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State of California
Department of Health Care Services
Comprehensive Quality Strategy

Draft Report for Public Comment

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Section 1. Executive Summary

Section 1.1 Overview

This 2020 State of California Department of Health Care Services (DHCS or Department) Comprehensive Quality Strategy (CQS) provides a summary of the extensive work being done to assess and improve the quality of health care and services paid for by the Department. It combines two previous quality reports last updated in 2018 into one: the DHCS Strategy for Quality Improvement in Health Care, which highlighted the Department's goals, priorities, guiding principles, and specific programs used to advance high quality care, and the Medi-Managed Care Quality Strategy Report, required by 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. The current comprehensive report outlines our process for developing and maintaining a broader quality strategy to assess the quality of care that all of our beneficiaries receive, regardless of delivery system, and then defines measurable goals and tracks improvement while adhering to regulatory managed care requirements. The Quality Strategy includes all of California's Medicaid managed care delivery systems as well as programs outside of managed care delivery systems.

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.

Section 1.2 Mission and Vision

The mission of DHCS is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. The Department's vision is to preserve and improve the overall health and well-being 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) systems. The Department and its partners, including counties, health plans, hospitals, and individual care providers, continue to transform health systems by innovating in complex care management, behavioral health, prevention, reducing health disparities, and social risk factors that affect health. The Department is also committed to align with the three linked goals outlined in the National Strategy for Quality Improvement in Health Care. The graphic below depicts the core components of our mission and vision.

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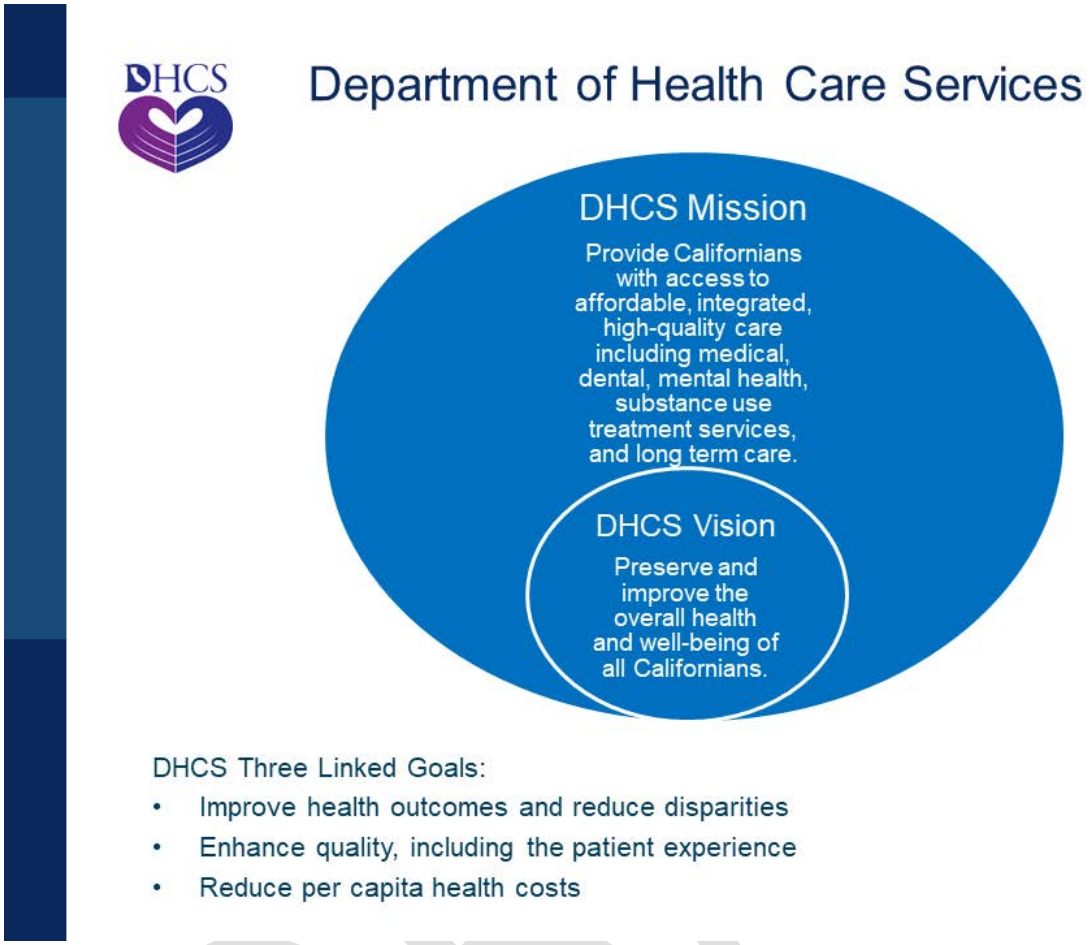
Figure 1. DHCS Mission and Vision



Section 1.3 Goals

DHCS remains committed to a culture of quality and is dedicated to supporting our mission and vison by identifying the following goals and tools to achieve high quality and integrated health care for all Californians. The DHCS Comprehensive Quality Strategy Goals are to:

- Improve health outcomes
- Improve health equity
- Address social determinants of health
- Improve data quality and reporting

Section 1.4 California Advancing and Innovating Medi-Cal (CalAIM)

To accomplish these goals, DHCS has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called California Advancing and Innovating Medi-Cal (CalAIM). CalAIM helps address many of the complex challenges facing California's most vulnerable residents, such as

homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, county mental health, substance use disorder, dental, In Home Supportive Services, etc.). As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

To achieve this, DHCS must take a person-centered approach to care that creates systems and processes to identify and mitigate social determinants of health and reduce health disparities or inequities. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost over time. In order to ensure that this new approach to offering Medi-Cal benefits is accessible to all enrollees, DHCS must eliminate or reduce complexity and variation across counties and plans, while still recognizing the importance of local innovation.

CalAIM Goals & Proposal Overview

CalAIM has three primary goals:

1. Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services are different depending on the county in which one lives. DHCS is proposing to standardize the enrollment into, and benefit for, managed care across the state to provide more predictability and reduce county-to-county differences. This will also allow DHCS to implement additional administrative mechanisms, financial efficiencies and standards.

Additionally, DHCS recommends investing in a new statewide benefit for enhanced care management and in-lieu-of-services. Examples of in-lieu-of-services include housing transition and sustaining services, recuperative care, short-term non-medical respite, sobering centers, and home and community-based wrap services for beneficiaries to transition to or reside safely in their home or community. In addition to the benefits for medically complex and homeless beneficiaries, investing in in-lieu-of-services allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization.

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Moreover, the state, in partnership with counties, must take serious steps forward to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. The first step to achieving this is undergoing behavioral health payment reform, where DHCS proposed to transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. Such a shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation and engage in value-based payment arrangements with their health plan partners in order to support better coordination and integration between physical and behavioral health.

DHCS feels behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to build the continuum of care for mental health and SUD services in the community.

The reforms of CalAIM are comprehensive and critical to the success of such delivery system transformation, which will result in better quality of life for Medi-Cal members, as well as long-term cost savings/avoidance that will not be possible to achieve absent these initiatives. DHCS will conduct extensive stakeholder engagement throughout 2019 and 2020 for both CalAIM and the renewal of the federal authorities under which Medi-Cal operates (i.e. 1115 and 1915b waivers).

Section 2. Introduction

DHCS is the single state agency responsible for the administration of California's Medicaid program, called Medi-Cal. 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 approximately 13[1] million Medi-Cal beneficiaries, or about one-third of all Californians, making the department the largest health care purchaser in California. Our success is made possible only through collaboration and cooperation with other state agencies, counties, providers, and other partners as we invest more than $104.4[2] billion annually in the care of low-income children, adults, families, pregnant women, seniors, and persons with disabilities. Medi-Cal benefits are provided through several different managed care and FFS delivery systems.

Section 2.1 Managed Care Delivery Systems

California has 4 different managed care delivery systems: 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. For purposes of the Final Rule

[1] Medi-Cal May 2019 Local Assistance Estimate for Fiscal Years 2018-19 and 2019-2020: https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2019_May_Estimate/M19_Med-Cal_Local_Assistance_Estimate.pdf
[2] Ibid

requirements, MCPs and DMC plans are Managed Care Organizations (MCOs[3]), and MHPs and DMC-ODS plans are Prepaid Inpatient Health Plans (PIHPs).

Managed Care Plans

Approximately 82 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 2018-19. 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 currently cover specialty mental health, substance use disorder, or dental benefits.[4] 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 10,698,000 MCP beneficiaries as of March 28, 2019.[5] This is an increase in membership of almost 5.4 million beneficiaries since the same time in 2013. Of this total, 42 percent (4.5 million) were children under age 18, and 58 percent (6.1 million) were adults. Women comprise 53 percent of beneficiaries and men 47 percent of beneficiaries. Of all MCP beneficiaries, 48 percent were Hispanic, 20 percent White, 8 percent Black, 9 percent Asian, 2 percent Native Hawaiian or other Pacific Islander, and 13 percent other/ unknown race/ethnicity. Detailed information regarding the breakdown of membership by MCP is in the DHCS Medi-Cal Managed Care Enrollment Reports.[6]
By aid code groups:[7]

- 12 percent (approximately 1.3 million) were children whose parents' income is 138 to 266 percent of the Federal Poverty Level (FPL).
- 6 percent (approximately 0.7 million) were Seniors and Persons with Disabilities (SPDs) including children.
- 29 percent (approximately 3.7 million) were Affordable Care Act (ACA) expansion population.
- 43 percent (approximately 5.8 million) were other populations (all other aid codes that do not include the groups listed above).

DHCS contracts with 24 full-scope MCPs and four full risk Population Specific Health Plans (PSPs) 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:

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[3]COHS plans are considered Health Insuring Organizations (HIO) but are held to the same requirements as MCOs per the DHCS to MCP contract.
[4] 1915 (b) Medi-Cal Specialty Mental Health Services Waiver: https://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx
[5] Medi-Cal Managed Care Performance Dashboard: https://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx
[6] Medi-Cal Managed Care Enrollment Report: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report
[7] 10 percent (approximately 968,000) were dually eligible for Medi-Cal and Medicare; these beneficiaries cross over multiple aid code categories

- 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 2.1 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 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 6.88 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 five health plans that serve more than 1.1 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 290,000 beneficiaries in 18 counties.
- The Imperial Model operates in Imperial County with two commercial health plans. It serves more than 76,000 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.

County Mental Health Plans

California's specialty mental health services (SMHS) are provided under the authority of a 1915(b) Waiver.[8]

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

[8] 1915 (b) Medi-Cal Specialty Mental Health Services Waiver: https://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx

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 Home Based Services, Therapeutic Foster Care Services, and Therapeutic Behavioral Services.[9]

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
- 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.

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

[9] 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.

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 participate in the 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 as a managed care plan.

Counties make DMC-ODS services available as a Medi-Cal benefit for all individuals who establish eligibility within the county, have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a SUD, and meet medical necessity to receive an ASAM level of care. The county administers these DMC-ODS services by selectively contracting with DMC certified providers, a managed care plan, or offering county-operated services. DMC-ODS services are as follows:

- Early Intervention
- Outpatient Treatment
- Intensive Outpatient Treatment
- Residential Treatment
- Partial Hospitalization (optional)
- Opioid Treatment
- Additional Medication-Assisted Treatment (optional)
- Case Management
- Physician Consultation Services
- Telehealth
- Recovery Support Services

In February 2017, the first county implemented services under the DMC-ODS. Four more counties implemented services in FY 16/17. Fourteen were added in FY17/18; eight were added in FY 18/19, and three in FY 19/20. As of November 2019, the total number of counties participating was thirty. A total of forty counties expressed interest in participating in the DMC-ODS. The remaining counties are working to ensure they can meet the requirements and have an adequate network of providers to meet the needs of beneficiaries. DHCS continues 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.

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Dental Managed Care

The DMC program provides a comprehensive approach to oral health care, combining both clinical services and administrative procedures to provide members access to primary and specialty dental care through a single, organized delivery system. The DMC program operates in Sacramento and Los Angeles counties. Members have the option of choosing from three DMC plans in each county. In Sacramento County, DMC enrollment is mandatory, whereas, in Los Angeles County, members have the option of enrolling in a DMC plan or remaining in the Dental FFS delivery system. Each DMC plan receives a monthly per capita payment for every member enrolled in the plan. DMC program members receive dental services from dentists within the plan's provider network, and are eligible for the same scope of benefits as members who access services through the Dental FFS delivery system. Approximately 986,013 Medi-Cal members are enrolled in DMC[10]

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, poor perinatal outcomes, 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.

[10] Source: MIS/DSS Data Warehouse (Query date: January 2019). Data represents members with 90 days continuous enrollment from 11/1/17 – 10/31/18.

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.

Section 2.2 Fee-for-Service (FFS) Delivery System

Medi-Cal benefits can be delivered through either a FFS or a managed care delivery system. In the FFS delivery model, the State pays the health care provider for each administered State plan service. Section 1902(a)(30)(A) of the Social Security Act governs the FFS system. In contrast, in the managed care delivery system, typically the state pays a contracted health plan a fixed capitated payment amount for each enrolled beneficiary. Managed care plans are then responsible for providing all delegated services. Certain categories of service, or specialized types of services within a particular category, are not delegated to the Medi-Cal managed care plan. These "carve-outs" are either administered pursuant to stand alone delivery arrangements (which can take either a FFS or managed care form, or both), or remain the responsibility of the State to reimburse through the FFS system. Key examples of Medi-Cal standalone delivery arrangements are: (1) Specialty Mental Health Services delivered/reimbursed exclusively via County Mental Health Plans (MHPs) pursuant to the State's 1915(b) waiver; (2) Substance Use Disorder Services delivered/reimbursed via the FFS Drug Medi-Cal program, or the Drug Medi-Cal Organized Delivery System (DMC-ODS); and, (3) Dental Services delivered/reimbursed via either FFS Denti-Cal or via standalone dental managed care plans in Sacramento and Los Angeles counties. Aside from these standalone arrangements, there are also specialized types of services within a category, or a level of service utilization beyond an enumerated threshold, that are not delegated to contracted Medi-Cal managed care plans. Examples of these carve-outs include most psychotherapeutic drugs, most HIV/AIDS drugs, non-medical dental services and Specialty Mental Health Services. In the case of a managed care enrollee receiving a small portion of care within a particular service category by way of FFS, their utilization is still driven and coordinated by the primary Medi-Cal managed care plan. There are approximately 18 percent certified eligibles[11] who receive their services through the FFS health care delivery system.[12] This is a system that primarily helps facilitate plan enrollment, provides coverage to select groups who through policy or other circumstances received health care services through Medi- Cal's FFS delivery system, and one that provides services to groups of individuals entitled to differing sets of benefits not aligned with the scope of services provided by contracted plans.

[11] The term Certified Eligible includes beneficiaries who have been determined eligible for Medi-Cal based on a valid eligibility determination. Certified eligibles do not include individuals who may be eligible to enroll in the program, or are in the process of becoming a certified eligible, but have not enrolled: https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx

[12] Medi-Cal Monthly Enrollment Fast Facts-March 2019 https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast-Facts-March2019.pdf

Section 2.3 Other DHCS Programs

As part of the Department's overarching strategy to approach QI in all of our programs across all delivery systems and funding sources, we have also included programs not part of the managed care delivery system. Information on these programs can be found in Section 7.

Section 2.4 Strategic Partnerships

DHCS has robust partnerships with multiple strategic entities. Our mission is accomplished through this collaboration with a number of agencies listed below. They include a number of state agencies and departments, counties, providers, provider associations, schools, and academic medical centers, including:

- California Departments of Public Health, Social Services, and Education
- County departments of health care services, public health, mental health, substance abuse, and social services
- California providers and provider organizations
- Medi-Cal members and member advocacy organizations
- Medi-Cal managed care plans and plan associations
- California's foundations focusing on health care
- California's elected leaders

Section 3. Quality Improvement Infrastructure

DHCS' commitment to quality improvement is present throughout the Department both at the centralized and program-level activities. These efforts are focused on fulfilling the Department's mission to provide eligible Californians with access to affordable, integrated, high-quality health care, and realizing our vision to preserve and improve the overall health and well-being of all Californians.

Section 3.1 Office of the Medical Director

The Office of the Medical Director (OMD) works with divisions and offices across DHCS to improve health outcomes and reduce disparities, enhance clinical quality, and reduce per capita costs. OMD coordinates the DHCS Comprehensive Quality Strategy which is a blueprint to advance the Department's mission and vision and documents the Department's strategy to assess and improve the quality of health care and services provided to the Californians that we serve. OMD provides clinical, policy, analytic, and quality improvement support to a variety of departmental programs through the Clinical Quality Improvement Learning Collaborative and the Quality Improvement Efforts around Adult Behavioral Health Core Set Measures workgroup, and works with colleagues throughout the Department on efforts to improve quality.

Section 3.2 Data Quality Improvements

The Chief Data Officer (CDO) and Deputy Director, leads the Information Management Division (IMD) and Research and Analytics Studies Division (RASD) to achieve improvements

to data management and data reporting necessary to support business and evaluation requirements at DHCS. The IMD includes the Office of the CMIO (OCMIO), the Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance (OHC), and the Office of Health Information Technology (OHIT). Data is essential for monitoring and reporting on Quality Improvement initiatives. Given the importance of data, DHCS has developed a number of initiatives that are driving quality improvement in data.

Department-wide initiatives that support quality improvement, particularly in relation to improvements in data quality, include the Medicaid Information Technology Architecture (MITA) initiative, the implementation of HIPAA and other national standards and requirements, and the Transformed Medicaid Statistical Information System (TMSIS). Under the MITA Initiative, the CDO serves as the Information Architecture Champion and the OHC leads efforts to mature and improve data management processes throughout the department. OHC works with the transactional systems across the department to monitor and support the implementation of HIPAA standards and regulations that create improved data quality, efficiency in claims processing, and thus decreased burden for our trading partners. The TMSIS initiative is led by a team which submits data monthly to CMS and investigates and solves data quality issues based on CMS and DHCS priorities. CMS has placed a focus on data quality through TMSIS which includes public reporting on data quality issues and imperatives to address specific data quality issues that are critical for program monitoring and reporting. Additionally, TMSIS data quality requirements have been incorporated into system modernization projects as they provide opportunities to improve data quality.

In parallel with improvements in administrative data, the OHIT supports the transformation of the health care industry with the Promoting Interoperability Program. The Promoting Interoperability Program, formerly named the Electronic Health Record (EHR) Incentive Program, supports adoption of EHRs and associated interoperability through Health Information Exchange (HIE) initiatives. This includes integration of EHRs and HIEs to support public health reporting, such as with the California Immunization Registry, care transitions, such as for the Whole Person Care Program, and routine transitions of care, managed through our managed care plans. As the health care industry continues to transform, DHCS expects to advance collection of data through EHRs and HIEs that will provide clinical outcome data to support more robust program monitoring and reporting.

Section 3.3 DHCS Clinical Quality Improvement Learning Collaborative

The DHCS Clinical Quality Improvement Learning Collaborative serves as a forum to support ongoing quality improvement efforts in the Department. It is a monthly workgroup where program activities and developments are shared, cross-cutting quality program issues are discussed, and guidance on the development of a comprehensive quality strategy are reviewed. The group is comprised of interdepartmental management level staff integral in the development and alignment of program quality improvement activities; representatives from programs across all delivery systems attend. The Learning Collaborative, which began in 2019, provides oversight and direction to ensure that the Department's mission and vision is incorporated in programmatic activities.

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Section 3.4 Program Quality Improvement Efforts

DHCS programs use performance measure data, External Quality Review Organizations (EQRO) technical reports, and improvement project results as primary tools for documenting and assessing quality programs and identifying areas that need additional focus. Those areas identified as needing additional focus result in improvement initiatives which require programs to apply quality improvement science tools and methods. Program efforts are explained in Section 6.Continuous Quality Improvement and Interventions.

Section 3.5 Focus on CMS Core Set Measures

The Affordable Care Act (Section 1139B), signed in March 2010, required the Secretary of Health and Human Services (HHS) to identify and publish a core set of health quality measures for adult and children Medicaid-enrollees. In 2012, DHCS received the CMS Adult Medicaid Quality Grant to improve capacity for standardized collection and reporting of data on the quality of health care provided to adults covered by Medicaid. Grant activities focused on collection, analyzing and reporting on 16 of the Initial CMS Core Adult Quality Measures and addressing data quality, particularly of encounter data, and analytic capability to compile the measures. Since the conclusion of the grant, DHCS has voluntarily reported many of the adult and child measures to CMS. The Department developed data programs for compiling Adult and Child Core Set measures using administrative data in the MIS/DSS data warehouse. For those measures also reported by the Medi-Cal Managed Care health plans, the OCMIO combines the results reported by the plans with the results identified using administrative claims data, producing statewide results representing all eligible Medi-Cal beneficiaries.

Both the full child core measure set and the adult behavioral health measures will be required to be reported to CMS in 2024. In 2019, DHCS announced that child and adult core set measures had been adopted for the Managed Care External Accountability Set (MCAS). DHCS is continuing to examine and streamline all of its measure sets to emphasize the inclusion of core set measures whenever appropriate, to maximally incentivize improvement on these measures at both the plan and provider level. Please see Appendix C for child and adult core set metrics.

To further work on alignment across delivery systems and improved performance on core set measures, in April of 2019, DHCS convened the Quality Improvement Efforts around Adult Behavioral Health Core Set Measures Workgroup to coordinate programmatic efforts to improve performance on behavioral health quality measures across delivery systems. Members of this workgroup include representation from multiple programs that have responsibilities that impact California's performance on these measures. The OMD facilitates the workgroup to assist DHCS programs in working together to improve statewide Medicaid performance on these measures. In late 2019, the workgroup chose to initially focus improvement efforts on two of these measures: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) and Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD). These initial measures were chosen because they cross multiple DHCS delivery systems and require program coordination; show room for improvement; and exhibit variable performance among health plans and counties, indicating

an ability to improve performance among some plans and counties. Over the next couple of years, improvement efforts will focus on coordination between programs; having those with higher rates share best practices with those with lower rates, and utilizing tools within individual programs to drive quality improvement, such as Performance Improvement Projects. DHCS will take the lessons learned and apply them to other core set measures as appropriate.

