly for analysis. DHCS provides its' contracted Plans with technical assistance as needed to address areas of concern identified in Plan-provided logs.

Non-Monetary Member Incentives

To monitor the use of non-monetary member incentives, DHCS requires Plans to submit requests for approval of all member-incentive programs. MMCD health education consultants review and approve requests and provide technical assistance to ensure that all member-incentive programs comply with standards. Plans are encouraged to use non-monetary incentives to enhance health education program efforts and promote good health practices (W&I Code §14407.1). Plans must submit evaluations at the end of each member-incentive program and annual updates for ongoing programs to justify their continued use of the incentive(s).

External Quality Review

In accordance with 42 CFR §438.204(d) and 42 CFR Subpart E §438.310 – §438.370, DHCS contracts with a qualified EQRO to perform several external quality review activities. Results from those activities allow the EQRO to evaluate the care Plans provide to their members in the areas of quality, access, and timeliness. HSAG has been contracted with DHCS for those services since 2008.

As currently contracted, the EQRO performs the CMS mandatory and optional activities and produces corresponding reports that summarize and/or evaluate results and present recommendations.

Mandatory Activities (and corresponding report)

- o Validation of performance measures; validated and reported annually: Medi-Cal Managed Care Program Technical Report & Plan-Specific Performance Evaluations.

- o Validation of small-group and individual performance improvements projects (referred to by DHCS as quality-improvement projects or QIPs); validated at least annually and reported quarterly: QIPs Status Report.

- o Validation of a statewide collaborative QIP; validated and reported annually: Statewide Collaborative QIP Report.

Optional Activities (and corresponding report)

- o Validation of encounter data; validated and reported annually; new activity added in 2012: first Encounter Data report scheduled to be released in late 2013.

- o Administration of the CAHPS® Survey; administered and reported biennially: CAHPS® Summary Report.

Technical Assistance to the Plans

The EQRO also provides technical assistance to the Plans in addition to and as part of many of the above-listed activities. As part of the Contract, the EQRO produces a *Quality Improvement Assessment Guide* to assist Plans with design, development, and reporting of their QIPs. The Guide is periodically updated to reflect QIP process improvements. Additionally, the EQRO holds individual and group technical assistance calls to facilitate the Plans' abilities to produce more meaningful individual and Statewide Collaborative QIPs. See the Monitoring and Compliance section on QIPs for additional information.

Plan-Specific Performance Evaluation Reports

The EQRO annually aggregates and evaluates each Plan's compliance with State and federal requirements for organizational and structural performance and includes an analysis and recommendations in each Plan-specific report.

Medi-Cal Managed Care Technical Report

In tandem with the Plan-specific evaluation reports, the EQRO reports on and evaluates DHCS's compliance-monitoring process in an annual Program Technical Report. The EQRO recommends modifications to improve DHCS's monitoring of Plan compliance with State and federal standards.

DHCS releases these EQRO-produced reports 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 methods, which include, where appropriate: levels of quality, access, and timeliness of services. 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.

SECTION III: STATE STANDARDS

Contract provisions established for 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 Standards

Standards for access to care include availability of services, assurances of adequate capacity and services, care coordination and continuity of care, and coverage and authorization of services as required by 42 CFR §438.206 – §438.210. The Medi-Cal Managed Care program promotes early intervention at the appropriate level of care, and ensures that preventive and primary care services are available and accessible to Plan members. Plans must establish accessibility standards in accordance with 28 CCR §1300.67.2 and §1300.67.2.2 to ensure that each member has a PCP and access to specialists for medically necessary services.

Plans must maintain standards of access to services and providers that address the 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 the availability of after-hours for physicians or appropriately licensed professionals under their supervision (Appendix F). Access standards must ensure that Plan members are offered appointments for covered health care services within a time period appropriate for their condition. If a Plan's provider network is unable to provide medically necessary services to a member, the Plan must timely and adequately cover these services for the member through out-of-network providers for as long as the Plan's provider network is unable to provide those services. The Plan must negotiate agreements 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 provided within the Plan's provider network and that appropriate medical care is provided. The following activities and reports document DHCS and Plan-specific efforts to monitor access to care and the status of available services.

Contract Report Template Standardization Workgroup
DHCS has formed a workgroup to standardize various contractually required reports by creating templates for the health plans to utilize in submitting data. This will create consistent data across all plans that is comparable and will be utilized in monitoring and reporting. After the workgroup internally finalizes templates, DHCS will share them with the health plans for review and feedback. Suggested changes will be incorporated, as appropriate. Contract language will be updated to reflect implementation of the new templates.

Provider Network Report
At startup, Plans must submit a provider network report to DHCS to provide evidence for the availability 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 PCPs, total physicians, and non-physician medical practitioners), meet the established standards for time and distance, and have adequate numbers and types of certified (or certification-eligible) specialists available within the network to accommodate members' specialty care needs. Plans submit quarterly *Change in Provider Network Reports* to DHCS, including a summary of provider network changes, the resulting impact of those changes, and related information, such as the network's percentage of traditional and safety net providers, the number of members assigned to each PCP, and which network providers are not accepting new patients.

A site review is required as part of the provider credentialing process when a facility or a provider is added to a Plan's provider network. If a provider is added to the Plan's provider network and the provider site has a current passing score from its site review survey, an additional site survey is not required for provider credentialing or re-credentialing.

Geographic Mapping Reports

Each quarter, Plans submit geographic mapping of their current provider networks to DHCS using Geographic Information Software (GIS) maps to display and analyze the composition of their provider networks. Geographical mapping of provider networks provides Plans to verify the availability and location of PCPs and specialists in relation to the needs of Plan members. DHCS standards require Plans to meet provider-to-member ratios of at least one full-time-equivalent PCP 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. They also provide a copy of the provider caseload report to DHCS upon request. DHCS contract managers review maps submitted by Plans and verify that Plans are meeting their contractual obligations.

Expansion

Prior to any expansion and when any new population is brought into managed care (e.g., mandatory enrollment of SPDs), DHCS establishes and monitors the initial and ongoing network adequacy to serve the newly enrolled members to ensure compliance with Title 42 CFR §438 and the Knox-Keene Act (Health and Safety Code, Section 1340, et seq.). This includes such items as: specialist-to-beneficiary ratios; geo-mapping of FFS providers in contrast to 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 FSRs before readiness) or other strategies to ensure adequate network resources to meet the needs of the individuals to be served.

Provider Directory

Each Plan issues, and periodically updates, a Provider Directory to inform members of PCPs, 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 ensure that Provider Directory submissions are current and accurate, DHCS conducts random telephone calls to approximately 10 percent of the listed providers to validate their contact information (i.e., address, phone number, office hours,

languages spoken, and accessibility). DHCS staff report the errors they identify to Plans so the Plans can correct their provider directories.

Care Coordination/Case Management

Plans must maintain procedures for how they monitor the coordination of care they provide to their members, determining whether members need targeted case management services, establishing referral processes, initiating and maintaining disease-management services, and processing authorizations for members who receive out-of-network 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 PCP who serves as the patient's medical home are responsible for the coordination of each member's case management services.

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

DHCS worked collaboratively with Plans to meet the requirements of 42 CFR §438.208 for care coordination for individuals with special health care needs. To assist Plans in identifying the SPDs that transitioned into Plans who required complex case management, DHCS provided FFS utilization data when it was available. DHCS also implemented the Health Information Form (HIF), a tool for members to self-identify their acute healthcare needs. DHCS sends the HIF information the Plan with the enrollment file; the Plan uses this information as part of the health-risk assessment process.

To ensure a seamless transition into managed care, DHCS allowed SPDs an extended period during which they could receive continuity of care. DHCS allowed SPDs to access their current out-of-network Medi-Cal FFS providers for up to 12 months after their initial enrollments into Plans.

DHCS will assess Plans compliance with case management/coordination-of-care requirements by conducting medical record reviews, 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 onsite verification by DHCS clinical staff auditors.

Cultural and Linguistic Services Program

DHCS requires Plans to have a Cultural and Linguistic Services Program that incorporates the requirements of 22 CCR §53876. Plans are required to monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.

DHCS also requires Plans to conduct a Group Needs Assessment (GNA) to identify the health education and cultural and linguistic needs of its Members, and to analyze the findings of the GNA to continuously develop and improve their contractually required health education and cultural linguistic programs and services. Plans must use multiple reliable data sources, and data-gathering methods, techniques, and tools to conduct the GNA. Plans must ensure that the composition of their provider networks meets the ethnic, cultural, and linguistic needs of their memberships.

Emergency Department Protocols

Plans must develop and maintain protocols that describe how they communicate and interact with emergency departments; Plans must distribute these protocols to emergency departments in their service areas. A health professional from the Plan or a contracting physician must be available 24-hours-per-day, seven-days-per-week to coordinate the transfer of their Plan members' care during emergent care situations, authorize medically necessary post-stabilization services, and communicate with emergency-room personnel. Written protocols must identify and describe Plan telephone triage and advice systems, who is the contact person responsible for coordinating services who can be contacted 24-hours-per-day, instruction and referral procedures, and procedures to ensure that the Plan member receives continuity of care and handling when the medical assessment determines that the member has a non-emergent condition.

Community Advisory Committee(s)

Plans must form a local Community Advisory Committee (CAC) to maintain community partnerships with consumers, community advocates, and traditional and safety-net providers. Plans must include and involve the CAC in policy decisions related to issues of education, operations, and cultural competence.

Structure and Operations Standards

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 §438.214 – §438.228. 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) laws and immediately report any breach of Protected Health Information (PHI) to DHCS. Plans and DHCS use secure data portals when they exchange data and information that contains PHI. In addition, DHCS employees complete an annual online training to identify and understand HIPAA laws and procedures related to 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:

Materials/Alternative Formats/Enrollment

Plans must make materials available in alternative formats (e.g., large print, Braille, or audio) when requested by a member. DHCS developed county-specific inserts to include in the

SPD enrollment packets that provide additional information about the choices SPDs may make. . The inserts were translated into the appropriate threshold languages for each county and are available on the DHCS webpage. For the Coordinated Care Initiative (CCI), DHCS is working with stakeholders to develop materials for the duals population, including notices, a new resource guidebook, and new choice enrollment forms.

