



State of California—Health and Human Services Agency
Department of Health Care Services



MEDI-CAL MANAGED CARE
QUALITY STRATEGY REPORT

June 29, 2018
Final Report

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1. EXECUTIVE SUMMARY

1.1 OVERVIEW

The Medicaid Managed Care and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), at 42 Code of Federal Regulations (CFR) 438.340, requires each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities in that state. The complete language of 42 CFR 438.340 is included in Appendix A.

This report describes California's Medicaid quality strategy, and how it meets the requirements of the federal regulations. This report includes quality strategies across all of California's Medicaid managed care delivery systems, including: i) Medi-Cal managed care plans (MCPs); ii) County Mental Health Plans (MHPs); iii) Drug Medi-Cal Organized Delivery Systems (DMC-ODS); and iv) Dental Managed Care (DMC) plans.

This report and stakeholder feedback on the draft version of the report are posted on the [DHCS website](#). More detailed reports and specific program measures are also available on the DHCS website and can be accessed through our [Quality Measures and Reporting webpage](#).

The California Department of Health Care Services (DHCS or Department) is the single state agency responsible for the administration of California's Medicaid program, called Medi-Cal. The vision of DHCS is to preserve and improve the physical and mental health of all Californians. In alignment with this vision, DHCS is committed to continuous improvement in population health and health care in all departmental programs, across both managed care and fee-for-service (FFS) delivery systems.

Medi-Cal Managed Care Quality Strategy Report

In compliance with 42 CFR 438.202(a), DHCS has prepared and submitted a *Medi-Cal Managed Care Quality Strategy* report, as an annual assessment yearly and as a Comprehensive Review every three years. Until now, this report has specifically addressed quality improvement (QI) for MCPs, which administer medical benefits for Medi-Cal beneficiaries. Going forward the Department will publish a comprehensive report, which will include information previously reported in the *Medi-Cal Managed Care Quality Strategy* report, and information for California's other three Medi-Cal managed care delivery systems (MHPs, DMC-ODS, and DMC plans).

Each of the four Medi-Cal managed care delivery systems has developed goals, objectives, metrics, and performance improvement projects aligned to the Triple Aim and seven department-wide priorities, described in further detail below. Some of the Medi-Cal managed care delivery systems already publish these and additional QI measures in other documents, and the current report includes links to these other documents when appropriate. This report also describes California's arrangements for external quality reviews, descriptions of transition

of care policies, plans to reduce health disparities, use of intermediate sanctions, and identification of persons who need long-term services and supports. The Department emphasizes learning and sharing of best practices among our managed care delivery systems, as DHCS has previously implemented many of the quality strategy reporting requirements for MCPs.

DHCS Strategy for Quality Improvement

The *2018 DHCS Strategy for Quality Improvement in Health Care (Strategy)* is a separate document that highlights the goals, priorities, guiding principles, and specific programs that advance population health and high-quality health care for all DHCS managed care and FFS delivery systems. The *Strategy* report is anchored by the DHCS' three linked goals known as the Triple Aim:

1. Improve the health of all Californians;
2. Enhance quality, including the patient care experience, in all DHCS programs; and
3. Reduce the Department's per capita health care program costs.

In conjunction with the Triple Aim, the *Strategy* includes seven department-wide priorities:

1. Improve patient safety;
2. Deliver effective, efficient, affordable care;
3. Engage persons and families in their health;
4. Enhance communication and coordination of care;
5. Advance prevention;
6. Foster healthy communities; and
7. Eliminate health disparities.

These seven priorities are all viewed as equally important and critical to drive improvements in population health and health care delivery.

1.2 STAKEHOLDER FEEDBACK ON MEDI-CAL MANAGED CARE QUALITY STRATEGY REPORT

DHCS published a draft version of this report on March 28, 2018, and requested public comment through April 27, 2018. DHCS received feedback from 11 different organizations and individuals, and posted all stakeholder comments on the [DHCS website](#). In addition, DHCS discussed the draft report with stakeholders on May 17, 2018 at the DHCS Stakeholder Advisory Committee meeting, and on May 24, 2018 at the Medi-Cal Tribal and Indian Health Program meeting.

DHCS updated the final version of this report in response to stakeholder comments, and to capture program changes that occurred after the draft report was published. Key changes include:

- MHPs: Updated Section 5.2, to amend the list of quality metrics and performance targets. DHCS notes that while the approved specialty mental health expenditures and service quantity per beneficiary is a metric that is currently reported on in the DHCS Performance Dashboards, transforming the data to a measurable quality indicator may not be feasible.
- DMC-ODS: Updated Sections 5.3 and 6.3, to add information about requirements for county Quality Improvement and Quality Management programs, as well as the DMC-ODS External Quality Review Organization (EQRO) performance measures for the first program year. DHCS shared these performance measures with stakeholders in November 2017, and is adding a list of the specific performance measures to this report based on stakeholder feedback. DHCS also updated the list of DMC-ODS services to include optional services, and clarified language on additional Medication-Assisted Treatment.
- DMC Plans: Updated several sections to add detail and clarifications in Section 4.4, Evidence Based Clinical Practice Guidelines, Section 5.4, Continuous Quality Improvement, Section 8.4, Reducing Health Disparities, and Section 11, Long Term Services and Supports and Special Health Care Needs.
- Indian Health: Added a specific section on this topic, including information on the tribal component of the DMC-ODS implementation and network adequacy considerations for Indians and Indian Health Care Providers (IHCPs).

DHCS also notes the following stakeholder feedback, which will be considered in future updates to this report.

- All Managed Care Entities:
 - For DHCS to consider how quality metrics connect across Medi-Cal delivery systems, and align performance measures across initiatives, waiver programs, and delivery systems. DHCS recognizes the value of such an approach, and is working with its partners to improve alignment of performance measures and care coordination across delivery systems.
 - For DHCS to prioritize the further identification of health disparities, and develop plans for the reduction of those disparities. DHCS will continue ongoing efforts to address health disparities and will provide updates in future versions of this report.
- MHPs:
 - For DHCS to include more information in Section 4.2, regarding evidence-based clinical practice guidelines for MHPs, and the medical necessity criteria for specialty mental health services. DHCS is reviewing this suggestion for changes in future versions of this report.
 - For DHCS to create a more-consumer friendly and actionable format for quality metrics and EQRO reports. DHCS is exploring improvements to reporting formats, and will be cognizant of this recommendation in future reporting efforts.
 - For DHCS to improve the County Cultural Competence Plan (CCP) process. DHCS notes that the analysis described in the QSR is a necessary first step toward improving

- the CCP process to better understand what MHPs are doing, identify common themes and approaches being used, and use this information to develop statewide goals and objectives related to this area. DHCS will continue to explore and pursue ways to make meaningful advancements with CCP strategies
- For DHCS to provide more information on the transition of care policies in Sections 7.2 and 7.3. DHCS intends to publish an Information Notice for Transition of Care by July 2018. In its recent Medicaid Mental Health Parity and Addiction Equity Act Compliance Plan, DHCS made clear that it intended to adopt a continuity of care policy for Substance Use Disorder (SUD) services, which we believe would extend to DMC-ODS counties and plans. This policy is under development and will be considered for future versions of this report.
 - Proposed changes to the evaluation process for MHPs' Quality Improvement Work Plans. As this work continues, there will be further stakeholder engagement opportunities.
- DMC-ODS:
 - For DHCS to provide more information on results and benchmarks for the quality measures for the DMC-ODS. DHCS is receiving initial data for these measures and will provide updates in future iterations of the report.
 - For DHCS to add more detail regarding Tribal Phase 5 of DMC-ODS implementation. DHCS is working with a variety of stakeholders as this plan is currently in development. Quality measurements related to this population will be considered for subsequent reporting.
 - For DHCS to adopt a continuity of care policy for SUD services, to extend to DMC-ODS counties and plans. This policy is under development, and will be considered for future versions of this report.
 - For DHCS to mention the 5 Evidence Based Practices that meet requirements under the ODS, and outline how counties need to select at least two for use by providers. DHCS will review this for consideration in future versions of this report.

In addition, DHCS received stakeholder feedback that was out of the scope of this report. DHCS will consider this input for other departmental efforts. In particular, DHCS notes the following efforts related to several stakeholder comments:

- Social Determinants of Health: DHCS is addressing social determinants of health through Medi-Cal delivery systems and waiver programs, including the current Medi-Cal 2020 Section 1115 Waiver. For more information, please refer to the DHCS Medi-Cal 2020 website and the [2018 DHCS Strategy for Quality Improvement in Health Care](#). Additionally, in accordance with Assembly Bill 340 (Chapter 700, Statutes of 2017), DHCS has convened a trauma screening advisory group regarding tools and protocols for screening children for trauma.

- **Maternal Health:** DHCS is committed to improving outcomes in maternal health, and works closely with MCPs, the California Department of Public Health, the March of Dimes, the California Maternal Quality Care Collaborative, and other partners to address disparities in maternal health. DHCS intends to advance ongoing efforts and provide more information in the future.
- **Stratified Performance Metrics:** Stakeholders suggested that DHCS provide more stratified performance metrics, to identify and address the unique needs of specific populations (e.g. pregnant women, individuals with disabilities, people living with HIV, homeless individuals, and American Indians and Alaskan Natives). While DHCS already publishes Medi-Cal demographic information on the DHCS website and on the California Health and Human Services Open Data Portal, the Department recognizes the continued stakeholder interest in performance measures stratified by specific populations and will consider these comments in future data publishing efforts.

2. MANAGED CARE DELIVERY SYSTEMS IN CALIFORNIA

DHCS provides Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. DHCS funds health care services for 13.5 million Medi-Cal beneficiaries, or about one-third of all Californians.

Medi-Cal benefits are provided through either managed care or FFS delivery systems. For purposes of the Final Rule requirements, MCPs and DMC plans are Managed Care Organizations (MCOs¹), and MHPs and DMC-ODS plans are Prepaid Inpatient Health Plans (PIHPs). These MCO and PIHP programs are included in this report.

2.1 MANAGED CARE PLANS

Approximately 80 percent of full-scope Medi-Cal beneficiaries, across all 58 counties in California, receive care through MCPs, totaling approximately \$49 billion dollars in funding in State Fiscal Year 2017-18. MCPs are responsible for coverage of the majority of medical benefits including primary and specialty care, as well as non-specialty mental health services for beneficiaries with mild to moderate functional impairments. MCP coverage of long-term care skilled nursing services varies across the state depending on the county. MCPs do not cover specialty mental health, substance use disorder, or dental benefits.

To meet the needs of MCP beneficiaries with high-quality and appropriate health services, it is important to know their demographics, including age, gender, and race-ethnicity. There were approximately 10,878,000 MCP beneficiaries as of December 1, 2017.² This is an increase in

¹ COHS plans are considered Health Insuring Organizations (HIO) but are held to the same requirements as MCOs per the DHCS to MCP contract.

² [Medi-Cal Managed Care Performance Dashboard](#)

membership of almost 4.7 million beneficiaries since the same time in 2013. Of this total, 41 percent (4.4 million) were children under age 18, and 59 percent (6.4 million) were adults. Females comprised 49 percent of the children under age 18. Women comprised 51 percent of the 18 to 20-year-olds, 57 percent of the 21 to 44-year-olds, and 56 percent of beneficiaries aged 45 years and older. Of all MCP beneficiaries, 46 percent were Hispanic, 21 percent were White, 8 percent were Black, 14 percent were Asian/Pacific Islander, and 12 percent were other/unknown race-ethnicity. Detailed information regarding the breakdown of membership by MCP is in the DHCS Medi-Cal Managed Care Enrollment Reports.³

By aid code groups⁴:

- 11 percent (approximately 1.1 million) were children whose parents' income is 138 to 266 percent of the Federal Poverty Level (FPL);
- 15 percent (approximately 1.6 million) were Seniors and Persons with Disabilities (SPDs) including children;
- 39 percent (approximately 4.2 million) were Affordable Care Act (ACA) expansion population; and
- 35 percent (approximately 3.8 million) were other populations (all other aid codes that do not include the groups listed above).

DHCS contracts with 25 full-scope MCPs and three Specialty Health Plans (SHPs) to provide health care services to Medi-Cal enrollees in all 58 counties. For this report, and in other quality of care reports, DHCS has reported on Kaiser Foundation Health Plan as two entities, Kaiser North and Kaiser South; however, they are considered to be one entity when counting MCPs.