Section 3.6 External Stakeholder Engagement

DHCS engages thousands of stakeholders to assist the department in developing policies for improving access to care, eliminating health disparities, addressing social determinants of health, improving health outcomes, and reducing overall costs for Medi-Cal's 13 million beneficiaries. The DHCS "Stakeholder Engagement Initiative" was launched in 2014 to improve departmental communication to stakeholders. After surveying stakeholders, DHCS initiated new guidelines and protocols to improve transparency, consistency and timeliness in communication with stakeholders. The DHCS Stakeholder Advisory Committee meets quarterly to provide valuable input about ongoing implementation efforts for the department's current 1115 Waiver and to help DHCS further its efforts to provide high-quality, appropriate care in keeping with the goals of national health care reform. Recent topics included strengthening oversight for managed care plans, the DHCS Access Assessment required under the 1115 Waiver, and input on what services to include under DHCS' next 1115 Waiver application. In 2019, DHCS created the Behavioral Health Stakeholder Advisory Committee (BH-SAC) to advise the DHCS director on the behavioral health components of the Medi-Cal program and behavioral health policy issues. The BH-SAC, which meets quarterly, is a consolidation of five mental health and substance use disorder stakeholder groups that advised DHCS on behavioral health topics. The consolidation aligns with DHCS' internal reorganization to further integrate behavioral health with not only the Medi-Cal program, but the broader health system in California. The first meeting occurred in July 2019.The Medi-Cal Children's Health Advisory Panel meets quarterly to advise DHCS on policy and operational issues that impact children in Medi-Cal. Each meeting takes a "deep dive" into one or two relevant topics affecting children. Recent topics included current initiatives to reduce perinatal and postpartum opioid use, and improvements to the Medi-Cal Children's Dashboard that include behavioral health services and pediatric network adequacy and corrective action. DHCS also convenes numerous workgroups and advisory groups on current legislative initiatives and efforts to improve quality of care.
Social Media Outreach

DHCS uses social media platforms — Facebook, Twitter and LinkedIn — to increase awareness of health care-related issues and to help improve the health of all Californians. Enrollment packets sent to each Medi-Cal beneficiary include information about the DHCS social media sites, prompting them to follow the Department for current Medi-Cal and health-care news. The metrics gathered and analyzed from DHCS' social media platforms reflect an increasing interest in the information that is circulated, including public health events, departmental job postings, health policy updates, and reposts from partner health organizations. Staff will continue to monitor metrics from the social media sites to help determine what the public is most interested in viewing and sharing, as well as the

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demographics of our audience. This information is analyzed quarterly to help tailor the scope of the social media posts.

3.7 Workforce Development

As a department, DHCS possesses a skilled, knowledgeable, and committed workforce of professionals who work hard to achieve its mission of providing Californians with access to affordable, integrated, and high-quality healthcare. We are committed to creating and sustaining an internal culture to support this mission and vision. The Strategic Planning and Workforce Development Branch (SPAWDB) was officially established in July 2008 and provides training opportunities and workforce development initiatives to ensure staff are able to meet the evolving needs of our members and partners with an emphasis on quality improvement, Medicaid policy, analytical skills, and leadership.

Competencies have been identified for each of the nine unique occupational groups within DHCS. These competency groups broadly define excellent performance within each employee classification and serve as benchmarks against which job performance can be assessed. DHCS offers a competency-based educational model that focuses on growing and building these specific competencies for all employees within the Department. This competency-based approach ensures that the training courses and workforce development initiatives are cost-effective, goal-oriented, and productive.

SPAWDB has developed a workforce succession plan to navigate predictable upcoming changes to the DHCS workforce and ensure that the transfer of knowledge continues through these changes. In this plan, DHCS has identified the key positions and classifications most impacted by projected vacancies and determined strategies to mitigate the negative impacts these vacancies will have on the organization.
Some of the organization and workforce development strategies that SPAWDB will implement over the next three years to help create a culture of continuous quality improvement include the following:

- Develop and launch a new DHCS Academy Plus program
  To build on the foundational knowledge provided by the DHCS Academy, DHCS will work collaboratively with external learning partners to create and launch a new DHCS Academy Plus program that will equip leaders with the ability to lead an organization and drive change. The curriculum expands people's ability to think constructively and nimbly in highly complex situations. The classes will help prepare students to speak and work effectively with state and federal control agencies, legislative staff, the media, other departments, and stakeholder groups.
- Enhance the learning component of DHCS manager-supervisor meetings
  To invest in our managers and supervisors, SPAWDB will incorporate a variety of engaging and informative one-hour training presentations during each DHCS manager-supervisor meeting. These presentations will focus on building proficiency and reinforcing core skills of leadership positions through competency-based training. The alignment of DHCS leadership development with CalHR's Leadership Competency Model will provide a holistic approach to development by emphasizing

the core leadership competencies that are key to our success.

- Establish a department-wide mentorship program
  Mentoring is an effective mechanism for grooming employees to fill key roles as part of DHCS' succession plan. SPAWDB will create a formal mentoring program that pairs experienced employees in higher level classifications with less experienced employees in lower level classifications, with the intent of fostering knowledge transfer and career development.
- Develop and publish a reorganization toolkit for managers
  A reorganization is an opportunity to eliminate overlapping functions, consolidate like-functions, and provide a higher standard of service to stakeholders. Reorganizations vary in size and shape from the internal restructuring of a branch, to a consolidation of large divisions to meet emerging business needs. SPAWDB wants to ensure DHCS has the right tools to guide the re-organizations and standardize these efforts across the department by creating a comprehensive toolkit with templates, resources and instructions to guide project managers in these efforts.
- Continue Lean White Belt training
  SPAWDB will continue to regularly offer internal instructor-led training sessions of the Lean White Belt training to equip employees and managers with basic on-the job Lean Methodology skills as part of GovOps' mission to modernize the processes of government through lean, data, leadership, and performance improvement.

Section 3.8 Monitoring and Reporting Data on Quality Improvement

The Department has focused on the use of data for performance monitoring and data transparency efforts across all program areas. With the use of tools such as the Data Publishing Style Guide, the DHCS Data De-identification Guidelines, and the California Health and Human Services Open Data Portal, departmental programs are increasing the availability of public data and the usability of data for stakeholders and members of the public. These tools support improvements in the consistency of publicly released data and the associated analyses. Moving forward, DHCS will further develop additional process and technical tools to improve the usability and meaningful of data for the Department and its partners.

In 2019, DHCS has purposefully worked on creating alignment of performance measures used across various programs. The primary set of performance measures used for this purpose is the annual CMS Adult and Child Core Set Measures, of which a subset have been reported voluntarily to CMS for a number of years. The Core Set Measures are being used to monitor MCPs, MHPs, DMC-ODS, and DMC plans, in addition incentivizing provider performance in the new VBP Program (see p. 114) and the QIP Program (see p. 108). This alignment of measures will allow DHCS to create synergistic quality improvement initiatives, support goals to decrease reporting burden, and focusi on processes and outcomes that assess integration of services across delivery systems.

In addition to efforts to improve data and the use of data within DHCS, the Department works closely with other departments to support data quality for registries and other data sources necessary to evaluate the Medi-Cal program. Work with programs in the California Department of Public Health (CDPH), which maintains a number of registries that are

important for Core Set Measures and other CMS reporting, include the Vital Records Registry, the Immunization Registry, the Childhood Blood Lead Registry, the Infectious Disease Reporting Registry, and the HIV/AIDS Registry. By using data governance and agency-wide data sharing agreements, DHCS has worked with CDPH to share data that is used to assist in monitoring the health of the Medi-Cal population. Similarly, DHCS is working with programs in the California Department of Social Services (CDSS) to share data specific to children in foster care and child welfare to monitor the use and coordinate care for children receiving psychotropic medications, specialty mental health services, and other Medi-Cal services. Creating a shared data set that links child welfare and Medi-Cal data allows for more holistic care and monitoring of this vulnerable population.

DHCS is also one of the funders for the California Health Interview Survey (CHIS) conducted by University of California, Los Angeles (UCLA) Center for Health Policy Research. CHIS is the nation's largest state health survey and a critical source of data on Californians as well as on the state's various racial and ethnic groups. Since 1999, DHCS has depended on CHIS for credible and comprehensive data on the health of Californians and to assist DHCS in the administration of the Medi-Cal program in California. DHCS programs are able to utilize CHIS data to examine disease prevalence, evaluate programs and develop policies that will benefit the Medi-Cal population. Priorities for DHCS questions include: family planning; prenatal care; dental health; delays in care; long term care; diagnosis and care; chronic disease diagnosis and treatment; substance use, telehealth in rural areas, tobacco use and health behaviors; communications with the provider; reasons for non-participation in Medi-Cal; disability status and determination; access to health care and utilization; and eligibility and enrollment in a health insurance plan. The large sample size and county-based sampling strategy allow this survey to obtain reliable and robust prevalence estimates for a wide variety of health behaviors and health conditions in California counties as well as for various racial and ethnic groups statewide.

Program areas within DHCS have developed program specific dashboards that look at a variety of measures across the delivery systems and include assessments by various demographic categories.

Performance Monitoring Dashboard Reports

Managed Care Plans

The Managed Care Performance Dashboard is a monitoring tool produced quarterly by DHCS. The Dashboard contains comprehensive data on a variety of measures including enrollment, health care utilization, member grievances, network adequacy and quality of care. Information contained in the Dashboard assists DHCS and its stakeholders in observing and understanding managed care plan (MCP) performance statewide, by plan model, and by MCP.

The Managed Care Performance Dashboard information is collected and aggregated from multiple sources. The managed care demographics and enrolment information is collected from managed care eligibility files. Utilization information is collected from managed care

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encounter data submitted by the MCPs. Grievance information is collected quarterly from managed care plans. State fair hearings are reported from the Department of Social Services. Network information is reported monthly from MCPs. Healthcare quality is measured using an Aggregated Quality Factor Score (AQFS) which accounts for plan performance on DHCS selected HEDIS® indicators. The most recent version of the Managed Care Performance Dashboard is located at the following DHCS web page: Managed Care Performance Dashboard.

County Mental Health Plans

Monitoring and reporting data on quality improvement for SMHS is an evolving area. DHCS implemented a performance and outcomes system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) SMHS. DHCS later built upon this foundation and expanded the performance outcomes system reports to include adults, creating the SMHS dashboard. DHCS publishes the SMHS dashboards annually for both statewide and at the county-level. The reports can be accessed at the Medi-Cal Specialty Mental Health Services Performance Dashboards website.

DHCS is incorporating the mental health measures from the Core Set of Behavioral Health Measures for Medicaid into the SMHS dashboards. DHCS has recently established a Quality Assessment and Performance Improvement Section (QAPIS) for Medi-Cal behavioral health to build an infrastructure for monitoring and data reporting for quality improvement for SMHS. Through the QAPIS, DHCS will build upon existing quality monitoring and reporting functions, such as the annual Quality Improvement Work Plans from county MHPs, the EQRO, and the SMHS dashboards, as well as developing new quality assessment and performance improvement activities for SMHS.

Drug Medi-Cal Organized Delivery System

The primary data collection and reporting system for SUD publicly funded services is the California Outcome Measurement System (CalOMS). This system was initially developed for limited treatment services and was designed to measure outcomes in four life domains: Criminal, Mental, Medical, and Family/Social. With the implementation of the DMC-ODS, DHCS is taking the opportunity to update the system. The first phase began in the spring of 2018, with a system revision to meet security, architectural, and programming standards. Due to unforeseen difficulties with the upgrade, progress was slower than anticipated. The second phase revisions are now scheduled to begin in FY 19/20 and will focus on enhancing CalOMS to collect more detailed service information so that data from all available levels of care can be collected and used to inform future quality improvement activities.

SUD Performance Dashboards are under development and once finalized will be posted on DHCS' website. DHCS anticipates that with the planned revision to CalOMS and the Performance Dashboards will serve as useful tools for both the Department and counties to measure service performance, identify areas for improvement, and monitor progress of improvement strategies through the data.

Dental Managed Care

DHCS maintains ongoing oversight of DMC utilization through monitoring of 13 performance measures (e.g., annual dental visit, preventive services, use of sealants, use of diagnostic services, use of dental treatment services, etc.). DHCS retrieves dental encounter data from the DHCS data warehouse to calculate and generate various dental data reports that are published on both the DHCS website and the California Health and Human Services (CHHS) Open Data Portal.

DHCS routinely publishes quarterly performance measure utilization reports to the Dental Data Reports page[13] on the DHCS website for both FFS[14] and DMC[15]. Each quarterly report encompasses a 12-month span of data. A new report is generated to replace data from the oldest quarter as new quarterly data becomes available. Updating quarterly reports on a "rolling annual" basis allows DHCS to evaluate ongoing utilization trends more accurately.

The CHHS Open Data Portal[16] compiles reports from various State agencies. DHCS contributes to the Open Data Portal by publishing seven dental-specific datasets[17] on Medi-Cal performance measure utilization. The datasets are inclusive of calendar year (CY) utilization data for both FFS and DMC. Protected health information is de-identified to allow researchers, stakeholders, dental professional associations, and other local health care agencies to access the data. In addition, the datasets allow users to filter data by various criteria such as year, age, county, ethnicity, dental service, etc., to extract desired information.

DHCS is able to leverage encounter data to share DMC plans' quality improvement efforts at various stakeholder meetings throughout the year hosted by either the Sacramento Medi-Cal Dental Advisory Committee or Los Angeles Dental Stakeholder Group. In addition, an annual report on DMC activities is submitted to the Legislature that includes data for each DMC plan's progress in meeting utilization goals.

Section 4. Comprehensive Quality Strategy Process

Section 4.1 Development Process

The 2020 CQS report is a document reflective of the ongoing quality improvement efforts within the Department and draws upon shared goals, objectives and priorities across DHCS programs, as well as those objectives and activities developed to meet the needs of specific populations. It combines two previous quality reports into one: the *DHCS Strategy for Quality Improvement in Health Care* and the *Med-Cal Managed Care Quality Strategy Report*, required by 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. It is a broader quality strategy assessing the quality of care that all of our beneficiaries receive,

[13] Dental Data Reports: https://www.dhcs.ca.gov/services/Pages/DentalReports.aspx
[14] Dental Fee-for-Service Performance Measures Reports https://www.dhcs.ca.gov/services/Pages/FFSPerformanceMeasures.aspx
[15] Dental Managed Care Performance Measures https://www.dhcs.ca.gov/services/Pages/DMCPerformanceMeasures.aspx
[16] California Health and Human Services Open Data Portal: https://data.chhs.ca.gov/
[17] California Health and Human Services Open Data Portal: Dental datasets: https://data.chhs.ca.gov/dataset?organization=department-of-health-care-services&q=dental

regardless of delivery system. A number of sources were taken into consideration when developing this report including: the DHCS Strategic Plan; CMS Considerations for Medicaid and Medicaid and CHIP Programs guidance letter; other states' quality strategy reports; the HHS National Quality Strategy for Improvement in Health Care, and stakeholder feedback received on the 2018 *Med-Cal Managed Care Quality Strategy Report*. This stakeholder feedback was a critical component, particularly comments regarding the need for a more cross-cutting view of the Department's strategy around quality and health equity, the importance of social determinants of health, and alignment of performance measures across initiatives, programs, and delivery systems. Following internal review by executive and program staff, the draft CQS is made available to external stakeholders through the posting of a draft document for public comment on the DHCS web site. Stakeholder feedback is then incorporated into the the final report, to the extent practicable, and then submitted to CMS.

Section 4.2 External Stakeholder Feedback

DHCS has published a draft version of this report on November 18, 2019, and requested public comment through December 23, 2019. All stakeholder comments will be posted on the DHCS Comprehensive Quality Strategy website. In addition, DHCS discussed the report with stakeholders during the May 23, 2019 and October 29, 2019 DHCS Stakeholder Advisory Committee meetings, the September 5, 2019 Managed Care Advisory Group meeting, the July 11, 2019 Managed Care Plan Medical Directors' meeting, and the October 18, 2019 Medi-Cal Tribal and Indian Health Program meeting.

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

Section 4.3 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 does for each managed care entity.

To address stakeholder comments on the 2018 *Managed Care Quality Strategy Report*, this comprehensive quality strategy report has added improving health equity as an overarching goal to be addressed by all DHCS programs. The managed care program is working to meet this goal through annually sharing unit level disparity data with MCPs to identify disparities so plans can tailor quality improvement resources to target populations (see p. 48). For each county, Mental Health Plans develop and implement cultural competence plans that include objectives for reducing disparities by tailoring the best practices in mental health services to beneficiaries' cultural and ethnic background and language preferences (see p. 53). The DMC-ODS plans work to improve access to culturally competent SUD services and use demographically stratified data to educate providers and members about the importance of prevention and early treatment of oral diseases and work with dental plans to address and prevent oral health disparities.

DHCS is continuing to work with county health departments, stakeholders and partner organizations, including the CDPH Office of Health Equity and the California Reducing Disparities Project (CRDP), to develop and deploy effective interventions to eliminate addressable health disparities and improve health literacy skills to meet the needs of Medi-Cal members. OMD facilitates a monthly DHCS health disparities meeting with representation from various programs to coordinate the department's efforts to reduce health disparities, especially concerning quality health care among our Medi-Cal members. DHCS continues to use data to drive decision-making by creating health disparities fact sheets on a wide variety of health, behavioral, and disease topics, including disaggregated data by race/ethnicity and a high level of granularity, when possible. 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.

DHCS is dedicated to helping eliminate disparities in health care and continues to align 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.

As part of the 1115 Medicaid Waiver (Public Hospital Redesign and Incentives in Medi-Cal or PRIME program), DHCS is serving as the data steward for the collection of Race, Ethnicity, and Language (REAL) and Sexual Orientation and Gender Identity (SO/GI) data. Designated Public Hospitals (DPH) and District Municipal Public Hospitals (DMPH) are working to systematically collect accurate and complete, REAL and SO/GI data. These data are being used to develop and implement REAL and SO/GI disparity reduction interventions. Hospitals are working to decrease health disparities in the areas of hypertension, diabetes, and colon cancer screening. In 2018, DHCS started a Health Disparities learning collaborative for the hospitals, and experts in the field have led webinars in hypertension, diabetes, social determinants of health, resilience, and colon cancer screening. To further encourage the hospitals' health equity efforts, DHCS continued to offer one on one expert consultation with subject matter experts at the 2019 annual PRIME conference.

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.

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Each county is required to develop and implement a Culturally and Linguistically Appropriate Services (CLAS) Plan that includes objectives for reducing health disparities using culturally, linguistically, and ethically appropriate strategies in mental health and substance use. Many counties have developed a single plan that addresses both Specialty Mental Health and DMC-ODS services. Included in the annual SUD county monitoring reviews are evidence of implementing CLAS standard requirements and an evaluation of the county plan. 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.

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. All programs are refining their demographic data collection and reporting methodologies to improve the ability to identify and reduce disparities. 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 annually completes a comprehensive health disparities analysis to more accurately identify health inequities and better target the neediest beneficiaries.

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.

Stakeholders have 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, we are continually adding demographic, utilization, and performance measures to the DHCS website and on the California Health and Human Services (CHHS) Open Data Portal. Utilization and performance measures for dental and specialty mental health on the CHHS Open Data Portal are stratified by various demographic variables. Utilization and performance measures are also presented for specific sub-populations, such as children in foster care in reports on the DHCS website. The Department recognizes the continued stakeholder interest in performance measures stratified by specific populations and will consider these comments in future data publishing efforts.

DHCS will continue to actively communicate with stakeholders and solicit feedback on its health disparities work through leading internal and external webinars, presentations, and sharing research and promising practices across all programs. Starting in 2018, OMD began a quarterly DHCS health disparities webinar series that includes presentations from organizations and education institutions throughout the state focused on a variety of health conditions that disproportionally impact the racial/ethnic sup-populations of our Medi-Cal population. As these efforts progress, the DHCS **health disparities website** will continue to serve as a central resource for on-the-ground programs and services that narrow the health gap between Medi-Cal sub-populations.

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Section 4.4 Review and Evaluation of the Effectiveness of the Quality Strategy

In accordance with Title 42 C.F.R. section 438.340(c)(2), this report must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years. Section 6 starting on page 36, "Continuous Quality Improvement and Interventions," addresses both individual programs' evaluation of the effectiveness of the quality strategy, considers the recommendations provided pursuant to section 438.364(a)(4) which include ways the State can target goals and objectives to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, and describes actions taken based on these recommendations.

Section 4.5 Revisions to the Comprehensive Quality Strategy

In accordance with 42 CFR 438.340(b)(11), the state must define what constitutes a "significant change" that would require revision of the CQS at an interval more frequent than three years. For DHCS managed care programs, a 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, carried out within DHCS.

Section 5. Managed Care Standards, Assessment, and Evaluation

Section 5.1 Assurance of Network Adequacy and Availability of Services

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. The DHCS network adequacy standards document was subsequently amended in March 2018 to reflect changes under AB 205 (Chapter 738, Statutes of 2017), which was codified in Welfare Institution Code (WIC) 14197 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. In addition, each managed care entity must submit their own report which demonstrates their compliance with the network adequacy standards set forth in WIC 14197. Individual reports can be found on the Department's Network Adequacy webpage.

Managed Care Plans

In accordance with Title 42 C.F.R. section 438.207(c)(3), DHCS must recertify the MCP's network when there is significant change that would affect the adequacy of capacity and services that is defined by DHCS. DHCS defines a significant change as a change in the composition of the MCP's network, services, benefits, geographic service area, or enrollment of a new population. The significant change may occur as a result of a termination, suspension or decertification of an MCP network provider or subcontractor.
DHCS reviews and determines if a significant change has occurred on an ongoing basis as

notifications of network changes are received. The MCP's network would be recertified if DHCS determines a network change impacts the MCP's ability to continue to provide covered services to beneficiaries within network adequacy standards. Upon completion of the recertification, DHCS submits an Assurance of Compliance Report to demonstrate compliance of the MCP's network. DHCS makes available to CMS, upon request, all documentation collected due to the significant change.

County Mental Health Plans

The county MHPs are classified as Prepaid Inpatient Health Plans (PIHPs) and must therefore comply with applicable federal managed care requirements. As such, each MHP must maintain and monitor a provider network adequate to serve, within scope of practice under State law, the population of adults and children/youth Medi-Cal beneficiaries eligible for SMHS. MHPs must meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment and the expected utilization of SMHS.

Effective July 1, 2018, MHPs had to also comply with the appointment time standards in accordance with section 1300.67.2.2(c)(1-4), (7) of Title 28 of the California Code of Regulations. Future network certification analyses will also include compliance with timely access standards. DHCS is modifying its Client and Services Information System (CSI) to include timely access reporting elements. It is expected this first phase of the CSI reporting will begin in the fall of 2020. More information can be found on Accessibility to SMHS can be found in Section 6.2.

Drug Medi-Cal Organized Delivery System

DHCS is responsible for certifying Drug Medi-Cal Organized Delivery System (DMC-ODS) provider networks on an annual basis. The network certifications are required to be submitted to CMS prior to July 1, of each year.

DHCS published Information Notice 18-011, which outlines the DMC-ODS network adequacy certification process and submission requirements. DMC-ODS counties are required to submit documentation that demonstrates the capacity to serve the expected enrollment in each service area in accordance with DHCS' standards for access to care established under the authority of CMS Medicaid and CHIP Final Rule, CMS-2390-F (Final Rule) Sections 438.68, 438.206 and 438.207.

DHCS conducts a comprehensive review of each DMC-ODS plan's provider networks and evaluates related policies and procedures. Based on this review, DHCS determines that each DMC-ODS county complies with the requirements or they receive a conditional pass with Corrective Action Plan (CAP) mandates.

Dental Managed Care

The Department conducted a comprehensive review of the provider networks for each of the six contracted Dental Managed Care (DMC) plans and has concluded that all DMC plan provider networks are compliant with the annual network certification requirements. Federal and state

laws and regulations establish state-specified network adequacy standards, which DMC plans are required to comply with as specified in the DMC contracts. DHCS' network evaluation consisted of a review of the DMC plans' ability to maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in both Sacramento and Los Angeles counties. Network Certification reports can be found on the DHCS website.

Section 5.2 Evidence-Based Clinical 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.