Medical Exemptions from Managed Care Enrollment

As provided by 22 CCR §53887, a Medi-Cal beneficiary who resides in Two-Plan Model counties and is already receiving treatment from a Medi-Cal FFS provider for specific medical conditions (e.g., a scheduled surgery or late-stage pregnancy) may be temporarily exempted from mandatory enrollment into a Two-Plan Model Plan until his or her condition is stable. An approved MER may provide for continuity-of-care services when the MER is 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 continued at a high rate through mid-2012. The amount of requests has now stabilized to pre-SPD mandatory enrollment levels. This has created an opportunity for DHCS to review applicable statutes and regulations and to improve its review processes and the consistency of its decision-making practices. DHCS is currently conducting efforts to educate beneficiaries and providers about existing continuity-of-care standards for Plan members that include alternatives to the exemption process.

In 2012, DHCS established a MER workgroup that includes key advocates, stakeholders, and DHCS and State Legislative staff. The purpose of the MER workgroup is to revise the MER application form, draft new informing materials, create call-center scripts, and participate in process and efficiency improvements.

DHCS is also undertaking a MER automation project to eliminate all manual steps that currently exist for processing MERs. The launch date for full automation is scheduled for June 2013.

Disenrollment

DHCS tightly regulates disenrollments in GMC and Two- Plan Models, and disenrollments rarely happen under 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 its decision. Only members with voluntary aid codes or those in need of long-term care or an organ transplant may be disenrolled from a Plan into FFS. The Plan must continue to cover and ensure that each member who disenrolls for these reasons continues to receive all medically necessary services until the member's disenrollment date is effective. Members are enrolled back into the Plan when they no longer need the services mentioned above.

Grievance Systems

Plans are required to maintain a member grievance system in accordance with 28 CCR §1300.68 and §1300.68.01, 22 CCR §53858, and its Contract with DHCS.

Plans must monitor their member grievance systems to ensure that their staffs meet the timeframes for member notification and that they report all member grievances to an appropriate level, ensuring that all grievances involving quality of care are referred to the plan's Medical Director or physician designee, and to ensure members are adequately informed and provided with a reasonable opportunity to present, in writing or in person, facts and law in support of their grievances.

A&I conducts annual medical reviews of all Plans. These audits include an overall review of the Plan's member grievance and appeals system and a review of the Plan's process for member notifications. DHCS requires Plans to prepare CAPs for findings of non-compliance. MMCD reviews and approves the Plan's CAP and conducts follow-up monitoring activities as deemed necessary.

Measurement and Improvement Standards

Plan Contracts require an ongoing program for quality assessment and performance improvement of the services provided to enrollees as required in 42 CFR §438.236 – §438.242. 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

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 disability, and to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury (22 CCR §51303). The DHCS clinical staff develops health care policy and Contract language, and provides 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 (EOC) deliverables, provider manuals, educational materials, and 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, guidelines of the following clinical and professional organizations:

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

DHCS's nurse consultants and physicians perform oversight to assure appropriate use of clinical guidelines by Plans, in part, by conducting onsite reviews of provider medical records, and in some cases, by evaluating Plan performance on select HEDIS® measures.

For all health services delivery areas in which DHCS has not specified standards of practice guidelines, Plans may adopt nationally recognized standards, best practices guidelines, 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 MOUs with county public health programs, such as local offices of the Women, Infants and Children (WIC) program, Comprehensive Perinatal Services Program (CPSP), and CCS to address practice and quality-of-care issues, referral and communication systems, and ongoing collaborative processes. 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.

Stakeholder Input/Workgroups

DHCS has various ongoing 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:

o Medi-Cal Managed Care Advisory Group: DHCS facilitates quarterly meetings with an advisory group that includes consumer advocacy representatives, Plan representatives, and State Legislature staff, promoting bi-directional communication between DHCS and stakeholders on issues that affect Medi-Cal beneficiaries.

o California Collaborative for Long Term Services and Supports (Collaborative): DHCS works with the Collaborative for its stakeholder review process for CCI. The Collaborative is made up of representatives from statewide organizations comprised of, or serving or advocating for, SPDs (over 35 groups/associations are represented in this Collaborative). This group includes representatives of health plans, providers, advocates and beneficiaries.

o DHCS/DMHC Medical Audits Committee: DHCS organizes quarterly multi-agency in-person meetings to plan and discuss issues related to collaborative joint audits of Plans.

o Health Education and Cultural Linguistics Workgroup (HECLW): DHCS meets quarterly with directors/managers of health education and cultural and linguistic services (C&L) from each Plan 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 workgroup provided input on revisions to the Staying Healthy Assessment (SHA) tool that may be used for the contractually required Individual Health Education Behavioral Assessment (IHEBA). The tool is slated for release, in all threshold languages, in the summer of 2013.

o Medical Directors Workgroup: Plan medical directors are responsible for overseeing and rendering decisions related to clinical services, provision of medical care, and health care quality improvement. Medical directors meet quarterly with DHCS's Medical Director, Deputy Director, and other clinical and policy 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.

o Pharmacy Directors Workgroup: Plan pharmacy directors are responsible for oversight of Plan formularies to ensure that Plan members have access to pharmaceutical medication sufficient to meet all medically necessary needs and that member access to pharmaceuticals is comparable to and consistent with the Medi-Cal FFS pharmacy services benefit. DHCS and the Plan pharmacy directors conduct conference calls as needed to discuss changes and updates to the formulary and pharmacy-related quality-improvement issues. DHCS will conduct quarterly conference calls with the Plan pharmacy directors in 2013. When critical issues or changes in the pharmacy benefit warrant, DHCS holds in-person meetings with the Plan pharmacy directors. In addition, FFS pharmacy consultants provide regular updates at the Medical Directors Workgroup meetings.

o Quality Improvement Workgroup: DHCS managers in the areas of quality improvement and performance measurement and Plan medical directors participate in quarterly teleconferences. Participants, including DHCS staff, discuss issues 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.

o State Fair Hearings Quality Circle: DHCS and the California Department of Social Services (CDSS) meet periodically to discuss and promote improvement in the quality and efficiency of the State Fair Hearing process.

Quality Assessment and Performance Improvement Program

As required by 42 CFR §438.240, Plans must implement a Quality Improvement System (QIS) in accordance with the standards of 28 CCR §1300.70, regarding Health Care Service Plan Quality Assurance Program. Each Plan must submit a written description and evaluation report of its QIS, which DHCS's EQRO reviews annually. Plans are required to submit to annual audits by the EQRO. The onsite HEDIS® Compliance Audit assesses the plans information and reporting systems and its methodologies for calculating performance measure rates. Plans must also report rates for an Under/Over-Utilization Monitoring Measure Set based on selected HEDIS® Use of Service measures, or any other standardized or DHCS-developed utilization measures selected by DHCS.

Plans must meet or exceed the DHCS-established MPL for each HEDIS® measure. For any measure that does not meet the MPL or was reported as a "Not Report" due to an audit failure, Plans are required to submit an IP for the subsequent year. Plans that have numerous or sustained rates of performance below the MPL or rates that have fallen

precipitously from the previous year, may be required to do a CAP, including but not limited to, additional QIPs.

Plans must also conduct or participate in at least one internal or small-group collaborative QIP, participate in the statewide collaborative QIP, and submit an annual status report to the EQRO for validation and to assess impact and effectiveness. And Plans must participate in the CAHPS® survey administered by the EQRO.

Health Information Systems

Plans must have a health information system that can collect, analyze, integrate, and report data on enrollees, providers, and services; and must ensure data is accurate and complete, as required by 42 CFR §438.242.

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. 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 of data DHCS receives. Quality measures using key indicators related to Plan performance are tracked and reported to allow for comparison to prior performance, from Plan to Plan, and with established benchmarks. Data quality results are shared with DHCS staff to enable appropriate reliance levels during analyses, with contracted plans to identify specific problem areas in which corrective action is needed for quality improvement and will be a component of a publicly available dashboard. Monitoring efforts, data quality measures, and reporting mechanisms are regularly evaluated and updated as appropriate to aid in continual quality assessment and improvement.

DHCS has determined minimum MIS requirements it expects of its Plans and periodically reviews Plan documentation to ensure that they meet these minimum requirements. The MIS shall have the capability to capture, edit, and utilize various data elements for the use of internal management and to meet the data-quality and timeliness requirements of DHCS's encounter data submissions. The MIS shall provide, at a minimum:

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

On execution of new or renewed Contracts, the Plan is required to submit a baseline assessment of its MIS and policies and procedures that provide DHCS 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.

Additional deliverables required at Contract execution or renewal include a description of the MIS as it relates to subsystems: financial, member/eligibility, provider, claims/encounters, quality management/utilization, data security, backup, or other data-disaster processes used in the event of a MIS failure; a detailed description of how the Plan monitors the flow of data from provider level to the organization; and sample reports generated by the MIS.

Should the Plan procure a new MIS or modify a current system, DHCS requires that it submit a detailed implementation plan that includes:

o   A full description of the acquisition of software and hardware, including the schedule for implementation;

o   Full documentation of support for software and hardware by the manufacturer or other contracted party;

o   System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;

o   Documentation of system changes related to HIPAA requirements.

SECTION IV: IMPROVEMENT and INTERVENTIONS

This *Quality Strategy Report* not only serves as a descriptive guide for DHCS's current quality-improvement activities, but also as a roadmap for planning future strategies that will prove instrumental in ensuring that quality and appropriate care and services are delivered to all Medi-Cal managed care enrollees (42 CFR §438.204(e) and (f)).

By updating the *Quality Strategy Report,* DHCS focuses on how best to use available resources to advance its mission and respond to the healthcare needs of Californians.

Future quality-improvement strategies, described throughout this report, include establishing additional collaborations with State and private agencies, ensuring access to the appropriate levels of care, and evaluating the utilization and effectiveness of care and medical services.