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

- A County Organized Health System (COHS) is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission. A COHS model has been implemented in 22 counties and operates as a single county-operated health plan. Medi-Cal beneficiaries in COHS counties do not have the option of accessing services through traditional Medi-Cal FFS unless authorized by the MCP or DHCS. The COHS model serves about 2.19 million beneficiaries through six health plans in 22 counties; six of those counties were added in 2013.
- In the Two-Plan Model, beneficiaries may choose between two MCPs; typically, one MCP is a Local Initiative (LI) and the other a commercial plan. DHCS contracts with both MCPs. The LI is established under authority of the local government with input from State and

³ [Medi-Cal Managed Care Enrollment Reports](#)

⁴ 10 percent (approximately 968,000) were dually eligible for Medi-Cal and Medicare; these beneficiaries cross over multiple aid code categories

federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The commercial plan is a private insurance plan that also provides care for Medi-Cal beneficiaries. The Two-Plan Model serves about 6.89 million beneficiaries through 12 health plans in 14 counties.

- In the Geographic Managed Care (GMC) Model, DHCS allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county). The GMC Model has six health plans that serve more than 1.16 million beneficiaries in Sacramento County and seven in San Diego County.
- The Regional Model consists of two commercial health plans that provide services to beneficiaries in the rural counties of the State, primarily in northern and eastern California. DHCS implemented this model in November 2013, bringing Medi-Cal Managed Care to counties that historically offered only FFS Medi-Cal. The Regional Model serves more than 300,000 beneficiaries in 18 counties.
- The Imperial Model operates in Imperial County with two commercial health plans. It serves more than 75,000 Medi-Cal beneficiaries.
- The San Benito Model operates in San Benito County, and provides services to beneficiaries through a commercial health plan and FFS Medi-Cal. The San Benito Model serves more than 8,000 beneficiaries. San Benito is California's only county where enrollment into managed care is not mandatory.

2.2 COUNTY MENTAL HEALTH PLANS

California's specialty mental health services (SMHS) are provided under the authority of a 1915(b) Waiver.⁵ The 1915(b) SMHS Waiver provides California with the opportunity to deliver Rehabilitative Mental Health Services to children and adults through a managed care delivery system. DHCS contracts with 56 county MHPs who are responsible for providing, or arranging for the provision of, SMHS to Medi-Cal beneficiaries who meet medical necessity criteria in a manner consistent with the beneficiary's mental health treatment needs and goals, and as documented in the beneficiary's treatment plan.

The county MHPs provide outpatient SMHS in the least restrictive community-based settings. The SMHS provided through the 1915(b) SMHS Waiver service delivery model are also covered in California's Medicaid State Plan, with the exception of Intensive Care Coordination, Intensive

⁵ [1915\(b\) Medi-Cal Specialty Mental Health Services Waiver](#)

Home Based Services, Therapeutic Foster Care Services, and Therapeutic Behavioral Services.⁶

SMHS are as follows:

- Mental Health Services;
- Medication Support Services;
- Day Treatment Intensive;
- Day Rehabilitation;
- Crisis Intervention;
- Crisis Stabilization;
- Adult Residential Treatment;
- Crisis Residential Treatment Services;
- Psychiatric Health Facility Services;
- Intensive Care Coordination;
- Intensive Home Based Services;
- Therapeutic Foster Care Services;
- Therapeutic Behavioral Services;
- Targeted Case Management; and
- Psychiatric Inpatient Hospital Services.

MHPs are reimbursed through a claims-based FFS payment structure based on their actual expenditures for services rather than on a capitated basis. MHPs negotiate reimbursement rates and contract with providers to ensure services are rendered in accordance with state and federal laws, policies, and regulations. SMHS are funded through multiple dedicated funding sources, including Medicaid, 1991 Realignment, 2011 Realignment, Mental Health Services Act, Block Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), and locally-generated matching funds for 1991 Realignment, or other local revenues.

2.3 DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

On August 13, 2015, the federal Centers for Medicare and Medicaid Services (CMS) approved the DMC-ODS waiver amendment to California's previous Section 1115(a) Waiver entitled *Bridge to Reform Demonstration*. The DMC-ODS waiver amendment authorized the State to test a pilot program for the organized delivery of health care services for Medicaid eligible individuals with a SUD.

The goal of the DMC-ODS is to demonstrate how organized SUD care improves beneficiary health outcomes, while decreasing system-wide health care costs. Counties that choose to

⁶ Intensive Care Coordination, Intensive Home Based Services, Therapeutic Foster Care Services, and Therapeutic Behavioral Services are available to Medi-Cal beneficiaries up to age 21 based on medical necessity. These SMHS are not Medicaid State Plan Services, as services provided through the Medicaid Early and Periodic Screening Diagnostic and Treatment Program are covered whether or not they are included in the Medicaid State Plan.

participate in DMC-ODS are required to provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria. This approach is expected to provide eligible enrollees with access to the care and services they need for a sustainable and successful recovery.

The DMC-ODS is a delivery system for SUD services in counties that choose to opt-in and implement the pilot. By opting into the DMC-ODS program and executing the DMC-ODS Intergovernmental Agreement, a county agrees to provide or arrange for the provision of DMC-ODS services through PIHPs.

The state implementation of the DMC-ODS will occur in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal and Urban Indian Health Programs. In February 2017, the first county implemented services under the DMC-ODS. By September 2017, DHCS had received a total of 40 county implementation plans; subsequently, DHCS reviewed and approved the plans according to their phase. As of March 2018, 11 counties have implemented DMC-ODS, with 29 additional counties in various stages of approval and contracting processes. DHCS is working with CMS and various stakeholders for the tribal implementation of the DMC-ODS. After this phase is finalized, the program protocols and requirements will be incorporated as Attachment BB into the Section 1115(a) Waiver's Special Terms and Conditions. More information about the Phase 5 implementation is available on the [DHCS website](#).

DMC-ODS services are as follows:

1. Early Intervention;
2. Outpatient Treatment;
3. Intensive Outpatient Treatment;
4. Residential Treatment;
5. Partial Hospitalization (optional);
6. Opioid Treatment;
7. Additional Medication-Assisted Treatment (optional);
8. Case Management;
9. Physician Consultation Services;
10. Telehealth; and
11. Recovery Support Services

The county makes DMC-ODS services available as a Medi-Cal benefit for all individuals who: reside within its county borders; have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a SUD; and meet the medical necessity to receive that particular service based on ASAM criteria for SUD treatment services. The county may make these DMC-ODS services available by selectively contracting with Drug Medi-Cal certified providers, a managed care plan, or offering county-operated services.

2.4 DENTAL MANAGED CARE

The DMC program provides a comprehensive approach to oral health care, combining clinical services and administrative procedures organized to provide timely access to primary and specialty dental care. The DMC program operates in Los Angeles and Sacramento counties, and beneficiaries can choose from among three DMC plans in each county. In Sacramento County DMC enrollment is mandatory, and in Los Angeles County beneficiaries have the option to enroll in a DMC plan or access dental benefits through the Dental FFS delivery system. Each dental plan receives a monthly per capita payment for every beneficiary enrolled in their plan. DMC program beneficiaries receive dental benefits from dentists within the plan's provider network, and have the same scope of benefits as beneficiaries who access benefits through the Dental FFS delivery system. Approximately 912,000 Medi-Cal beneficiaries are enrolled in DMC.

2.5 INDIAN HEALTH SERVICES

According to the most recent census data, California is home to more people of Native American/Alaska Native heritage than any other state in the country. There are currently 109 federally recognized Indian tribes in California and 78 entities petitioning for recognition. Tribes in California currently have nearly 100 separate reservations or Rancherias. There are also a number of individual Indian trust allotments. These lands constitute "Indian Country", and a different jurisdiction applies in Indian Country. For Indians and Indian Country there are special rules that govern state and local jurisdiction. There may also be federal and tribal laws that apply.

The Indian Health Care Improvement Act amended the Social Security Act to permit reimbursement by Medicare and Medicaid for services provided to American Indians and Alaska Natives in Indian Health Services (IHS) and tribal health care facilities. DHCS administers the Medi-Cal managed care program in accordance with federal and state law and regulations which includes special protections for American Indians in managed care.

The health status of California Indians is recognized as one of the lowest of any ethnic group in the state, with Native Americans having higher prevalence of infant mortality, asthma, substance use disorders, diabetes, and other chronic diseases than that of the general population. DHCS meets regularly with tribes regarding the Medi-Cal program, and will continue to partner with tribes, MCPs, and providers on efforts to improve the health status of California Indians.

Further, DHCS notes that the CMS Final Rule Contract Amendment with the MCPs includes specific requirements that direct plans to include Indian Health Clinics (IHCs) in their provider network, as well as requires plans to inform American Indian members of their rights to request and access services through contracted IHC and choose an American Indian Health Care Provider within the plans contract network as their primary care provider. The contract amendments specify IHCs as a mandatory provider type for plans. DHCS issued All Plan Letter [\(APL\) 17-020](#) to provide guidance to plans regarding the requirement to contract with IHCs. Currently, through the Annual Network Certification process, DHCS monitors plans to ensure that they are making attempts to, or have contracted with, an IHC. IHCs are considered a mandatory provider type for the purposes of the network certification and each plan's service

area is reviewed to ensure compliance with the requirement. Any plan that does not meet the requirement will have a corrective action plan applied until a contract with an IHC is established or if the plan can provide a suitable attestation as to why they are unable to contract with an IHC.

3. NETWORK ADEQUACY AND AVAILABILITY OF SERVICES STANDARDS

The Final Rule requires this report to include the State-defined network adequacy and availability of services standards for managed care. DHCS published its network adequacy standards in July 2017, in compliance with the network adequacy provisions of the Final Rule.⁷ The DHCS network adequacy standards document was subsequently amended in March 2018 to reflect changes under AB 205 (Chapter 738, Statutes of 2017), which codified and amended California's network adequacy standards. The amendments in the updated [network adequacy standards](#) are primarily to base the standards on the population density of each county, rather than population size.

4. EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES

The Final Rule requires this report to include examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236. It further requires the MCPs, MHPs, DMC-ODS, and DMC Plans to adopt and disseminate these clinical practice guidelines to the Plans' providers and Medi-Cal beneficiaries.

DHCS requires all contracted managed care entities to develop and implement processes that reflect evidence-based clinical practice guidelines. The Department provides specific guidelines to each type of managed care entity, based on the type of benefits administered by the entity. Clinical practice guidelines are based on medical evidence and allow managed care entities to monitor the safety and effectiveness of provider services. DHCS and its contractors review and update clinical practice guidelines regularly to provide consistency with best practices.

4.1 MANAGED CARE PLANS

Through its contracts with the MCPs, DHCS requires that the MCPs develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction for Seniors and Persons with Disabilities or chronic conditions. DHCS also requires through its contracts that MCPs ensure that their pre-authorization, concurrent review and retrospective review decisions are based on a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. MCPs must utilize evaluation criteria and standards to approve, modify, defer, or deny services, and must document the manner in which providers are involved in the development and or adoption of specific criteria used by the MCP.

⁷ Please refer to the full network adequacy report on the [DHCS website](#) for further details.

MCPs must submit policies and procedures for ensuring providers receive training on a continuing basis regarding clinical protocols and evidence-based practice guidelines. MCPs are audited on their utilization management practices, including the application of evidence-based guidelines, and provider training protocols, as a part of the medical compliance audits conducted on all MCPs by DHCS on an annual basis.

4.2 COUNTY MENTAL HEALTH PLANS

Through its contracts with the MHPs, DHCS requires that the County MHPs adopt and disseminate clinical practice guidelines as specified in the Final Rule. Each MHP is also required to implement mechanisms to monitor the safety and effectiveness of medication practices, at least annually. As such, a majority of the MHPs have adopted clinical practice guidelines pertaining to clinical monitoring practices for psychotropic medications, consistent with the best practices in the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care.

In 2016 DHCS and the California Department of Social Services jointly released the “California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care” (Guidelines). This inter-departmental effort produced a guide to best practices for the treatment of mental health conditions affecting children and youth in out-of-home care.