Managed Care Plans

Through its contracts with MCPs, DHCS requires that 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.

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.

County Mental Health Plans

Through its contracts with MHPs, DHCS requires that County MHPs adopt and disseminate clinical practice and guidelines as specified in 42 CFR 438.236. DHCS' contract with MHPs specifies requirements for conducting medical necessity evaluations and includes criteria and guidelines for documenting beneficiary assessments, treatments plans, medication consents,

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and progress notes. MHPs must have processes in place to disseminate this information to providers, and beneficiaries upon request. MHPs submit their procedures to DHCS for review during triennial compliance reviews.

Furthermore, as with MCPs, DHCS requires MHPs to ensure that their authorization decisions are based on a set of written criteria or guidelines for utilization review that is based on clinical practice standards, is consistently applied, and regularly reviewed, and updated as appropriate. MHPs must utilize DHCS' medical necessity criteria and standards to approve, modify, defer, or deny services. 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 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.
- 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 website. DHCS conducts compliance reviews to ensure that MHPs implement in accordance with state and federal requirements.

Drug Medi-Cal Organized Delivery System

Counties that implement the DMC-ODS are required to use the American Society of Addiction Medicine (ASAM) criteria to ensure that eligible beneficiaries gain access to the SUD services that best align with their treatment needs and identified level of appropriate care. The ASAM criteria is the result of a collaboration of experts that began in the 1980s to define a national set of criteria for proving 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 comprehensive set of guidelines for assessing patient needs and optimizing placement into SUD treatment.

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Counties are responsible for ensuring their network providers are trained and conduct ASAM assessments on beneficiaries seeking SUD services.

DMC-ODS counties must identify and train their network providers to use two of the five Evidence Based Practices (EBPs) listed below.

- Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
- Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.
- Relapse Prevention: A behavioral coping-focused process that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
- Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.
- Trauma-Informed Treatment: Services take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.

In addition to ASAM and the above EBPs, research shows that a combination of Medication Assisted Treatment (MAT) and behavioral therapies is a successful method to treat a SUD.

MAT services under DMC-ODS include Narcotic Treatment Program (NTP) services provided in NTP-licensed settings. Counties contracting to participate in DMC-ODS are required to cover and ensure access to NTP services. NTPs participating in DMC-ODS are required to offer and prescribe medication to patients covered under the DMC-ODS formulary, including methadone, buprenorphine, naloxone, and disulfiram. Services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of California requirements.

Dental Managed Care

Through its contracts with DMC plans, DHCS requires DMC plans to abide by the clinical criteria outlined in the Medi-Cal Dental Program Provider Handbook (Handbook), inclusive of Section 5 – Manual of Criteria (MOC). The MOC provides dental clinical parameters for providers treating Medi-Cal members, setting forth program benefits and clearly defining limitations, exclusions, and special documentation requirements. The MOC outlines DHCS policy for procedures offered through the program that DMC plans are required to adopt and

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disseminate to providers. The Handbook serves as a reference guide for all Medi-Cal dental providers but is available to members as well. The Handbook contains the criteria for dental services; program benefits and policies; and instructions for completing forms used in the Dental FFS program. The DMC contract also requires DMC plans to maintain their own Provider Manual which, following DHCS approval, shall be disseminated to providers and, upon request, to members and potential members. The plan-specific Provider Manual must rely on clinical evidence and specific clinical practice guidelines to which providers must adhere.

The DMC contract requires DMC plans to provide dental services in accordance with intervals that meet reasonable standards of dental practice, including the American Academy of Pediatric Dentistry periodicity schedule for dental services to children. 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 services must be furnished in an amount, duration, and scope that is no less than the same services furnished to members under the Dental FFS program.

Section 5.3 Coordination and Continuity of Care

DHCS requires, in accordance with 42 CFR 438.208, that managed care plans must support coordinated care by ensuring that enrollees have an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee and that timely and coordinated access to all medically necessary services is provided to all beneficiaries. DHCS also requires that contracted plans provide appropriate continuity of care for members to ensure uninterrupted access to services and to minimize the disruption of care.

Managed Care Plans

In 2017, DHCS released APL 17-12, which addresses care coordination requirements for managed long term services and supports, as well as APL 17-017 which addresses long term care coordination, disenrollment and continuity of care. In 2018, DHCS released APL 18-008 which addresses continuity of care requirements for Medi-Cal members who transition from FFS into managed care. DHCS contracts with MCPs also address coordination of care requirements, including basic and comprehensive care management, person centered planning for seniors and persons with disabilities, discharge planning, targeted case management and out of network case management and coordination of care. The contracts also outline the requirement for memoranda of understanding between the MCPs and several external partners including but not limited to California Children's Services, local public health departments, county mental health providers and local education agencies, for the purpose of coordinating care for members.

County Mental Health Plans

County MHPs are required to coordinate care for all Medi-Cal beneficiaries receiving SMHS,

in accordance with Title 42 of the Code of Federal Regulations, § 438.208, and the terms of the MHP Contract. Care coordination requirements include, but are not limited to: the coordination of services between settings of care, coordination with services the beneficiary receives from any other managed care entity, in FFS from community and social support providers, and other human services agencies used by the MHPs' beneficiaries. In addition, per the MHP Contract and Title 9 of the California Code of Regulations, §1810.370, MHPs are required to enter into a Memorandum of Understanding with any Medi-Cal managed care plan serving the MHPs' beneficiaries.

Drug Medi-Cal Organized Delivery System

DMC-ODS counties are responsible for coordination and continuity of care for their enrolled beneficiaries. The county is required to ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. Information on how to contact their designated person or entity at enrollment must be provided to beneficiaries. To support an effective care coordination system, Counties are required to enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. MOUs must include a description of how responsibilities will be divided and provided to include comprehensive substance use, physical health, and mental health screenings, the delineation of case management responsibilities, availability of clinical consultations, and collaborative treatment planning.

Care coordination includes:

- Coordinating changes between levels of care, including discharge planning;
- Connecting beneficiary to community and recovery supports;
- Coordinating health care services through their MOUs with all managed care plans operating in the county.

Through the coordination process, continuity of care is achieved reducing fragmentation of services and thus improving patient safety and quality of care.

Dental Managed Care

Title 42, CFR, §438.208(b) incorporated additional requirements for the delivery of care and coordination of services for all DMC members. To demonstrate alignment with these federal requirements, DHCS issued Dental APL 18-007 and amended the DMC contracts to ensure DMC plans: 1) Conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful; and 2) Share with DHCS or other managed care plans serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities.

Additionally, Title 42, CFR, §438.208(c) addressed specific services for members with Special Health Care Needs (SHCN). Each DMC plan is required to: 1) Implement mechanisms to

comprehensively assess members identified as having SHCN to identify any ongoing special conditions that require a course of treatment or regular care monitoring; and 2) Produce a member-specific treatment or service plan for those members that are determined through assessment to need a course of treatment or regular monitoring. APL 18-007 establishes a definition for members with SHCN to assist DMC plans in identifying members with SHCN for the purpose of conducting assessments and developing treatment plans.

In July 2018, DHCS reviewed and approved all DMC plans' submitted policies and procedures and Oral Health Information Forms to confirm that DMC plans have effective processes in place to demonstrate compliance with these requirements.

Section 5.4 Transition of Care

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. Each managed care program has developed specific transition of care policies, detailed in the sections below.

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.

County Mental Health Plans

DHCS issued Mental Health and Substance Use Disorder Services Information Notice 18-059, which established 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 is consistent with its policy for Medi-Cal managed care. In accordance with the policy guidance, all eligible Medi-Cal beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the county MHP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner). SMHS shall continue to be provided, at the request of the beneficiary, for a

period of time not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP, in consultation with the beneficiary and the provider, and consistent with good professional practice.
This policy applies to all Medi-Cal beneficiaries who are transitioning as follows:

- The provider has voluntarily terminated employment or the contract with the MHP.
- The provider's employment or contract has been terminated for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program.
- Transitioning from one county MHP to another county MHP due to a change in the beneficiary's county of residence.
- Transitioning from an MCP to an MHP, or
- Transitioning from Medi-Cal FFS to the MHP.

Drug Medi-Cal organized Delivery System

The transition of care policy for DMC-ODS counties (MHSUDS Information Notice No. 18-051) ensures a beneficiary continued access to the same provider during a county's transition from a State Plan DMC network into a DMC-ODS network or a beneficiary's move from one DMC-ODS county to another DMC-ODS county. Counties are required to allow a beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. SUD treatment services with the existing provider shall continue for a period of no more than ninety days unless medical necessity requires the services to continue for a longer period of time, not exceeding twelve months.

Dental Managed Care

In April 2018, DHCS released Dental APL 17-011E, which provided DMC plans with updated policy guidance regarding transition of care requirements for individuals who transition to DMC plans from Dental FFS or from other DMC plans. Medi-Cal members 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 members 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 members may require continuity of care for services they have been receiving through Medi-Cal Dental FFS or through another DMC plan.

Section 5.5 Intermediate Sanctions

The Final Rule requires this report to include the State's appropriate use of intermediate sanctions 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.

Managed Care Plans

DHCS released 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.

Dental Managed Care

In January 2017, DHCS released Dental APL 16-011 to mandate compliance with the managed care Final Rule regulations effective July 2016. DHCS incorporated the Final Rule provisions into the DMC contracts as well as strengthened the sanction policy to comply with the Final Rule. The contracts detail DHCS' options for intermediate sanctions, including but not limited to, termination hearings, appointment of temporary management, civil money penalties, and member and contractor rights in the case of temporary suspension orders and contract termination.

Section 5.6 Long-Term Services and Supports 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 algorithms for the following populations: 1) Full benefit Duals who opt-out of Cal MediConnect[13]; 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 members 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 who also require health or related services of a type or amount beyond those generally required by members. DMC plans must perform a comprehensive assessment for members identified as having special health care needs and develop a member-specific treatment or service plan as needed. The treatment or service plan must be reviewed and revised upon reassessment at least every 12 months or when circumstances or needs change significantly or at the request of the member per Title 42, CFR 441.301(c)(3). DMC plans are required to have a mechanism in place to allow the member to directly access a specialist as appropriate for the member's condition and identified needs.

Section 5.7 Performance and Quality Outcomes for Primary Care Case Management

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.

Section 5.8 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.

Section 5.9 Non-Duplication of External Reviews

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.

Section 6. 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. The Final Rule also requires that this review includes an evaluation of the June 29, 2018 *Medi-Cal Managed Care Quality Strategy Report*, and take into consideration the recommendations provided pursuant to § 438.364(a)(4) for improving the quality of health care services furnished by each MCO, PIHP,

PAHP, or PCCM entity including how the State can target goals and objectives to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

Program-specific goals, quality metrics, performance targets, performance improvement projects (PIP) or quality improvement projects (QIP), program evaluation of the effectiveness of the 2018 *Medi-Cal Managed Care Quality Strategy Report* and evaluation key findings, and program actions based on evaluation recommendations are within the subsections below.

Section 6.1 Managed Care Plans

For the MCPs, DHCS has identified seven priority focus areas for quality improvement. The focus areas were chosen because they reflect DHCS priorities and overarching goals, 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: 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.

DHCS Goals and MCP Program Objectives

DHCS Goals and MCP Program Objectives	• Improve health outcomes: DHCS works to improve health outcomes via the priority focus areas discussed above; namely, improving postpartum care and immunizations of two year olds, improving diabetes care and the control of hypertension, and increasing tobacco cessation efforts. DHCS is further working to improve health outcomes by reducing health disparities and by fostering healthy communities through reducing opioid misuse and overuse. • Improve health equity: DHCS is working to reduce health disparities through policy initiatives that will require the MCPs to utilize data from DHCS' annual Health Disparities Report, along with other available data sources, for purposes of identifying health disparities and developing an action plan to address health disparities as part of the revised group needs or population needs assessment. DHCS also continues to produce and improve upon its annual Health Disparities Report produced by the EQRO. DHCS will also continue to require the MCPs to conduct one Performance

	Improvement Project (PIP) on a statistically significant health disparity identified within the MCP's member population. To support MCPs in their quality improvement (QI) work on health disparities, DHCS and its EQRO have quarterly collaborative calls with the MCPs devoted to their QI work during which promising practices and challenges are shared. DHCS has also developed a Health Equity QI Newsfeed that it shares with the MCPs twice a year. Finally, DHCS hosted its every two-year quality conference in October of 2019, the theme of which was Health Equity: Building Skills to Bridge the Health Divide. • Address social determinants of health: DHCS is in the process of revising its current member assessment and re-assessment process and working towards requiring a population health management strategy of the MCPs which would include the collection of social determinants of health data. Included in the population health management strategy will be a data driven risk stratification process, a new standardized member assessment, collection of social determinants of health data, and the provision of in lieu of services to help address identified social needs. • Improve data quality and reporting: DHCS continues its work to improve encounter data accuracy and completeness through its annual Encounter Data Validation Study and its Encounter Data Stoplight reports which compare the amount of utilization reported through each MCP's rate development template and the amount of encounter data reported to DHCS. DHCS is also developing an annual Preventive Services Utilization Report which will utilize encounter data to determine the rates of provision of appropriate preventive services in accordance with American Academy of Pediatrics (AAP) Bright Futures for children and in accordance with the United States Preventative Services Task Force(USPSTF) Grade A and B recommendations for adults.
Quality Metrics and Performance Targets for Reporting Years (RY) 2019 and 2020	• For RY 2019 (measurement year [MY] 2018), 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 19 of 30 indicators in RY 2019. • For health care services provided in MY 2018 (RY 2019), for indicators for which DHCS held MCPs accountable to meet the MPLs, 88 percent of the rates were above the MPL.

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	• In RY 2019, the MCPs exceeded the High Performance Level (HPL) for 14 percent of the indicators. • Beginning with RY 2020, DHCS has modified its managed care quality monitoring process: • MCPs will be required to report annually on a subset of CMS Adult and Child Core Set measures, which will constitute the Managed Care Accountability Set (MCAS). • DHCS has increased its MPL on applicable performance measures from the national Medicaid 25th percentile, as determined by the NCQA's Quality Compass, to the 50th percentile.

Performance Improvement Projects (PIPs)	• DHCS requires MCPs to conduct and/or participate in two PIPs annually, in alignment with Federal requirements.
	• For 2017-2019, the first PIP topic focused on addressing health disparities:
	  o MCPs were encouraged to select an area where they had a demonstrated need for improvement.
	• For 2017-2019, the second PIP topic aligned to one of four DHCS pre-selected priority focus areas including:
	  o timeliness of postpartum care
	  o diabetes
	  o hypertension
	  o childhood immunizations
	• For 2019 – 2021, the MCPs will participate in two new PIPs.
	  o The first PIP topic will again focus on reducing a health disparity.
	  o The second PIP topic must focus on an area of needed improvement in the arena of child and adolescent health.

Quality Metrics and Performance Targets

DHCS requires MCPs with which it contracts to report on a set of quality performance measures. These measures were previously known as the External Accountability Set (EAS), and consisted primarily of HEDIS measures developed by the National Committee for Quality Assurance (NCQA). Beginning with RY 2020, DHCS has announced that it will require MCPs to report on and be held accountable to a selection of CMS Adult and Child Core Set measures. MCPs will report on these new measures, known as the Managed Care Accountability Set (MCAS), for the first time in RY 2020. Also for RY 2020, DHCS has increased the MPL from the national Medicaid 25th percentile, to the national Medicaid 50th percentile (for those measure for which a benchmark is currently available). For a complete list of MCAS measures for RY 2020, see the Appendix D.

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Evaluation of the Effectiveness of the 2018 Medi-Cal Managed Care Quality Strategy Report

For MYs 2017 and 2018, MCPs reported performance on 17 measures consisting of 30 individual indicators.[18]

- For MYs 2017 and 2018, DHCS held MCPs accountable for performing at least as well as the national Medicaid 25th percentile, or the MPL, on 21 of 30 indicators.
- For health care services provided in 2017, the MCPs exceeded the MPLs for 87 percent of the indicators. This left 13 percent of indicators falling below the MPLs. For the same year, MCPs exceeded the HPLs for 16 percent of the indicators.
- For health care services provided in 2018, for indicators for which DHCS held MCPs accountable to meet the MPLs, 88 percent of the rates were above the MPLs, demonstrating a 1 percentage point increase from the prior year. For the same year, MCPs exceeded the HPLs on 14 percent of the indicators.

Listed below are objectives set in the 2018 Medi-Cal Managed Care Quality Strategy for services to be provided in calendar year or MY 2018, for the five quality metric linked focus areas. The targets were set in comparison to the baseline year of 2015. This built 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 reported below was collected from January to December 2017, and was reported in July 2017, as well as from January to December 2018, and reported in July 2018. Due to the timing of the release of the 2018 DHCS Managed Care Quality Strategy, that report did not include performance measurement results from calendar year or MY 2017. Therefore, this report contains results from both MYs 2017 and 2018.

Focus Area	Quality Metrics and Performance Targets
Postpartum Care	**Objective 1:** Increase the Medi-Cal weighted average for timely postpartum care to at least 64 percent for MY 2018. • Target for 2018: 64 percent. • Baseline from 2015: 59 percent. • Target reached in 2016: 64 percent; target reached two years ahead of goal. Results for MY 2017 remained steady at 64 percent. Results for MY 2018 increased to 67 percent, surpassing the target of 64 percent. • Target for 2019: Given the new MPL of 50 percent for RY 2020 DHCS will continue to work to improve its gains for 2019. **Objective 2:** Increase the percentage of Medi-Cal Managed Care

[18] Medi-Cal Managed Care Accountability Sets: MCAS/EAS for MY 2017and 2018: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx

	reporting units meeting the MPL for timely postpartum care to at least 80 percent for MY 2018. • 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. Results for MY 2017 decreased to 88 percent. Results for MY 2018 increased to 95%. • Target for 2019: Given the new MPL of 50 percent for RY 2020, DHCS will work to improve on its gains for 2019.
Immunization of Two-Year-Olds	**Objective:** Increase to at least 80 percent the proportion of MCP beneficiaries with up-to-date immunizations by their second birthday during MY 2018. • Target for 2018: 80 percent. • Baseline from 2015: 71 percent. • Progress toward goal: DHCS maintained the rate of 71 percent for 2016. In MY 2017, the rate decreased slightly to 70 percent. For MY 2018 the rate increased slightly to 71 percent. • Target for 2019: Given the new MPL of 50 percent for RY 2020, DHCS will continue to strive to make improvements in immunization rates for two year olds.
Hypertension	**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 MY 2018. • Target for 2018: 66 percent. • Baseline from 2015: 61 percent. • Progress toward goal: DHCS increased the control of blood pressure rate by 2 percentage points to 63 percent in 2016, and maintained that rate in MY 2017. DHCS did not hold the MCPs to the MPL for MY 2018 due to significant changes to the measure specifications. However, despite this, the rate increased to 65 percent in MY 2018. • Target for 2019: Given the new MPL of 50 percent for RY 2020, DHCS will work to improve upon the gains made in 2019.
Diabetes	**Outcome Objective**: Decrease to 35 percent the proportion of MCP beneficiaries with diabetes who had HbA1c testing greater than 9 percent or unknown in MY 2018. • Target for 2018: 35 percent. • Baseline from 2015: 40 percent.

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	• Target reached in 2017l: 35 percent; target reached one year ahead of goal. For MY 2018, the rate increased yet again to 34 percent. • Target for 2019: Given the new MPL of 50 percent for RY 2020, DHCS will work to improve upon the gains made in 2019. **Process Objective:** Increase to 91 percent the proportion of MCP beneficiaries with diabetes who had HbA1c testing during MY 2018. • Target for 2018: 91 percent. • Baseline from 2015: 86 percent. • Progress towards goal: DHCS increased the number of beneficiaries with diabetes receiving HgbA1c testing by 1 percentage point to 87 percent in 2016, and maintained that rate for MY 2017. For MY 2018, the rate increased to 88 percent. • Target for MY 2019: Given the new MPL of 50 percent for RY 2020, DHCS will work to improve upon the gains made in 2019.
Tobacco Cessation	**Target 1:** Increase to 76 percent the median proportion of smokers who report being counseled to quit in the prior six months (as measured by the 2019 Consumer Assessment of HealthCare Providers and Systems [CAHPS] survey). • Target for 2019: 76 percent. • Baseline from 2016 CAHPS: 65 percent. • Data for 2019 not yet available at the time of this report. • Target for 2021: To be determined after 2019 data available. **Target 2:** Increase to 45 percent the median proportion of smokers who report a provider discussed tobacco cessation medications in the prior six months (as measured by the 2019 CAHPS survey) • Target for 2019: 45 percent. • Baseline from 2016 CAHPS: 38 percent. • Data for 2019 not yet available at the time of this report. • Target for 2021: To be determined after 2019 data available.

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

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with both MCPs and external stakeholders to address these critical areas.

Focus A	Quality Metrics and Performance Targets
Health Disparities	**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. • Target met: The Health Disparities Report based on MY 2015 data is publicly available on the DHCS website. This report targeted 12 specific DHCS managed care quality performance measures. The report based on MY 2016 data, which analyzes all but two DHCS managed quality performance measures by demographic factors and looks for state level disparities, is now available online[19]. The Health Disparities Report based on MY 2016 is the first disparities analysis for which DHCS will share reporting unit level disparity data with the MCPs so that the MCPs are better able to identify disparities in their populations and better direct their QI resources to targeted populations. • New Target: Release reports based on MY 2017 and 2018 data. Continue to produce annual Health Equity Reports and share the results and data with MCPs so it can be used to develop targeted interventions for disadvantaged populations. **Objective 2:** Establish first annual Health Disparities MCP Award. • Target met: The First Annual Health Equity Award was given to Molina HealthCare of California in October 2018 for its Mothers of Molina (MOM) Program designed to increase postpartum visit rates in African-American mothers. Molina partnered with local Black Infant Health leaders to develop interventions targeted to the population. Five MCPs submitted nominations for the first Annual Health Equity Award. Ten MCPs submitted nominations for the second Annual Health Equity Award in the fall of 2019. The winner of the Health Equity award was CalViva Health for its Postpartum Visit Disparities Project with United Health Center (UHC) Mendota Clinic. CalViva Health partnered with UHC Mendota Clinic to increase the number of number of postpartum visits by addressing the cultural practices of the La Cuarentena (40 days) rituals. The runner up award was given to Health Net Community Solutions, Inc. for its Cervical Cancer Screening (CCS) disparity project among Chinese women in San Gabriel Valley. In order to address multiple barriers impacting CCS, an

[19] 2016 Health Disparity report: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MCQMD_Disp_Rpts/CA2016-17_HealthDisparitiesReport_F1.pdf

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	intervention was customized for two provider offices serving Mandarin members. • New Target: Continue to promote the Annual Health Equity Award to increase the number of submissions in subsequent years, and invite the 2019 Health Equity winner and runner up to present their projects to other MCPs during collaborative calls in 2020. **Objective 3:** Establish health disparity focused MCP PIP in 2017. Target met: DHCS successfully established health disparities as a mandatory PIP topic for all MCPs for 2017. DHCS also established a QI collaborative with MCPs related to the health disparity focused PIP. New Target: DHCS will continue with the required health equity PIP for the next round of PIPs from 2019 – 2021.
Fostering Healthier Communities	**Objective 1:** Continue to participate in department and statewide workgroups on opioid overuse and misuse with the goal or reducing opioid addiction and increasing access to medication assisted therapy for opioid addiction. • Target met: DHCS continues its participation in these workgroups. **Objective 2:** Continue to work with MCPs on strategies to support judicious prescribing practices, to improve beneficiary outcomes, to provide alternative therapies for pain, to facilitate patient review and restriction programs, and to promote the use of naloxone. • Target met: 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.