Intermediate Sanctions

Sanctions

DHCS may impose sanctions on Plans when they fail to meet reporting requirements. DHCS may also impose sanctions when Plans fail to fulfill their timelines and activities for corrective actions. 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. DHCS is currently working toward setting up a standard structure for sanctioning plans that will first include a provision of technical assistance and then impose a CAP. If a plan continues to show deficiencies, a financial penalty will be imposed. DHCS is implementing the technical assistance and CAP piece now and intends to add the penalty structure by 2014. Types of sanctions that may be used include, but are not limited to:

o   Stopping default enrollments

o   The ceasing of activities

o   Denial of payments

o   Appointment of temporary management if the plan has repeatedly failed to meet the contractual requirements

o   Require plan to temporarily suspend or terminate personnel or subcontractors

o   Take other appropriate action as determined necessary by DHCS

Health Information Technology

In accordance with 42 CFR §438.204(f), DHCS information systems directly support the departmental and MMCD quality strategies. DHCS is currently conducting an updated state self-assessment of its Medicaid Information Technology Architecture (MITA). As part of the MITA assessment, DHCS has identified many opportunities to advance the maturity of business processes, information management, and technology support that will increase MITA maturity. While DHCS is moving forward with technology that increasingly has reusable components and supports integration and interoperability between systems, there is also a significant focus on the information architecture. As part of the advancement of the information architecture, DHCS

is working aggressively on: completing all conversions from local codes to HIPAA compliant codes; a project to convert the specifications for file transmissions from the current 35-C format to a HIPAA consistent 837 format for data coming from the Plans to DHCS; and development of data models that will improve consistency between data dictionaries.

Encounter Data

As part of California's participation in the Duals Demonstration project, DHCS has focused on improving encounter data that has been received from the plans. DHCS recognizes the importance of this data to be able to assess utilization, outcomes, disparities and quality both by DHCS and CMS. This data is transmitted to CMS through the MSIS and is then combined with data from other states for use in CMS Data Marts and for use by researchers through ResDAC. To improve the quality of encounter data, DHCS initiated the Encounter Data Improvement Project (EDIP), which is focused on business processes at DHCS and the Plans and on review of technology that can better support data delivery.

DHCS recognizes that the quality of encounter data received from Plans is directly related to the ability to assess the quality of services provided to enrolled beneficiaries. Opportunities exist in all areas of encounter-data collection, processing, storage and monitoring to improve the data's quality and usability. In September 2012, DHCS began the EDIP to ensure that the encounter data used routinely by DHCS is robust and capable of supporting accurate program monitoring, quality management, and reporting. To further this work, EDIP established an internal workgroup of subject-matter experts from throughout DHCS to review, recommend, and implement appropriate revisions to current policies, processes, and requirements for encounter data.

DHCS currently maintains managed care data-element dictionaries, which specify the proprietary formats and manner in which the Plans must submit encounter data on a monthly basis. As part of its effort to improve data quality and in coordination with the implementation of ICD-10, DHCS is working to modify systems and processes to accommodate acceptance of encounter data in standard formats. This will eliminate the need for the Plans to translate the encounter data to a non-standard format, reducing the potential for mapping errors, and will provide a more robust data set for analysis of the quality of services provided.

DHCS is undertaking many initiatives that depend on the availability and use of high-quality encounter data; therefore, DHCS will continue to improve the quality of its encounter data in support of its analytic and program monitoring purposes. The following list is just a sample of the initiatives DHCS is undertaking that depend on the availability and use of high-quality encounter data:

o CCI includes both the Duals Demonstration (now called the Cal MediConnect Program) and Managed Long-Term Services and Supports (MLTSS)

o Medicaid Statistical Information Systems (MSIS) / Transformed Medicaid Statistical Information Systems (T-MSIS)

o Medicaid Expansion under the ACA

o Healthy Families Transition

- o Medi-Cal Adult Quality Care Improvement: Measuring Diabetes, Maternal, and Mental Health Management (MAQCI)

- o Medi-Cal Incentives to Quit Smoking (MIQS) Project

SECTION V: DELIVERY SYSTEM REFORMS

California's focus on health care reform includes implementing the ACA and expanding the Medi-Cal Managed Care program. DHCS is expanding the State's managed care delivery system both geographically and by including new populations of beneficiaries. DHCS is expanding its data collection and monitoring activities to assess and improve the quality of managed care services delivered and to ensure that all Plans comply with Contract and federal requirements.

In addition to the HEDIS® and CAHPS® tools DHCS currently uses, DHCS will monitor Potentially Preventable Events (PPEs) by analyzing encounter data with a computer programming model. The PPEs include Potentially Preventable Readmissions, Potentially Preventable Admission, Potentially Preventable Emergency Room Visits, and Potentially Preventable Complications. DHCS will calculate the expected event rates based on encounter data and will compare them with the actual event rates.

DHCS is expanding the Medi-Cal Managed Care program to increase access to quality and appropriate health care services to more Medi-Cal beneficiaries throughout California. Below are examples of delivery system reforms that DHCS has recently implemented or is in the process of implementing.

SENIORS AND PERSONS WITH DISABILITIES

Transition of the Seniors and Persons with Disabilities Population into Managed Care
The Waiver allowed the transition of the SPD population from FFS into Medi-Cal Managed Care. This change allows DHCS to achieve care coordination, better manage chronic conditions, and improve health outcomes for the SPD population. In June 2011, DHCS began to enroll the SPD population according to their birth months into Plans in 16 counties. The transition of the SPD population was completed in May 2012, and approximately 240,000 beneficiaries were enrolled. Because of the higher level of medical needs of the SPD population, DHCS continues to 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 learned valuable lessons from the SPD transition, specifically in the areas of beneficiary outreach and education, provider engagement, continuity of care, and data sharing. A comprehensive statewide survey of 1,521 SPDs who participated in the transition yielded generally positive results, including:

- o 74% reported their quality of care as the same or better.

- o 63% reported being somewhat or very satisfied with their benefits.

- o 71% reported their ability to make appointments with a primary care doctor was about the same or easier.

- o 80% stated their providers' understanding of how to care for persons with their specific health condition was the same or better.

Other key lessons from the study were:

- o In most areas, about two-thirds of SPDs said the transition improved or did not affect their care.

- o About a quarter-to-a-third of SPDs reported problems with notification or care in various areas.

- o Opportunities to improve beneficiary notification and support were identified.

Health Research for Action at the University of California, Berkeley, School of Public Health will publish the full survey results in a final report in 2013.

DHCS believes the lessons it learned from the challenges it faced during the SPD transition will help it improve its administration of the CCI (described on page 39), including:

- o Greater education of beneficiaries and providers to ensure that the demonstration guarantees continuity of care.

- o Educating providers on the MER process to limit denials and incomplete applications, and to ensure that providers and beneficiaries understand the continuity-of-care provisions.

- o Working with stakeholders to ensure that their input is solicited, gathered, and included on notices and materials developed for beneficiaries.

- o Enhance processes and procedures for engaging and educating beneficiaries, beyond the U.S. Mail and telephone calls.

- o Develop better processes and protocols for data sharing to ensure that Plans receive accurate FFS data in a timely manner and that Plans transmit assessment data to providers in a timely manner.

SPD Member-Specific Data

In an effort to enhance Plans' abilities to provide prompt and effective coordination of care for transitioning SPDs, DHCS provides Plans with information about their newly enrolled SPD members. Each month, Plans are able to access data that provides up to 12 months of historical FFS claims and Treatment Authorization Request (TAR) data for each Plan's new SPD members. This data includes information about FFS providers seen, services rendered, and services authorized but not yet accessed during the 12-month period prior to the SPD member's enrollment into the Plan.

This data-sharing effort began in June 2011, with the mandatory enrollment of SPDs in the GMC and Two-Plan Model counties, and was expanded to all COHS Plans effective January 2013. As California expands its use of the managed care service delivery system to new populations, such as the upcoming rural expansion into California's non-managed care counties and the implementation of the CCI, DHCS intends to continue the practice of sharing historical member-specific FFS claims and TAR data for SPD members with the assigned Plans for use in care coordination.

DMHC Medical Surveys for SPDs

Every three years, DMHC conducts medical surveys of Plans that serve SPDs to effectively assess their overall performance.

HEDIS® and QIPs Focusing on SPDs

For 2013, DHCS is requiring Plans to report on fifteen HEDIS® performance measures, using data from HEDIS® measurement year 2012 (Appendix B). To monitor the quality of care for the SPDs, Plans must stratify five of the fifteen performance measures to report separately on the SPD and non-SPD populations. The five measures are:

- o   Ambulatory care services provided to members of all ages,
- o   Monitoring for patients on persistent medication,
- o   Children & adolescents' access to primary care,
- o   Comprehensive diabetes care, and
- o   All-cause readmissions, the statewide collaborative.

In nine counties, five Plans are conducting QIPs on comprehensive diabetes care, and a COHS Plan that operates in two other counties is conducting a QIP on annual monitoring for patients on persistent medications. Both of these are HEDIS® measures that will be stratified to allow the Plan to report separately on their SPD and non-SPD populations. In addition, SCAN is doing a QIP on care for older adults.

CAHPS® Survey and SPDs

The CAHPS® survey will identify respondents who are SPDs, allowing for comparative analysis of beneficiary satisfaction between SPDs and the Medi-Cal managed care population as a whole. The survey results will help DHCS assess the consequences of the SPD transition from the customer's point-of-view. The survey topics include member responses to rating their Plan, all health care, personal doctor, and specialist seen most often. The results of five composite measures reflect member experiences with accessing needed care, accessing care quickly, how well doctors communicate, customer service, and shared decision-making.

COMMUNITY-BASED ADULT SERVICES

Transition to Community-Based Adult Services

Under terms of the Waiver, DHCS provides Community-Based Adult Services (CBAS), as an additional benefit only available through Plans to SPDs and dual eligibles. CBAS is also available to FFS beneficiaries who reside in counties that have not yet implemented managed care and to persons who do not qualify for or who have received exemptions from Medi-Cal Managed Care. CBAS evolved as a service from DHCS's elimination of Adult Day Health Care (ADHC), which had been established through the Medicaid State Plan.