While it is not mandatory for county MHPs to adopt the Guidelines, they are intended to be used by SMHS providers when prescribing psychotropic medication to children and youth in foster care as a SMHS activity or as part of an array of SMHS. The Guidelines outline:

- Basic principles and values;
- Expectations regarding the development and monitoring of treatment plans;
- Principles for emotional and behavioral health care, psychosocial services, and non-pharmacological treatments;
- Principles for informed consent to medications; and,
- Principles governing medication safety.

The Guidelines may evolve over time in response to updated research, evolution of best practices, and in response to feedback from youth, families, prescribers, other providers, and additional community stakeholders. For these reasons, the Guidelines are reviewed annually and updated as needed. The Guidelines are accessible on the [DHCS website](#).

4.3 DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

Counties that implement the DMC-ODS are required to use the ASAM Criteria to ensure that eligible beneficiaries have access to the SUD services that best align with their treatment needs. The ASAM Criteria is the result of a collaboration of experts that began in the 1980s to define a national set of criteria for providing outcome-oriented and results-based care in the treatment of a SUD. The ASAM Criteria is a proven model in the SUD field, and is the most widely used and

comprehensive set of guidelines for assessing patient needs and optimizing placement into SUD treatment.

In addition, DMC-ODS pilot counties have the option to offer additional Medication Assisted Treatment (MAT). Additional MAT offered by DMC-ODS counties can be offered via either FFS Medi-Cal or DMC-ODS, and is linked to the ASAM continuum of care to ensure access to a comprehensive scope of services that meet the biopsychosocial needs of patients. The components of additional MAT include ordering, prescribing, administering, and monitoring of medications for SUD. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

4.4 DENTAL MANAGED CARE

Through its contracts with DMC plans, DHCS requires the DMC plans to abide by the clinical criteria in the [Medi-Cal Dental Program Provider Handbook](#), inclusive of Section 5 – Manual of Criteria (MOC). The MOC provides dental clinical parameters to providers treating Medi-Cal beneficiaries. It sets forth program benefits and clearly defines limitations, exclusions, and special documentation requirements. The Manual outlines the DHCS policy that DMC plans are required to adopt and disseminate to their providers and beneficiaries for procedures offered through the program. In addition, the Dental Program Provider Handbook is a reference guide prepared by the Department and available to all Medi-Cal dental providers. It contains the criteria for dental services; program benefits and policies; and instructions for completing forms used in the Dental FFS program. This handbook is available to beneficiaries as well. The DMC contract also requires DMC plans to have their own Provider Manual which, following DHCS approval, shall be disseminated to providers and, upon request, to beneficiaries and potential beneficiaries. These Manuals include reliable clinical evidence and specific clinical practice guidelines that providers must adhere to.

The DMC contract provides the DMC plans' with clinical practice guidelines, such as the American Academy of Pediatric Dentistry periodicity schedule for dental services to children, including a mandatory first visit by the enrollee's first birthday. DHCS has also provided DMC plans and dental providers with information regarding intravenous sedation and general anesthesia services, as well as services for pregnant women and those who are postpartum. The contract also states that frequency limitations identified may be exceeded based on dental necessity and appropriateness of care, but in no case shall the frequency limitations be more restrictive.

5. CONTINUOUS QUALITY IMPROVEMENT

The Final Rule requires this report to include the State's goals and objectives for continuous quality improvement, which must be measureable and take into consideration the health status of all populations in the State served by the MCOs and PIHPs. In addition, this report includes the quality metrics and performance targets the Department is using to measure the performance and improvement of each managed care entity. Program-specific goals, quality

metrics, performance targets, the performance improvement project (PIP) or quality improvement project (QIP), and relevant reports are within the subsections below.

DHCS' vision is to preserve and improve the physical and mental health of all Californians. In alignment with this vision, DHCS is committed to continual improvement in population health and health care in all departmental programs. This is a time of rapid transformation and innovation for the health care system in California. The Department and its partners in health care, including health plans, hospitals, and individual care providers, are in the midst of implementing exciting advances in health systems, behavioral health, prevention, health disparities, and social determinants of health. For example, DHCS is using several federally approved waivers, including a \$7.2 billion 1115 Medicaid Waiver (Medi-Cal 2020 Demonstration, 11-W-00193/9), to test innovative models aimed at improving clinical care and population health. Throughout this innovation and transformation, the Department remains committed to providing Californians with the highest quality health care services in ways that maximize efficiency, value, and equity.

To this end, the Department has developed several managed care directed payment programs (in accordance with 42 C.F.R. §438.6(c)) to align, augment, and support the quality improvement initiatives promulgated through the managed care delivery systems and the Medi-Cal 2020 Demonstration. While each of these directed payment programs focus on a distinct health care delivery sector, they all have been designed to promote and maintain access to care and will each concentrate efforts on the department-wide priority of delivering effective, efficient, affordable care to Medi-Cal beneficiaries.

As part of the recently approved Designated Public Hospital (DPH) Quality Incentive Pool, the State will direct MCPs to make Quality Incentive Pool payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. This program will increase the amount of funding tied to quality outcomes, while at the same time further aligning state, MCP, and hospital system goals. This payment arrangement builds on the foundational work of the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program by moving California further towards value-based alternative payment models.

Access to comprehensive, high-quality health care services is essential for promoting and maintaining physical, behavioral (mental health and SUD), and oral health, preventing and managing disease, reducing unnecessary disability, and achieving health equity for all Californians. To promote access, the directed payment programs ensure that essential providers, in public and private hospitals as well as outpatient physical and oral health settings, receive adequate payment to deliver health care services to Medi-Cal beneficiaries in diverse settings. The State will perform an evaluation for each directed payment proposal to measure the degree to which these novel payment arrangements advanced access, improved health outcomes for Medi-Cal managed care beneficiaries, and advanced health care delivery in California.

5.1 MANAGED CARE PLANS

For MCPs there are seven focus areas for quality improvement. The focus areas were chosen because they reflect DHCS priorities, address large performance gaps, and have interventions readily available to improve the health of significant segments of the Medi-Cal Managed Care population. Five of the focus areas are directly linked to quality metrics, including chronic diseases (diabetes and hypertension), services within maternal/child health (postpartum care and immunization of two-year-olds), and tobacco cessation (a key prevention strategy). Two of the focus areas are not linked to a single quality metric including identifying and reducing health disparities among beneficiaries, and reducing opioid medication misuse and overuse in an attempt to help foster healthier communities.

The table below provides a summary of program goals and objectives, as well as quality metrics and performance improvement projects. Additionally, the [Medi-Cal Managed Care Quality Strategy Report Annual Update](#), published in October 2017, has a full description of all quality strategy efforts for MCPs.

<p>Program Goals and Objectives</p>	<ul style="list-style-type: none"> • Maternal and child health: <ul style="list-style-type: none"> ○ Postpartum care ○ Childhood immunizations • Chronic disease: <ul style="list-style-type: none"> ○ Diabetes care ○ Control of hypertension • Tobacco cessation • Reducing health disparities • Fostering healthy communities through reducing opioid misuse and overuse.
<p>Quality Metrics and Performance Targets for Reporting Year (RY) 2017</p>	<ul style="list-style-type: none"> • For 2016 MCPs reported performance on 17 measures consisting of 30 individual indicators. • DHCS held MCPs accountable for performing at least as well as the national Medicaid 25th percentile, or the Minimum Performance Level (MPL), on 18 of 30 indicators. • For health care services provided in 2016, for indicators for which DHCS held MCPs accountable to meet the MPLs, 89 percent of the rates were above the MPLs. • In 2016, the MCPs exceeded the High Performance Level (HPL) for 11 percent of the indicators.
<p>Performance Improvement Projects</p>	<ul style="list-style-type: none"> • DHCS requires MCPs to conduct and/or participate in two PIPs annually. • First PIP topic aligns to one of four DHCS pre-selected priority focus area topics including: <ul style="list-style-type: none"> ○ timeliness of postpartum care ○ diabetes ○ hypertension ○ childhood immunizations

	<ul style="list-style-type: none"> • Second PIP topic must be focused on addressing health disparities: <ul style="list-style-type: none"> ○ MCPs were encouraged to select an area where they had a demonstrated need for improvement
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Quality Metrics and Performance Targets

Listed below are the objectives for services to be provided in 2018, for the five quality metric linked focus areas. The targets were set in comparison to the baseline year of 2015. This builds upon the targets set in the Managed Care Quality Strategy Report for 2013, some of which were achieved in 2014 and sustained in 2015, and some of which DHCS and its MCPs are still working to achieve. The data was collected from January to December 2016, and was reported in July 2017.

Focus Area	Quality Metrics and Performance Targets
Postpartum Care	<p>Objective 1: Increase the Medi-Cal weighted average for timely postpartum care to at least 64 percent for 2018.</p> <ul style="list-style-type: none"> • Target for 2018: 64 percent • Baseline from 2015: 59 percent. • Target reached in 2016⁸: 64 percent, target reached two years ahead of goal. DHCS will continue work to improve upon this performance. <p>Objective 2: Increase the percentage of Medi-Cal Managed Care reporting units meeting the MPL for timely postpartum care to at least 80 percent for 2018.</p> <ul style="list-style-type: none"> • Target for 2018: 80 percent. • Baseline from 2015: 75 percent. • Target reached in 2016: 92 percent, target reached and exceeded two years ahead of goal. DHCS will continue work to improve upon this performance.
Immunization of Two-Year-Olds	<p>Objective: Increase to at least 80 percent the proportion of MCP beneficiaries with up-to-date immunizations by their second birthday during 2018.</p> <ul style="list-style-type: none"> • Target for 2018: 80 percent • Baseline from 2015: 71 percent • Progress toward goal⁷: DHCS maintained the rate of 71 percent for 2016 and will aggressively work towards improving childhood immunization rates by 2018.

⁸ Source: Reported as aggregate data by MCPs and audited by the Department’s EQRO, which calculated the statewide Medi-Cal Managed Care weighted average.

<p>Hypertension</p>	<p>Objective: Increase to 66 percent the proportion of MCP beneficiaries 18 to 85 years of age with hypertension whose blood pressure is adequately controlled during 2018.</p> <ul style="list-style-type: none"> • Target for 2018: 66 percent • Baseline from 2015: 61 percent • Progress toward goal⁷: DHCS increased the control of blood pressure rate by 2 percentage points to 63 percent in 2016, and will continue to work towards the goal of 66 percent in 2018
<p>Diabetes</p>	<p>Outcome Objective: Decrease to 35 percent the proportion of MCP beneficiaries with diabetes who had HbA1c testing greater than 9 percent or unknown in 2018.</p> <ul style="list-style-type: none"> • Target for 2018: 35 percent • Baseline from 2015: 40 percent • Progress toward goal⁷: DHCS decreased the number of beneficiaries with poor control of blood glucose by 2 percentage points to 38 percent in 2016, and will continue to work towards the goal of 35 percent in 2018. <p>Process Objective: Increase to 91 percent the proportion of MCP beneficiaries with diabetes who had HbA1c testing during 2018.</p> <ul style="list-style-type: none"> • Target for 2018: 91 percent • Baseline from 2015: 86 percent • Progress towards goal⁷: DHCS increased the number of beneficiaries with diabetes receiving HgbA1c testing by 1 percentage point to 87 percent in 2016, and will continue to work towards the goal of 91percent by 2018.
<p>Tobacco Cessation</p>	<p>Prior Target 1: Increase to 76 percent the median proportion of smokers who report⁹ being counseled to quit in the prior six months</p> <ul style="list-style-type: none"> • Target for 2016: 76 percent • Baseline from 2013: 71 percent • Target not reached in 2015¹⁰: 65 percent of smokers reported receiving counseling. <p>Current Target 1: Will maintain same target as DHCS did not achieve the target, and feels it is still a realistic and important goal.</p> <p>Prior Target 2: Increase to 45 percent the median proportion of smokers who report⁸ a provider discussed tobacco cessation medications in the prior six months</p> <ul style="list-style-type: none"> • Target for 2016: 45 percent • Baseline from 2013: 40 percent

⁹ As measured during 2016 Adult CAHPS® survey

¹⁰ Adult CAHPS® survey

	<ul style="list-style-type: none"> Target not reached in 2015⁹: 38 percent of smokers reported a provider discussed cessation medications. <p>Current Target 2: Will maintain same target as DHCS did not achieve the target, and feels it is still a realistic and important goal.</p>
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In addition to the five aforementioned focus areas, there are two additional focus areas, which do not have linked quality metrics but are essential to addressing the health of MCP beneficiaries. For these two focus areas, identifying and reducing health disparities and reducing opioid misuse and overuse, DHCS is engaging in non-measure related interventions with both MCPs and external stakeholders to address these critical areas.