Performance Improvement Projects

DHCS requires MCPs and population specific health plans (PSPs) to conduct and/or participate in two PIPs annually. The current PIP process, started in September 2015, places a greater emphasis on improving outcomes using QI science. The 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 2017, having finished the first set of PIP topics, MCPs and PSPs selected two new PIP topics. For the first topic, DHCS required that the MCPs choose a statistically significant health disparity (e.g., race, ethnicity, language spoken, gender, geographical location, provider, etc.) that they

identified within their member population. The MCPs or PSPs were encouraged to choose a health disparity related to an EAS measure on which the MCP or PSP was not performing well, when possible. For their second PIP topic, MCPs had to 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 above, the second PIP topic had to focus on:

- Controlling High Blood Pressure, Comprehensive Diabetes Care, or Prenatal and Postpartum Care: MCPs performing below the MPL on one of these topics had to have a PIP on that topic. If an MCP was performing below the MPL for more than one of these measures, the MCP had to choose the measure for which it had performed below the MPL for consecutive years or a measure for which the MCP's performance had 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, had to choose a PIP topic for any area in need of improvement.

The MCPs and PSPs have worked on both PIP topics throughout 2017, 2018, and early 2019. The current set of PIPs ended in June of 2019. New PIP topics have been chosen for 2019-2021. Similar to the last round of PIPs, all MCPs/PSPs must focus their first PIP on a statistically significant health disparity within their member population. For their second PIP, the MCPs/PSPs must choose a topic related to child or adolescent health. As with previous PIPs, the MCPs/PSPs are encouraged to focus their PIP topic on an area of needed improvement, often related to their performance on DHCS required quality measures.

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.
- DHCS continues to use a rapid cycle Plan-Do-Study-Act (PDSA) approach for MCPs that perform below the MPL on required quality measures.
- 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 2019-2020 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.

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- DHCS continues to hold quarterly QI collaborative discussions with MCPs on the topics relevant to their PIP and PDSA work. The collaborative discussion topics throughout 2018 and 2019 have focused on three areas: health disparities, childhood and adolescent immunizations, and improving data collection to assist in QI work.
- DHCS continues to conduct annual surveys of MCPs on the PDSA process to better tailor technical assistance, provide better resources and support to the MCPs on their rapid cycle improvement projects.
- DHCS continues to release quarterly quality performance measure Highlights, on topic such as breast cancer screening, reducing imaging studies for low back pain, and diabetes testing, highlighting promising practices from MCP PDSA or PIP projects to promote the sharing of promising practices.
- In the spring of 2019, DHCS released its Quality Improvement Toolkit designed for MCP use. The Toolkit includes multiple QI resources, including those specific to DHCS quality measures and quality improvement requirements, as well as those that pertain to broader QI principles. The Toolkit is organized in one interactive document and is available via SharePoint to all MCP QI, HEDIS, data and health education staff.

External Independent Reviews

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 PSPs to Medi-Cal beneficiaries. DHCS' MY 2017 and 2018 performance measures consisted of 16 HEDIS measures and one non-HEDIS measure originally developed by DHCS and MCPs (with guidance from EQRO) to be used for a statewide collaborative QIP. Several of the 17 required quality 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 reports for each year are titled Medi-Cal Managed Care External Quality Review Technical Report: July 1, 2016- June 30, 2017 and Medi-Cal Managed Care External Quality Review Technical Report: July 1, 2017 – June 30, 2018.

DHCS also contracts with its EQRO to conduct focused studies on a particular aspect of clinical or nonclinical services to gain a better understanding of and identify opportunities for improving care provided to managed care beneficiaries. Focused studies are an optional external quality review activity described at 42 CFR §438.358(c)(5) and are conducted by the EQRO in accordance with CMS protocols. Summarized below are the focused studies conducted by the EQRO between 2017 and 2019 which involved the MCPs.

Long-Acting Reversible Contraceptives (LARC) Focused Study:

In support of the advance prevention goal of increasing the availability of the most highly efficient reversible contraceptives (i.e., LARCs), DHCS contracted with its EQRO to conduct a focused study to learn more about MCPs' LARC utilization patterns and contraceptive

management policies to potentially shape future Medi-Cal Managed Care (MCMC) guidance and improve access to LARCs. The LARC Utilization Focused Study addressed the following questions: 1. To what extent does LARC utilization among women in MCMC differ across the 25 MCPs included in the study? 2. What are MCPs' utilization management policies regarding LARCs, and to what extent may these policies impact LARC utilization among Medi-Cal beneficiaries? The EQRO utilized both a questionnaire for MCPs and an administrative analysis of calendar year 2015 LARC utilization data from the Office of Family Planning (OFP) to answer the focused study questions.

Questionnaire responses reflected that all MCPs actively work to meet Medi-Cal's family planning coverage standards concerning LARC devices for MCMC adult and adolescent beneficiaries. MCPs have no Utilization Management (UM) policies requiring prior authorization, step therapy, or multiple visits. A review of administrative data revealed that the overall 2015 LARC utilization rate of 4.2 percent was low relative to the national rate of 7.2 percent. The EQRO found that LARC utilization rates varied based on beneficiary age, race/ethnic group, and preferred language as well as the plan model type. Beneficiaries between 21 and 44 years of age had higher LARC utilization than beneficiaries between 15 and 20 years of age. Alaskan Native/American Indian and White beneficiaries had higher LARC utilization rates than beneficiaries in the Asian or Pacific Islander, Black or African American, Hispanic or Latino, and Other/Unknown race/ethnic groups. Beneficiaries who indicated that English was their preferred language had higher LARC utilization rates than beneficiaries who indicated that they preferred Spanish or Other/Unknown language.

Managed Long-Term Services and Supports (MLTSS) Focused Study:

In order to determine the most effective methodology for identifying the Medi-Cal only MLTSS population, DHCS contracted with its EQRO to conduct a focused study assessing the segment of the population receiving MLTSS benefits solely through MCMC. To make recommendations to DHCS regarding a standardized process for identifying this population, the EQRO conducted an assessment with the following three objectives: 1. Determine which methods already exist for identifying the Medi-Cal-only MLTSS population through a survey of two MLTSSPs and DHCS. 2. Compare existing methods for identifying the MLTSS population. 3. Determine the best method for identifying the MLTSS population from the methodologies detailed in the survey responses.

The EQRO concluded that survey data and administrative analyses demonstrated the complexity of identifying Medi-Cal-only MLTSS beneficiaries through use of enrollment data. While no formal process exists to identify the Medi-Cal-only subset of MLTSS beneficiaries, DHCS has worked to streamline the processes by which aid codes and Coordinated Care Initiative (CCI) risk category indicators are updated to identify beneficiaries receiving MLTSS services.

The EQRO determined that there was no single "best method" among the methodologies submitted by the Managed Long-Term Services and Supports Plans (MLTSSPs) and DHCS, with advantages and limitations identified through review of enrollment data alone, as well as through review of enrollment and encounter data. The EQRO's review of encounter data

quantified the extent to which the lags in updates to CCI risk category indicators limited the reliability of enrollment data to identify MLTSS beneficiaries. Regardless of the enrollment identification criteria, the EQRO's encounter data assessment consistently produced beneficiaries receiving long-term care/skilled nursing facility services who were not identifiable through aid codes or CCI risk category indicators.

Opioid Focused Study

DHCS contracted with its EQRO to conduct an evaluation of opioid use and medication assisted treatment within the State's MCMC population to determine the need and capacity for addressing opioid overuse. The results of this study will inform programmatic design activities for DHCS.

Tobacco Cessation Focused Study

DHCS contracted with its EQRO to conduct an assessment of the utilization of tobacco cessation services and medications among MCPs' and population specific health plans (PSPs)' beneficiaries. The focused study addressed the following questions: 1. To what extent does tobacco cessation utilization among MCMC beneficiaries differ across the MCPs/PSPs and how do tobacco cessation efforts/activities vary across MCPs/PSPs? 2. To what extent can DHCS' administrative health care utilization data (i.e., claims/encounter data) be used to identify tobacco users and what role do MCPs'/PSPs' methods for identifying tobacco users play in the ability to identify these beneficiaries from DHCS' administrative data?

In general, MCPs/PSPs are monitoring their providers to ensure that the providers have instituted a tobacco user identification system and are tracking beneficiaries who may need tobacco cessation services. MCPs/PSPs are collaborating with providers to assist with this monitoring by offering provider training, ensuring the proper documentation of tobacco use during initial assessments, and preparing detailed provider training manuals. MCPs/PSPs reported that the main limitations to tracking and monitoring beneficiary tobacco use and tobacco cessation services are inconsistent coding by providers, the inability to link data across data sets, and beneficiaries participating in free programs not associated with MCPs/PSPs.

The EQRO determined that tobacco use was reported at a higher rate among men, beneficiaries ages 50–59, and beneficiaries from the Alaskan Native and American Indian and White race/ethnicity groups. Among the reported tobacco users, the rate of tobacco cessation therapy use was the highest among women, beneficiaries ages 40–49 and 50–59, and beneficiaries from the White race/ethnicity group.

The EQRO's administrative analysis supported findings from the questionnaire results, and reported rates of tobacco use were lower than expected across the State, which is likely due to inconsistent reporting of tobacco use by providers with the ICD-10 codes. The EQRO's comparison of beneficiaries identified as tobacco users by the administrative data and those identified by MCPs/PSPs further indicates using administrative data alone does not identify

all tobacco users. The inconsistent reporting of tobacco use by providers can present a challenge with identifying the tobacco users through diagnosis codes alone.

Program Evaluation Key Findings

On an annual basis, DHCS's EQRO produces a Medi-Cal Managed Care External Quality Review Technical Report which assesses the quality and timeliness of, and access to health care services furnished to Medi-Cal managed care members. Recommendations are both at a State level as well as at the individual MCP level. In the most recent Technical Report, at the State level, the EQRO recommended that when DHCS evaluates whether or not to change the required measures for MLTSSPs that DHCS obtain input from MLTSSPs and other stakeholders regarding the feasibility and applicability of requiring MLTSSPs to report the newly created Long-Term Services and Supports HEDIS measures. The EQRO makes MCP level recommendations for each individual MCP in the Plan Specific Evaluation Reports which are found at the end of the Technical Report (https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2017-18_EQR_Technical_Report_F1.pdf).

Program Actions Based on Evaluation Recommendations

DHCS has reviewed the newly created Long-Term Services and Supports HEDIS measures and given these new measures, is in the process of evaluating whether to make changes to the current MLTSS measures. DHCS has also modified its process with regards to the MCP specific EQRO recommendations. Specifically, for future Technical Reports, DHCS has instructed the EQRO to evaluate each MCP's actions in response to the prior two years of EQRO recommendations in order to monitor MCP responses.

Section 6.2 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.

DHCS Goals and MHP Program Objectives

These quality objectives for SMHS were selected based on current priorities, with consideration to challenges in assessing and measuring quality for SMHS, particularly as related to data collection and reporting. The quality objectives discussed below are intended to address performance gaps for which improvement efforts are underway.

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DHCS Goals and MHP Program Objectives	• Improve health outcomes: DHCS continues to work toward providing high-quality and accessible SMHS. In compliance with federal network adequacy requirements, DHCS established network adequacy standards to ensure adequacy of the MHPs' provider networks. On a quarterly basis, DHCS monitors the MHPs' compliance with time and distance standards, provider-to-beneficiary ratio standards, and timely access standards. As FY 2018-19 was the first year for which DHCS collected data and conducted an assessment of MHP networks, DHCS continues to work to enhance and improve data collection and data quality for network monitoring. These efforts include expanding automated collection of 274 transactions (provider directory data collection system) to include MHPs, and implementing automated collection of timely access to SMHS. An additional QI goal is to improve access to mental health services for children/youth who are placed in foster care. In FY 2018-19, DHCS and CDSS, through an established data sharing agreement, developed a methodology to track access to SMHS for children in foster care. Specifically, DHCS and CDSS are reporting quarterly on the following metrics: o The number/percent of children/youth who are screened for a potential mental health need. o Of those who screened positive for a potential mental health need, the number/percent of children/youth who are referred to a county MHP. o Of those who are referred to a county MHP, the number and percent of children/youth who did (or did not) make contact with the county MHP. • Improve health equity: During FY 2018-19, DHCS conducted an analysis of MHPs' Cultural Competence Plan (CCP) updates to identify strategies that MHPs are using to reduce disparities, and to determine common mental health disparities and/or strategies for addressing them among MHPs. Address social determinants of health: Family dynamics and living arrangements influence mental health risk and outcomes, particularly for children and youth in the foster care system. As a result of Senate Bill (SB) 1291 (Chapter 844, Statutes of 2016), the EQRO is establishing baseline information to determine the impact of children and youth in foster care having increased access to specialty mental health services, such as home-based mental health services, crisis intervention, and use of appropriate levels of psychotropic medication on reducing the traumatic effects of

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	changing foster care placements. The goal is to stabilize children and youth's mental health conditions and behaviors. The long-term goal is to reduce the trauma associated with changing foster care placements. DHCS will report on this effort as data and information become available via the EQRO's findings. Factors such as culture, ethnicity, and language influence mental health risk and outcomes. The availability of bilingual clinicians, and clinicians that are familiar with or share the same cultural background as the beneficiaries they serve can help beneficiaries engage in and benefit from mental health services, leading to improved outcomes. DHCS will monitor MHPs' implementation of cultural competence plan activities per Title 9, CCR, Section 1810.410 for evidence that MHPs are effectively addressing these important social determinants of health. • Improve data quality and reporting: 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. DHCS has had various QI functions in place for SMHS, and will soon be reporting on the nationally recognized Child and Adult Behavioral Health Core Set performance measures specifically related to SMHS. 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, race/ethnicity, and spoken/written language. Sexual orientation and gender identity (also referred to as SOGI) data are currently

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	collected and stored in the DHCS centralized data warehouse, but are not available for reporting at this time. 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.

Quality Metrics and Performance Targets	• SMHS Penetration Rate
	  o Received one or more SMHS visit
	  o Received five or more SMHS visits
	• Follow-Up Care for Children Prescribed ADHD Medication (ADD)
	• Antidepressant Medication Management (AMM)
	• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
	• Follow-Up After Hospitalization for Mental Illness (FUH)
	• Follow-Up After Emergency Department Visit for Mental Illness (FUM)
	• Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
	• Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Performance Improvement Projects	Each MHP is required to conduct two PIPs, one clinical and one non-clinical, during the 12-months preceding the EQRO review.
	• Clinical PIPs may target one of the following:
	  o Prevention and care of acute and chronic conditions
	  o High-volume services
	• Non-Clinical PIPs may target one of the following:
	  o Coordination of care
	  o Appeals, grievances process
	  o 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

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	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

Quality Metrics and Performance Targets

DHCS has developed several quality measures, which it currently reports and monitors. DHCS is also continuing efforts to identify data sources and data collection methodologies for additional quality measures, expanding upon what has already been established through the SMHS performance outcomes system and Performance Dashboard.

Performance Outcomes System/Performance Dashboards

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

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

To meet this mandate, through collaborative efforts with stakeholders, DHCS established a performance measurement paradigm, which is a conceptual framework comprised of outcomes measurement at the individual, provider, system, and community levels. There are six domains of measures and indicators in the paradigm, which cross the four levels of outcomes measurement: access, engagement, service appropriateness to need, service effectiveness, linkages and cost effectiveness and satisfaction. These domains reflect domains used by SAMHSA.

Although the performance outcomes system was originally developed to track services for children/youth, it was expanded to include adults in order to meet additional requirements for the 1915(b) SMHS Waiver STCs. 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.

Building off of the performance outcomes system, DHCS developed a performance dashboard

that stratifies the measures by statewide and county levels. [20,21] Benchmarks and performance targets for SMHS are evolving areas and DHCS continues efforts to determine appropriate benchmarks and performance targets related to SMHS. Updated annually, the quality indicators currently reported for SMHS are as follows:

- 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.
- 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)

In 2019, DHCS will incorporate into the SMHS performance dashboard the Core Set of Behavioral Health Measures for Medicaid (child and adult measures).[22] These measures, and links to their definitions have been included below:

- Follow-Up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

[20] DHCS also publishes population-based reports stratified by Small Rural, Small, Medium, Large, Very Large county sizes.

[21] DHCS is currently preparing statewide and county SMHS service penetration and engagement rates for Medi-Cal beneficiaries parsed into spoken language by child and adult age group. When completed, this information will be made available on the DHCS Performance Dashboard.

[22] Beneficiaries who received five or more unique SMHS for the 2017 calendar year were included for analysis of the seven selected measures. The measures are stratified by the Statewide and County levels. The data will be extracted from the DHCS Medi-Cal Management Information System / Decision Support System (MIS/DSS), which includes 30 different data sources such as Short-Doyle/Medi-Cal II, Eligibility, and Pharmacy data.

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- Follow-Up After Hospitalization for Mental Illness
- Follow-Up After Emergency Department Visit for Mental Illness
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications

All SMHS performance dashboard data are published in accordance with DHCS data de-identification guidelines and are posted to the DHCS website, as well as the California Health and Human Services (CHHS) Open Data Portal*..

The Statewide and County level measure scores will also be posted on the California Health and Human Services (CHHS) Open Data Portal* at https://data.chhs.ca.gov/ in accordance with DHCS data de-identification guidelines.

Functional Assessment Tools

In May 2017, DHCS selected two functional assessment tools that will be used to capture 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 version of the Pediatric Symptom Checklist (PSC-35). In July 2018, DHCS began implementing the CANS and PSC-35 data collection, and is now beginning to report on the data as it matures.

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 evaluate treatment outcomes data in relation to 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 that appropriate interventions may be initiated as early as possible.

DHCS, in consultation with stakeholders, continues to develop a catalog of 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.

Timeliness Metrics

In late March 2019, DHCS released MHSUDS IN 19-020, which requires counties to begin collecting data elements related to the timeliness of requested SMHS assessment appointments

and treatment for Medi-Cal beneficiaries. DHCS is deploying the capture of the timeliness data in its Client and Services Information (CSI) system in two phases. When Phase I is fully implemented, DHCS will be able to report on the following data elements:

- Date of first contact to request services
- Assessment appointment first offer date
- Assessment start date
- Assessment end date
- Treatment appointment first offer date
- Treatment start date
- Closed out date

Phase II is optional, and would allow counties to provide a more complete picture of the path to services. Phase II data elements include:

- Referral Source
- Assessment appointment second offer date
- Assessment appointment third offer date
- Assessment appointment accepted date
- Treatment appointment second offer date
- Treatment appointment second offer date
- Treatment appointment accepted date
- Closure reason
- Referred to

Using the Phase I data, at a minimum, DHCS will be able to measure whether the MHP provides an assessment appointment within 10 business days, and will additionally measure whether the MHP is providing treatment appointments in accordance with timely access standards. Given the data that will be captured, DHCS will not be able determine the nature of a request (e.g., psychiatric vs non-psychiatric) and, thus, reports will focus only on the timeliness of non-urgent, non-psychiatry mental health service appointments. All county MHPs must begin collecting timeliness data by late June 2019, and submitting it to DHCS by July/August 2019.

Social Determinants of Health and Mental Health

Family dynamics and living arrangements influence mental health risk and outcomes, particularly for children and youth in the foster care system. As a result of Senate Bill (SB) 1291 (Chapter 844, Statutes of 2016), the EQRO is establishing baseline information to determine the impact of children and youth in foster care having increased access to specialty mental health services, such as home-based mental health services, crisis intervention, and use of appropriate levels of psychotropic medication on reducing the traumatic effects of changing foster care placements. This baseline information and data will allow DHCS to determine the responsiveness and efficient delivery of mental health services to children and youth in foster care, residing in a given county. In addition, data trends in upcoming years will assist DHCS in identifying deficiencies and to take corrective actions.

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The goal of these efforts is to stabilize children and youth's mental health conditions and behaviors in order to avoid the emotional consequences and harmful effects of multiple placements with different foster parents and caregivers. Ongoing emotional trauma associated with multiple placements may lead to the development of attachment disorders that will interfere with educational and professional goals in the future. For this reason, the long-term goal is to reduce the trauma associated with changing foster care placements. DHCS will report on this effort as data and information become available via the EQRO's findings.

Evaluation of the Effectiveness of the 2018 Managed Care Quality Strategy Report

Mental Health Disparities

During FY 2018-19, DHCS conducted an analysis of MHPs' CCP updates to identify common mental health disparities and to determine what strategies MHPs are using to reduce these disparities. The results indicate that MHPs are making positive strides in engaging ethnic and cultural communities and educating their staff to improve levels of cultural and linguistic competence, and to exercise cultural humility. In addition, the findings indicate that MHPs use community-defined and evidence-based best practices, tailored to their beneficiaries' cultural and ethnic backgrounds. Many MHPs use demographic data to develop their CCPs, identifying disparities and setting targets for improvement. Counties are also identifying gaps between their workforce and the needs of their beneficiaries.

EQRO Reporting on the Delivery of Specialty Mental Health Services
Key findings from the EQRO report, entitled Medi-Cal Specialty Mental Health External Quality Review – FY2017-18 Statewide 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. The HEDIS and timeliness metrics will be included in the SMHS performance dashboard as described above. The EQRO has been reporting on these measures on the interim, until DHCS has fully incorporated them into the SMHS dashboard. Moving forward, the EQRO will continue to validate the performance measures, and to assess their accuracy as well as the extent to which MHPs follow specific State specifications and reporting requirements.

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

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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 EQRO noted that MHPs' PIPs submitted for review focused on three topic areas, including (1) improving kept appointments, (2) timeliness to appointment, and (3) timeliness to appointment following hospitalization. This reflects the increasing importance of addressing timeliness of SMHS within the MHPs. These topic areas are clearly of great relevance to the MHPs. The development of statewide timeliness standards for assessments and access to care will provide MHPs with a goal for success in PIPs that seek to measure improvement in timeliness. DHCS will monitor the EQRO's recommendation to have MHPs replace outdated paper-based access and timeliness tracking processes (e.g., faxing; using multiple lists) with electronic-based systems to better manage appointments, and improve reporting on access and timeliness measures.

In FY 17/18, MHPs demonstrated a remarkable adaptability in expanding beneficiary access to care through collaboration with community agencies, and leveraging the MHPs' networks of contract providers. Adaptability was related to the internal mechanisms that MHPs used to affect access. MHPs adapted services by expanding programs (e.g., offering new crisis services), increasing hours of service provision, and using physician extenders. Some MHPs increased their reach by relying on collaboration with hospitals, law enforcement, housing agencies, and others with whom they shared beneficiaries. Many MHPs identified Whole Person Care grants as the mechanism for stronger collaboration and provision of varied services to vulnerable beneficiaries. MHPs that were able to leverage pre-existing relationships with contract providers had an advantage; many MHPs were able to modify contracts to allow contract providers to facilitate access for beneficiaries in outlying and rural areas or to facilitate access to lower levels of care.