The amendment provides CBAS to Medi-Cal eligibles who meet specified medical-necessity criteria and:

- o   Meet "Nursing Facility Level of Care A" (NF-A) or above; or

- o Have a moderate-to-severe cognitive impairment, including moderate to severe Alzheimer's Disease or other dementia; or

- o Have a developmental disability; or

- o 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

- o 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.

The goal of the CBAS benefit is to assist Medi-Cal beneficiaries to stay in their communities and avoid long-term institutional placement.

Many of these individuals who have Medi-Cal had been receiving ADHC services under the State Plan. They are now CBAS participants and, to continue receiving CBAS, they must enroll in managed care, effective July 1, and October 1, 2012. Beneficiaries who are found not eligible for CBAS upon DHCS's face-to-face assessment are provided with Enhanced Case Management (ECM). 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. The transition of CBAS participants into plan members began on July 1, 2012. CBAS participants in COHS counties (except Ventura) were transition on July 1, 2012. DHCS transitioned CBAS participants in Two-Plan Model and GMC counties during the period of October 2012 through December 2012 (including COHS county Ventura). During this transition period, CBAS participants were provided choices of Plans and expedited enrollment process to ensure the continuity of CBAS services. FFS CBAS was available for CBAS participants pending transitions or CBAS participants who were exempted from managed care enrollment (individuals who were enrolled in non-matching Medicare managed care plans)[3]. Managed care transition of CBAS participants was completed by December 31, 2012.

Key Quality Strategy Design Elements

- o Accessibility: Plans were required to contract with all licensed and certified ADHC Centers (the official provider type for CBAS benefits) in their covered ZIP code areas and in adjacent ZIP code areas where Plan members may go for CBAS services, and to assure that CBAS benefits are accessible to their members. Some Plan members who meet CBAS eligibility criteria cannot access CBAS because a CBAS Center closes or existing CBAS Centers are geographically, culturally, or linguistically inaccessible. For

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[3] CBAS participants in ZIP codes, counties or geographical areas without Medi-Cal managed care coverage remains on a FFS basis. Nothing will be changing for these CBAS participants.

those members, Plans would be responsible for making, providing, or coordinating the delivery of services (or unbundled CBAS) covered under Plan benefits (e.g., medical services, home health) or coordinate with local community resources (senior centers, independent living programs, In-Home Supportive Services (IHSS), or local nutritional programs) to assist plan members to remain in the community.

o <u>Provider Qualification and Licensure</u>: CBAS benefits are provided by ADHC Centers licensed by CDPH and certified by the California Department of Aging (CDA). Plans may only contract with ADHC Centers that are licensed and whose certifications are in good standing. On a periodic basis, CDA monitors the ADHC Centers for their compliance with licensing and staffing requirements, regulations, quality, and performance. CDA will make monitoring findings and corrective action requirements available to Plans. Plans are required to have policies and procedures to assure that ADHC Centers that provide CBAS benefits to their members who are properly certified.

o <u>CBAS Benefit Eligibility Determination and Individualized Care Planning</u>: Plans are required to have sufficient registered nurses, employed or contracted, who are trained in CBAS eligibility determination by DHCS to complete face-to-face assessments and to determine the eligibility status of Plan members who request CBAS within the timeframe required of all service requests by Plan members (30 days). Upon determining eligibility, Plans' registered nurses are to review and approve individualized care plans prepared by the CBAS provider's interdisciplinary team (RN, social worker, therapists, health aides). Plans' registered nurses are to coordinate the delivery of CBAS benefits in relation to other medical services or community based services their members would need. CBAS benefits are re-authorized every six months or sooner if Plan members' health status changes. Each Plans' registered nurses are required to review the CBAS individualized care plans and make changes when appropriate. Similarly, for Plan members who are eligible but cannot access CBAS, each Plans' registered nurses are to case manage and coordinate Plan-covered benefits with other community resources the Plan members may need in order to avoid institutionalization.

o <u>Quality Assurance and Improvement</u>: Plans are to integrate CBAS providers in their ongoing quality assurance and improvement programs and monitor their members' complaints and grievances regarding the CBAS benefits they receive. Plan-operated quality assurance and improvement programs will also monitor members' CBAS requests; and the timeliness of assessments, reauthorizations, and discharges, particularly the timeliness of discharges from CBAS to long-term nursing facilities.

o <u>DHCS Oversight of Plans that Assume the Responsibility of CBAS Benefit</u>: Monitor network adequacy and accessibility issues;

- Monitor eligibility determination, six-month reauthorization, and timeliness of these determinations/reauthorizations;

- Monitor complaints, grievances, appeals, and State Fair Hearings from Plan members regarding the Plans' management of CBAS benefits; and

- Monitor discharges from CBAS and the reasons of discharges.

DHCS is developing templates for Plans to use when reporting program information to DHCS; DHCS will distribute these templates to the Plans. DHCS will also monitor Plans' arrangements and outcomes for members known to have had to receive unbundled CBAS services because CBAS Centers had closed.

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

o   Program activities emphasize access to comprehensive health services and prevention-oriented health care that promotes health, well-being, and individual choice.

o   DHCS's consistent collaboration with stakeholder workgroups has enabled it to identify key program issues and to plan meaningful improvement strategies.

o   DHCS addresses access issues with Plans and other stakeholders to assure ongoing basic access to the appropriate level of health care services for both current and future CBAS enrollees.

o   DHCS promotes program transparency and better-informed dialogue among stakeholders by sharing quality-improvement and performance-measurement results with the public.

HEALTHY FAMILIES PROGRAM

Shifting the Healthy Families Program into Medi-Cal Managed Care

DHCS began to transition beneficiaries of HFP, California's version of CHIP, to the Medi-Cal Managed Care program on January 1, 2013. Between January 1 and April 1, the State has transitioned over 555,300 children to Medi-Cal Managed Care. By Fall 2013, another 155,800 children will have transitioned. DHCS required Plans into which the HFP beneficiaries were transitioning to meet specified performance standards and comply with all existing performance standards and measurements required by the law prior to the transition of any children. DHCS required all Plans to submit the necessary provider network data to ensure that their networks met the required network adequacy standards prior to the transition of HFP beneficiaries. A thorough review of their networks was completed and submitted to CMS for approval prior to implementing the HFP children transition. The majority of the children that have transitioned have been able to maintain access to the same PCP they were seeing while in the HFP. Through a monthly monitoring report submitted to CMS, DHCS is able to keep both CMS and stakeholder groups informed on how the transition is going and address any concerns that become apparent during the transition.

The upcoming phases of the transition that will be implemented on August 1 and September 1 will require beneficiaries to choose a new Plan. DHCS will notify affected beneficiaries by mailing them a notice at least 90 days prior to their transition into a Plan. Beneficiaries will be informed that they are transitioning to Medi-Cal Managed Care and will be provided with the necessary tools to choose a new Plan in their counties of residence. DHCS will inform those beneficiaries who live in a COHS county of the Plan they will transition into. DHCS expects the upcoming phases of the transition to run smoothly and to result in minimal-to-no disruption of care or services for Plan members.

QIPS Focusing on Children and Adolescents

A few Plans are conducting QIPs that focus on children and/or adolescents. One Plan that is operating in two counties is conducting a QIP on management of attention deficit hyperactivity disorder (ADHD) in members 6–12 years old. Two of the Plans, including a COHS that operates in 6 counties, are conducting a QIP on children and adolescents' access to primary care providers. This is one of the HEDIS® measures that will be stratified to allow Plans to report separately on their SPD and non-SPD populations.

RURAL EXPANSION

Statewide Expansion of Medi-Cal Managed Care

California's SFY 2012-13 budget calls for the extension of Medi-Cal Managed Care statewide starting in September 2013. To ensure a smooth transition, DHCS has set up performance metrics and monitoring activities that focus on how Plans are meeting the needs of the transitioned beneficiary population. DHCS will review collected data and analyze it to ensure that beneficiaries have access to providers and continuity of care. Plans must report the following information:

o Health Plan Grievances/Appeals Related to Access to Care – This information includes grievances made to both DMHC and/or to DHCS. DHCS evaluates the data based on significant increases in such activities beyond current trends once the transition begins.

o Continuity-of-Care Requests and Outcomes – Plans report this information to DHCS on a monthly basis; it is used to monitor each Plan's ability to continue to provide services without disruption of care.

o Time and Distance Requirements for PCPs (Geo Access) – This information is used as a component of each Plan's provider network adequacy review.

o Member Rights and Program Integrity Audits – DHCS performs annual audits on its Plans regarding how well each Plan's fulfills its obligations to its members regarding providing access to services and providers, responding to grievances, and supplying information.

o Office of the Ombudsman – Plan members who experience difficulties are able to telephone the Office of the Ombudsman to report these issues and to receive help and guidance. DHCS tracks each call that comes in and is able to run reports on what issues Plan members are reporting and which Medi-Cal population these members represent.

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

o Network adequacy for Plans
o Primary care assignments for Plan providers
o Ombudsman inquiries for Plans
o Beneficiary/Provider call-center inquiries for health services
o Continuity-of-care referrals and outcomes
o Grievances and appeals

- o Beneficiary satisfaction phone survey
- o Telemedicine utilization

The data collection, reports, and analysis will ensure that DHCS sufficiently monitors the expansion of managed care and that Plans meet the needs of the transitioned beneficiary population.