Focus Area	Quality Metrics and Performance Targets
Health Disparities	<p>Objective 1: Review the first annual analysis of health disparities released by the EQRO that will analyze 2015 Healthcare Effectiveness Data and Information Set (HEDIS) rates by demographic variables. Utilize the findings from the report to target MCP QI activities, particularly those activities related to HEDIS measures.</p> <ul style="list-style-type: none"> Target not met: Due to a delay in obtaining finalized data as well as methodology adjustments to ensure a robust analysis, DHCS expects to meet this objective by fall 2017. In addition, DHCS will review the second health disparities annual analysis when available, which will analyze 2016 HEDIS indicators by demographic variables. <p>Objective 2: Establish first annual Health Disparities MCP Award in 2016.</p> <ul style="list-style-type: none"> Target not met: DHCS did not meet this objective due to a delay in the first annual health disparities analysis, but intends to move forward with this award when feasible. <p>Objective 3: Establish health disparity focused MCP PIP in 2017.</p> <ul style="list-style-type: none"> Target met: DHCS successfully established health disparities as a mandatory PIP topic for all MCPs for 2017 and will monitor progress of these PIPs throughout 2017 and 2018. DHCS will establish a QI collaborative with MCPs related to the health disparity focused PIP.
Fostering Healthier Communities	<p>Objective 1: Continue to participate in department and statewide workgroups on opioid overuse and misuse with the goal of reducing opioid addiction and increasing access to medication assisted therapy for opioid addiction.</p> <ul style="list-style-type: none"> Progress towards goal: DHCS continues its participation in these workgroups <p>Objective 2: Continue to work with MCPs on strategies to support judicious prescribing practices, to improve beneficiary outcomes, to</p>

	<p>provide alternative therapies for pain, to facilitate patient review and restriction programs, and to promote the use of naloxone.</p> <ul style="list-style-type: none"> • Progress towards goal: DHCS continues to work with MCPs and external partners on promoting safe opioid prescribing, facilitating patient review and restriction programs, and providing alternative therapies for pain.
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The objectives above will help DHCS meet its overall Quality Strategy priorities of delivering effective, efficient, and affordable care; engaging persons and families in their health; enhancing communication and coordination of care; eliminating health disparities; fostering healthy communities; and advancing prevention. They also address a number of the Department’s commitments to the people it serves. For objectives that DHCS has reached already, DHCS will continue efforts to sustain and surpass this improvement. For objectives that DHCS has not reached, DHCS will continue to work towards achieving the objectives.

In addition to the seven focus areas, DHCS requires the MCPs with which it contracts to report on a set of quality metrics known as the External Accountability Set (EAS). The EAS consists primarily of HEDIS measures developed by the National Committee for Quality Assurance (NCQA).

For 2016, MCPs reported performance on 17 measures consisting of 30 individual indicators, 21 of which are in the CMS Adult and Child Core Sets.

- For 2016, DHCS held MCPs accountable for performing at least as well as the national Medicaid 25th percentile, or the MPL, on 18 of 30 indicators.
- For 2017, DHCS will hold the MCPs accountable to the MPL for 21 of the 30 indicators; this is because in 2016, four metrics were new and DHCS does not hold the MCPs to the MPL in the first year of reporting a new metric. For 2017, DHCS will hold the MCPs to the MPL on the two metrics that have a national benchmark; the other two metrics do not yet have a national benchmark.
- For health care services provided in 2015, the MCPs exceeded the MPLs for 78 percent of the indicators. This left 22 percent of indicators falling below the MPLs. For the same year, MCPs exceeded the HPLs for 11 percent of the indicators.
- For health care services provided in 2016, for indicators for which DHCS held MCPs accountable to meet the MPLs, 89 percent of the rates were above the MPLs, demonstrating an 11 percentage point increase from the prior year.

Note that the number of indicators to which DHCS held MCPs to the MPLs decreased in 2016 due to four of the indicators being first year indicators on the EAS. Additionally in 2016, the MCPs exceeded the HPLs for 11 percent of the indicators.

Performance Improvement Projects

DHCS requires MCPs to conduct and/or participate in two PIPs annually. In September 2015, MCPs embarked on a new PIP process. The new process places a greater emphasis on improving outcomes using QI science. The new approach guides MCPs through the process using rapid-cycle improvement methods to pilot small changes, which also aligns with the Plan-Do-Study-Act (PDSA) process MCPs engage in for quality indicators below the MPL.

In 2015, MCPs selected their first PIP topic, which was one of four DHCS pre-selected topics that align with the priority focus areas of timeliness of postpartum care, diabetes, hypertension, and childhood immunizations. Of the 23 full-scope MCPs that participated in the first round of PIPs, five selected the topic of improving childhood immunization rates, eight selected the topic of timely postpartum visit care, eight selected the topic of diabetes care, and two selected the topic of controlling high blood pressure. Of the three SHPs, one selected diabetes care, one selected controlling high blood pressure, and one selected a separate topic due to the preselected topics not being appropriate for the SHP's specialized population.

In January 2016, MCPs selected their second PIP topic. Under the guidance of DHCS and the EQRO, MCPs provided information supporting their choice of topic and were encouraged to select an area where they had a demonstrated need for improvement. Many of the MCPs chose another of the four DHCS pre-selected topics that align with the priority focus areas, but others chose topics related to other areas in need of improvement such as cervical cancer screening, the medication management of people with asthma, and increasing developmental screenings in children. These first two PIPs concluded in June 2017. Results of the PIPs will be included in the 2017-18 annual EQRO Technical Report.

Currently, MCPs are in the process of selecting new PIP topics for 2017-18. DHCS has required that each MCP participate in a PIP focused on a statistically significant health disparity (e.g., race, ethnicity, language spoken, gender, geographical location, provider, etc.) for their first PIP topic. The health disparity identified by the MCP may be related or unrelated to any of the current EAS metrics, but each MCP or SHP is encouraged to choose a health disparity related to an EAS metric on which the MCP or SHP is not performing well, when possible. For their second PIP topic, MCPs must follow the following algorithm:

- Childhood Immunizations (CIS-3): MCPs performing below the MPL below the statewide Medi-Cal managed care average with declining performance on CIS-3 in 2017:

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

- Controlling High Blood Pressure, Comprehensive Diabetes Care, or Prenatal and Postpartum Care: MCPs performing below the MPL on one of these topics must have a PIP on that topic. If an MCP is performing below the MPL for more than one of these

measures, the MCP should choose the measure for which it has performed below the MPL for consecutive years or a measure for which the MCP's performance has been significantly declining for consecutive years.

OR

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

Once DHCS and the EQRO have approved the MCPs' new PIP topics for 2017-18, the MCPs will begin work on those topics.

In addition to required yearly PIPs, DHCS continues to work towards improving all MCP performance.

- DHCS continues to work to reduce time lags in identifying and addressing poor performance.
- In 2014, DHCS initiated a new approach to QIPs that focuses on rapid cycle QI which can increase the potential for improved outcomes
- DHCS continues to use instructions and a template for developing objectives using interim outcomes to facilitate use of PDSA methods. DHCS also modified the instructions and template for 2016-17 after obtaining MCP input.
- DHCS continues to require MCPs with substandard performance to conduct triannual evaluations of their PDSA cycles, with DHCS engagement throughout the year to monitor progress, provide technical assistance, and share lessons learned across MCPs.
- DHCS continues to hold quarterly collaborative discussions with MCPs on the four DHCS-priority topics (i.e., diabetes, hypertension, postpartum care, and immunizations of two-year-olds). With the new PIP topics for 2017-18, DHCS will continue with the collaborative discussions but modify the content as appropriate to the PIP topics.
- In 2017, DHCS conducted the first of what will be annual surveys of the MCPs on the PDSA process to better tailor technical assistance, provide better resources and support to the MCPs on their rapid cycle improvement projects.
- In 2017, DHCS released its first two EAS Highlights, on cervical cancer screening and childhood immunizations, highlighting promising practices from MCP PDSA or PIP projects to promote the sharing of promising practices.

5.2 COUNTY MENTAL HEALTH PLANS

DHCS conducts statewide continuous QI efforts to improve the quality and performance of the SMHS program, including monitoring and oversight of the MHPs' performance and QI activities. Examples of DHCS' QI efforts are described below.

Program Quality Improvement Focus Areas	<ul style="list-style-type: none"> • Care coordination for children and youth • Disparities in mental health.
Quality Metrics and Performance Targets	<ul style="list-style-type: none"> • SMHS Penetration Rate <ul style="list-style-type: none"> ○ Received one or more SMHS Visit ○ Received five or more SMHS Visits • Time to Step Down <ul style="list-style-type: none"> ○ Time between Inpatient Discharge and Step Down Service
Performance Improvement Projects	<ul style="list-style-type: none"> • Each MHP is required to conduct two PIPs, one clinical and one non-clinical, during the 12-months preceding the EQRO review. <ul style="list-style-type: none"> ○ A clinical PIP might target some of the following: <ul style="list-style-type: none"> ▪ Prevention and care of acute and chronic conditions ▪ High-volume services ▪ High-risk procedures ○ A non-clinical PIP might target some of the following: <ul style="list-style-type: none"> ▪ Coordination of care ▪ Appeals, grievances process ▪ Access or authorization • The current focus of PIPs is on improving access to services, decreasing no show rates via better scheduling and contacting interventions, and improving availability and access to wellness and recovery centers. • The EQRO's findings are summarized in individual MHP reports, quarterly PIP reports, and in the annual aggregate summary reports. The reports can be found at CalEQRO's website.

The Performance Outcomes System (POS), required by Welfare and Institutions Code Section 14707.5, and the 1915(b) SMHS Waiver Special Terms and Conditions (STCs) are driving QI efforts for the SMHS program. Through these efforts, both involving collaborative stakeholder processes, DHCS is defining quality domains and measures and has developed and published MHP performance data.

While DHCS has had various QI functions in place for SMHS, there is a lack of nationally or locally agreed upon mental health quality measures and corresponding state or national benchmarks and standards. The Performance Outcomes System (POS) and the 1915(b) STCs both require DHCS to develop SMHS performance reports and dashboards. Through developing these reports and dashboards, DHCS has established initial quality measures and reporting methodologies that serve as a foundation upon which DHCS will further build a SMHS quality assessment and performance improvement program.

While DHCS collects some demographic and mental health program performance data, the data are limited in terms of the level of detail captured, data elements not collected through DHCS' mental health data collection systems, and/or how program performance and service outcomes measures have been defined. For example, through the mental health data collection systems,

DHCS captures demographic data such as age, sex, and race/ethnicity, but not primary language spoken or gender identity/sexual orientation. Such information could inform QI efforts, by enabling DHCS and MHPs to better understand the SMHS population and their service needs. Similarly, DHCS captures some data that are useful in quality monitoring, but does not yet capture all data elements necessary for performance and outcomes measures. Finally, DHCS is continuously working on improving quality benchmarks and a methodology for comparing MHPs' performance in quality indicators measures.

QI Goals and Objectives for SMHS

The QI goals and priorities for SMHS are to:

1. Provide high-quality and accessible SMHS; and
2. Improve coordination of care within DHCS' service delivery systems as well as other service systems the SMHS beneficiaries commonly access.

The quality objectives for SMHS were selected based on current DHCS priorities, with consideration to challenges in assessing and measuring quality for SMHS. The quality objectives are intended to address performance gaps for which improvement efforts are underway.

Children and Youth

- An additional QI goal is to improve care coordination for children and youth involved in the SMHS and child welfare systems.
- By July 2019, develop a methodology for tracking referrals for SMHS from county child welfare to MHPs.
- By July 2019, establish baseline proportion of children and youth referred for SMHS from county child welfare who received:
 1. A SMHS within 10 days of referral from child welfare.
 2. Two to four services within 90 days of referral from child welfare.

Mental Health Disparities

- An additional QI goal is to improve DHCS' ability to identify disparities in mental health and increase access to SMHS.
- By July 2019, develop a report identifying populations disproportionately affected by mental health conditions and disparities in access to SMHS.
- By July 2019, define new demographic and client characteristic data elements, to better identify and address disparities in access to SMHS.