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.
    - 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:

- Addressed required QIWP elements.
- Provided an adequate evaluation of the previous year's QIWP, and, if applicable.
- Proposed plans of correction that are methodologically sound. In Fiscal Year (FY) 2019-20, 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.

Tracking Access to SMHS for Children/Youth in Foster Care

During FY 2018-19, DHCS used the mental health screenings and referrals documented in CWS/CMS to determine children/youth who have had a positive mental health screening 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 targeted 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 at least one service. The findings from the study sample revealed that 72.2 percent of children with a positive mental health screening and a referral to mental health received at least one specialty mental health service.

For the children/youth who did penetrate into the SMHS system (i.e., had at least one service), CDSS and DHCS plan to continue monitoring these data quarterly to track improvements to this pathway into mental health services.

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.

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External Independent Reviews

In addition to the Final Rule, CMS requires each MHP to be evaluated annually by an EQRO. As required by Title 42, Code of Federal Regulations, Part 438, Subpart E, DHCS contracts with an EQRO. The EQRO conducts reviews of Mental Health Plans (MHPs) to analyze and evaluate information related to quality, timeliness, and access to Specialty Mental Health Services (SMHS) provided by California's 56 MHPs and/or their subcontractors to Medi-Cal beneficiaries. Behavioral Health Concepts, Inc. is serving as California's External Quality Review Organization for Medi-Cal Specialty Mental Health. The findings are summarized in individual MHP and Annual Aggregate statewide reports which is titled Medi-Cal Specialty Mental Health External Quality Review – FY2017-18 Statewide Report.

Program Evaluation Key Findings

The EQRO provides critical information resulting from the following: consumer and family focus groups, service delivery capacity of the MHP; accessibility of services; beneficiary satisfaction; the MHPs' service delivery system and meaningful clinical issues affecting beneficiaries, including safety and effectiveness of medication practices; and continuity and coordination of care with physical health care providers and other human services agencies. EQRO mandatory performance measures are assessed as a part of each annual review.

The EQRO also produces an annual aggregate report across 56 MHPs and the findings of the fiscal year (FY) 17/18 report show that between calendar years 2014 and 2016, the penetration rates for the Hispanic/Latino population has remained fairly unchanged and remains on average below4 percent. For the Asian/Pacific Islander population the average penetration rate was 2.5 percent, while the African-American penetration rate averaged at approximately 8 percent across regions and MHP size. More detailed results can be found at https://www.calegro.com/mh.

The department is exploring the possibility of having MHPs develop and implement PIPs that contain strategies and interventions to facilitate access to mental health care for culturally, ethnically, and linguistically different populations. The goal is to assess the mental health needs more vigorously and to use practices that best assist in reducing disparities.

Program Actions Based on Evaluation Recommendations

- DHCS will monitor the EQRO's recommendation to have MHPs replace outdated paper-based access and timeliness tracking processes (e.g., faxing; using multiple lists) with electronic-based systems to better manage appointments, and improve reporting on access and timeliness measures.
- MHPs demonstrated a remarkable adaptability in expanding beneficiary access to care through collaboration with community agencies, and leveraging the MHPs' networks of contract providers. DHCS will monitor this positive trend which should have a significant impact on level of care provided to beneficiaries as well as treatment outcomes.

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- DHCS will monitor MHPs efforts to reduce racial, ethnic and cultural disparities and to improve access to services for various populations and communities within their system of care. MHPs with bilingual staff, for example, were better able to engage beneficiaries of different cultural/ethnic backgrounds. Some MHPs relied on cultural brokers (e.g., *promotoras*) to connect to beneficiaries one-on-one, while others conducted more general outreach to connect with beneficiaries through cultural/ethnic events, forums, and committees. MHPs were attuned to the populations they serve and reached out to them accordingly, including to beneficiaries transitioning from jail to the community and those otherwise disconnected from services. DHCS will ensure that MHPs use community-defined and best practice interventions and approaches to reduce barriers to access to care.
- DHCS has the following objectives related to network data collection for SMHS:
    - By July 2020, implement electronic MHP 274 data reporting, to automate data collection from MHPs and improve network data quality.
    - By October 2020, begin monitoring timely access data collected from MHPs to assess compliance with timely access standards for SMHS.
- In FY 2019-20, DHCS and CDSS will conduct ongoing monitoring of children screened and referred to SMHS by county child welfare, to track improvements in the pathway from screening to referral to receipt of service. DHCS' objectives for FY 2019-20 in this area are:
    - By July 2020, collaborate with CDSS to develop a method for tracking referrals to SMHS from county child welfare.
    - By July 2020, implement quarterly data monitoring to track improvements in the pathway from child welfare screening and referral, to SMHS.

- In FYs 2019-20 and 2020-21, DHCS will emphasize the importance of using demographic data to identify disparities and to inform CCP development, to increase the number of MHPs using these data. DHCS also continues to refine its demographic data collection and reporting methodologies to improve the ability to identify disparities in mental health and increase access to SMHS. DHCS plans to begin reporting data stratified by language in its effort to identify and address disparities.

  In addition, via technical assistance and training, DHCS will enable MHPs to report on universal and variant metrics annually. Universal metrics will be a same set of metrics required of all MHPs. Variant metrics will differ between MHPs and will be tailored to the unique strategies and target population(s) of each individual MHP. The goal is that MHPs will be able to approach disparities from a Continuous Quality Improvement (CQI) perspective, and to improve on their SMHS delivery system.

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Section 6.3 Drug Medi-Cal Organized Delivery System

DMC-ODS is at the end of a five-year 1115 Demonstration Waiver, and DHCS is aiming to renew and update the program in a new waiver, as part of a broader initiative called CalAIM (see Section 1.4). Counties did not begin to implement the service delivery system until February 2017. Although data collection and evaluation are underway, there is only preliminary data from a small number of counties available at this time, making decisions on system wide quality improvement activities premature. The performance measures in the table below are based on some of the required performance measures the EQRO is monitoring and reporting on and link to the four overall DHCS goals for improvement in health care. As the DMC-ODS matures and the volume of data increases from additional counties implementing DMC-ODS services, performance targets will be identified.

DHCS Goals and DMC Program Objectives

DHCS Goals and DMC-ODS Program Objectives	• Improve health outcomes: o Use (EBPs to determine clinically appropriate level of care (ASAM) and clinical interventions. • Improve health equity: o Increase access to culturally competent SUD services. • Address social determinants of health: o Provide timely access to services for all beneficiaries, regardless of geographical residence. o Improve service coordination between physical health, mental health, and DMC-ODS. • Improve data quality and reporting: o Develop a comprehensive and accurate data collection system. o Incorporate the Centers for Medicare and Medicaid Core Set Measures for Behavioral Health: • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.
Quality Metrics and Performance Targets	• Number of days from initial ASAM assessment contact to treatment admission. • Average number of days from ASAM assessment contact to the first dose of MAT for opioid use disorder (OUD) diagnoses. • Penetration rates for beneficiaries, including racial/ethnic groups,

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	age, language, and risk factors. • Certification and monitoring of DMC-ODS counties for time and distance requirements. • Utilize beneficiary experiences on care coordination from the provider annual Treatment Perception Survey (TPS). • Require Plans to certify in writing that the data they submit is accurate, complete, and truthful. • Update CalOMs data system to include additional DMC-ODS levels of care for examining beneficiary treatment outcomes. • Utilize DMC-ODS performance dashboard to make data driven decisions to improve access, quality and outcomes.

Performance Improvement Projects	• Each DMC-ODS plan is required to conduct two PIPs, one clinical and one non-clinical, during the 12-months preceding the EQRO review. A list of PIPs for counties participating in the waiver from March 2017 through December 2018 is available on the DHCS webpage.
	• The EQRO identified the following areas for improvement in PIP design and implementation for counties participating in the DMC-ODS:
	  o DMC-ODS counties should add interventions each year for an active PIP to continue and refine impacts and outcomes.
	  o Counties should consider implementing PIPs in stages to ensure that a larger population of consumers benefits from them.
	  o Embed PIP processes into the county quality improvement initiatives so that counties have regular mechanisms for items such as defining a problem, asking stakeholders what should be done about a problem, designing interventions to address a problem, implementing those interventions, and measuring the effect those interventions have on the problem.
	  o Clinical PIPs target:
	  ▪ Increasing continuity of care for those in withdrawal management (WM).
	  ▪ Increasing access to treatment services for youth, disabled beneficiaries, and those with serious mental illness.
	  ▪ Improving time linkage to treatment services

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	following out of county residential treatment or withdrawal management. o Non-Clinical PIPs target: ▪ Improving timeliness to treatment: o Reducing the number of no shows. o Increase engagements and timely access to treatment. ▪ Improving retention in MAT by implementing procedures to improve timely linkage to non-methadone MAT services. ▪ Expanding access to treatment with buprenorphine in Narcotic Treatment Programs/Opioid Treatment Programs. • Implementing procedures to improve timely linkage to continuing treatment services following discharge from WM. Each PIP should have one or more measured indicators to track performance and improvement over a specific period of time.

Quality Metrics and Improvement Performance Targets

The table above lists the DMC-ODS Quality Metrics and Improvement Performance Targets.

Evaluation of the Effectiveness of the 2018 Managed Care Quality Strategy

Behavioral Health Concepts Inc. (BHC) provides the required External Quality Reviews (EQRs) of the DMC-ODS counties for DHCS (CalEQRO). Both the county-specific reports and the statewide annual report for FY 2017-18 present the results of the EQRO's validation of the 12 performance metrics (PMs) for the first year of implementation of DMC-ODS services.
Three counties launched new and expanded services beginning in early 2017 as part of the DMC-ODS. All three counties reviewed in the FY 2017-18 report worked with BHC to review the reporting results of the PMs and understand the implications of the results for this initial year. Other than when service data were not available in the DMC-ODS expenditures, most PMs positively covered the issues anticipated by the EQRO Clinical Advisory Committee and laid a foundation for helpful PMs linked to quality outcomes for SUD treatment. Among the PM results, initial access to medication (methadone) dosing through NTPs was rapid in all three counties (three-and-a-half days or less). It was rare for any clients to use Withdrawal Management for three or more episodes without other SUD treatment, suggesting that these high-risk clients are more engaged in treatment. Baselines were also set for residential transitions to other levels of care (LOC) and Access Call Center key indicators.

CalEQRO also found that the three counties observed in the DMC-ODS 2017-2018 EQRO report shared common strengths that contributed to each county's implementation of services. These counties had leadership that communicated with the community. They also, launched services

as well as expanded DMC-ODS services to clients with SUDs to meet network adequacy and ensure there were no undue delays in access to care. DMC licensing and certification was expanded significantly in each county in addition to additional out-of-county contracts needed for special needs and unique access. Major training efforts were launched in many areas with the change to ASAM assessment and treatment models, increased use of EBPs, and shifting to individualized treatment from program-driven services. Each county improved access to care with 24-hour call centers and worked with CalEQRO to review the reporting results of the PMs and understand the implications of the results for the initial year. In addition, these counties also launched billing and fiscal tracking systems within months of beginning services, created partnerships with criminal justice partners, and planning on continuous QI and examination of outcomes.

Quality Improvement Programs

DHCS conducts annual monitoring of DMC-ODS counties for compliance to the quality improvement requirements in the Intergovernmental Agreement. When deficiencies are identified, the county is required to submit a corrective action plan (CAP). DHCS monitors the CAP and provides technical assistance until implementation is complete.

All counties must have a Quality Improvement (QI) Program that includes a work plan with documented annual evaluations and revisions as needed. The county's QI work plan must evaluate the impact and effectiveness of its quality assessment and performance improvement program including:

- Evidence of 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 QI activities, including PIPs, have contributed to meaningful improvement in clinical care and beneficiary service.
- A description of completed and in-process QI activities, including PIPs such as:
    - Monitoring efforts for previously identified issues.
    - Objectives, scope, and planned QI activities for each year.
    - 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 including but not limited to:
    - Responsiveness goals for the county's 24-hour toll-free telephone number.
    - Timeliness for scheduling of routine appointments.
    - Timeliness of services for urgent conditions.
    - Access to after-hours care.
- Evidence of compliance with the requirements for cultural and linguistic competence.

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Counties develop and implement cultural competence plans that include objectives for reducing disparities by tailoring best practices mental health services to beneficiaries' cultural and ethnic background and language preferences.

The QI Committee reviews all of the above and other quality indicators when executing their required duties which 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.
- Documenting QI Committee minutes regarding decisions and actions taken.

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 EQR 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 the DMC-ODS, the EQRO is required to review the first 12 PMs listed below for the first EQR of each County and must include the results in the individual county reports and in the EQRO annual statewide report. After the initial year of service, an additional four measures to total 16 PMs will be included in subsequent EQRs. These PMs include quality metrics in relation to access, cost effectiveness, quality, timeliness, and outcomes, and can be used by counties in the development of their PIPs. The 16 PMs are listed below:

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 (LOC) 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).
13. Appropriate matching of clients to SUD treatments based upon ASAM Criteria. (Access and Quality).
14. Initiation and engagement in SUD treatment (Timeliness and Quality).
15. Retention in SUD treatment (Quality).
16. Effective discharge planning (Outcomes).

External Independent Reviews

Three counties launched new and expanded services beginning in early 2017 as part of the DMC-ODS. Behavioral Health Concepts Inc. (BHC) provides the required EQRs of the DMC-ODS counties for DHCS. BHC provides the required EQRs of the DMC-ODS counties for DHCS. In the FY 2017-18 review, the initial focus of the EQR was the counties' launch of the comprehensive redesign of the SUD care system. This includes treatment, operations, and administrative aspects of the Waiver. BHC staff conducted onsite reviews from April through June 2018 and reviewed claims, eligibility, and quality-related data provided by DHCS and the UCLA, as well as other information on programs and services, access to services, and quality plans from the DMC-ODS counties. Based on required federal protocols, the CalEQRO reviewed the specific quality metrics, including PMs, PIPs, an information system capacity assessment (ISCA), key stakeholder focus groups, and other indicators of quality including access to care, timeliness of services, quality of care, and outcomes from care.

<u>Performance Improvement Plans (PIP)</u>

As part of the EQR, the EQRO evaluates each DMC-ODS County's Performance Improvement Plans (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.

Each DMC-ODS County 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. Counties are expected to conduct a thorough analysis of the problem, establish a baseline and key indicators, and then implement interventions designed to enhance quality and outcomes that benefit the beneficiaries receiving DMC-ODS services.

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The ultimate goal of a PIP is to drive continuous QI activities. As part of the EQR, the EQRO evaluates each DMC-ODS County'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.

Each of the three counties reviewed in FY 2017-18 had two active PIPs, reflecting a variety of positive focuses in terms of learning for the Waiver. One county had a PIP on expansion of youth services linked to schools, County Social Services, and Probation, with tracking of outcomes through CalOMS discharge ratings. Their other PIP examined transitions in care for clients being discharged from residential treatment, also with tracking outcomes through CalOMS discharge information. Another county had a PIP focusing on treatment of clients with both mental health disorders and SUD and used multiple evaluation measures, including the TPS and Comprehensive Health Outcome Information System. This county's remaining PIP was focused on reducing the number of readmissions to WM within 30 days by enhancing their care coordinator outreach from pre-discharge through follow-up to first outpatient appointment. Finally, the third county's active PIPs involved adding ASAM criteria-based assessments and recommendations to the courts and care management for post-release from detention to enhance post-release engagement in treatment and positive outcomes for criminal justice clients. Their second active PIP focused on providing WM assessments using ASAM criteria, linking clients to their next LOC with discharge planning supports, and tracking readmissions. All of these focus on important system changes to enhance outcomes of care and effective use of treatment resources.

In addition to the review of the first three counties, which had begun implementation of Waiver services, the EQRO provided extensive training and technical assistance to other counties in their PIP development The EQRO identified areas for improvement in PIP design and implementation for counties participating in the DMC-ODS including the following:

- DMC-ODS counties should add interventions each year for an active PIP to continue and refine impacts and outcomes.
- Counties should consider implementing PIPs in stages to ensure that a larger population of consumer benefits from them.
- Counties should embed PIP processes into QI initiatives so that counties have regular mechanisms for items such as defining a problem, asking stakeholders what should be done about a problem, designing interventions to address a problem, implementing those interventions, and measuring the effect those interventions have on the problem.

Clinical PIPs conducted by counties from May 2017 – December 2018 included the following:

- Increasing continuity of care for those in withdrawal management (WM).
- Increasing access and treatment services for youth, disabled clients, and those with a serious mental illness.
- Improving time linkage to treatment services following out of county residential treatment or withdrawal management.

Non-clinical PIPs conducted by counties from Mary 2017 – December 2018 included the following:

- Improving timeliness to treatment.
- Reducing the number of no-shows.
- Increasing engagements and timely access into treatment.
- Improving retention in MAT by implementing procedures to improve timely linkage to non-methadone MAT services.
- Expanding access to treatment with buprenorphine in Narcotic Treatment Programs/Opioid Treatment Programs.
- Implementing procedures to improve timely linkage to continuing treatment services following discharge from WM.

A DMC-ODS PIP Master List for the time period March 2017 – December 2018 is available on the EQRO website.

Program Evaluation Key Findings

UCLA examined implementation in counties that had begun delivering DMC-ODS services in the first half of 2017 and compared them to counties that were still preparing for DMC-ODS participation ("Pre-Implementation counties"), and to counties that had no plans to participate in the DMC-ODS pilot ("Non-Waiver counties"). The 2018 evaluation report on the DMC-ODS can be found on the UCLA website. The UCLA report divided the findings under the categories of Access; Quality; and Integration/Coordination.

The UCLA evaluation found that the DMC-ODS is making progress and having a positive impact in a number of areas. Beneficiaries are accessing treatment in increasing numbers and are reporting high satisfaction with their care. Counties are engaging in processes intended to improve quality and coordination of care, and they are reporting that the DMC-ODS has had a positive impact on these efforts. At the same time, stakeholders are also navigating a number of challenges, particularly in capacity expansion, beneficiary movement between systems and levels of care, and fully understanding new benefits and processes.

In the area of quality, UCLA found the following:

- Levels of care. Preliminary analysis of level of care data suggest that about 90 percent of referrals were made to the level of care indicated on ASAM screenings or assessments, which indicates that the tools are being used as intended. This also suggests that the expanding use of residential treatment in DMC-ODS counties represents better matching of patients to their appropriate level of care.
- Successful treatment engagement. DMC expenditure data suggest that treatment engagement in DMC-ODS counties varied between modalities, ranging from 54

percent in outpatient and 96 percent in residential, which is consistent with or above engagement rates found in the literature.

- Beneficiary transitions along the continuum of SUD care. DMC expenditure data indicates that beneficiaries in DMC-ODS counties did not typically move along the continuum of care to receive subsequent treatment (e.g., outpatient) or case management within 14 days of discharge from withdrawal management or residential services. Improving transitions following these levels of care should be a priority to provide better care consistent with the ASAM Criteria and to guard against "revolving door" use of these services.
- Developing practices. Survey results indicate that there is a challenging learning curve as counties begin to implement utilization management, DMC billing, and evidence-based practices.
- Quality-related requirements. Every DMC-ODS county reported having implemented a quality improvement committee, a written SUD quality improvement plan, ASAM Criteria-based assessment and placement, evidence-based practices, licensed practitioners of the healing arts, and physician consultation services. DMC-ODS counties also unanimously reported that the DMC-ODS requirements had a positive impact on their quality improvement activities, as did 92 percent of Pre-Implementation counties.
- Beneficiary perceptions of treatment. Beneficiaries participating in the TPS anonymously rated their treatment in DMC-ODS counties on five domains: access, quality, care coordination, outcomes, and general satisfaction. Participants overwhelmingly expressed positive ratings of their treatment (93 percent positive).

As a result of their analyses, UCLA recommended that training and technical assistance be provided in the following areas: ASAM Criteria assessment and placement; DMC billing; utilization management; patient flow along the continuum of SUD treatment, especially provision of additional services after discharge from residential treatment and withdrawal management; and evidence-based practices, particularly trauma-informed treatment and motivational interviewing.

Program Actions Based on Evaluation Recommendations

- DHCS will provide DMC-ODS comprehensive training to the counties and work with the DMC-ODS training contractor to provide the necessary trainings to providers.
- Based on EQRO reviews, training is essential in all components of clinical documentation, including how the components interface with one another and how often to document changes in client status. The training should include the models and elements of client-centered care and focus on unique needs of clients wanting more case management and individual and family therapies as part of their care.
- Counties have tended to focus during the initial startup of the DMC-ODS on compliance with the basic treatment requirements, and not the longer-term view of recovery from a chronic disease perspective. During Year Two of service implementation and in subsequent years, counties have expressed their plans for the expansion recovery

residences and recovery services that will contribute vital components to its continuum of care. DHCS will provide guidance to counties to assist in the development of recovery service plans.

- Counties have expressed confusion with the definition of case management services and have requested guidance/training on case management. DHCS will provide guidance on the appropriate use of case management and work with the DMC-ODS training contractor to provide training. Trainings will include how much case management a client should get, how to approach reimbursement for clients who have been assessed, but not treated and/or assessed but delayed treatment (clients from the justice partners), and clear case management guidelines.
- The DHCS Medi-Cal Behavioral Health Division and contracted training entities will continue to provide technical assistance to counties on how to implement various aspects of the ASAM Criteria (e.g., brief screening, initial assessment, follow-up assessment, treatment planning), including optional DHCS-approved ASAM Criteria-based screening/assessment tools, and guidance for assessing fidelity to the ASAM.
- The DHCS will continue expansion of MAT access in residential treatment programs and detention centers. These efforts, led by the DHCS Community Support Division, will enhance client outcomes in treatment and for detention releases and also could prevent potential deaths from overdose and recidivism.

Section 6.4 Dental Managed Care

The Medi-Cal Dental Program, including the DMC program, aims to improve the oral health of all members. 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 affect all aspects of children's lives.

DHCS Goals and DMC Program Objectives

DHCS Goals and DMC Program Objectives	• Improve health outcomes: The DMC program objectives, which aim to improve oral health of all members through increased utilization, fully align with and support the DHCS overarching goals of improving health outcomes and reducing social determinants and health disparities by addressing barriers to dental services utilization. One of DHCS' prime objectives is to increase preventive services utilization for all DMC members, particularly children, due to the prevalence of chronic disease for this age group. DHCS continues to collaborate with the California Department of Public Health to achieve the California Oral Health Plan's overarching goals to: integrate oral health and primary health care, prevent disease and promote oral health, increase access to oral health and eliminate disparities, and improve oral health literacy. • Improve health equity: DHCS examined Annual Dental Visit (ADV) utilization for DMC health plan members across ethnic

	groups for both children and adults over the past three calendar years (2016, 2017, and 2018) to identify disproportionate utilization that may affect members' access to care. • Address social determinants of health: Through continual tracking of DMC utilization, the Medi-Cal Dental Services Division (MDSD) analyzes data to identify and address any notable trends in oral health disparities and social determinants, such as race/ethnicity, income, and education, which may affect members' access to care. • Improve data quality and reporting: Consistent with the DHCS goal of improving data quality and reporting, MDSD strives to develop effective strategies to accurately monitor dental utilization for all DMC members.
Quality Metrics and Performance Targets	• Annual Dental Visit (ADV): There is also a 60 percent target utilization goal for children for the Medi-Cal Dental program, including the DMC health plans. Since adult dental benefits were restored in 2018, DHCS is internally monitoring the plans' progress toward meeting this goal for both adults and children combined • Preventive Services: Increase the annual percent of children who receive any preventive dental service by 10 percent over a five-year period. • Use of Sealants • 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 • Overall Utilization of Dental Services • Continuity of Care • Usual Source of Care
Performance Improvement Projects	• DHCS requires each DMC health plan to implement two DHCS-approved quality improvement projects (QIPs) per year, a Statewide Collaborative QIP and an Individual QIP, and submit quarterly reports documenting progress in meeting measurable goals.