COORDINATED CARE INITIATIVE (CAL MEDICONNECT PROGRAM, MANDATORY ENROLLMENT OF DUAL ELIGIBLES, AND MANAGED LONG-TERM SERVICES AND SUPPORTS)

The CCI was adopted as part of California's State Budget for SFY 2012-13 to integrate Medicare and Medicaid benefits for dual eligibles, and to integrate long-term services and supports (LTSS) into Plans (Senate Bill (SB) 1008, Chapter 33, Statutes of 2012; and SB 1036, Chapter 45, Statutes of 2012). The primary objectives of the CCI are to improve health outcomes and beneficiary satisfaction for low-income SPDs, while achieving savings from rebalancing service delivery away from institutional care and into the home and community. CMS has authorized the State to implement the CCI in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara; the CCI will become effective no sooner than January 1, 2014. There are three major components to the CCI:

Cal MediConnect

The Cal MediConnect program is a three-year demonstration project for beneficiaries who are dual eligible. This program will combine the full continuum of acute, primary, institutional, and Home and Community-Based Services (HCBS) into a single benefit package, delivered through an organized service delivery system. DHCS will passively enroll dual-eligible beneficiaries into a Cal MediConnect Plan, but they may choose to opt out at any time.

CMS approved the framework for the Cal MediConnect program on March 27, 2013, and documented its approval in a MOU between CMS and DHCS. The MOU can be found online at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf

Mandatory Enrollment of Dual Eligibles

All dual-eligible beneficiaries, subject to certain exceptions, will be mandatorily enrolled into a Plan to receive their Medi-Cal benefits. This includes dual eligibles who opt out or are excluded from the Cal MediConnect program. Currently, dual eligibles may voluntarily enroll into a Plan in GMC and Two-Plan Model counties.

Inclusion of Managed LTSS

One component of the CCI is inclusion of LTSS as benefits for nearly all Plan members in the eight CCI counties (this includes dual-eligible and Medi-Cal-only SPDs). Plans will provide LTSS, when appropriate, to individuals who are Medi-Cal-eligible and meet specific medical-necessity criteria for the following services: Nursing Facility custodial and non-custodial care, IHSS, and 1915(c) HCBS Multipurpose Senior Services Program (MSSP).

By consolidating the responsibility for all covered services into a single health plan, the CCI is expected to achieve the following goals:

o   Improve the quality of care provided to beneficiaries;

o   Maximize the ability of beneficiaries to remain safely in their homes and communities, with appropriate services and supports, in lieu of institutional care;

o   Coordinate Medi-Cal and Medicare benefits across health care settings, and improve continuity of care across acute care, long-term care, behavioral health, and HCBS settings using a person-centered approach; and

o   Promote a system that is sustainable, person- and family-centered, and enables beneficiaries to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including HCBS and mental health and substance use disorder services.

The CCI will build on lessons learned during the Waiver transition of Medi-Cal-only SPDs into managed care, which include the following:

o   *Continuity of Care:* Beneficiaries and stakeholders have repeatedly emphasized the importance of care continuity when considering new delivery models. Beneficiaries will be informed about their enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices. This information will be delivered in a format and language accessible to enrollees. DHCS is working collaboratively with physician organizations, Plans, and advocacy groups to improve all participants' understanding and abilities to implement care protections and processes. DHCS will include this work in its beneficiary and provider outreach. Further, MMCD will continue to work with the members of its Advisory Group to improve both the understanding of these important protections and the processes through which they are pursued.

o   *Person-Centered Care Coordination:* Plans will be responsible for providing seamless access to networks of providers across this broader continuum of care and for upholding strong beneficiary protections established through the stakeholder process. The model of care will include person-centered care coordination supported by interdisciplinary care teams and other coordination strategies, including behavioral health, substance use, LTSS, and other covered services.

o   *Beneficiary Protections:* The CCI transition will include unified requirements and administrative processes that accommodate both Medicare and Medicaid, including network-adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes.

o   *Plan Monitoring and Oversight:* DHCS will work closely with CMS, DMHC, stakeholders, and beneficiaries to provide strong monitoring and oversight of Plans, and to evaluate the CCI's impact on quality and satisfaction, service utilization patterns, and costs.

o   *Provider Outreach and Engagement:* DHCS and CMS will coordinate efforts to engage and educate providers about the CCI before and during its implementation. This work is

already underway through the stakeholder workgroup process that focuses on provider outreach and engagement. DHCS continues to consider all stakeholder recommendations concerning the optimal tools, forums, and strategies to engage providers and beneficiaries on how the CCI can improve the delivery of care to beneficiaries.

o   *Transparency:* DHCS considers transparency and meaningful involvement of external stakeholders, including beneficiaries, as cornerstones in the development of the CCI: these will remain throughout its implementation. California has embarked on a stakeholder workgroup process and will require Plans to demonstrate ongoing stakeholder involvement at the local level that includes, at a minimum, a process for gathering ongoing feedback from beneficiaries and other external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other beneficiary protections.

Core Quality Measures for CCI

DHCS will require Cal MediConnect Plans to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient-caregiver experience, screening and prevention, and quality of life. This includes a requirement to report HEDIS®, Medicare Health Outcome Survey (HOS), CAHPS® data, and measures related to LTSS. DHCS will report HEDIS®, HOS, and CAHPS® measures consistent with Medicare requirements for HEDIS® plus any additional Medi-Cal measures identified by DHCS. DHCS will also collect all existing Part D metrics. The monitoring thresholds and reporting frequency for each of the core quality measures is currently in development between CMS and DHCS.

For Cal MediConnect, the core quality measures are described in the MOU between CMS and DHCS (*Figure 7-1: Core Quality Measures under the Demonstration,* pages 108–115). The MOU can be found online at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf

DHCS will provide more detail on the measures in the three-way contracts between CMS, DHCS, and each Cal MediConnect Plan, to be executed in the fall of 2013. CMS and DHCS will analyze the reported measures from the combined set of core quality measures for various purposes, including for program implementation and ongoing monitoring, assessing Plan performance and outcomes, and to allow DHCS to evaluate and compare Plan quality against the quality of other Plans that operate under the same model. The specific measurement definitions for the State-specific measures are currently under development between CMS and DHCS.

DHCS will work closely with CMS to monitor other measures related to community integration. DHCS and CMS will continue to work jointly to refine and update these quality measures in years two and three of the Cal MediConnect program.

In addition, DHCS, DMHC, and CDSS will implement the monitoring requirements by doing the following:

- o DMHC and DHCS will submit an annual joint report on financial audits performed on Plans.

- o DHCS will coordinate with DMHC, CDSS, and CMS to monitor Plans and institute CAPs, when appropriate.

- o DHCS will continue to work with stakeholders and CMS to develop ongoing quality measures for Plans, which will include primary and acute care, LTSS, and behavioral health services.

- o DHCS will continue to contract with an EQRO to audit Plans for quality measures and validate encounter data.

In conjunction with the Cal MediConnect program evaluation efforts, DHCS, CDSS, and CDA will monitor the utilization of medical services and LTSS (including IHSS), and will identify and share any significant changes in aggregate or average utilization of medical services among beneficiaries participating in the CCI.

The core LTSS quality measures developed for the Cal MediConnect program will be leveraged and adjusted as appropriate to evaluate the Plans in the eight CCI counties.

Quality Withhold Measures for the Cal MediConnect Program

Under the Cal MediConnect program, both Medicare and Medi-Cal will withhold a percentage of the capitation rate from each Cal MediConnect Plan. Medicare and Medi-Cal will repay these amounts to each Plan subject to the Plan's performance consistent with established quality thresholds. DHCS bases these thresholds on a combination of certain core quality-withhold measures and State-specified quality measures.

CMS and DHCS will share information as needed to determine whether Plans have met quality requirements and to calculate the final payments they must make to each Cal MediConnect Plan. Whether or not each Plan has met the quality requirements in a given year will be made public, as will relevant quality scores in Demonstration Years 2 and 3.

The quality-withhold measures for Demonstration Year 1 will be utilized as the basis for the one percent withhold. Although Year 1 crosses calendar and Contract years, the plans will be evaluated to determine whether they have met the withhold requirements at the end of calendar year 2014. The quality withhold will increase to two percent in Demonstration Year 2 and three percent in Demonstration Year 3 and will be based on performance in the quality withhold measures for those years (Appendix G). Additional detail regarding the measures will be included in the three-way contracts.

Passive Enrollment Measures

DHCS will employ a passive enrollment process for the Cal MediConnect Program. Beneficiaries scheduled to be enrolled into a Cal MediConnect Plan will receive an advance notification at least 90 days prior to the date they are scheduled to be enrolled. This letter

explains that the beneficiary may opt-out or make another enrollment decision prior to the enrollment's effective date. If the beneficiary does not make an active enrollment choice, the beneficiary will be passively enrolled into the Cal MediConnect Plan that was identified in the notice.

CMS and DHCS have identified passive enrollment measures that may be used to re-assess passive enrollment into a particular Cal MediConnect Plan if the thresholds for any of these measures have been met. The passive enrollment measures examine such areas as the percent of claims denied, members with health assessments and care plans within specified timeframes, and member grievances related to their demonstrated inability to get an appointment with a PCP. The passive enrollment measures will be fully defined in the three-way contracts for the Cal MediConnect Program.

Rapid Cycle Quality Improvement Process

To ensure quality and performance improvement, each of the Cal MediConnect Plans will participate in a "Rapid Cycle Quality Improvement Process" (RCQIP). For the duration of the demonstration project, DHCS and the Plans will develop QIPs that follow the RCQIP: a QIP for all Cal MediConnect Plans, similar to the current Statewide Collaborative process; and Plan-specific QIPs, similar to the current process.

The QIP for all Cal MediConnect Plans is expected to be related to one of the quality withhold measures. This QIP would run the duration of the Cal MediConnect Program. DHCS will conduct the planning process (data monitoring and identification) for this QIP during Demonstration Year 1, and then run annually for Demonstration Years 2 and 3, consistent with the timing of the monitoring and reporting of the quality withhold measures.

Similar to the current QIP process, the Cal MediConnect QIP should be related to a specific deficiency. The duration of this QIP will be annual and will consist of two projects related to the specific measure agreed upon between the Cal MediConnect Plan and DHCS. These Plans will report data periodically to DHCS and, contrary to the QIP for all Cal MediConnect Plans, this QIP may end after several reporting periods if the QIP has proven to have successfully met its goals. In that case, DHCS and the Cal MediConnect Plan would then identify a new QIP that follows the periodic reporting process.