Quality Metrics and Performance Targets

DHCS has developed several quality measures, which it currently reports and monitors. DHCS also continues efforts to identify data sources and data collection methodologies for additional quality measures, which have been defined through the POS and SMHS Performance Dashboard stakeholder processes.

Performance Outcomes System (POS)

DHCS is responsible for the development and operation of a statewide SMHS POS. State statute requires DHCS to consider the following objectives, among others, in developing the POS:

1. High quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law;
2. Information that improves practice at the individual, program and system levels;
3. Minimization of costs by building upon existing resources to the fullest extent possible; and
4. Reliable data that are collected and analyzed in a timely fashion.

The performance measurement paradigm is a conceptual framework for the POS, which was built on the Mental Health Services Act measurement paradigm. DHCS developed the paradigm in collaboration with a wide array of stakeholders. In the paradigm there are four levels for outcomes measurement: individual, provider, system, and community. There are six domains of measures and indicators in the paradigm, which cross the four levels of outcomes measurement. These domains reflect domains used by SAMHSA. Following are the six domains selected for the POS measurement paradigm:

- Access;
- Engagement;
- Service Appropriateness to Need;
- Service Effectiveness;
- Linkages; and
- Cost Effectiveness and Satisfaction.

DHCS publishes three types of POS reports on the [DHCS website](#).

- Statewide Reports;
- Population Based Reports (Small Rural, Small, Medium, Large, Very Large); and
- County Level Reports.

Although the POS has been focused on EPSDT beneficiaries, it will eventually address performance outcomes for Medi-Cal beneficiaries across the lifespan. The measures and reports for the POS have been used as a foundation to develop the SMHS Performance Dashboards, required pursuant to the 1915(b) SMHS Waiver STCs.

Performance Dashboards

In July 2015, CMS approved DHCS' 1915(b) SMHS Waiver renewal for a five-year term, July 2015 – June 2020. With the waiver renewal, CMS also required DHCS to develop and publish a SMHS Performance Dashboard for each MHP, which must be published on both the State's and MHPs' websites in a manner that is easily accessible by the public. The SMHS Performance Dashboards are required to include MHP performance in the following areas: quality, access, timeliness, and translation/interpretation capabilities. The Statewide Aggregate SMHS Performance Dashboard and the County Level SMHS Performance Dashboards are accessible on the [DHCS website](#).

Benchmarks and performance targets for SMHS are evolving areas and DHCS continues efforts to determine appropriate benchmarks and performance targets related to SMHS.

The quality indicators currently reported for SMHS are outlined below:

- Access
 - Number of children and adults that received SMHS
- SMHS Penetration Rate
 - Received one or more SMHS Visit: proportion of beneficiaries eligible for SMHS who received one or more SMHS.
 - Received five or more SMHS Visits: proportion of beneficiaries eligible for SMHS who received five or more SMHS.
- Time to Step Down
 - Time between Inpatient Discharge and Step Down Service
- Utilization: Approved SMHS
 - Expenditures and Service Quantity per Beneficiary: service utilization in minutes by unique beneficiary and service type.
- Satisfaction
 - General Satisfaction (youth and adult surveys)
 - Perception of Participation in Treatment Planning (youth and adult surveys)
 - Perception of Access (youth and adult surveys)
 - Perception of Cultural Sensitivity (youth and adult surveys)
 - Perception of Quality and Appropriateness (adult survey)
 - Perception of Outcomes of Services (youth and adult surveys)
 - Perception of Functioning (youth and adult surveys)
 - Perception of Social Connectedness (youth and adult surveys)

The [POS Measures catalog](#) provides detailed information about the quality measures for SMHS. Functional Assessment Tools

In May 2017, DHCS selected two functional assessment tools which will provide treatment outcomes data: (1) A 50-item version of the Child and Adolescent Needs and Strengths (CANS) Scale (CANS Core 50); and, (2) The 35-item parent report form of the Pediatric Symptom Checklist (PSC-35).

The CANS includes items to be rated in the following domains: Child Behavioral/Emotional Needs, Life Domain Functioning, Risk Behaviors, Cultural Factors, Strengths Domain, and Caregiver Resources and Needs. Children and youth receiving SMHS will be assessed by CANS-certified county staff every six months.

Implementation of the CANS will allow DHCS to analyze treatment outcome data according to a variety of independent variables, including beneficiary diagnosis, type(s) and frequency of SMHS received, types of psychopharmacological agents prescribed (if applicable), and other factors potentially relevant to outcomes.

The PSC-35 is a psychosocial screening tool containing 35 questions that parents/caregivers answer about their child. The PSC-35 is designed to facilitate the recognition of cognitive, emotional, and behavioral problems so appropriate interventions can be initiated as early as possible.

DHCS, in consultation with stakeholders, continues to develop a catalog of 28 potential measures, based on data from the CANS and PSC-35. The measures catalog will define measures and benchmarks for each measure. DHCS and stakeholders will also continue to research and discuss an overall quality assessment and performance improvement framework and process, which may include monitoring and comparing MHP performance relative to established benchmarks.

Performance Improvement Activities

Each county MHP is required to complete and submit an annual QI Work Plan (QIWP), as well as an annual QIWP evaluation to DHCS for review. The QIWP must include the following:

- Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records reviews;
- Evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
- A description of completed and in-process QI activities, including performance improvement projects, including:
 - Monitoring efforts for previously identified issues, including tracking issues over time;
 - Objectives, scope, and planned QI activities for each year; and
 - Targeted areas of improvement or change in service delivery or program design.
- A description of mechanisms the MHP has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the MHP's 24-hour toll-free telephone number, timeliness for scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care; and
- Evidence of compliance with the requirements for cultural competence and linguistic competence specified in the MHP's contract with DHCS.

DHCS reviews each QIWP to ensure that the MHP has: (1) addressed required QIWP elements; (2) provided an adequate evaluation of the previous year's QIWP, and, if applicable, (3) proposed plans of correction which are methodologically sound. In Fiscal Year (FY) 2018-19, DHCS will implement a more robust and intensive QIWP evaluation process, and will continue to provide technical assistance and training in this area. The State's fiscal year cycles run from July through the following year in June. Each MHP's QIWP is available on the [DHCS website](#).

Care Coordination

During FY 2018-19, DHCS will use the mental health screenings and referrals that have been documented in CWS/CMS to determine children/youth who have had a positive mental health screening and were referred to the MHP for SMHS and either were or were not provided with services in the SMHS system, as evidenced by claim(s) in the Short Doyle / Medi-Cal System. Specifically, DHCS will be targeting two populations: 1) children/youth who were screened and referred by child welfare, but did not receive SMHS and 2) children/youth who were screened and referred by child welfare who received only one to four services (penetration, but not engagement). DHCS will sample from each of these population groupings and work with counties to determine the reasons why children/youth were referred, but did not receive SMHS and, for those who did 'penetrate' into the SMHS system (i.e., had at least one service), why they did not 'engage' with the SMHS system (i.e., had fewer than five services). Using the results of county case reviews, DHCS will establish an ongoing mechanism for tracking, comparing, and monitoring referrals from foster care to SMHS.

Performance Improvement Projects

Each MHP is required to conduct two PIPs, one clinical and one non-clinical, during the 12-months preceding the annual EQRO review. Each PIP is expected to produce consumer-focused outcomes. MHPs select PIP topics based on outcomes they think will serve the MHP.

The ultimate goal of a PIP is to drive continuous QI activities according to the PDSA QI model. The majority of PIPs over the course of the last two fiscal years focused on improving access to services via the 24/7 access line, improving no show rates via better scheduling and contacting interventions, improving quality of care for children and youth, and improving availability and access to wellness and recovery centers. The EQRO summarizes its findings in individual MHP reports, quarterly PIP reports, and in the annual aggregate summary reports. The reports can be found at [CalEQRO's website](#).

5.3 DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

The DHCS quality measures for the DMC-ODS are intended to measure whether organized SUD care increases the success of DMC beneficiaries while decreasing other system health care costs.

<p>Program Goals and Objectives</p>	<ul style="list-style-type: none"> • Measure progress towards improvement in quality metrics and performance targets to demonstrate how organized substance use disorder care increases the success of DMC beneficiaries. • Develop and implement performance measures by the DMC-ODS EQRO examining access, timeliness, and outcomes. • Develop relevant data collection and reporting systems through the augmentation of the California Outcomes and Measurement System (CalOMS) and the release of DMC-ODS dashboards. DHCS is developing a two-part process to improve data collection, described in the chart below.
<p>Quality Metrics and Performance Targets</p>	<ul style="list-style-type: none"> • As part of the DMC-ODS Implementation Plan requirements, counties must submit a narrative about their QI Program that includes a QI plan addressing the monitoring of accessibility of service delivery and capacity, in addition to beneficiary grievance submissions and other areas identified for quality improvement.
<p>Performance Improvement Projects</p>	<ul style="list-style-type: none"> • Each DMC-ODS plan is required to conduct two PIPs, one clinical and one non-clinical, during the 12-months preceding the EQRO review. <ul style="list-style-type: none"> ○ Clinical PIPs might target: <ul style="list-style-type: none"> ▪ Prevention and care of acute and chronic conditions ▪ High-volume services ▪ Special health care needs ○ Non-Clinical PIPs might target: <ul style="list-style-type: none"> ▪ Coordination of Care ▪ Appeals, Grievance Process ▪ Access or Authorization ▪ Member Services • Each PIP should have one or more measured indicators to track performance and improvement over a specific period of time.

Quality Metrics and Performance Targets

As part of the DMC-ODS Implementation Plan requirements, counties must submit a narrative about their QI Program that includes a QI plan. The FY 2016-17 DMC-ODS Intergovernmental Agreement (IA) contains provisions for Quality Management (QM) Programs. The requirements for QI and QM are similar, but counties should review their approved QI program to ensure they are compliant with the QM requirements in their executed IA. For counties that have an integrated behavioral health department, the DMC-ODS QI Plan may be combined with the MHP QI Plan; the county may also use the same MHP QI committee with SUD participation.

Counties must have a QI Plan that includes monitoring accessibility of service delivery and capacity. Capacity should include the description of the current number and types of SUD services, as well as the geographic distribution within the county.

The monitoring of accessibility of services outlined in the QI Plan, at minimum, must include:

- Timeliness of first initial contact to face-to-face appointment;
- Frequency of follow-up appointments in accordance with individualized treatment plans;
- Timeliness of services of the first dose of NTP services;
- Access to after-hours care;
- Responsiveness of the beneficiary access line;
- Strategies to reduce avoidable hospitalizations;
- Coordination of physical and mental health services with waiver services at the provider level;
- Assessment of the beneficiaries' experiences, including complaints, grievances, and appeals; and
- Telephone access line and services in the prevalent non-English languages.

The QI Plan must include information on how beneficiary grievance data will be collected, categorized, and assessed for monitoring. At a minimum, the QI Plan must include information on:

- How to submit a grievance, appeal, and request for a state fair hearing;
- The time frame for resolution of appeals;
- The content of an appeal resolution;
- Record keeping;
- Continuation of benefits; and
- Requirements of state fair hearings.

The county QI Committee reviews the quality of SUD services provided to beneficiaries. The QI Committee duties must include:

- Recommending policy decisions;
- Reviewing and evaluating the results of QI activities;
- Reviewing data elements;
- Instituting needed QI actions;
- Ensuring follow-up of QI processes; and
- Documenting QI Committee minutes regarding decisions and actions taken.

Each DMC-ODS county must have a QM Work Plan covering the current IA cycle with documented annual evaluations and revisions as needed. The county's QM Work Plan must evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan includes:

- Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.
- Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.
- A description of completed and in-process QM activities, including performance improvement projects. This includes:
 - Monitoring efforts for previously identified issues;
 - Objectives, scope, and planned QM activities for each year; and
 - Targeted areas of improvement or change in service delivery or program design.
- A description of mechanisms the county has implemented to assess the accessibility of services within its service delivery area. This includes:
 - Responsiveness goals for the county's 24-hour toll-free telephone number;
 - Timeliness for scheduling of routine appointments;
 - Timeliness of services for urgent conditions; and
 - Access to after-hours care.
- Evidence of compliance with the requirements for cultural and linguistic competence.