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Quality Metrics and Performance Targets

DHCS monitors DMC health plan performance across the 13 performance measures listed in the above table, which were established in consultation with stakeholders and are documented in state law. They also reflect oral health measures identified by CMS. DHCS publishes the results of DMC health plan performance on these 13 measures on the DHCS website.[23] The performance measure results are updated quarterly, with each quarterly report encompassing a rolling 12-month span of data. While DHCS retrieves dental encounter data from the DHCS data warehouse to calculate and generate the various dental data reports that are published on the website, DHCS also validates the encounter data against self-reported performance measure reports received by DMC health plans on a quarterly basis. In March 2018, DHCS released Dental APL 18-006, which directed all DMC health plans to use an updated template when submitting performance measure reports to DHCS. This template included additional guidance on calculating performance measures as well as expanded the age range and data stratifications for reporting.

Evaluation of the Effectiveness of the 2018 Managed Care Quality Strategy Report

DHCS examined ADV utilization for DMC health plan members across ethnic groups for both children and adults over the past three calendar years (2016, 2017, and 2018)[24] to identify disproportionate utilization that may affect members' access to care. The highest utilizing ethnic groups for children ages 0-20 have consistently been Hispanics (47.27 percent) and Asians (45.92 percent), and the lowest have been African Americans (33.79 percent) and Caucasians (34.16 percent). For adults, the disparity amongst ethnic groups is less pronounced with only a 3.22 percent difference between the highest and lowest utilizing ethnic groups. The highest utilizing ethnic groups for adults have been African Americans (21.94 percent) and Native Hawaiians or Pacific Islanders (20.50 percent), and the lowest have been Alaskan Natives or American Indians (18.72 percent) and Asians (19.34 percent). Despite these observations, no single ethnic group has been consistently identified as either the highest or the lowest utilizer for both the children and adult age group categories. DHCS notes that while patterns do exist, ADV utilization overall has been stable across ethnic groups for the past three calendar years, with all ethnic groups showing a gradual increase in utilization from CY 2016 to CY 2018. Given the historically lower utilization rates for DMC versus FFS as a whole, DHCS determined that no prominent disparities warrant intervention; however, DHCS will strive to eliminate the gaps in ethnic groups while also striving to achieve a 60 percent utilization for all DMC members.

Consistent with CMS' oral health goals for Medicaid as well as the Domain One objective of the Dental Transformation Initiative (DTI), DHCS established a performance measure benchmark for preventive services for children ages 1-20. Using SFY 2016-17 as a baseline, the goal is to increase the annual percentage of preventive services utilization of children ages 1-20 by 10 percent over a five-year period, or a minimum of 2 percent each fiscal year. While DHCS has established baselines and monitors DMC health plans' individual progress on meeting target benchmarks through mandated QIPs, DHCS also monitors the collective

[23] Dental Data Reports: https://www.dhcs.ca.gov/services/Pages/DentalReports.aspx
[24] Encounter data retried from the DHCS Data Warehouse. (Query date: June 2019). Percentages noted in this section are for CY 2018 data.

utilization of all DMC services. From SFY 2016-17 to SFY 2017-18, preventive services utilization for all DMC children ages 1-20 increased from 34.83 percent to 36.49 percent, with an overall increase of 1.66 percent.[25] When broken down by county, there was a slightly higher overall increase in utilization for Public Health Plans (PHP) plans (2.23 percent) as compared to GMC plans (1.63 percent).

Performance Improvement Projects

DMC health plans are contractually required to participate in two QIPs per year, a "Statewide Collaborative QIP" and an "Individual QIP." For the Statewide Collaborative QIP, DHCS designates the topic of review, choosing a key area for all DMC plan to focus on. To assist with this goal, DMC health plans have implemented various interventions designed to increase preventive services utilization including conducting member outreach through outbound phone calls, text message campaigns, targeted mailers, and partnering with local community organizations. For the Individual QIP, DMC plans have the discretion to focus on any area self-identified as in need of improvement. DHCS monitors the DMC health plans' progress on both the Statewide and Individual QIPs through review of quarterly progress reports.

- **Statewide Collaborative QIP**

  In January 2018, DHCS issued APL 18-002, establishing the goal of the Statewide Collaborative QIP. Consistent with the objective of Domain One of the DTI, the Statewide Collaborative QIP aims to increase the annual percentage of preventive services utilization of children ages 1-20 by 10 percent over a five-year period. Therefore, each DMC health plan must aim to increase preventive measure utilization by 2 percent each year. In April 2018, DHCS issued subsequent guidance to DMC health plans, establishing individual SFY 2016-17 baseline measurements and subsequent SFY benchmarks for each health plan.

  Using encounter data retrieved from the DHCS data warehouse[26], DHCS measured DMC plans' individual progress in meeting the Statewide QIP goals. Both Health Net of California, Inc. and Liberty Dental Plan of California, Inc. met or exceeded the two percent goal. Although Access Dental Plan PHP improved by only 1 percentage point, it should be noted that this plan was already by far, the highest performing plan. Access Dental Plan, a low scoring plan, did not show improvement from the previous year

- **Individual QIP**
  - <u>Access</u>

The goal of Access' Individual QIP is to increase the annual percentage of ADV utilization of children ages 0-20 by 10 percent over a five-year period, with a target annual increase of 2

[25] High Level Dental Performance Measures: https://www.dhcs.ca.gov/services/Pages/Dental_Performance_Measures-High_Level.aspx
[26] Dental Managed Care Performance Measures: https://www.dhcs.ca.gov/services/Pages/DMCPerformanceMeasures.aspx

percent. Using encounter data retrieved from the DHCS data warehouse[27], DHCS measured Access' progress in meeting its annual goal. Drawing a comparison between baseline (SFY 2016-17) and re-measurement (SFY 2017-18) data, ADV utilization decreased for GMC (0.35 percent) and increased for PHP (1.25 percent). While the annual 2 percent goal was not met, the plan continues to deploy a number of interventions to increase ADV utilization such as: developing best practices from successful provider offices; implementing a text message campaign aimed at increasing benefit awareness and member engagement; and continued partnership with Early Smiles and both Sacramento County and UCLA LDPPs under Domain Four of the DTI.

- Health Net and Liberty
  Both Health Net and Liberty's Individual QIPs focus on the following two shared goals:
  1. By the end of the first quarter of 2020, increase utilization of preventive services overall for children ages 6-9 and 10-14 by 4 percent.
  2. By the end of the first quarter of 2020, increase utilization of sealant services for the targeted experimental group (select low-utilizing zip codes) for children ages 6-9 and 10-14 by 8 percent.

Results for Health Net and Liberty's progress in meeting its secondary goal show a positive correlation between the plans' targeted interventions as sealant utilization for the experimental group increased for both plans in GMC and PHP. In a comparison between baseline (CY 2017) and re-measurement (CY 2018) data, Health Net had a positive change of 5.1 % and 2.0% (GMC, PHP respectively),and Liberty saw a positive change of 3.0% and 3.5% (GMC and PHP respectively). DHCS anticipates utilization to continue to increase as more current encounter data becomes readily available. In the meantime, Health Net and Liberty continue to deploy a number of interventions to increase sealant utilization such as providing basic oral health education and encouragement to members to utilize services, specifically sealants, through targeted mailings and outbound phone calls to members in low-utilizing ZIP codes.

To assist with this goal, DMC plans have implemented various interventions designed to increase preventive services utilization including conducting member outreach through outbound phone calls, text message campaigns, targeted mailers, and partnering with local community organizations. For the Individual QIP, DMC plans have the discretion to focus on any self-identified area in need of improvement. DHCS monitors the DMC plans' progress on both the Statewide and Individual QIPs through review of quarterly progress reports.

External Independent Reviews

In December 2018, CMS approved a contract amendment allowing DHCS to expand the scope of its existing contract with the EQRO that performs oversight activities of MCPs to include oversight activities pertaining to DMC health plans. The EQRO is tasked with producing the annual technical report in compliance with federal requirements. Beginning in April 2020, the EQRO will release the first annual technical report summarizing access and quality of care

[27] Dental Managed Care Performance Measures:https://www.dhcs.ca.gov/services/Pages/DMCPerformanceMeasures.aspx

findings for DMC plans, reporting on SFY 2018-19 data. DHCS is working in close collaboration with the EQRO and DMC health plans to perform mandatory activities, including validation of performance measures, compliance reviews, and implementation of the required Statewide and Individual QIPs.

Program Evaluation Key Findings

Quality dental care is essential to a child's overall well-being. With tooth decay as the single most common chronic disease among children, the DMC program's fundamental objective continues to focus on increasing utilization of dental visits, particularly preventive services for children. To closely track and monitor the DMC program's progress in meeting this core objective, DHCS established a performance measure benchmark for preventive services for children ages 1-20 with the goal of increasing the annual percentage of preventive services utilization of children ages 1-20 by 10 percent over a five-year period (approximately 2 percent each SFY). Through quarterly encounter data and QIP progress reports, DHCS has not only monitored DMC health plans' individual performance on meeting target benchmarks, but the collective utilization of all DMC health plans combined. From SFY 2016-17 to SFY 2017-18, individual DMC health plan performance varied across plans with two health plans (Health Net and Liberty) exceeding the 2 percent annual goal, and one health plan (Access) not meeting the goal. However, for DMC plans combined, preventive services utilization for all DMC children ages 1-20 increased by 1.66 percent, slightly shy of the 2 percent annual goal.

Program Actions Based on Evaluation Recommendations

Throughout the next SFY, DHCS will maintain the goal of the Statewide QIP and continue to monitor DMC health plans' progress in meeting the 10 percent increase in preventive services utilization for children ages 1-20 over a five-year period, with an annual target increase of 2 percent each SFY. For the Individual QIP, while results have been partially successful, DHCS will work with its contracted EQRO to better refine the QIP process and review new topics proposed by DMC health plans. The EQRO will closely monitor the DMC health plans' adherence to the rapid cycle process to ensure the use of measurable goals and prompt revision of interventions when favorable results are not achieved.

DHCS will maintain ongoing oversight of DMC utilization through continual monitoring of the 13 performance measures, producing quarterly reports to identify trends and conducting gap analyses as necessary. DHCS will continue to share the DMC health plans' quality improvement efforts at various stakeholder meetings and continue its collaboration with the California Department of Public Health in achieving the goals of the California Oral Health Plan.

Section 7. Other DHCS Programs

DHCS is committed to continual improvement in population health and health care in all departmental programs and across all delivery systems. For all programs, attention to outcomes and sustaining a culture of quality are important to achieving the four goals of the Department. The programs below exemplify advancing quality improvement.

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Section 7.1 Fee-for-Service

California Children Services (CCS)

The California Children's Services (CCS) is a state program which provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to approximately 180,000 Medi-Cal eligible children and youth under age 21 with CCS-eligible medical conditions through a network of CCS paneled specialty and subspecialty providers and Specialty Care Centers (SCCs). CCS-eligible conditions include a wide array of congenital anomalies, chronic medical conditions, traumatic injuries, infectious diseases producing major sequelae, accidents, and infants with a high level of illness acuity in a neonatal intensive care unit (NICU). CCS Program administration ensures eligible children receive expert diagnosis and treatment that meet specified standards of care and quality. The program objective is to provide access to high-quality medically necessary care to individuals under age 21 with chronic or serious health issues, and develop and maintain access to subspecialty and complex primary care through a network of facilities and providers who meet CCS standards of care.

The CCS program is administered as a partnership between county health departments and DHCS. Health and Safety Code, Section 123800 et seq. is the enabling statute for the CCS program. The explicit legislative intent of the CCS program is to provide necessary medical services for children with CCS medically eligible conditions whose parents are unable to pay for these services, wholly or in part. The statute also requires that DHCS and the county CCS program to seek eligible children by cooperating with local public or private agencies and providers of medical care to bring potentially eligible children to sources of expert diagnosis and treatment.

The CCS program is mandated by the Welfare and Institutions Code and the California Code of Regulations (Title 22, Section 51013) to act as an "agent of Medi-Cal" for Medi-Cal beneficiaries with CCS medically eligible conditions. Medi-Cal is required to refer all CCS-eligible clients to CCS for case management services and authorization for treatment. The statute also requires all CCS applicants who may be eligible for the Medi-Cal program to apply for Medi-Cal.

The metrics and performance targets include:

<u>Access to Care Measures:</u>

1. Routine primary care: The percentage of members 12 months–19 years of age who had a visit with a PCP.
    - Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
    - Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
2. Depression Screening: The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

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- Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument.
- Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of screening positive for depression.

Care Coordination Measures:

1. Specialty care services: Percentage of children and youth with special healthcare needs (CYSHCN) with select conditions (cystic fibrosis, hemophilia, sickle cell, leukemia, diabetes) who have a documented visit with a CCS Special Care Center (SCC) within 90-days of referral.
    - Utilization of out-patient (OP) visits for CYSHCN
    - Utilization of prescriptions for CYSHCN
    - Utilization of mental health services for CYSHCN
2. Hospital readmission rate: For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
    - Utilization of emergency room (ER) visits for CYSHCN
    - Utilization of ER visits with an inpatient (IP) admission for CYSHCN
    - Utilization of IP admissions for CYSHCN
3. Percentage of CYSHCN discharged from a hospital who had at least 1 follow-up contact with a PCP or Specialist (face-to-face or telemedicine) within 28 days post-discharge
4. Transition of care (to adult services):
    - CYSHCN 14+ years of age who are expected to have chronic health conditions that will extend past their 21st birthday with biannual review for long-term transition planning to adulthood

Quality of Care Measures:

1. Immunization status: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis vaccines.
2. Diabetes management: The percentage of members 18–21 years of age with diabetes (type 1 and type 2) who had each of the following:
    - Hemoglobin A1c (HbA1c) testing.
    - HbA1c poor control (>9.0%).
    - HbA1c control (<8.0%).
    - HbA1c control (<7.0%) for a selected population*
    - Eye exam (retinal) performed.
    - Medical attention for nephropathy
    - BP control (<140/90 mm Hg).
3. Family satisfaction and family participation (by survey).

Standards for CCS special care centers (subspecialty centers) are being updated with validated performance metrics, to ensure that clients are referred to the center that provides the most appropriate, medically necessary services.

The program is evaluated through the Title V family survey which occurs every 5 years, and will be evaluated through the metrics described above when they are finalized.

Coordination of actions to take based on these evaluations still needs to be determined including how to report on these measures in both straight FFS CCS and in the Whole Child Model counties where CCS care is delivered through managed care. All of the measures listed align well with the DHCS goals of improving health outcomes, eliminating health disparities, addressing social determinates of health, and improving data quality and reporting.

CCS Neonatal Intensive Care Units (NICU) and High Risk Infant Follow-up (HRIF) Programs

CCS implements quality improvement for ill newborns via extensive and systematic clinical performance evaluation at all 123 CCS-approved NICUs, which then informs targeted improvement efforts that include formal hypothesis testing. Aggregated data analysis has identified and informed statewide opportunities for improvement including unwarranted wide practice variation in antibiotic use and inborn NICU admission[28]. Additionally, CCS collaborates with the California Perinatal Quality Care Collaborative (CPQCC) and its 137 member NICUs in education, performance evaluation, research, and large multi-site collaborative improvement projects, identified every 1-2 years via evidence-based deliberations of CPQCC's broadly representative perinatal quality improvement panel. The 2018-2019 project derives from CCS data revealing among very low birth weight infants (VLBWs, < 1500 grams) a relatively high incidence of growth failure by the time of discharge from the NICU. The collaborative seeks to optimize the growth and nutrition of VLBWs through evidence-based standardization of care.

The CCS High Risk Infant Follow-up (HRIF) Program identifies infants who may develop CCS-eligible conditions after discharge from a CCS-approved NICU. It provides at least three standard visits for diagnostic services during at least three standard visits for infants and children up to three years of age. These services include a comprehensive history and physical examination with a neurologic assessment, a developmental assessment such as the Bayley Scales of Infant Development, a family psychosocial assessment, hearing and ophthalmologic assessments, and coordinator services to assist families in accessing identified interventions and facilitating linkages to appropriate agencies and services. The HRIF Program implements the web-based HRIF Quality Care Initiative database to identify quality improvement opportunities for NICUs in the reduction of long-term morbidity, to use data to evaluate the relationship between eligibility and functional outcomes, and to analyze social, medical, and program factors contributing to or interfering with the program's success. The system collects data on high risk infants up to their third birthday and is linked with the CPQCC database to identify maternal and perinatal factors associated with child outcomes. Analyses of perinatal, NICU, and HRIF data have led to data-driven performance improvement and benchmarking for the delivery of NICU care throughout California.

Newborn Hearing Screening Program (NHSP)

[28] Pediatrics. 2015; 135:826-833. JAMA Pediatr. 2018 Jan 1; 172(1):17-23. Pediatrics 2018; 142(3):e20180115.

California's NHSP is a comprehensive coordinated system of early identification and provision of appropriate intervention and support services for infants with hearing loss and their families. Families of infants delivered at any general acute care hospital with licensed perinatal services in the State of California are given the option to have their baby's hearing screened. Infants who do not pass the initial screening in the hospital will be referred for additional testing after discharge. If the baby does not pass the outpatient hearing screening, a referral for diagnostic evaluation will be made to determine the presence of hearing loss. If hearing loss is confirmed, the infant and family will be referred to California's Early Start Program for additional services. California's NHSP goals are aligned with the Federal Early Hearing Detection and Intervention (EHDI) goals of 1-3-6.

- All infants should have access to hearing screening using a physiologic measure at no later than one month of age.
- All infants who do not pass the initial hearing screening and the subsequent rescreening should have appropriate audiological and medical evaluations to confirm the presence of hearing loss at no later than three months of age.
- All infants with confirmed permanent hearing loss should receive early intervention services as soon as possible after diagnosis but at no later than six months of age.

Integrated Systems of Care (ISCD) shares a grant with Department of Education (CDE) through the Health Resources & Services Administration (HRSA). ISCD does not receive grant funding, but continues to participate in grant responsibilities voluntarily. HRSA requires grantees to develop Aim statements with identifiable performance measures/goals to assist in meeting the Early Hearing Detection and Intervention (EHDI) Nationals goals of 1-3-6. California's NHSP Aim Statements include:

- Aim 1: All infants with an initial inpatient refer result will receive a repeat screen prior to hospital discharge. Baseline 96 percent, Goal 100 percent.
- Aim 2: Decrease the No-Show rate for outpatient screening appointments Baseline 5 percent, Goal 4 percent.
- Aim 3: Decrease the No-Show rate for diagnostic evaluation appointments. Baseline 7 percent, Goal 6 percent.
- Aim 4: Increase the percentage of Well-Baby Nursery infants identified deaf or hard of hearing (DHH) by three months of age. Baseline 70 percent, Goal 77 percent.

The shared grant with California Department of Education (CDE) requires both departments to meet monthly to conduct a Quality Improvement (QI) Collaborative with stakeholders. The Collaborative discusses all topics related to the NHSP process including the monthly Aim Statement data. If there is a lack of progression towards the goals, a Plan, Do, Study, Act (PDSA) cycle is developed/revised to help meet the targeted Aims.

Additionally, DHCS contracts with three (3) geographically based Hearing Coordination Centers (HCC's) in Northern, Southern, and South Eastern California. They are responsible for tracking and monitoring all newborns that are referred on their initial hearing screening exam; and ensuring babies do not get lost to follow-up in the process. The HCC's play an integral role in helping the Department meet NHSP program objectives.

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As an obligation of grant participation, ISCD must comply with HRSA's reporting requirements. HRSA requires ISCD to report on the annual objectives and performance data of the NHSP. This includes Aim Statement data, a description of current practices to achieve the targets, and other pertinent narratives and statistics outside of the Aims. The additional statistics include, but are not limited to, number of infants that refer and complete outpatient and diagnostic evaluations, number of confirmed cases of hearing loss, number of infants enrolled into intervention services by six months of age, and number of infants lost to follow-up.

The NHSP also voluntarily participates in the Center for Disease Control & Prevention (CDC) annual EHDI Survey. The survey data is similar to the information provided to HSRA and is aggregated on a full calendar year basis.

If the CDC or HRSA have any questions or concerns, they will contact the NHSP coordinator for a meeting and/or follow-up items.

Based on evaluation of National EHDI Survey data, California has the largest birthing population in the country, yet it remains the nation's leader in overall hearing screening rates. California also ranks amongst the best in the nation for other Federal benchmarks including referrals and lost to follow-up rates.

These performance outcomes are due, in part, through Quality Strategy improvements implemented by the NHSP. Consistently, high screening rates are a result of effective, efficient, and affordable testing services offered at all birthing hospitals. Enhanced communication and care coordination as well as family involvement in health outcomes have yielded improvements in beneficiary's commitment to meet follow-up appointments and other necessary services. In addition, early intervention services such as Early Start and Parent Links provide much needed support to children and families to help foster a healthy sense of self and community.

Every Woman Counts (EWC)

EWC provides free breast and cervical cancer screening and diagnostic services to California's underserved populations. EWC is funded by the CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP), proposition 99 and, as needed, and state general funds. The mission of EWC is to save lives by preventing and reducing the devastating effects of cancer for Californians through public and provider education, early detection, diagnosis, case management, and integrated preventive services.

EWC is committed to providing quality breast and cervical cancer screening and diagnostic services to its program recipients. EWC pursues this goal by offering technical assistance to providers to improve performance by implementing innovative, cost-effective education, and monitoring their Core Program Performance Indicators (CPPIs). The CPPIs and their performance benchmarks were developed by the CDC to assess grantee achievement.

The aims of the CPPIs are to ensure: 1) screening of priority populations; 2) timely and complete diagnostic follow-up of abnormal breast and cervical cancer screening results; and 3) timely

treatment initiation for program recipients diagnosed with breast and cervical cancers or pre-cancerous cervical conditions. EWC requires that the program's providers to meet the defined CPPIs.

Quarterly, an error remediation report is generated and sent to the Regional Clinical Coordinators (RCC), who are the EWC program liaisons that work directly with the program providers. This report tracks errors due to the noncompliance to the CPPIs per recipient, as well as reporting anomalies. RCC are required to work with the providers to address and resolve the errors and educate and provide continuing education on timeliness and diagnostic follow up. Twice a year, EWC analyzes the CPPIs for all EWC providers and shares the reports with the RCC. The reports reflect the aggregate CPPI results for all providers in the RCC's region and the CPPI results for the individual EWC provider. The RCC calls or schedules site visits to provide technical assistance and training to resolve issues related to poor CPPI outcomes. The CPPI report is used as a tool to educate the EWC providers so that timeliness and diagnostic follow up are improved and brought up to the NBCCEDP benchmarks.