Ongoing Monitoring of CCI Participating Plans

To ensure the goals of the CCI program are being accomplished and beneficiaries are receiving the care that they need, a dedicated Contract management team will be responsible for day-to-day monitoring of each participating Plan in the eight CCI counties. This includes the Plans participating in Cal MediConnect program and the Medi-Cal Managed Care program. The responsibilities of the Contract management team will include, but are not limited to:

o Monitoring Contractor compliance with reporting requirements;

o Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;

o Coordinating periodic audits and surveys of the Contractor;

- o Receiving and responding to complaints;

- o Reviewing reports from the Ombudsman;

- o Reviewing direct stakeholder input on both Plan-specific and systematic performance;

- o Conducting regular meetings with each Prime Contractor Plan;

- o Coordinating requests for assistance from Contractors, and assigning appropriate State and CMS staff to provide technical assistance;

- o Coordinating review of marketing materials and procedures; and

- o Coordinating review of grievance and appeals data, procedures, and materials.

SECTION VI: CONCLUSIONS and OPPORTUNITIES

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, DHCS has established, maintained, and expanded a successful, well-organized program.

Another major success has been a greater degree of transparency that results from 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, Medicaid programs from other states, and other 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 a more informed dialogue among stakeholders.

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.

As discussed previously, DHCS is engaged in a MITA State self-assessment and has developed a strategic vision. This vision will enable DHCS to address HIT components that are necessary to advance its information architecture, including data-collection methods; data management and storage; metadata; and the data models and analytics capabilities necessary to support quality measurement, reporting, and transparency. In addition to improvements expected through EDIP and transformations as part of the conversions from local codes and file formats to HIPAA-compliant formats, DHCS is focused on capacity and use of the centralized MIS/DSS, DHCS's centralized data repository and analytic platform. Improvements include: incorporation of reference data that will improve capabilities to analyze population characteristics, care delivery models and quality measures; training for and upgrades to diagnosis grouping software that supports calculation of preventable quality indicators; and data quality reports that are used by program areas to work with data providers to improve quality. DHCS has also begun the process to re-procure the MIS/DSS support contract, which will provide specific opportunities to increase MITA maturity and support DHCS's quality strategy.

Adoption of Electronic Health Records

To support advancements of HIT in the clinical care environment experienced by Medi-Cal beneficiaries, DHCS has implemented the Medicaid Electronic Health Record (EHR) Incentive Program. This program provides incentives to providers serving Medi-Cal beneficiaries when the providers adopt a certified EHR and use it in a meaningful way, as specified in CMS regulations. As of March 1, 2013, over 7,200 eligible professionals and

eligible hospitals had received over $480-million in incentive payments through the Medi-Cal EHR Incentive Program.

In most cases, when providers enter the third year of the incentive program or stage two of meaningful use, they must begin to report clinical quality measures (CQMs) to Medi-Cal. DHCS plans to leverage existing technical capacities in support of the MITA to receive the CQMs. In stage two of the incentive program, the CQMs specifically align with the National Quality Strategy.

DHCS works closely with other Health Information Technology for Economic and Clinical Health (HITECH) grantees to support providers in the implementation of EHRs. Grantees include CHHS, which is responsible for the Health Information Exchange Cooperative Agreement, the four Regional Extension Centers, the Beacon Program in San Diego, the Workforce Program, and the California Telehealth Network. This group of grantees works in partnership with lead coordination by CHHS to assist in the adoption of EHRs and the implementation of infrastructure necessary to connect EHRs with each other and with the ancillary services necessary to support meaningful use.

Over the coming years, California will continue to leverage 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 standards of care will include the use of EHRs in all practice settings that have the capacity to exchange health information to improve patient care. The State will integrate EHRs with government systems through bi-directional data exchange that will enable improved quality assurance, program evaluation, and population and public health assessments that result in the improved health and well-being of Californians.

A special project under the EHR Incentive Program is specifically addressing registry functionality related to immunizations for Medi-Cal members. DHCS has received funding that supports the implementation of a new California Immunization Registry (CAIR 2.0), which will support meaningful-use requirements, will be run by CDPH at the State level (as opposed to the current model with 10 regional registries), and will support DHCS's efforts to increase immunization rates among the Medi-Cal population.

One of DHCS's priorities for the EHR Incentive Program is to engage patients and families in their care. Across the State, increasing numbers of providers have adopted the use of personal health records and the "Blue Button." DHCS plans to follow the Medicare model and develop the "Blue Button" capacity so that members can directly view their personal health information, as represented by claiming systems and other reporting mechanisms.

DHCS is serving as the lead for California's participation in the HIT Trailblazer Initiative. The goal of HIT Trailblazer States is to support the alignment of state-level HIT activities and other efforts to transform the health care delivery system. The initiative is supported by the Office of the National Coordinator for Health Information Technology (ONC), the National Academy for State Health Policy (NASHP), Research Triangle Institute (RTI), and Deloitte Consulting LLP. The Trailblazer States Initiative has included two phases to date. California

was one of seven grantees selected to participate in this nationwide effort. On January 16, 2013, California convened a symposium in partnership with NASHP and ONC to further our collective goals toward quality measurement and reporting statewide. Participants discussed California's quality improvement landscape, priorities and opportunities for alignment, and federal alignment activities for quality measurement and reporting.
http://www.ohii.ca.gov/calohi/eHealth/MakingHIEHappen/PlansReports/HITTrailblazers.aspx.

Dashboard

As Medi-Cal Managed Care has expanded, most recently to include SPDs, so has the need for improved program oversight and monitoring. Although DHCS collects numerous measures of Plan performance using many tools and surveys, no structured mechanism exists to gather this disparate information in one place and in one standard format, prioritize which measures are most important and identify the gaps, and assess what the information means in terms of Plan performance or of the performance of the Medi-Cal Managed Care program overall. Because Plans are each structured differently and have differing information systems, they do not consistently report their data by category. To standardize Plan reporting, MMCD is currently developing an online performance measurement dashboard that will present its first iteration in June 2013. This dashboard will continue to change and grow with the needs of the program.

Health Homes Assessment

Section 2703 of the ACA provides states the 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 for two years with no deadline to apply or implement the activity. The payments are made to designated providers for coordinated health care provided to individuals with two chronic conditions, with one chronic condition and risk of a second, or with a serious and persistent mental health condition. DHCS continues to assess the viability of this optional benefit. To be effective, a model should provide effective care management; coordinate services to an appropriate population in a widespread, cost-neutral model; and be fiscally sustainable beyond the two years of enhanced funding.

California continues to transition new populations into the Medi-Cal Managed Care program, each of which differs from existing Plan populations in complex ways. The State is working to expand and strengthen its quality and monitoring efforts among its contracted Plans. These actions will improve data quality and completeness, strengthen its internal and external administrative and clinical relationships, create tools that will assist with monitoring, and ensure program-wide alignment with the DHCS Quality Strategy. California continues to strive toward meeting and beating national standards for quality of care. This Report is one step in the process of meeting that goal.

SECTION VII: APPENDICES

A. Medi-Cal Managed Care Health Plan Demographics (March 2013)

B. External Accountability Set (EAS) Measures w/SPD Stratification: 2013

C. CMS Initial Core Set of Adult Health Care Quality Measures for Medicaid-Eligible Adults

D. CMS Initial Core Set of Children's Health Care Quality Measures

E. Internal/Small Group Quality Improvement Projects & Statewide Collaborative (April 2013)

F. Access to Care Contract Requirements

G. Quality Withhold Measures for the Cal MediConnect Program

H. Acronyms

APPENDIX A: HEALTH PLAN DEMOGRAPHICS (March 2013)

Medi-Cal Managed Care Enrollment Report - March 2013				
Plan Type	County	Year	Plan Name	Totals
Two-Plan Model Local Initiative Plans and Commercial Plans **(Two-Plan)**	Alameda	1996	Alameda Alliance for Health	138,428
			Anthem Blue Cross	34,986
	Contra Costa	1996	Contra Costa Health Plan	82,802
			Anthem Blue Cross	14,375
	Fresno	1996	CalViva Health	163,353
			Anthem Blue Cross	73,739
	Kern	1996	Kern Family Health	125,207
			Heath Net	45,574
	Kings	2011	CalViva Health	14,028
			Anthem Blue Cross	13,559
	Los Angeles	1997	LA Care	1,027,354
			Health Net	496,753
	Madera	2011	CalViva Health	19,920
			Anthem Blue Cross	13,018
	Riverside	1996	Inland Empire Health Plan	272,648
			Molina Healthcare	41,114
	San Bernardino	1996	Inland Empire Health Plan	304,854
			Molina Healthcare	55,402
	San Francisco	1996	San Francisco Health Plan	64,700
			Anthem Blue Cross	14,917
	San Joaquin	1996	Heath Plan of San Joaquin	123,894
			Health Net	5,690
	Santa Clara	1996	Santa Clara Family Health	138,067
			Anthem Blue Cross	40,310
	Stanislaus	1997	Health Plan of San Joaquin	29,209
			Health Net	52,603
	Tulare	1999	Anthem Blue Cross	76,033
			Health Net	54,328
	Total Two-Plan Enrollment			**3,536,865**

APPENDIX A: HEALTH PLAN DEMOGRAPHICS (March 2013)

Medi-Cal Managed Care Enrollment Report - March 2013				
Plan Type	County	Year	Plan Name	Totals
Geographic Managed Care Plans (GMC)	Sacramento	1994	Anthem Blue Cross	99,624
			Health Net	71,504
			Kaiser Foundation	41,228
			Molina Healthcare	36,899
	San Diego	1998	Care 1st Health Plan	30,185
			Community Health Group	148,029
			Health Net	33,669
			Kaiser	27,549
			Molina Healthcare	86,748
	Total GMC Enrollment			575,435
County Operated Health Systems (COHS)	Marin	2011	Partnership Health Plan of CA	17,251
	Mendocino	2011		20,104
	Napa	1998		14,093
	Solano	1994		61,564
	Sonoma	2009		55,208
	Yolo	2001		27,289
	Merced	2009	Central California Alliance for Health	74,410
	Monterey	1999		91,708
	Santa Cruz	1996		39,143
	Santa Barbara	1983	CenCal	73,587
	San Luis Obispo	2008		29,537
	Orange	1995	CalOptima	418,490
	San Mateo	1987	Health Plan of San Mateo	65,520
	Ventura	2011	Gold Coast Health Plan	101,443
	Total COHS Enrollment			1,089,347
Total for Two-Plan, GMC and COHS				5,202,495