Through ongoing measurements and intervention, these QI activities are designed to achieve significant improvement and are expected to have a favorable, sustainable effect on health outcomes and beneficiary satisfaction.

Performance Measures

Performance measures are a key component of the external quality review and are linked to access, timeliness, and outcomes. The National Quality Forum, the Healthcare Effectiveness Data and Information Set, the Agency for Healthcare Research and Quality, the United States Department of Veterans Affairs, and the Washington Circle were consulted to determine these measures. For DMC-ODS reporting, a minimum of 12 performance measures must be included in the annual EQRO DMC-ODS individual county reports and in the EQRO annual statewide report. These performance measures include quality metrics and can be used by counties in the development of their PIPs.

1. Total beneficiaries served by each county DMC-ODS (Access);
2. Number of days to first face-to-face DMC-ODS service after referral (Access);
3. Total costs per beneficiary served by each county DMC-ODS (Access/Cost Effectiveness);
4. Cultural competency of DMC-ODS services to beneficiaries (Access);
5. Penetration rates for clients, including ethnic groups, age, language, and risk factors validated for access (Access);
6. Coordination of Care with physical health and mental health (Quality);
7. Timely access and numbers of beneficiaries accessing non-methadone MAT (Access);
8. Timely access to medication for narcotic treatment program (NTP) services (Access/Quality Outcomes);

9. Timely transitions in levels of care after residential treatment in year one of the waiver (Quality);
10. 24-hour access call center line is available to link clients to ASAM assessments and treatment (Access);
11. Special needs of high-cost beneficiaries are identified and coordinated (Quality);
12. Percentage of clients with three or more withdrawal management episodes and no other treatment to improve engagement. (Quality)

Both the county-specific reports and the statewide annual report will present the results of the EQRO's validation of the 12 performance measures for year one of the DMC-ODS.

Data Collection System Improvement

The primary SUD data collection and reporting system for California is the CalOMS. This system was developed for State Plan Drug Medi-Cal services and was designed to measure treatment outcomes in four life domains: Criminal, Mental, Medical, and Family/Social. With the implementation of the DMC-ODS, the Department is taking this opportunity to update the CalOMS to collect DMC-ODS data on outcomes in the expanded services.

In accordance with standard data collection practices and to ensure the data collected is meaningful for the State and interested parties, DHCS conducted several stakeholder meetings to solicit input from County behavioral health and SUD directors, treatment providers, and beneficiaries in 2017. Once all input has been compiled and reviewed, DHCS will determine changes in, or expansion of, data elements, including revision of the current data standards such as protocols and terminology. The system improvement process will be conducted in phases. Phase one, to collect stakeholder comments, is projected to be completed by Summer 2018. This phase will reflect the above described planning and initial programmatic changes that do not require extensive development.

Examples of known changes are listed below:

- Update gender identification section
- Add elements reflective of Withdrawal Management in DMC-ODS services
- Create a web portal for submissions of data and corrections to improve data quality and timelines

Phase two will then involve identifying broader changes more specific to the DMC-ODS waiver services, which will provide an extensive representation of the DMC-ODS service delivery impact for evaluation purposes. This phase is projected to be completed in the Fall of 2018. Upon completion, a SUD dashboard including CalOMS treatment outcomes data will be developed to assist the State and stakeholders with identification of gaps in services, disparities, and quality metrics.

5.4 DENTAL MANAGED CARE

The Medi-Cal Dental Program, including the DMC program, aims to improve the oral health of all beneficiaries. The program has a fundamental objective, to increase utilization of dental visits, particularly preventive services for children. Quality dental care is essential to ensure a child's overall well-being. Tooth decay is the single most common chronic disease among children, and dental disease can impact all aspects of children's lives.

Program Goals and Objectives	<ul style="list-style-type: none"> • Improve oral health of all beneficiaries. • Increase utilization of dental visits, particularly preventive dental services among children. • Reduce incidence of caries/tooth decay among all beneficiaries.
Quality Metrics and Performance Targets	<ul style="list-style-type: none"> • Annual dental visits • Preventive dental services: Increase the annual percent of children who receive any preventive dental service, by 10 percentage points over a five year period. • Use of sealants: Increase by four percentage points over a two-year period, the proportion of children ages 6-9, who receive a dental sealant on a permanent molar tooth. • Count of sealants • Count of fluoride varnishes • Use of diagnostic services • Treatment/Prevention of caries • Exams/Oral Health Evaluations • Use of dental treatment services • Preventive services to fillings ratio • Overall utilization of dental services • Continuity of care • Usual source of care
Performance Improvement Projects	<ul style="list-style-type: none"> • DHCS requires each DMC plan to maintain two QIPs per year approved by DHCS, which includes both quarterly and annual reporting. Current QIPs include beneficiary and provider outreach efforts, and community education.

Quality Metrics and Performance Targets

DHCS monitors DMC plan performance across 13 performance measures listed above, which were established in consultation with stakeholders, and reflect oral health measures identified by CMS. DHCS publishes the results of DMC plan performance on these measures on the DHCS website. The performance measure results are updated quarterly, on a 12-month rolling basis.

The contracts with DMC plans include detailed specifications for these measures, with subsequent clarifications in Dental APLs. DHCS released Dental [APL 16-017](#) in October 2016,

notifying all DMC plans of the implementation of an updated Performance Measures Template. DHCS is currently preparing a new APL that will update the Performance Measures Template by expanding the age range and stratifications for data submissions, and refining the reporting period for plan data reporting submissions.

DHCS established a performance measure benchmark for DMC plans for FY 2017-18 that is consistent with the Medicaid oral health goals developed by CMS. That benchmark is to increase, among children ages 1-20 enrolled in the respective DMC plan for at least 90 continuous days, the annual percent of children who receive any preventive dental service, by 10 percentage points over a five year period. Consequently, each DMC plan should aim to increase its preventive dental service performance measure by a minimum of 2 percentage points each fiscal year, beginning with FY 2017-18. The benchmark of each individual DMC plan is calculated based on the encounter data submitted by the plans for delivery of preventive services to Medi-Cal beneficiaries during the baseline FY 2016-2017. DMC plans must use this benchmark to develop one of their QIPs.

Performance Improvement Projects

Each DMC plan is required to conduct or participate in at least two QIPs per year approved by DHCS. One QIP must be either an Internal QIP or a Small Group Collaborative facilitated by a dental plan or DHCS. In addition, one QIP must be a DHCS established and facilitated Statewide Collaborative.

DHCS released Dental [APL 18-002](#) in January 2018 on Quality Improvement Systems. The APL clarified existing QI and Plan Accreditation requirements already present in the DMC contract. Additionally, it informed the plans of the Final Rule regulations on QI and Plan Accreditation. The APL also provided plans with a QI quarterly report submission template that was previously established by CMS. DMC plans are now required to use the quarterly report submission template to send quarterly status updates on all of their QIPs to DHCS, in addition to the annual reports they were already required to submit.

DHCS is currently establishing a state led collaborative QIP with the DMC plans. DHCS established the objective of that QIP in Dental APL 18-002. The objective of the Statewide QIP is to increase among children ages 1-20 enrolled in the DMC plan for at least 90 continuous days, the annual percentage of children who receive any preventive dental service by 10 percentage points over a five-year period. In February 2018, DHCS met with the dental directors of each DMC plan to discuss their individual QIPs, and to discuss next steps for the state led collaborative QIP. The DMC plans discussed their efforts to reduce disparities based on language and ethnicity, to reach the overarching objective of the Statewide QIP. DHCS will continue to hold quarterly meetings with the dental directors to monitor the DMC plans' progress on their QIPs and facilitate the sharing of best practices among the DMC plans.

DMC QIPs include efforts to maximize provider participation, increase and target outreach to families, and partner with oral health stakeholders. QIPs have focused on the use of preventive services, use of sealants, and strategies included refreshed beneficiary materials, beneficiary town hall/focus groups, and sponsored qualifier days and community education. Other DMC plan QIPs have implemented a Primary Care Provider fluoride varnish and Primary Care Dentist referral initiative to increase preventive and sealant utilization.

6. EXTERNAL INDEPENDENT REVIEWS

The Final Rule requires this report to include the State's arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to the services covered by each managed care entity. In accordance with existing federal requirements, DHCS contracts with multiple EQROs to conduct external quality reviews and evaluate the care provided to Medi-Cal beneficiaries by MCPs, MHPs, DMC-ODS, and DMC plans in the areas of quality, access, and timeliness. The EQRO presents external quality review activities, results, and assessments in reports that help DHCS and its managed care contractors understand where to devote resources to improve the quality of care for the populations they serve.

6.1 MANAGED CARE PLANS

The Medi-Cal Managed Care External Quality Review Technical Report presents performance measures that DHCS annually selects through which to evaluate the quality of care delivered by the contracted MCPs and SHPs to Medi-Cal beneficiaries. DHCS consults with MCPs, SHPs, EQRO, and stakeholders to determine the performance measures DHCS will require. DHCS' 2016 performance measures consisted of 15 HEDIS measures and two non-HEDIS measures, one originally developed by DHCS and MCPs (with guidance from EQRO) to be used for a statewide collaborative QIP, and a non-HEDIS depression screening measure. Several of the 17 required HEDIS measures include more than one indicator, bringing the total number of performance measure rates required for MCP reporting to 30. Collectively, the performance measure results reflect the quality and timeliness of, and access to, care provided by MCPs to beneficiaries. The full report is titled [Medi-Cal Managed Care External Quality Review Technical Report: July 2015 – June 2016](#).

6.2 COUNTY MENTAL HEALTH PLANS

In addition to the Final Rule, CMS requires each MHP to be evaluated annually by an EQRO. The findings are summarized in individual MHP and Annual Aggregate statewide reports. The most recent completed reporting period is FY 2016-17.

Key findings from this report include MHPs improved reporting rates in tracking timeliness indicators for two key HEDIS timeliness measures (first appointment and inpatient follow-up) along with maintenance of reporting rates for a third HEDIS measure, the 30-day re-hospitalization rate. Improvements in reporting rates also occurred for first psychiatry appointments. Particularly, large and medium-sized MHPs reduced their wait times significantly during the past three fiscal years.

In terms of MHPs' efforts to improve on best practices, the EQRO report describes telemedicine along with onsite visits as an effective best practice approach in establishing a therapeutic alliance with beneficiaries fearful of taking psychotropic medications. Qualitative information derived from Consumer and Family Member (CFM) focus groups determined that beneficiaries appear to benefit more from a combined use of telemedicine and in person visits with a psychiatrist, rather than using telemedicine alone.

Other reported quality improvement efforts include coordination and collaboration efforts between health, substance use, and mental health care as essential to promoting access, timeliness, quality, and positive mental health outcomes. The report also indicates that MHPs are moving toward a broader view of wellness and recovery, and embracing the power of consumer voice. In addition, the report identifies trends toward data-driven and evidence-based practices. The report is titled [Medi-Cal Specialty Mental Health External Quality Review – FY 2016-17 Statewide Report](#).

6.3 DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

EQRO reports for DMC-ODS were completed in May 2018, and will be included in subsequent versions of this report. These reports require pilot counties to have active PIPs. The EQRO provides a county specific report after each review, as well as a statewide annual report, which summarizes the findings from all completed reviews. The reports include the results of the EQRO's validation of 12 PMs for year one of the DMC-ODS waiver.

The EQRO also evaluates each county DMC-ODS plan's PIPs to include: an assessment of the county DMC-ODS plan's study methodology, an evaluation of the overall validity and reliability of PIP results through field reviews, and a central research team analysis with oversight by the EQRO's subject matter experts. Quarterly status reports to DHCS on all PIPs will also be supplied by the EQRO.

6.4 DENTAL MANAGED CARE

DHCS is currently in the process of securing a contractor to perform the DMC EQRO functions to review network adequacy and quality improvement activities. DHCS will perform contract management monitoring and oversight of the EQRO to ensure adherence to provisions in the Final Rule. The validations the EQRO is required to perform will yield more reliable data and analytics for effective strategic planning which will improve the quality of dental care to Medi-Cal beneficiaries.

DHCS requires DMC plans, at least annually, or as designated by DHCS, to arrange for an EQRO review by an entity qualified to conduct such reviews. On an annual basis, DMC plans must submit to an on-site audit to assess the DMC plan's information and reporting systems, as well as the DMC plan's methodologies for calculating performance measure rates. DMC plans must calculate and report all performance measures at the county level for audit by the EQRO. DMC plans must provide DHCS with a copy of the audit report.