Prostate Cancer Treatment Program (PCTP)

The PCTP provides prostate cancer treatment services to eligible men diagnosed with prostate cancer. Eligible men are: low-income, uninsured, and underinsured California men who are 18 years old and older. PCTP services include culturally competent and linguistically appropriate case management to enrolled men.
The program objectives are:

- Develop, expand, and ensure high-quality prostate cancer treatment services
- Improve prostate cancer treatment short and long-term outcomes
- Increase utilization of treatment visits
- Improve health literacy
- Improve quality of care

Specifically to:

- Provide prostate cancer treatment to eligible men diagnosed with prostate cancer who reside in California.
- Screen and enroll program eligible men via the statewide toll-free telephone systems. Eligible men are enrolled for an initial 12 month treatment regimen.
- Conduct additional program eligibility screening, enrollment, retention and utilization monitoring activities for underinsured men.
- Develop a contract turnover report that includes a plan to transfer all program information and documents to DHCS or future contractor.
- If applicable, implement a contract takeover plan from the current contractor or DHCS.
- Develop and maintain a Prostate Expert Workgroup (PEW) to provide clinical program oversight and guidance to for PCTP contracted activities.
- Develop, maintain, and recruit a statewide network of prostate cancer specialists who provide clinical treatment service using Medi-Cal procedures and reimbursement

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rates.
- Provide case management for each man enrolled in PCTP.
- Develop and maintain a financial and fiscal management system.
- Recruit, hire, and/or retain appropriately qualified staff as outlined in the contract's budget.
- Collect, analyze, and report on aggregated demographic and program data on a regular basis.
- Conduct, evaluate, and improved statewide outreach activities.
- Conduct evaluation activities and create an evaluation plan for the PCTP case management model.
- Starting in contract year 2 [State Fiscal Year (SFY) 2019/20] contractor shall make all efforts possible to increase PCTP enrollment by 5 percent each fiscal year.

UCLA, coordinates treatment for low-income patients diagnosed with prostate cancer. UCLA utilizes a patient navigation model that consists of nurse case managers (NCMs) who work with patients in a culturally competent and linguistically appropriate manner to coordinate care, provide resources (social, educations, and nutritional) teach self-care/self-efficacy, interpret information, coach and counsel. The care coordination provided by NCMs is a proactive approach to prevent adverse health outcomes, unnecessary emergency room visits and hospitalizations, and to overcome barriers and facilitate timely access to high-quality care. Metrics include:

- Emergency room visits
- Number of nurse case management interventions
- Number of calls received
- Website traffic
- Number of patient education materials sent to providers and community clinics
- Number of outreach events attended
- Enrollment statistics
- Number of patient education materials sent to enrolled men
- Number of contracts with providers
- Number of purchase orders processed for patient claims
- Dollars spent on direct patient care
- Number of patients receiving each type of treatment
- Patient demographics

DHCS requires UCLA to conduct patient outreach and make all efforts possible to increase current enrollment numbers by 5 percent each FY, starting in contract year 2. DHCS is currently working with UCLA to collaboratively create an evaluation plan for the PCTP case management model.

UCLA's activities include:

- Coordinate with DHCS to identify the necessary data, information, and analysis needed for development of an evaluation plan for the PCTP case management model.

- Identify prostate cancer specific short and intermediate disease and/ or treatment outcomes of the case management model.
- Develop standards and methods to monitor, assure, and improve quality of care.
- Develop a system or process to ensure that quality assurance and quality improvement standards are implemented.
- Create and maintain a risk assessment tool that standardizes the identification of men in need of case management services.
- Coordinate with DHCS to create a logic model of the PCTP program.

UCLA will develop clinical management protocols; create and maintain an evaluation plan and timeline; create and submit to DHCS a risk assessment tool; create a logic model of PCTP; submit necessary data, information, analysis to DHCS; evaluate outreach activities for improving outreach strategies each state fiscal year.

Family Planning, Access, Care and Treatment Program (Family PACT)

The Office of Family Planning (OFP) is charged by the California Legislature "to make available to citizens of the State who are of childbearing age comprehensive medical knowledge, assistance, and services relating to the planning of families". The purpose of family planning is to provide women and men a means by which they can decide for themselves the number, timing, and spacing of their children. The OFP administers the Family Planning, Access, Care, and Treatment (Family PACT) program. Family PACT is California's innovative approach to provide comprehensive family planning services to eligible low income (under 200 percent federal poverty level) men and women. Currently, Family PACT serves approximately 1.1 million income eligible men and women of childbearing age through a network of 2,200 public and private providers. Services include comprehensive education, assistance, and services relating to family planning.

The Program objectives are to:

- Improve chlamydia screening strategies in Medi-Cal family planning programs.
- Increase the number of Family PACT providers capable of providing Long Acting Reversible Contraceptives (LARCs) to increase access to LARCs.

The metrics and performance targets include:

- Increase the chlamydia screening rate in women 24 and younger by 10 percent for private providers and public providers.
- Decrease chlamydia screening rates in women 25 years and older to no more than 50 percent.
- A 10 percent increase in number of providers who are trained to provide LARCs (i.e. subdermal implants and intrauterine devices).

The performance improvement projects are:

- Family PACT provider chlamydia screening dashboard/report card.

- LARC trainings for Family PACT providers.

The Program evaluation includes:

- Annually monitor and evaluate chlamydia screening rates in women 24 and younger vs. women 25 and older in Medi-Cal family planning programs through private providers.
- Annually monitor and evaluating chlamydia screening rates in women 24 and younger vs. women 25 and older in Medi-Cal family planning programs through public providers.
- Annually monitoring the number of LARC trainings completed by Family PACT providers and ultimately evaluate effect on LARC utilization in the Program. The actions that will be taken based on the evaluation:
- Conduct audits and desk reviews on Family PACT provider sites to assess the impact of LARC trainings.
- Increase the number of LARC trainings in areas that are in need of LARC providers.
- Annually publish LARC trainings and utilization in the Family PACT Annual Report.
- Provide access to the Family PACT chlamydia-screening dashboard to providers in order to increase awareness of performance.
- Annually publish chlamydia screening rates in the Family PACT Annual Report.

Section 7.2 Grants

Medication Assisted Treatment (MAT) Expansion Project

In an effort to address the opioid epidemic throughout the state, DHCS is implementing the California MAT Expansion Project. The California MAT Expansion Project aims to increase access to MAT, reduce unmet treatment need, and reduce opioid overdose related deaths through the provision of prevention, treatment, and recovery activities. The California MAT Expansion Project focuses on populations with limited MAT access, including rural areas and American Indian & Alaska Native tribal communities, and is funded by federal grants from the(SAMHSA.

The MAT Expansion Project consists of six main objectives:

- Develop additional MAT locations with a focus on rural locations.
- Provide MAT access to specialized and under-served communities.
- Transform entry points for individuals with OUDs and create effective referrals into treatment.
- Develop coordinated referral processes to manage high-risk transitions.
- Engage current and potential MAT prescribers.
- Enact overdose prevention activities to prevent opioid misuse and overdose deaths.

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DHCS is implementing a variety of projects that span a range of settings where individuals with opioid use disorder (OUD) may seek help, including:

- Clinical settings such as emergency departments, hospitals, tribal health centers, and primary care clinics.
- County and state criminal justice systems, including jails, prisons, and juvenile justice.
- Communities, through media campaigns, opioid safety coalitions, naloxone distribution, drug take-back, and supportive housing.
- SUD treatment programs, including community outpatient programs, narcotic treatment programs, and residential facilities.

Implementation of these projects has led to improved patient health outcomes, mitigating health disparities, addressing social determinants of health, and improved data quality and reporting, including:

- 52 new emergency departments with integrated or improved MAT programs for the identification, treatment, and care coordination of individuals with an OUD and a SUD.
- The California Hub and Spoke System (CA H&SS) has implemented 18 Hubs with over 215 Spokes across more than 36 counties.
    - UCLA is completing an evaluation of the CA H&SS and has received detailed monthly reports for clients inducting and receiving MAT for the project.
- More than 20,000 patients have been served in the CA H&SS that would otherwise not have received care for OUD and other SUD.
- Over 220,000 naloxone kits have been delivered to more than 500 organizations, including law enforcement, fire departments, homeless shelters, community organizations, and universities.
- 29 counties have integrated new or enhanced existing MAT programs in their county jails, which serve more than 80 percent of the State's populations.
- More than 15 Indian Health Programs have received MAT program enhancement, including implementation of telehealth services.

For more information about the California MAT Expansion Project, please visit CaliforniaMAT.org.

Strategic Prevention Framework Partnerships for Success (SPF PFS)

The SPF PFS is a 5-year grant from the SAMSHA. Its focus is to reduce prescription drug use among youth aged 12 to 25 years in eight California rural counties. DHCS selected the project counties using a data-informed approach. DHCS completed a needs assessment, reviewing data on consumption, contributing factors and consequences of prescription drug use among youth, and then identified ranking the counties with the highest need for prevention interventions. The counties awarded through this process were Shasta, Lake, Humboldt,

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Mendocino, Plumas, Butte, Tuolumne and Siskiyou. As a requirement of funding, all counties are required to complete a local Health Disparities Impact Statement to inform their local strategy selection. Programs implemented in each of the awarded counties include:

- Medication safe storage and disposal strategies
- Media campaigns and local health fairs
- Public presentations and evidence-based education
- Coalition development and participation

The grant also requires DHCS convene a State Epidemiology Workgroup (SEW) and a Evidence-Based Practices Workgroup (EBPW) to provide direction on grant implementation.

The program objectives are:

Program Objective 1

- To increase public understanding of the risk of harm associated with prescription drug misuse and abuse in the eight sub recipient counties.
    - Butte County is the lead county that will spearhead media efforts. The media will focus on messaging to parents and youth. Tuolumne County will be the pilot for the webpage platform. It is expected that the webpages will be operational by December 2019.

Program Objective 2

- To increase the capacity of sub recipient county's SUDagencies to provide effective prevention activities.
    - All eight SPF PFS counties are required to establish and/or provide the backbone support to local opioid safety coalitions. This will assist in growing the counties ability to work collaboratively across systems to combat the opioid crisis. This requires counties to work with other partners such as local criminal justice agencies and primary care providers.

Program Objective 3

- To increase state capacity to identify SUD prevention priorities and facilitate implementation of effective strategies in targeted communities.

The program metrics and performance targets for the above objectives are:

Program Objective 1

- Implementation and reach of each of the developed public service announcements and completion of published websites.

Program Objective 2

- Results from the SPF PFS Capacity Assessment Survey.

Program Objective 3

- The collaborative activities undertaken between the Statewide Epidemiological Workgroup, and Evidence-Based Practice Workgroup.

SPF PFS's SEW functions as an expert data advisory group that recognizes the importance of regular statewide evaluations to monitor and track outcomes. SEW provides support for the Substance Abuse Block Grant (SABG), current and future federal discretionary grants, as well as provides data advisory group support to multiple state-level efforts. An Executive Leadership Team (ELT) functions as the core of the SEW, and plans, organizes, and leads efforts related to the following:

- Peer review data, data analysis, and evaluation methodologies and reports.
- Provide guidance to data collection efforts and encourage data-informed decision making to the Interagency Prevention Advisory Council (IPAC) prevention priorities, multiple state departments, state indicator reports, the Statewide Needs Assessment and Planning (SNAP) report, etc.
- Review, analyze and report trends related to substance use and mental health issues and disorders that cause harm.
- Support IPAC efforts to annually update the Annual Prevention Priorities and Strategies Report.

Over the next two years, the SPF PFS SEW hopes to:

- Plan for continuous data quality improvement.
- Continue to support the Epi-Center and other data collection efforts.
- Respond to ad hoc data queries from federal, state, and local stakeholders

SPF PFS's EBPW for Primary Prevention works to expand the statewide use of (EBPs), programs, policies, and strategies to positively impact statewide outcomes. The EBPW provides support for SABG, current and future federal discretionary grants, and provides input and support to multiple state, county, and provider efforts. EBPW works to streamline the process of moving from problem identification to achieving changes in outcomes. EPBs include the most efficient and effective methods to change behaviors, perceptions, attitudes, and policies related to consumption, consequences, and contributing factors of substance misuse and abuse. Currently, California uses a very narrow definition of EBPs that is limited to those listed on SAMHSA's National Registry of Evidence-Based Programs and Practices.

Over the next two years, the SPF PFS EBPW hopes to accomplish the following:

- Create a definition of EBPs to fit California's diverse needs.
- Develop a "menu" of common SUD-related consequences, consumption, contributing factors and indicators, and their related evidence-based policies, programs, interventions, promising practices, and best practices.
- Encourage the development of local innovative programs by creating criteria that will allow acknowledgement of developed and implemented programs not yet having

outcomes.

- Work collaboratively with DHCS SUD prevention planning, IPAC prevention priorities, and the SEW to create a model that incorporates the problem, supporting data, and possible solutions.

Creation of the SEW and EBPW followed the Strategic Prevention Framework planning process and uses a project management methodology to monitor and track progress.
DHCS will prepare a formal evaluation plan and tailor its programmatic needs based on annual evaluation of project goals and county ability to comply with project work plans.

Substance Abuse Prevention and Treatment Block Grant (SABG) - Programs

Mandated by Congress, SAMHSA administers the SABG non-competitive, formula grant through SAMHSA's Center for Substance Abuse Treatment (CSAT) Performance Partnership Branch, in collaboration with the Center for Substance Abuse Prevention (CSAP) Division of State Programs. In California, the SABG is allocated to all 58 California counties. SABG funding is used to support SUD prevention, early intervention, treatment and recovery services that are not already covered by Medicaid, Medicare, or private insurance.
For prevention, approximately $41 million of California's SABG funds are made available to each of the 58 counties. Every three to five years, each county is required to conduct an SUD needs assessment and use that data to develop a strategic prevention plan that informs what strategies/activities should be implemented in each county. Common strategies selected are as follows:

- Information dissemination strategies such as media campaigns, community presentations, and informational websites.
- SUD prevention education for both adults and youth.
- Youth/Adult leadership activities and mentoring.
- Community-based coalition activities and efforts to change the social norms of alcohol and drug use.

Other set-asides of the SABG are specifically earmarked for the youth and perinatal population with a focus on early intervention and treatment programs that include improving life skills and strengthening families. The discretionary dollars of the SABG are used to fill gaps in service not otherwise covered by Drug Medi-Cal such as recovery residences.

California Health and Safety Code, Division 10.5, Part 1, Chapter 1, Section 11755 (f) states that DHCS shall provide technical assistance and training to local SUD programs to assist in the planning and implementation of quality services. Therefore, DHCS dedicates a portion of the SABG toward developing the SUD workforce. The program objective is to increase the number of SUD professionals trained in disciplines that are recognized to improve health outcomes and address determinants of health such as trauma-informed care, adverse childhood experiences, social determinants of health and cultural competency.

DHCS also provides SABG funding for the Community Prevention Initiative (CPI), a platform originally intended to provide training for the SUD Prevention workforce on local strategic

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planning. More recently, the CPI aims to make state-of-the-art research and practices in the field of SUD prevention more accessible to communities throughout California. Professional competencies have been developed which focus on emerging issues and proven practices in the SUD prevention field. Other efforts are in place that provide continuing education opportunities for SUD prevention and treatment professionals through the university systems. Trainings have recently been expanded to include best practices for serving special populations and cultural competence. Trainings are available online and onsite. More information can be found at http://ca-cpi.org/.

DHCS received additional SABG funding from SAMHSA to be used specifically for providing technical assistance to the field. DHCS entered into an Interagency Agreement with the University of California, San Francisco to provide five regional trainings to the SUD workforce on best practices in cognitive behavioral therapy, trauma-informed care and motivational interviewing.

The trainings provided through each of the three contracts described above are selected based on results of an annual workforce survey. DHCS will conduct workforce education follow up surveys with 63 initial and 56 follow-up as baseline and will tailor its workforce needs based on feedback from workforce education follow up surveys.

DHCS will increase the number of persons trained by 5 percent using 2,174 professionals trained and 500 CEU's provided as baseline. The metrics and performance targets will be presented in the CPI annual report and University of California, San Francisco final report

Medicare Rural Hospital Flexibility (FLEX) Program Grant

The Health Resources and Services Administration, Federal Office of Rural Health provides funding to state governments or other designated entities to support Critical Access Hospitals (CAHs) in quality improvement, quality measures reporting, performance improvements and benchmarking, designating rural hospitals as CAHs, population health improvements and the provision of rural emergency medical services.

The California State Office of Rural Health (CalSORH) Flex Program objectives include improving the quality of care provided by CAHs by increasing and sustaining the participation of CAHs in the Medicare Beneficiary Quality Improvement Project through consistent reporting of specified patient safety, patient engagement, care transitions and outpatient quality measures and support of best practice quality improvement interventions.

The CalSORH Flex Program is using the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey, which is a national, standardized, publicly reported survey of patients' perspectives of hospital care, as the metrics for overall patient engagement improvements in CAHs. Baseline are the California CAH averages for each HCAHPS question. The targets are the national averages for CAHs for each survey question.

The Flex Program provides CAHs with technical assistance for reporting and project implementation, education and training on HCAHPS best practices and funding for hospital-

specific HCAHPS projects. The projects vary by number and hospital each year.

Mixed method evaluation techniques will be used to determine the effectiveness of interventions and whether program area goals and objectives are met. For hospital specific projects, HCAHPS data will be evaluated on an annual basis against pre-determined benchmarks. Pre and Post tests will be conducted as part of educational workshops to measure what participants learned. Staff interviews will be used to assess behavior and process change during and after projects, workshops and trainings

At the end of each grant year, the CalSORH Flex Program will use the evaluation data to drive the development of the program and inform decisions on future activities and interventions.

American Indian Perinatal Services (AIPS) Program

The DHCS Primary, Rural and Indian Health Division (PRIHD) – Indian Health Program (IHP) provides grants to Indian health program for the AIPS program. The AIPS program focuses on the health of American Indian women during and after pregnancy as well as the care of American Indian infants for their first year of life.

Statewide data demonstrates that American Indian women experience higher rates of late prenatal care, higher prevalence of diabetes and hypertension during pregnancy, and late or no postnatal care. As a result, American Indian infants are at an increased risk for birth complications. Data also shows that the American Indian population has one of the highest infant mortality rates in California. The IHP provides funding to support perinatal case management and home visitation services in Fresno, Humboldt, Shasta, and Placer counties to improve American Indian perinatal outcomes. Funded counties were determined through a review of statewide data utilizing a need-based formula. The services provided by AIPS promote healthy American Indian mothers and infants through culturally sensitive interventions.

The objectives of the AIPS program include providing health education and case management to improve perinatal outcomes for American Indian women and infants ages 0-1 in targeted counties. The objectives will be achieved by providing funding to Indian health programs for the provision of one or combination of the following approaches:

- Home Visitation: Provide health education to pregnant American Indian women with infants to improve maternal-child health outcomes utilizing evidenced- based home visitation by trained American Indian paraprofessionals who are supervised by public health nurses. Services include basic health education, advocacy, transportation, and referrals for clinic or other community health provider services.
- Perinatal Case Management: Utilize case management certified clinic staff to provide direct case management services and care coordination to assist pregnant American Indian women to receive health care monitoring, education, emotional support, and referrals to social services during pregnancy and 6 weeks post-delivery.

PRIHD will use data from Fiscal Year 19-20, which represent the first full year of AIPS to

establish baseline data for funded programs.
Through the AIPS program, PRIHD's performance improvement projects will include:

- Improving prenatal care initiation to prevent low birth weight of infants and prevent pre-term births.
- Increase postpartum behavioral health screenings.

Mixed method evaluation techniques will be used to determine the effectiveness of interventions and whether program area goals and objectives are met. Quarterly progress reports on the provision, type and quality of services will be required by each grantee. DHCS staff will review progress reports and interview grantees as needed. Grantees are required to gather clinical data on perinatal outcomes for American Indian women and infants ages 0-1 over the course of the grant. This data will be used to identify best practices and interventions for future grant years.

Palliative Care

Effective January 1, 2018[29], DHCS implemented the Medi-Cal palliative care program in accordance with Senate Bill 1004 (Hernandez, Chapter 574, Statutes of 2014), establishing standards and providing technical assistance to ensure delivery of palliative care services. Palliative care consists of patient-and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. When the Pediatric Palliative Care Waiver ended on December 31, 2018, DHCS provided continuity of care for services to the children receiving palliative care through the waiver by transitioning that care to Medi-Cal's FFS system or Medi-Cal managed care health plan (MCP) as part of the services available to members under 21 in accordance with the EPSDT Medi-Cal benefit.[30]

Section 8. Delivery System Reform

Section 8.1 Medi-Cal 2020 Waiver

California's Section 1115(a) Medicaid Waiver, entitled Medi-Cal 2020, was approved by the CMS on December 30, 2015, and is effective through December 31, 2020. The Medi-Cal 2020 Demonstration aims to transform and improve the quality of care, access, and efficiency of health care services for over 13 million Medi-Cal members. The initiatives listed below embody the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system. In the fall of 2019, the Department began a stakeholder engagement process for the development of the next 1115 and 1915(b) waiver renewal applications and program elements.

[29] All Plan Letter18-020 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-020.pdf
[30] Pediatric Palliative Care Waiver End Date and Transition Plan: http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_27529.asp

Dental Transformation Initiative (DTI)

The DTI was included in the Medi-Cal 2020 Demonstration waiver as a mechanism for improving dental health for children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. With funding of up to $750 million over a five-year period, the DTI allows DHCS to implement targeted pilot and incentive programs that go beyond the scope of benefits currently allowed under the State Plan, SMA, and the Manual of Criteria. This flexibility affords DHCS the opportunity to test different approaches for maximizing provider participation and increasing children's utilization through various domains. The CMS Medi-Cal 2020 Special Terms and Conditions provides governance over DTI.

- Domain 1 – Increase statewide proportion by 10 percentage points over a five-year period of children ages 1 through 20 enrolled in Medi-Cal who receive a preventive dental service.

- Domain 2 – Diagnose early childhood caries for children ages 6 and under, by utilizing Caries Risk Assessments (CRA).

- Domain 3 – Increase dental continuity of care for children, who receive annual dental exams from the same dentist and service office location year after year.

- Domain 4 – Through innovative Local Dental Pilot Projects (LDPPs), increase dental prevention, caries risk assessment and disease management, and continuity of care among Medi-Cal children.

The following are the performance metrics for Domains 1, 2, 3, and 4:

- Domain 1 – Increase preventive Services Utilization for Children (Statewide)
  a. <u>Prevention</u>
     Increase the utilization of children ages 1 through 20 enrolled in Medi-Cal who receive any preventive dental service, by at least 10 percentage points over a five- year period. Utilization toward this goal is measured from January 1, 2016 – December 31, 2020.
  b. <u>Access to Care</u>
     Increase the number of actively participating providers in each county who provide preventive services.