Source: DHCS CAPMAN Capitation Report

APPENDIX B: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES w/SPD STRATIFICATION: 2013

#	HEDIS®[4,5] Acronyms	HEDIS® Measure	Measure Type (Methodology)	SPD Stratification Required[6]	Used in Auto Assignment Algorithm
1.	AMB-OP AMB-ED	Ambulatory Care: • Outpatient visits • Emergency Department visits	Admin measure (Medicaid) - addresses members <1 year through 85+ years	Yes	No
2.	MPM-ACE MPM-Dig MPM-Diu	Annual Monitoring for Patients on Persistent Medications (without anticonvulsant, 3 indicators): • ACE inhibitors or ARBs • Digoxin • Diuretics	Admin measure (Medicaid) - addresses members 18 years & older	Yes	No
3.	AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Admin measure (Medicaid)	No	No
4.	CCS	Cervical Cancer Screening	Hybrid measure (Medicaid)	No	Yes
5.	CIS-3	Childhood Immunization Status – Combo 3	Hybrid measure (Medicaid)	No	Yes
6.	CAP-1224 CAP-256 CAP-711 CAP-1219	Children & Adolescents' Access to Primary Care Practitioners: • 12-24 Months • 25 Months – 6 Years • 7-11 Years • 12-19 Years	Admin measure (Medicaid)	Yes	No
7.	CDC-E CDC-LS CDC-LC CDC-HT CDC-H9 CDC-H8 CDC-N CDC-BP	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 (Medicaid)	Yes	Yes, for *HbA1c Testing* indicator **only**
8.	IMA-1	Immunizations for Adolescents	Hybrid measure (Medicaid)	No	No
9.	PPC-Pre PPC-Pst	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Hybrid measure (Medicaid)	No	Yes, for *Timeliness of Prenatal Care indicator* **only**
10.	LBP	Use of Imaging Studies for Low Back Pain	Admin measure (Medicaid)	No	No

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

[5] Uses data from 1/1/12 through 12/31/12 "measurement year."

[6] Stratification is required to identify Seniors and Persons with Disabilities. MMCD will provide the Plans with a reporting template for reporting the SPD population and non-SPD population.

APPENDIX B: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES w/SPD STRATIFICATION: 2013

#	HEDIS® Acronyms	HEDIS® Measure	Measure Type (Methodology)	SPD Stratification Required	Used in Auto Assignment Algorithm
11.	WCC-BMI WCC-N WCC-PA	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents • BMI percentile • Counseling for nutrition • Counseling for physical activity	Hybrid measure (Medicaid)	No	No
12.	W-34	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	Hybrid measure (Medicaid)	No	Yes

NEW FOR 2013					
13.	ACR	All-Cause Readmissions – Statewide Collaborative QIP measure	Admin measure Non-NCQA measure: Statewide Collaborative QIP to define specific measure	Yes	No
14.	CBP	Controlling High Blood Pressure	Hybrid measure	No	No
15.	MMA	Medication Management for People with Asthma	Admin measure	No	No
		Total Number of Measures	8 Hybrid and 7 Admin measures		

Performance Measures Required for Specialty Plans Reporting Year 2013

AHF Healthcare Centers
• Colorectal Cancer Screening
• Controlling High Blood Pressure

Family Mosaic Project
• *Inpatient Hospitalizations:* The percentage of Medi-Cal managed care members enrolled in Family Mosaic who have a mental health admission to an inpatient hospital facility during the measurement period.
• *Out-of-Home Placements:* The percentage of Medi-Cal managed care members enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.

SCAN
• Breast Cancer Screening (BCS)
• Osteoporosis Management in Women Who Had a Fracture (OMW)

2012 HEDIS® Performance Measure Eliminated
From the Required External Accountability Set (EAS)

2011 HEDIS® Measure	Measure Type (Methodology)
Adolescent Well-Care Visits [AWC]	Hybrid measure

Medi-Cal Managed Care Division, Program Monitoring & Medical Policy Branch (12-19-12)

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APPENDIX C: CMS INITIAL CORE SET OF ADULT HEALTH CARE QUALITY MEASURES

Category of Adult Measure	NQF #†	Measure Steward‡	Measure Name	Programs in Which the Measure is Currently Used¥	DHCS Reports
Management of Chronic Conditions	0018	NCQA	Controlling High Blood Pressure	MU1, HEDIS®, NCQA Accreditation, PQRS GPRO, Shared Savings Program	MCP Reporting
	0063	NCQA	Comprehensive Diabetes Care: LDL-C Screening	MU1, HEDIS®, NCQA Accreditation, PQRS	AMQG MCP Reporting
	0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Testing	MU1, HEDIS®, NCQA Accreditation, PQRS	AMQG – must stratify on two demographic categories MCP Reporting
	0105	NCQA	Antidepressant Medication Management	MU1, HEDIS®, NCQA Accreditation	AMQG
	N/A	CMS-QMHAG	Adherence to Antipsychotics for Individuals with Schizophrenia	VHA	AMQG
	0021	NCQA	Annual Monitoring for Patients on Persistent Medications	HEDIS®, NCQA Accreditation	AMQG MCP Reporting
Family Experiences of Care	0006 & 0007	AHRQ & NCQA	CAHPS® Health Plan Survey v 4.0 - Adult Questionnaire with CAHPS® Health Plan Survey v 4.0H - NCQA Supplemental	HEDIS®, NCQA Accreditation, Shared Savings Program (NQF#0006)	No
Care Coordination	648	AMA-PCPI	Care Transition – Transition Record Transmitted to Health care Professional	Health Homes Core	No
Availability	0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	MU1, HEDIS®, Health Homes Core	No
	1391	NCQA	Prenatal and Postpartum Care: Postpartum Care Rate	HEDIS®	AMQG – must stratify on two demographic categories MCP Reporting

Notes:
† NQF ID National Quality Forum identification numbers are used for measures that are NQF-endorsed; otherwise, NA is used.
‡ Measure Steward
        AHRQ – Agency for Healthcare Research and Quality
        CMS – Centers for Medicare & Medicaid Services
        CMS-QMHAG – Centers for Medicare & Medicaid Services, Quality Measurement and Health Assessment Group
        HCA, TJC – Hospital Corporation of America-Women's and Children's Clinical Services, The Joint Commission
        NCQA –National Committee for Quality Assurance
        Prov/CWISH/NPIC/QAS/TJC – Providence St. Vincent Medical Center/Council of Women's and Infant's Specialty Hospitals/National Perinatal Information Center/Quality Analytic Services/The Joint Commission
        TJC – The Joint Commission
¥ Programs in which measures are currently in use:
        CHIPRA Core – Children's Health Insurance Program Reauthorization Act - Initial Core Set
        CMS QIP – CMS Quality Incentive Program
        HIP QDRP – Hospital Inpatient Quality Data Reporting Program
        Health Homes Core-- CMS Health Homes Core Measures
        MU1 – Meaningful Use Stage 1of the Medicare & Medicaid Electronic Health Record Incentive Payment Programs
        PQRS – Physician Quality Reporting Program Group Practice Reporting Option
        Shared Savings Program – Medicare Shared Savings Program
        VHA – Veterans Health Administration

APPENDIX D: CMS INITIAL CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES

NQF #	Measure Steward	Measure Name	California Reports
1517	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care	MCP Reporting
1391	NCQA	Frequency of Ongoing Prenatal Care	
1382	CDC	Percentage of Live Births Weighing less than 2,500 Grams	
0471	California Maternal Quality Care Collaborative	Cesarean Rate for Nulliparous Singleton Vertex	
0038	NCQA	Childhood Immunization Status	MCP Reporting Healthy Families
1407	NCQA	Immunizations for Adolescents	MCP Reporting
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	MCP Reporting
1448	CAHMI and NCQA	Developmental Screening in the First Three Years of Life	
0033	NCQA	Chlamydia Screening in Women	MCP Reporting
1392	NCQA	Well-Child Visits in the First 15 Months of Life	Healthy Families
1516	NCQA	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	MCP Reporting Healthy Families
NA	NCQA	Adolescent Well-Care Visit	Healthy Families
NA	CMS	Total Eligibles Who Received Preventive Dental Services (ages 1-20)	
NA	NCQA	Child and Adolescent Access to Primary Care Practitioners	MCP Reporting Healthy Families
0002	NCQA	Appropriate Testing for Children with Pharyngitis	
0657	AMA-PCPI	Otitis Media with Effusion (OME)–Avoidance of Inappropriate Use of Systemic Antimicrobials	
NA	CMS	Total Eligibles Who Received Dental Treatment Services (ages 1-20)	
NA	NCQA	Ambulatory Care: Emergency Department Visits	
0139	CDC	Pediatric Central-line Associated Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	
1381	Alabama Medicaid	Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits (ages 2-20)	
0108	NCQA	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	
0060	NCQA	Annual Pediatric Hemoglobin A1C Testing	
0576	NCQA	Follow-up After Hospitalization for Mental Illness	
NA	NCQA	CAHPS® 4.0H (child version including Medicaid and children with chronic conditions supplemental items)	

AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CAHMI: Child and Adolescent Health Measurement Initiative; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; NA: Measure is not NQF endorsed; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum.