7. TRANSITION OF CARE POLICY

The Final Rule requires this report to include the State's managed care transition of care policy. Effective July 1, 2018, Title 42 of the CFR, part 438.62 requires the State to have in effect a transition of care policy to ensure continued access to services during a beneficiary's transition from Medi-Cal FFS to a managed care program or transition from one managed care entity to another, when the beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.¹¹ Each managed care program has developed specific transition of care policies, detailed in the sections below.

7.1 MANAGED CARE PLANS

DHCS released [APL 18-008](#) in March 2018, which set forth continuity of care requirements for Medi-Cal beneficiaries who transition into Medi-Cal managed care. Medi-Cal beneficiaries assigned a mandatory aid code and who are transitioning from FFS into a MCP have the right to request continuity of care in accordance with state law and the MCP contracts, with some exceptions. All MCP beneficiaries with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible beneficiaries may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.

7.2 COUNTY MENTAL HEALTH PLANS

During FY 2017-18, DHCS developed a continuity of care policy for the SMHS delivery system. To ensure compliance with CMS' Parity in Mental Health and SUD Final Rule (Parity Rule) in the Federal Register (81.Fed.Reg. 18390), DHCS' transition of care policy for SMHS, which will take effect July 1, 2018, is consistent with its policy for Medi-Cal managed care. As such, Medi-Cal beneficiaries, who meet SMHS criteria and who transition into an MHP's care from FFS, from an MCP to an MHP, or from one MHP to another MHP, have the right to request continuity of care in accordance with DHCS' policy. Per the MHP contract with DHCS, MHPs are required to allow the services and/or treatment to continue for up to 12 months with the beneficiary's current provider if certain criteria are met, even if the provider is out-of-network. Additional information is available in [DHCS' Parity Compliance Plan](#), which was published on October 2, 2017.

7.3 DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

Counties that opt in to the DMC-ODS waiver must develop a continuum of care for SUD services, modeled after the ASAM criteria. These services are available to beneficiaries residing within the DMC-ODS waiver county. To ensure that all beneficiaries experience a seamless transition between levels of SUD services, DMC-ODS plans will coordinate case management services. All beneficiaries must have access to a person or entity formally designated as primarily responsible for coordinating their case management services. If a beneficiary physically moves

¹¹ 42 C.F.R. § 438.62(b)

from one DMC-ODS county to another, the new DMC-ODS county of residence will assume responsibility for continuing the beneficiary's treatment.

Counties must secure a Memorandum of Understanding (MOU) with any MCP that enrolls beneficiaries served by the DMC-ODS. The MOU must incorporate collaborative development of care plans that include the beneficiary, caregivers and all providers, and comprehensive substance use, physical, and mental health screenings.

7.4 DENTAL MANAGED CARE

DHCS released Dental [APL 17-011](#) in December 2017, which provided DMC plans with instructions regarding transition of care policy requirements for individuals who transition to DMC plans from Dental FFS or from other DMC plans. Medi-Cal beneficiaries mandatorily enrolled in DMC and who are transitioning from FFS into a Medi-Cal DMC plan have the right to request continuity of care in accordance with state law and the DMC contracts, with some exceptions. All DMC beneficiaries with pre-existing provider relationships who make a continuity of care request to a DMC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal dental FFS provider. These eligible beneficiaries may require continuity of care for services they have been receiving through Medi-Cal Dental FFS or through another DMC plan.

8. REDUCING HEALTH DISPARITIES

The Final Rule requires this report to include the State's plan to identify, evaluate and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status. Additionally, the Final Rule requires the State to identify this demographic information for each Medicaid enrollee and provide it to the MCO or PIHP at the time of enrollment, which DHCS routinely provides to each managed care entity at the time of enrollment.

Regarding demographic information, DHCS sends a monthly file with beneficiary information to the MCPs and DMC plans. DHCS also sends out a smaller daily file to these plans, which provides updates to the monthly file. The files contain eligibility information, name, aid codes, eligibility dates, and other information for beneficiaries enrolled with that plan. In addition, DHCS provides beneficiary demographic data to county MHPs and DMC-ODS programs.

Regarding health disparities, DHCS is dedicated to helping eliminate disparities in health care and is aligning its health equity efforts with the CMS Quality Strategy and the U.S. Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Disparities. Despite progress in total population health, the gaps among racial and ethnic groups in the quality, experience, outcomes, and the social determinants of health must close at a faster pace. Communities of color experience poorer health outcomes, are less likely to have a usual source of care or receive routine preventive services, and have higher rates of morbidity and

preventable conditions than non-minorities. Disparities in health care exist even when controlling for gender, condition, age, disability, socioeconomic status, and other factors. Eliminating disparities is essential for improving the health care delivery system for all Californians.

DHCS is working with stakeholders and partner organizations, including the California Department of Public Health (CDPH) Office of Health Equity and the California Reducing Disparities Project (CRDP), to inform and execute a comprehensive strategy to promote health equity and eliminate health disparities. DHCS' goal in this area is to ensure that all DHCS beneficiaries have access to and receive person-centered, equitable, effective, safe, timely, and efficient care and services.

Another aspect of this comprehensive effort includes improving data collection and utilizing evidence-based interventions to better identify, measure, and analyze disparities across programs and policies. Several programs, such as Medi-Cal Managed Care, have begun to identify and address certain disparities such as racial disparities in hypertension and maternal care. To this end, each MCP is required to complete a PIP focused on a plan-specific health disparity and the EQRO is completing a comprehensive health disparities analysis to more accurately identify health inequities and better target the neediest beneficiaries.

In addition, each county MHP and SUD program is required to develop and implement a Culturally and Linguistically Appropriate Services (CLAS) Plan that include objectives for reducing health disparities using culturally, linguistically, and ethically appropriate strategies. Most counties have developed a single plan that encompasses both Mental Health and SUD services. Further, DMC plans are leveraging pilot programs within the Dental Transformation Initiative (DTI) to create data systems to identify and address racial and ethnic disparities in pediatric dental populations.

Furthermore, Section 1557 of the ACA sets forth the requirements for non-discrimination and language assistance for beneficiaries. For example, managed care entities post notices of non-discrimination and accessibility requirements and provide written translation of these and all other beneficiary informing materials based on the numbers and percentages of persons who speak a language other than English in a specified geographic area. Section 1557 requires taglines be posted in English and at least the top 15 non-English languages in California.

DHCS will continue to actively communicate with stakeholders and solicit feedback on its health disparities work through leading internal and external webinars, presentations, sharing research and promising practices across all programs, and participating in site visits to learn about work being done to tackle health disparities at all system levels. As these efforts progress, the DHCS [health disparities website](#) will continue to serve as a central resource for real-time, on-the-ground programs and services that narrow the health gap between Medi-Cal sub-populations.

8.1 MANAGED CARE PLANS

One of the focus areas for MCPs is reducing health disparities because the accurate identification of health inequities and targeted interventions thereof are key to achieving meaningful improvements in other metrics. In previous reports, DHCS has identified wide gaps in MCP

performance by race and ethnicity. For example, African-American or Black beneficiaries had a nearly 20 percent higher prevalence of hypertension than other race and ethnic groups as reported in 2013. Additionally, African-American or Black women with recent births had the lowest postpartum visit rate of any race or ethnic group in 2013. In order to more accurately identify and address health inequities, DHCS commissioned its EQRO to perform a health disparities analysis in 2016. Additionally, DHCS successfully established health disparities as a mandatory PIP topic for all MCPs for 2017 and will monitor progress of these PIPs throughout 2017 and 2018. The health disparity identified by the MCP may be related or unrelated to any of the current EAS metrics. Although it is their choice, the MCPs are encouraged to choose a health disparity related to an EAS metric on which they are not performing well, when possible. To support the MCPs in their QI work on health disparities, DHCS and its EQRO, have a quarterly improvement collaborative call devoted to the MCPs' PIP work on health disparities.

8.2 COUNTY MENTAL HEALTH PLANS

State regulations require MHPs to develop and implement CCPs that include objectives for reducing disparities using culturally, linguistically, and ethnically appropriate strategies, as well as a plan for workforce development and training.¹² Each MHP is required to update its CCP annually. DHCS worked with subject matter experts in the field of cultural competence to incorporate the enhanced national CLAS standards published in 2013 by the HHS Office of Minority Health into the statewide Cultural Competence Plan Requirements (CCPRs). The CCPRs offer a strong framework for tailoring mental health services to the beneficiaries' culture and language preferences as well as the provision of high quality mental health care. The CCPRs address the entire public mental health delivery system by focusing on the following eight domains:

- Organizational commitment to cultural competence;
- Assessment of population and service needs;
- Strategies and efforts for reducing disparities;
- Participation of client, family and community members in the delivery system;
- Culturally competent training activities;
- Commitment to growing a multicultural workforce;
- Language capacity; and
- Adaptation of services to meet the needs of beneficiaries.

Findings from the FY 2016-17 EQRO Validation of Performance Measures Report indicate an increasing demand for SMHS. This is due in part to the increase in Medi-Cal eligibles as a result of the ACA. The increased demand for mental health services appears to have led to lower penetration rates for the Latino/Hispanic and Asian/Pacific Islander populations, averaging around 3.0 and 1.9 respectively. This issue will need to be addressed in the MHPs' CCPs.

¹² 9 Cal. Code.Regs., Section 1810.410(c)

There is also a growing trend at some MHPs to use trauma-informed care as a cultural competence component to provide mental health services to victims of trauma and torture. These services focus on recovery and are strength based, client and family driven, and culturally competent.

During FY 2018-19, DHCS will conduct an analysis of MHPs' CCP updates, to assess mental health disparities across the state and identify strategies MHPs are using to reduce disparities. The analysis will consider whether all population groups in the counties are getting access to needed mental health services, by looking at service provision by demographics. The completed analysis will inform DHCS about community informed and culturally competent practices implemented by MHPs to meet the needs of their diverse communities in accessing in SMHS.

8.3 DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

The Final Rule clarifies existing nondiscrimination requirements and sets forth new standards to implement, particularly with respect to the prohibition of discrimination on the basis of sex in health programs. Prior to the DMC-ODS waiver, certain SUD treatment services were available to women only. The waiver requires counties to provide a comprehensive continuum of care for both men and women as well as adolescents.

All counties must have in place a CLAS Plan. Most counties have developed a single plan that encompasses both Mental Health and SUD services. The Performance and Integrity Branch monitors counties annually to ensure a plan is in place for SUD and the 15 CLAS Standards have been implemented.

FY 2017-18 is a baseline data collection year. Currently available data through CalOMS and the Short Doyle claims system will be utilized to develop baseline data for informing future decisions regarding disparities among age groups, gender, and race. Additionally, each DMC-ODS Waiver county must be reviewed annually by an EQRO. Principles and practices of effective culturally competent service delivery is a component of the current EQR process and will provide important information on penetration rates.

8.4 DENTAL MANAGED CARE

The need to identify and address dental health disparities in the Medi-Cal delivery system is important to provide quality care to all beneficiaries regardless of income, age, race, or any other identifiable area. In an effort to further address oral health disparities, DHCS has recently created processes to help differentiate dental encounter data by age, county, race, and ethnicity. DHCS published Dental Performance Measures from 2013 to 2016 by age, county, and race-ethnicity on the [California Health and Human Services Open Data Portal](#). DHCS also publishes quarterly Dental Performance Measures by DMC plan. DHCS intends to utilize this information to work with the DMC plans to address and prevent oral health disparities in the future.

In addition, current efforts that will assist in creating planning tools to address the disparities are occurring in pilot programs for the Dental Transformation Initiative (DTI) under the Medi-Cal 2020

Section 1115 Waiver. Domain 2 - Caries Risk Assessment focuses on age-specific early interventions, which include behavior modification through motivational interviewing, nutritional counseling, and the use of antimicrobials. The goal is to diagnose early childhood caries by utilizing caries risk assessments to treat it as a chronic disease. DHCS also requires DMC plans to implement communication strategies targeted to different audiences in multiple languages and various formats to educate providers and beneficiaries about the importance of prevention and early treatment of oral diseases, thereby improving oral health literacy and utilization of dental services.

9. INTERMEDIATE SANCTIONS FOR MANAGED CARE ORGANIZATIONS

The Final Rule requires this report to include the State's appropriate use of intermediate sanction for Managed Care Organizations. In California, MHPs and DMC-ODS are PIHPs, therefore these requirements do not apply to them. DHCS has sanction policies in place for MCPs and DMC plans, which are described in further detail below.

9.1 MANAGED CARE PLANS

DHCS released an [APL 18-003](#) in January 2018 to remind Medi-Cal managed care health plans of existing law and policy that authorizes DHCS to impose administrative and financial sanctions on MCPs that violate applicable California Medi-Cal and federal Medicaid laws, the Knox-Keene Health Care Services Act of 1975 (Knox-Keene Act) standards, or the terms of their MCP contracts with DHCS.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including APLs and Dual Plan Letters. DHCS' readiness review process terms of their MCP contracts with DHCS. MCPs must receive prior approval from DHCS for each delegate.

9.2 DENTAL MANAGED CARE

DHCS amended the DMC contracts to strengthen the sanction policy to comply with the Final Rule. The contracts detail the Department's options for intermediate sanctions, termination hearings, the imposition of temporary management, civil money penalties, and enrollee and contractor rights in the case of temporary suspension orders and contract termination.

10. PERFORMANCE AND QUALITY OUTCOMES FOR PRIMARY CARE CASE MANAGEMENT (PCCM)

The Final Rule requires this report to include a description of how the State will assess the performance and quality outcomes achieved by each PCCM entity described in § 438.310(c)(2). This section is not applicable to DHCS, as the Medi-Cal program does not include PCCM entities.

11. LONG-TERM SERVICES AND SUPPORTS (LTSS) AND SPECIAL HEALTH CARE NEEDS

The Final Rule requires this report to include the mechanisms implemented by the State to comply with § 438.208(c)(1), relating to the identification of persons who need long-term services and supports or persons with special health care needs. This section is not applicable to MHPs or DMC-ODS.

MCPs are required to establish a risk-stratification mechanism or algorithm for the following populations: 1) Full benefit Duals who opt-out of Cal MediConnect¹³; 2) Full-benefit Duals who are excluded from Cal MediConnect; 3) Partial benefit Duals; and 4) Seniors and Persons with Disabilities. The risk-stratification mechanism should be designed to stratify newly enrolled beneficiaries into high or low-risk groups. For purposes of this risk-stratification, an individual may be deemed high-risk if the individual has been authorized to receive In-Home Supportive Services greater than or equal to 195 hours per month, Community Based Adult Services (CBAS), and/or Multipurpose Senior Services Program (MSSP) Services. MCPs are also required to follow risk-stratification requirements for newly enrolled Medi-Cal only SPD beneficiaries. The Health Risk Assessment must include specific LTSS referral questions. These questions are intended to assist MCPs in identifying beneficiaries who may qualify for and benefit from LTSS services (refer to [APL 17-013](#) titled, “Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities.”)

DMC plans are required to identify beneficiaries with special health care needs by determining whether they have, or are at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition and also require health or related services of a type or amount beyond that required by beneficiaries generally. DMC plans must assess beneficiaries with special health care needs to determine if a treatment or service plan is needed. The treatment/service plan must be reviewed and revised upon reassessment of functional need, at least every 12 months, or when circumstances or needs change significantly.

12. NON-DUPLICATION OF EXTERNAL QUALITY REVIEW ACTIVITIES

The Final Rule requires this report to include information required under §438.360(c), relating to non-duplication of EQRO activities and Medicare coordination. DHCS does not have any information to report under this section.

13. DEFINITION OF “SIGNIFICANT CHANGE”

The Final Rule requires this report to include a description of how the State defines significant change. For DHCS managed care programs, significant change is defined as a change to the managed care population or within state or federal regulations that necessitates a modification in Medi-Cal managed care policies, benefits, or quality improvement processes and activities,

¹³ California’s duals demonstration program.

carried out within DHCS. DHCS would first assess the overlap percentage of MCP network providers compared to the change prior to designating a significant change. The Department intends to provide an updated Managed Care Quality Strategy Report on an annual basis to capture any significant changes within a 12-month period.

14. APPENDICES

14.1 APPENDIX A: FINAL RULE REQUIREMENTS

§ 438.340 Managed care State quality strategy.

(a) General rule. Each State contracting with an MCO, PIHP, or PAHP as defined in § 438.2 or with a PCCM entity as described in § 438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP or PCCM entity.

(b) Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following:

(1) The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by §§ 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with § 438.236.

(2) The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP.

(3) A description of -

(i) The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with § 438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required under § 438.10(c)(3); and

(ii) The performance improvement projects to be implemented in accordance with § 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.

(4) Arrangements for annual, external independent reviews, in accordance with § 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in § 438.310(c)(2)) contract.

(5) A description of the State's transition of care policy required under § 438.62(b)(3).

(6) The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability.

(7) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.

(8) A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity described in § 438.310(c)(2).

(9) The mechanisms implemented by the State to comply with § 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).

(10) The information required under § 438.360(c) (relating to nonduplication of EQR activities); and

(11) The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.

(c) *Development, evaluation, and revision.* In drafting or revising its quality strategy, the State must:

(1) Make the strategy available for public comment before submitting the strategy to CMS for review, including:

(i) Obtaining input from the Medical Care Advisory Committee (established by § 431.12 of this chapter), beneficiaries, and other stakeholders.

(ii) If the State enrolls Indians in the MCO, PIHP, or PAHP, consulting with Tribes in accordance with the State's Tribal consultation policy.

(2) Review and update the quality strategy as needed, but no less than once every 3 years.

(i) This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.

(ii) The State must make the results of the review available on the Web site required under § 438.10(c)(3).

(iii) Updates to the quality strategy must take into consideration the recommendations provided pursuant to § 438.364(a)(4).

(3) Submit to CMS the following:

(i) A copy of the initial strategy for CMS comment and feedback prior to adopting it in final.

(ii) A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.

(d) *Availability.* The State must make the final quality strategy available on the Web site required under § 438.10(c)(3).

14.2 APPENDIX B: ACRONYMS AND GLOSSARY

Term	Definition
APL	All Plan Letter – Written instructions that DHCS may use to convey information or interpretation of changes in policy or procedure, and provide instruction to managed care plans on how to implement these changes on an operational basis.
ASAM	American Society of Addiction Medicine – A professional medical society representing over 5000 physicians, clinicians and associated professionals in the field of addiction medicine.
CalOMS	California Outcomes and Measurement System – California's data collection and reporting system for substance use disorder treatment services.
CANS	Child and Adolescent Needs & Strengths Scale – A multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
CCP	Cultural Competency Plan – MHP deliverable that includes objectives for reducing disparities using culturally, linguistically, and ethnically appropriate strategies, as well as a plan for workforce development and training.
CCPR	Cultural Competency Plan Requirements – A framework for tailoring mental health services to the beneficiaries’ culture and language preferences as well as the provision of high quality mental health care
CLAS	Culturally and Linguistically Appropriate Services – Objectives for reducing health disparities using culturally, linguistically, and ethically appropriate strategies.
CMS	Centers for Medicare & Medicaid Services – The federal agency responsible for administration of the Medicare and Medicaid programs.
COHS	County Organized Health Systems – A nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers.

DMC	Dental Managed Care – A dental services delivery system carried out through contracts established between DHCS and dental plans licensed with the Department of Managed Health Care. DMC is offered only in Los Angeles County and Sacramento County.
DMC-ODS	The Drug Medi-Cal Organized Delivery System – A pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with SUD.
DMHC	Department of Managed Health Care – The State agency responsible for regulating the Knox-Keene Act licensed managed care health plans. DHCS works in partnership with DMHC on monitoring Medi-Cal managed care plans that are Knox-Keene licensed.
DTI	Dental Transformation Initiative – A program of the Medi-Cal 2020 waiver which provides direct incentives to providers through program domains that promote overall children’s utilization of preventive services and oral health disease management through prevention and risk assessment models, and increase dental continuity of care.
EAS	External Accountability Set – A set of quality metrics used to measure MCP performance, consisting primarily of HEDIS measures.
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment – A Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility.
EQRO	External Quality Review Organization – A peer review organization (PRO) like entity or accrediting body that has expertise in reviewing the quality of health care provided to Medicaid beneficiaries in a state’s Medicaid managed care plans. CMS requires state Medicaid managed care programs to contract with an EQRO to receive enhanced federal financial participation.
FFS	Fee-for-Service – A payment model where services are unbundled and paid for separately. FFS occurs when doctors and other health care providers receive a fee for each service, such as an office visit, test, or procedure. Payments are issued retrospectively, after the services are provided.
FY	Fiscal Year – The budgetary year. The state fiscal year runs from July 1 - June 30. The federal fiscal year runs from October 1 - September 30.

GMC	Geographic Managed Care – A managed care plan model which allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county).
HEDIS	Healthcare Effectiveness Data and Information Set – A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.
HIO	Health Insuring Organization – An entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services. In California, COHS plans are considered Health Insuring Organizations but are held to the same requirements as MCOs per the DHCS to MCP contract.
IA	Intergovernmental Agreement – An agreement by which a county agrees to provide or arrange for the provision of DMC-ODS services through Prepaid Inpatient Health Plans.
KKA	Knox-Keene Act – The governing laws that regulate Health Maintenance Organizations (HMOs) and managed care plans within California.
LI	Local Initiative – A Managed Care Plan established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community
MCO	Managed Care Organization – In California Managed Care Plans and Dental Managed Care Plans are MCOs
MCP	Managed Care Plan – An established network of organized systems of care that emphasize primary and preventive care. DHCS pays the MCP a capitated payment per member each month to provide care. The MCP helps beneficiaries find doctors, pharmacies, and other providers in the MCP's network.
MAT	Medication Assisted Treatment – The use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders.

MHP	Mental Health Plan – Prepaid inpatient health plans that have primary funding and programmatic responsibilities for the majority of Medi-Cal mental health programs. MHPs authorize specialty mental health services for Medi-Cal beneficiaries. There are 56 county-operated MHPs contracted with DHCS.
MOC	Manual of Criteria – A compilation of criteria which apply to some services provided under the Medi-Cal program.
MOU	Memorandum of Understanding – A nonbinding agreement between two or more parties outlining the terms and details of an understanding, including each parties' requirements and responsibilities.
NCQA	National Committee for Quality Assurance – An independent 501(c)(3) non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
NTP	Narcotic Treatment Program - any system of treatment provided for chronic heroin or opiate-like drug-dependent individuals that administers narcotic drugs under physicians' orders either for detoxification purposes or for maintenance treatment in a rehabilitative context offered by any county board of health, partnership, corporation, association, or person or groups of persons engaged in such administration.
PHIP	Pre-paid Inpatient Health Plan – An organization that is responsible for managing Medicaid services related to behavioral health and development disabilities. In California Mental Health Plans and Drug Medi-Cal Organized Delivery Systems are PHIPs.
PIP	Performance Improvement Project – The federal term for QIPs. A structured process of identifying and measuring a targeted area (clinical or nonclinical), analyzing the results, implementing interventions for improvement, and re-measuring to determine if improvement in performance was achieved.
POS	Performance Outcome System – A system used to evaluate the domains of access, engagement, service appropriateness to need, service effectiveness, linkages, cost effectiveness and satisfaction.
PSC-35	Pediatric Symptom Checklist – A psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

QI	Quality Improvement – Systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.
QIP	Quality Improvement Project – A structured process of identifying and measuring a targeted area (clinical or nonclinical), analyzing the results, implementing interventions for improvement, and re-measuring to determine if improvement in performance was achieved.
QM	Quality Management – A requirement of the Intergovernmental Agreement between the state and DMC-ODS which conducts performance monitoring activities throughout the county’s operations.
QIWP	Quality Improvement Work Plan – An annual requirement for Mental Health Plans to submit to DHCS assurance of quality improvement activities.
SAMHSA	Substance Abuse and Mental Health Services Administration – The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
SHP	Specialty Health Plan – Health plans that serve a specialized population in the Medi-Cal managed care program.
SMHS	Specialty Mental Health Services – A “carve-out” of the broader Medi-Cal program which is provided by county MHPs, which operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act.
SUD	Substance Use Disorder – Recurrent use of alcohol and/or drugs which causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
STC	Special Terms and Conditions – Outline the requirements to participate in the DMC-ODS.