APPENDIX E: INTERNAL & SMALL GROUP QUALITY IMPROVEMENT PROJECTS (April 2013)

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.	Baseline
Anthem Blue Cross Partnership Plan (Alameda, Contra Costa)	Improving Diabetes Management	To increase the number of adult members aged 21 to 65 who receive appropriate and timely HbA1c and retinal eye exam screening to monitor blood sugar control and eye problems related to their diabetes diagnosis.	Proposal
Anthem Blue Cross Partnership Plan (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 (Fresno, Kings, Madera)	Improving Diabetes Management	To increase the number of adult members aged 21 to 65 who receive appropriate and timely HbA1c and retinal eye exam screening to monitor blood sugar control and eye problems related to their diabetes diagnosis.	Proposal
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	Baseline
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 increases the likelihood of desired health outcomes of enrollees.	Baseline
CenCal Health	Annual Monitoring for Patients on Persistent Medications	To increase annual therapeutic monitoring for patients that need continuous emollient criteria and have at least 180 treatment days of one more of these medications during the measurement year and ensuring better compliance with these important monitoring tests.	Proposal

APPENDIX E: INTERNAL & SMALL GROUP QUALITY IMPROVEMENT PROJECTS (April 2013)

Health Plan	Internal QIP Title	Objective	Current Phase
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	TBA	TBA	New Proposal due June 15, 2013
Contra Costa Health Plan	Improving Perinatal Access and Care	To improve the care women receive during and right after pregnancy. The project will identify barriers to care, both within the health care system and within populations, and will attempt to remove those barriers. The project will also seek to ensure that the care received is of high quality and meets our standards, based on those of the American College of Obstetricians and Gynecologists.	Baseline
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	New proposal due June 2013
Health Net Community Solutions (Kern, Los Angeles, Stanislaus, Tulare, Fresno)	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

APPENDIX E: INTERNAL & SMALL GROUP QUALITY IMPROVEMENT PROJECTS (April 2013)

Health Plan	Internal QIP Title	Objective	Current Phase
Kaiser Permanente North	Childhood Immunization Status (CIS)	To increase immunization rates for children from low-income families and those covered by Medi-Cal program lags behind children under commercial insurance.*although the HEDIS® measure is not required to be reported for Medi-Cal members, it affords the plan an opportunity to evaluate why the immunization rates are lower for the Sacramento GMC children compared to other Kaiser regions.	Baseline
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.	Baseline
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 (Riverside, Sacramento, San Bernardino, San Diego)	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
Partnership Health Plan (Napa, Sonoma, Yolo, Sonoma, Marin, Mendocino)	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.	Baseline
San Francisco Health Plan	Improving the Patient Experience	Improving communication to improve the patient experience with care.	Proposal
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) ≥ 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)	Re-Measurement 1

STATEWIDE COLLABORATIVE

Statewide Collaborative: All Plans except: AIDS Healthcare Foundation and Family Mosaic	All-Cause Readmissions	To identify effective strategies to improve patient outcomes and reduce hospital readmission rates for Medi-Cal Members 21 years of age and older who have an acute inpatient care.	Baseline

APPENDIX F: 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: ♦ 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	• Change in Provider Network Quarterly Report • Geographic Mapping Reports • Medical Surveys Conducted by A&I and DMHC • Plan Subcontractors Quarterly Report • Provider Directory (updated semi-annually) • Subcontractors' Agreements/Records
Access and Availability	Plans communicate, enforce and monitor provider compliance with the following standards: ♦ 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)	• Consumer Satisfaction Survey • Emergency Department Protocols • Evidence of Coverage Member Handbook • Inpatient Days Information • Medical Surveys Conducted by A&I and DMHC • Policies and Procedures • Quality Improvement Projects
Care Coordination	Plans and contracted providers provide the following care coordination services: ♦ 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 ♦ Discharge Planning ♦ Risk Stratification and Health Risk Assessment for SPDs ♦ Individualized Care Plans for SPDs	• Consumer Satisfaction Survey • MOU with Local Health Departments • Policies and Procedures • Annual Plan Care Coordination Survey • FSR Oversight including Medical Record Review Reports

APPENDIX F: ACCESS TO CARE CONTRACT REQUIREMENTS

Domain	Contract Requirements	Compliance Documentation, Monitoring and Evaluation
Providers	Plans monitor provider compliance in the following areas: ♦ 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	• Geographic Mapping Reports • FSR Master Trainer and Reviewer Certification • FSR Oversight, including Medical Record Review Reports • Medical Surveys Conducted by A&I and DMHC
Member Services	Plans and providers must comply with standards re: ♦ 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 ♦ Continuity of Care	• Call Center Reports Quarterly • Consumer Satisfaction Survey • Grievance Log • Medical Surveys Conducted by A&I and DMHC • Member Services Guide • Oversight by Member Rights/Program Integrity • Policies and Procedures • Quality Improvement Projects • Quarterly Grievance Report • Monthly Continuity of Care Report for Targeted Low-Income Child Members
Scope of Services	Plans assure that the following services are provided: ♦ 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	• Consumer Satisfaction Survey • HEDIS® External Accountability Set • Medical Surveys Conducted by A&I and DMHC • Over/Under Utilization Monitoring • Quality Improvement Projects • Policies and Procedures • FSR Oversight, including Medical Record Review Reports • Grievance Logs

APPENDIX G: QUALITY WITHHOLD MEASURES FOR THE CAL MEDICONNECT PROGRAM – YEAR 1

Measure	Description	Source	State Specified Withhold Measure
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements	CMS/State defined process measure	
Assessments	Percent of members with initial health assessments completed within 90 days of enrollment	CMS/State defined process measure	
Beneficiary Governance Board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements	CMS/State defined process measure	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctors' office or clinic as soon as you thought you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS®	
Customer Service (for CY 2014 only)	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS®	
Behavioral Health Shared Accountability Process Measure Phase A	Policies and procedures attached to an MOU with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing.	CMS/State defined process measure	X
Behavioral Health Shared Accountability Process Measure 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	CMS/State defined process measure	X
Documentation of Care Goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined measure	X
Ensuring physical access to buildings, services and equipment	The health plan has an established work plan and identified an individual who is responsible for physical access compliance.	CMS/State defined process measure	X
Case Manager Contact with Member	Percent of members who have a case manager and have at least one case manager contact during the measurement year.	State defined process measure	X

APPENDIX G: QUALITY WITHHOLD MEASURES FOR THE CAL MEDICONNECT PROGRAM – YEARS 2 AND 3

Measure	Description	Source	State Specified Withhold Measure
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®	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS® Survey data	
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members 6 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®	
Screening for Clinical Depression and Follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	
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.	HOS	
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®	
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	
Behavioral Health Shared Accountability Outcome Measure	Reduction in Emergency Department Use for Seriously Mentally Ill and Substance Use Disorder enrollees (greater reduction in Demonstration Year 3)	State defined measure	X
Documentation of Care Goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined measure	X
Case Manager Contact with Member	Percent of members who have a case manager and have at least one case manager contact during the measurement year.	State defined process measure	X

Link to Memorandum of Understanding (MOU) between CMS and DHCS: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf
Core Quality Measures listed in Figure 7-1 (pages 108-115)
Quality Withhold Measures listed in Figures 6-3 and 6-4 (pages 52-54)

APPENDIX H: ACRONYMS

AAP	American Academy of Pediatrics		HIT	Health Information Technology
ACA	Affordable Care Act		HITECH	Health Information Technology for Economic and Clinical Health
ACIP	Advisory Committee on Immunization Practices		IHSS	In-Home Supportive Services
ACOG	American College of Obstetricians and Gynecologists		IP	Improvement Plan
ADHC	Adult Day Health Care		LTSS	Long-Term Services and Supports
AHRQ	Agency for Healthcare Research and Quality		MAQCI	Medi-Cal Adult Quality Care Improvement
AQMG	Adult Quality Measures Grant		MEDS	Medi-Cal Eligibility Data System
CAC	Community Advisory Committee		MIS/DSS	Management Information System/Decision Support System
CAP	Corrective Action Plan		MIQS	Medi-Cal Incentives to Quit Smoking Project
CAHPS	Consumer Assessment of Healthcare Providers and Systems		MITA	Medicaid Information Technology Architecture
CBAS	Community-Based Adult Services		MLTSS	Managed LTSS
CCI	Coordinated Care Initiative		MPL	Minimum Performance Level
CCS	California Children's Services		MMCD	Medi-Cal Managed Care Division
CDA	California Department of Aging		MOU	Memorandum of Understanding
CDPH	California Department of Public Health		MSIS	Medicaid Statistical Information Systems
CDSS	California Department of Social Services		MSSP	Multipurpose Senior Services Program
CFR	Code of Federal Regulations		NASHP	National Academy for State Health Policy
CHHS	California Health and Human Services Agency		NCQA	National Committee for Quality Assurance
CHIP	Children's Health Insurance Program		OMB	Office of Management and Budget
CMS	Centers for Medicare and Medicaid Services		ONC	Office of the National Coordinator for Health Information Technology
COHS	County Organized Health Systems		PCCM	Primary Care Case Management
CPSP	Comprehensive Perinatal Services Program		PCP	Primary Care Provider
CQM	Clinical Quality Measures		PHI	Protected Health Information
DHCS	Department of Health Care Services		PHP	Prepaid Health Plans
DMHC	Department of Managed Health Care		Plan	Medi-Cal Managed Care Plan
EAS	External Accountability Set		PPE	Potentially Preventable Events
EDIP	Encounter Data Improvement Project		QI	Quality Improvement
EDV	Encounter Data Validation		QIP	Quality Improvement Projects
EOC	Evidence of Coverage		QIS	Quality Improvement System
EHR	Electronic Health Record		RCQIP	Rapid Cycle Quality Improvement Project
EQRO	External Quality Review Organization		RTI	Research Triangle Institute
FFS	Fee-for-Service Medi-Cal		SPD	Seniors and Persons with Disabilities
FMAP	Federal Medical Assistance Percentage		T-MSIS	Transformed Medicaid Statistical Information Systems
FSR	Facility Site Review		USPSTF	U.S. Preventive Services Task Force
GIS	Geographic Information Software		WIC	Women, Infants, and Children
GMC	Geographic Managed Care		§	Section
GNA	Groups Needs Assessment			
HCBS	Home and Community-Based Services			
HEDIS	Healthcare Effectiveness Data and Information Set			
HFP	Healthy Families Program			
HIF	Health Information Form			
HIPAA	Health Insurance Portability and Accountability Act			