- Domain 2 – Caries Risk Assessment and Disease Management Pilot (29 Pilot Counties)
  a. <u>Eligibility</u>
     Children ages 0 to 6 who receive services in one of the selected pilot counties.

b. Caries Risk Assessment (CRA)

Diagnosing early childhood caries by utilizing CRAs and associated dental services based on identified CRA risk levels and identifying the effectiveness of CRA and treatment plans for eligible children.

c. Caries Management

Increase ratio of utilization of preventive services versus restorative; Decrease utilization rates of emergency room and oral surgery for dental related reasons among children.

- Domain 3 – Increase Continuity of Care (36 Pilot Counties)

a. Eligibility

Individuals ages 0 to 20 who receive services in one of the selected pilot counties.

b. Continuity of Care

Increase utilization of children continuously enrolled in the Medi-Cal Dental Program who received services performed by the same provider in two, three , four, five, and six consecutive year periods.

- Domain 4 – Local Dental Pilot Projects (LDPPs)

The goals, outcomes, and performance metrics for analyzing the success of the Local Dental Pilot Projects are consistent with and build upon both the performance metrics of the three (3) DTI domain and each LDPPs individually identified performance metrics.

DHCS meets regularly with various stakeholder groups to provide updates as well as brainstorm and discuss methods to increase provider participation and improve the respective outcomes of the DTI Program. The various work groups discuss a variety of topics such as updates on domain participation, expenditures to date, status of outreach initiatives, and potential policy changes that DHCS may enact in the future.
DHCS also holds individual domain sub-workgroups that provide a specific forum for further discussion between the Department and its stakeholders. These are smaller groups that are meant to facilitate discussion amongst domain specific subject matter experts to ensure transparency as well as solicit feedback of the Department's ongoing initiatives.

Mathematica Policy Research (Mathematica) has been contracted by DHCS to perform the independent evaluation of the DTI outcomes as required in the Medi-Cal 2020 Special Terms and Conditions. Mathematica has been in routine communication with DHCS for project updates and has continued to maintain a presence in the DMC stakeholder groups. The final evaluation is set to be completed by October 31, 2021.

Mathematica is still in the process of conducting their evaluation, and provides updates to the Department through quarterly progress reports as well as bi-weekly teleconferences. Mathematica will also be submitting an interim report to DHCS. DHCS will subsequently submit this report to CMS. The report will consist of provider surveys, Medicaid encounter and claim data, enrollment data, as well as other data elements needed to support

performance measurement. CMS will have an opportunity to review and provide comment within 60 days of the draft. Furthermore, DHCS will also submit a mandated Summative Evaluation Report upon the expiration of the waiver. Lessons learned from this demonstration will assist the Department in assessing and evaluating potentially new dental policies.

Whole Person Care (WPC) Pilot Program

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. Participation as a WPC Pilot is offered to a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority. WPC Pilots receive support to test out innovative approaches in reaching and integrating care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress.

WPC pilots are expected to improve service delivery and health outcomes; enhance sustainability of local program infrastructure improvements and program interventions; and reduce costs through reductions in avoidable utilization.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

The PRIME Program is now in its fifth year of demonstration under the current Medi-Cal 2020 Waiver. The PRIME Program builds upon the foundational delivery system transformation work, expansion of coverage, and increased access to coordinated primary care achieved through the prior California Section 1115 Bridge to Reform Demonstration. The activities supported by the PRIME Program are designed to accelerate efforts by participating PRIME entities to change care delivery, to maximize health care value, and to strengthen their ability to successfully perform under risk-based alternative payment models in the long term, consistent with CMS and Medi-Cal 2020 goals.

The PRIME Program aims to advance improvements in the quality, experience and value of care that Designated Public Hospitals (DPH) and District Municipal Public Hospitals (DMPH) provide. PRIME incentive funding emphasizes advances in primary care, cross-system integration, and data analytics.

PRIME Projects are organized into three domains. Participating DPH systems implemented a minimum of nine PRIME projects, and participating DMPHs implemented a minimum of one PRIME project, as part of the participating PRIME entity's Five-year PRIME Plan. Participating DPH systems must select at least four Domain 1 projects (three of which are specifically required), at least four Domain 2 projects (three of which are specifically required), and at least one Domain 3 project.

Projects included in Domain 1 – Outpatient Delivery System Transformation and Prevention, are designed to ensure that patients experience timely access to high-quality and efficient patient-centered care. Participating PRIME entities will improve physical and behavioral health outcomes, care delivery efficiency, and patient experience, by establishing or expanding fully integrated care, culturally and linguistically appropriate teams—delivering coordinated comprehensive care for the whole patient. One component of PRIME system transformation also includes addressing health disparities in the PRIME entities' population. Entities improved documentation and stratification by patient demographics and then required to identify one disparity reduction project during PRIME. Key themes from disparity reduction projects included incorporating equity into strategic goals and priorities, training staff to provide culturally responsive care, engaging patients in care delivery design, using data to drive performance improvement for disparity reduction and collaborating with community leaders and organizations.

Projects included in Domain 2 – Targeted High-Risk or High-Cost Populations, focus on specific populations that would benefit most significantly from care integration and coordination: individuals with chronic non-malignant pain and those with advanced illnesses.

Projects included in Domain 3 – Resource Utilization Efficiency, will reduce unwarranted variation in the use of evidence-based, diagnostics, and treatments (antibiotics, blood or blood products, and high-cost imaging studies and pharmaceutical therapies) targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services.

DMC-ODS Authority

On August 13, 2015, CMS approved the Drug Medi-Cal Organized Delivery System (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.

Renewal of the DMC-ODS waiver is part of a broader Medi-Cal transformational initiative, CalAIM (California Advancing and Innovating Medi-Cal (see Section 1.4).

Section 8.2 Directed Payment Programs

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. The Department remains committed to providing Californians with the highest quality health care services in ways that maximize efficiency, value, and equity. 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.

CMS instituted the Medicaid and CHIP Managed Care Final Rule, which modernized Medicaid managed care regulations. 42 CFR section 438.6 (c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments that focus on delivery system reform. To promote access, the managed care 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 Department has developed several managed care directed payment programs to align, augment, support, and further the quality improvement initiatives promulgated through the managed care delivery systems and the Medi-Cal 2020 Demonstration. While each of these programs focus on a distinct health care delivery sector, they have been designed to promote and maintain access to high quality care and will concentrate efforts on the department-wide priority of delivering effective, efficient, affordable care to Medi-Cal beneficiaries. The State will perform an evaluation for each program proposal.

Quality Incentive Program (QIP)

As part of the recently approved Designated Public Hospital (DPH) Quality Incentive Pool, the State will direct MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The performance metrics in each category include process, outcomes, system transformation, and other indicators that are consistent with state, MCP, and DPH delivery system reform and quality strategy goals. Measures are drawn from nationally vetted and endorsed measure sets (e.g., National Quality Forum, National Committee for Quality Assurance, the Joint Commission, etc.) or measures in wide use across Medicare and Medicaid quality initiatives (e.g. the Medicaid Child and Adult Core Set Measures, CMS Core Quality Measures Collaborative measure sets, and Merit-based Incentive Payment System and Alternative Payment Model measures, etc.) This program will increase the amount of funding tied to quality outcomes, and further align state, MCP, and hospital system goals. To receive QIP payments, the DPHs must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements.

This payment arrangement builds on the foundational work of the PRIME program by moving California further towards value-based alternative payment models.

Section 8.3 Care Coordination

Health Homes

The Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based LTSS needed by eligible beneficiaries. The HHP

provides six core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act Section 2703, allows states to create Medicaid health homes to eligible beneficiaries with chronic conditions. California's Assembly Bill (AB) 361(Mitchell) (Chapter 642, Statutes of 2013) provides state authority to operate the HHP. The HHP is structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP serves as the central point for coordinating patient-centered care and will be accountable for improving member outcomes and reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays.

Continuum of Care Reform (CCR)

CCR is a large-scale, system reform effort between CDSS and DHCS, which started in 2015 with the passage of AB 403. The goal of CCR is to comprehensively reform treatment and placement options for youth in foster care, with children and youth who must live apart from their biological parents in permanent homes with committed adults who can meet their needs. CCR provides counties the statutory and policy framework to ensure services and supports, including mental health services, provided to children, youth, non-minor dependents, and families are tailored toward the goals of reducing reliance on congregate care; increasing focus on permanency; and building authentic and genuine family engagement, service planning, and decision-making through the child and family team process. CCR has also included an overhaul of the former Group Home and Rate Classification Level (RCL) system. Children and youth in foster care who would have previously been placed in a group home, are now placed in either a Resource Family Home or in a Short-Term Residential Therapeutic Program (STRTP). Placement is dependent on the child/youth's needs. Children/youth placed in STRTPs must meet criteria for needing STRTP level of services to meet their behavioral or therapeutic needs. These facilities are specifically designed to serve difficult children with high-intensity needs.

The passage of AB 501 added to the continuum of services for children and youth. The goal of AB 501 is to address a critical component missing in California's continuum of mental health crisis services for children and youth: crisis residential treatment services (CRTS). While CRTS are a long-standing State Plan SMHS, for children and youth, there has never been a licensing category in which these services can be provided. AB 501 provided the authority to implement a facility type under the STRTP licensure to provide CRTS. This facility type is the Children's Crisis Residential Programs (CCRPs). These facilities are specifically designed to serve difficult children with high-intensity needs who are in crisis.

DHCS continues to work in close collaboration with CDSS on CCR implementation, including the following efforts that specifically involve the provision of specialty mental health services (SMHS) to foster children and youth impacted by CCR.

Children and Youth Specialty Mental Health Services Regional County and Provider Convenings – "Supporting Collaboration and Partnership"

DHCS, in collaboration with CDSS and the California Institute for Behavioral Health Solutions and in consultation with a planning committee planned and conducted six regional provider and county convening's throughout FY 2018-19 to support implementation efforts and initiatives related to STRTPs, Presumptive Transfer, Therapeutic Foster Care (TFC), and Intensive Services Foster Care. These convenings were well attended and included provider representatives as well as county representatives (i.e. Foster Family Agencies (FFAs) and STRTPs), and other stakeholders.

STRTP Mental Health Program Approval Protocol and Interim Regulations

DHCS continues to work collaboratively with CDSS and stakeholders regarding the DHCS Mental Health Program Approval process for STRTPs. In FY 2019-20, DHCS will update the: 1) Interim STRTP Regulations; 2) Interim STRTP Mental Health Program Approval Protocol, and 3) the STRTP Mental Health Program Approval Application. DHCS created forms for the Delegation of the Mental Health Program Approval Task to the County MHPs and for Program Flexibility Requests. In FY 2018-29, DHCS issued MHSUDS Information Notice 18-049 regarding the delegation of the Mental Health Program Approval Task to MHPs. 11 MHPs have accepted delegation, and 45 have declined.

DHCS continues to receive applications for Mental Health Program Approval, which are in various stages of review and approval to ensure all program requirements are met. DHCS continues to work in partnership with the respective MHPs to jointly conduct Mental Health Program Approval onsite reviews of STRTPs. This collaboration has provided DHCS and MHPs the opportunity to jointly use the Mental Health Program Approval Protocol and to identify areas where clarification or refinement may be needed. DHCS continues to communicate with MHPs in order to provide technical assistance, information, and updates on an ongoing basis. -

Transitioning Children and Youth into Home-Based Care

Regarding the provision of SMHS for children and youth upon release from an STRTP, MHPs are responsible for providing or arranging for the provision of SMHS to all Medi-Cal beneficiaries that meet SMHS medical necessity criteria. Foster children and youth exiting STRTPs are Medi-Cal eligible and are entitled to medically necessary SMHS based on their mental health needs and goals, in accordance with their treatment plans. DHCS oversees and monitors MHPs' provision of SMHS.

SMHS are an entitlement under the EPSDT Program. The provision of SMHS is based on individual needs and clinical determinations. Therefore, the amount and intensity of services varies depending on the individual needs of the child or youth. Children and youth in STRTPs begin or continue receiving SMHS while in the STRTP. Prior to discharge, a transition plan is developed that, among other things, describes the plan for ongoing services following discharge to support the stability and success of the child or youth's post-STRTP placement, whether that is in foster home, with their biological parents, or with other family members.

DHCS, or MHPs that accepted delegation, conduct initial and annual onsite mental health program approvals to determine STRTP compliance with STRTP interim regulations. This includes reviewing Policies and Procedures related to Transition Plan Determinations and Clinical Reviews, Collaboration and Determinations as well as reviewing the actual transition plans and clinical reviews related to children transitioning from a STRTP to another level of care.

Presumptive Transfer Ongoing Implementation

DHCS and CDSS continue to work collaboratively to implement the provisions of AB 1299, (Ridley-Thomas, Chapter 603, Statutes of 2016) known as Presumptive Transfer. Although not directly related to CCR statute, Presumptive Transfer plays a role in achieving the goals of CCR. DHCS and CDSS have released three joint ACL/INs providing initial and ongoing presumptive transfer policy guidance. (ACL 17-77/IN 17-032, ACL 18-60/IN 18-027 and ACL 19-94/IN 19-041). ACL 19-94/IN 19-041 specifically addresses issues with Presumptive Transfer for children and youth placed in STRTPs.

The primary goal of presumptive transfer is to ensure that foster youth placed out of their counties of original jurisdiction receive timely access to medically necessary SMHS. The most recently released ACL/IN reminded County MHPs and County Child Welfare Services Agencies that they have a shared responsibility to meet that goal and need to work in close collaboration and communication to appropriately serve these foster children and youth. The ACL/IN encourages counties to work together to ensure that placing agencies have the information they need to make informed and appropriate presumptive transfer waiver determinations. In addition, it encourages MHPs to be proactive in establishing contracts with STRTPs where foster youth from their counties are typically placed, and know what options are available to allow them to quickly enter into a contract with an out of county STRTP in cases where presumptive transfer is waived.

Therapeutic Foster Care (TFC) Services Implementation

DHCS continues efforts to fully implement TFC. TFC implementation supports the goals of CCR by providing an intensive, supported treatment option that allows children and youth to be placed in home settings. TFC may be an appropriate short-term transitional treatment option for children or youth exiting STRTPs, or may avoid placement in STRTPs.

Counties continue to move forward with implementing TFC, with several counties having already implemented TFC, and several FFAs that are certified to provide TFC.
However, there continues to be hesitation from some counties in moving forward with implementing TFC as well as from some FFAs. On behalf of CDSS and DHCS, the Center for Health Care Strategies, Inc. (CHCS) conducted key informant interviews with FFAs and county leadership across the state to identify key challenges—and possible solutions—related to implementation of TFC in California.

Through this process, CHCS observed that there is a clear commitment to CCR throughout

that state, and that TFC is a key component of the continuum of care available to children and youth. CHCS provided implementation and policy recommendations that include clarifying the state vision for TFC utilization (i.e. how service should be operationalized); addressing opportunities for further development in the TFC model; addressing financing structure and continue the conversation with stakeholders. DHCS is analyzing the recommendations proposed by CHCS to determine next steps, action items and timeframes.

Section 8.4 Value-Based Payment (VBP) Program

Beginning in FY 2019-20, DHCS implemented a VBP program through the MCPs that provides incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. These risk-based incentive payments are provided to providers who meet specific achievement on metrics targeting areas such as behavioral health integration; chronic disease management; prenatal/post-partum care; and early childhood prevention. To address and consider health disparities, DHCS will pay an increased incentive amount for events tied to beneficiaries diagnosed as having a substance use disorder or serious mental illness, or who are homeless. This program is funded with $180 million in Proposition 56 funds, with a Federal match, for $360 million in total funds, annually, and will be implemented for at least three years. A complete list of VBP measures can be found here: Value Based Program Measures.

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Section 9 Appendices

Section 9.1 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.

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(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).

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Section 9.2 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.

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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 – The delivery of SUD services through a county managed care plans to expand access to SUD treatment services for Medi-Cal beneficiaries, also called SUD Managed Care Plans.
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.

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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 for Specialty Health Services – Responsible for care of Medi-Cal beneficiaries with serious mental illness and/or Serious Emotional Disturbance. 56 county-operated MHPs contract with DHCS.
MOC	Manual of Criteria – A compilation of criteria which apply to some services provided under the Medi-Cal program.

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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.
PSP	Population Specific Plan – Health plans that serve a specialized population in the Medi-Cal managed care program.
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.

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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.
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.
VBP	Value-Based Payment Program – MCPs provide incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations.

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Section 9.3 Appendix C: CMS Core Set Metrics

2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	Administrative or hybrid
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	Administrative or hybrid
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)	Administrative or hybrid
NA	NCQA	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)	Administrative
Maternal and Perinatal Health			
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)	Medical records (CDC's NHSN)
0471	TJC	PC-02: Cesarean Birth (PC02-CH)	Hybrid
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	EHR
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 15–20 (CCW-CH)	Administrative
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5–18 (AMR-CH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Administrative
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Administrative
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Administrative
Dental and Oral Health Services			
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	Administrative
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Administrative (Form CMS-416)

NQF #	Measure Steward	Measure Name	Data Collection Method
Experience of Care			
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

* This measure is no longer endorsed by NQF.

CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NHSN = National Healthcare Safety Network; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21–24 (CHL-AD)	Administrative or EHR
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)	Administrative or hybrid
Maternal and Perinatal Health			
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	Hybrid or EHR
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 21–44 (CCW-AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	Administrative or hybrid
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19–64 (AMR-AD)	Administrative
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)	Administrative
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Administrative or EHR
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Administrative
2605	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)[a]	Administrative
2605	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)[a]	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Administrative or hybrid

NQF #	Measure Steward	Measure Name	Data Collection Method
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Administrative
NA**	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Administrative
Experience of Care			
NA***	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)	Survey

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

* This measure is no longer endorsed by NQF.

** The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure (NQF #1879).

*** The Adult Core Set includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006).

[3] The FUA-AD and FUM-AD measures were previously included in the Adult Core Set as a single measure (FUA/FUM-AD). For the 2019 Adult Core Set, they are included as two separate measures.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

Section 9.4 Appendix D: Managed Care Accountability Set

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Managed Care Accountability Set (MCAS) for Medi-Cal Managed Care Health Plans (MCPs)
Measurement Year 2019 | Reporting Year 2020

Based on Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Sets for Reporting Year 2019

	MEASURE ACRONYM	MEASURE Total Number of Measures = 39 (13 Hybrid and 26 Administrative)	MEASURE TYPE METHODOLOGY	HELD TO MPL?
1	PCR[i]	Plan All-Cause Readmissions	Administrative	Yes[ii]
2	AWC	Adolescent Well-Care Visits	Hybrid	Yes
3	ABA	Adult Body Mass Index (BMI) Assessment	Hybrid	Yes
4	AMM-Acute	Antidepressant Medication Management: Acute Phase Treatment	Administrative	Yes
5	AMM-Cont	Antidepressant Medication Management: Continuation Phase Treatment	Administrative	Yes
6	AMR	Asthma Medication Ratio[iii]	Administrative	Yes[iv]
7	BCS	Breast Cancer Screening	Administrative	Yes
8	CCS	Cervical Cancer Screening	Hybrid	Yes
9	CIS-10	Childhood Immunization Status: Combination 10	Hybrid	Yes
10	CHL	Chlamydia Screening in Women[iii]	Administrative	Yes[iv]
11	CDC-HT	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Hybrid	Yes
12	CDC-H9	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Hybrid	Yes
13	CBP	Controlling High Blood Pressure	Hybrid	Yes
14	IMA-2	Immunizations for Adolescents: Combination 2	Hybrid	Yes
15	PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Hybrid	Yes
16	PPC-Pst	Prenatal and Postpartum Care: Postpartum Care	Hybrid	Yes
17	WCC-BMI	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	Hybrid	Yes
18	W15	Well-Child Visits in the First 15 Months of Life: Six or More Well-Child Visits	Hybrid	Yes
19	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid	Yes
20	AMB-ED[1]	Ambulatory Care: Emergency Department (ED) Visits	Administrative	No
21	ADD-Init	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	Administrative	No
22	ADD-C&M	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	Administrative	No
23	CAP-1224[i]	Children and Adolescents' Access to Primary Care Practitioners: 12–24 Months	Administrative	No
24	CAP-256[i]	Children and Adolescents' Access to Primary Care Practitioners: 25 Months–6 Years	Administrative	No
25	CAP-711[i]	Children and Adolescents' Access to Primary Care Practitioners: 7–11 Years	Administrative	No
26	CAP-1219[i]	Children and Adolescents' Access to Primary Care Practitioners: 12–19 Years	Administrative	No
27	CCW-MMEC	Contraceptive Care—All Women: Most or Moderately Effective Contraception [iii]	Administrative	No

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	MEASURE ACRONYM	MEASURE Total Number of Measures = 39 (13 Hybrid and 26 Administrative)	MEASURE TYPE METHODOLOGY	HELD TO MPL?
28	CCW-LARC	Contraceptive Care—All Women: Long Acting Reversible Contraception (LARC)[iii]	Administrative	No
29	CCP-MMEC3	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception— 3 Days [iii]	Administrative	No
30	CCP-MMEC60	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days [iii]	Administrative	No
31	CCP-LARC3	Contraceptive Care—Postpartum Women: LARC—3 Days [iii]	Administrative	No
32	CCP-LARC60	Contraceptive Care – Postpartum Women: LARC—60 Days [iii]	Administrative	No
33	DEV	Developmental Screening in the First Three Years of Life	Administrative	No
34	HVL	Human Immunodeficiency Virus (HIV) Viral Load Suppression	Administrative	No
35	MPM-ACE/ARB	Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	Administrative	No
36	MPM-Diu	Annual Monitoring for Patients on Persistent Medications: Diuretics	Administrative	No
37	COB	Concurrent Use of Opioids and Benzodiazepines	Administrative	No
38	OHD	Use of Opioids at High Dosage in Persons Without Cancer	Administrative	No
39	CDF	Screening for Depression and Follow-Up Plan [iii]	Administrative	No

MCAS for Population-Specific Health Plans (PSPs)
Measurement Year 2019 | Reporting Year 2020

PSPs are:

- AIDS Healthcare Foundation (AHF)
- Rady Children's Hospital—San Diego (RCHSD)
- SCAN Health Plan (SCAN)

	MEASURE ACRONYM	MEASURE	MEASURE TYPE METHODOLOGY	PSP	HELD TO MPL?
1	ABA	Adult Body Mass Index (BMI) Assessment	Administrative	AHF, SCAN	Yes
2	BCS	Breast Cancer Screening	Administrative	SCAN	Yes
3	CBP	Controlling High Blood Pressure	Hybrid	AHF, SCAN	Yes
4	CDC-HT	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Hybrid	AHF, SCAN	Yes
5	CDC-H9	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Hybrid	AHF, SCAN	Yes
6	WCC-BMI	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	Hybrid	RCHSD	Yes
7	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid	RCHSD	Yes
8	AWC	Adolescent Well-Care Visits	Hybrid	RCHSD	No
9	AMB-ED	Ambulatory Care: Emergency Department (ED) Visits	Administrative	RCHSD	No
10	MPM-ACE/ARB	Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	Administrative	AHF, SCAN	No
11	MPM-Diu	Annual Monitoring for Patients on Persistent Medications: Diuretics	Administrative	AHF, SCAN	No
12	CAP-1224	Children and Adolescents' Access to Primary Care Practitioners: 12–24 Months	Administrative	RCHSD	No
13	CAP-256	Children and Adolescents' Access to Primary Care Practitioners: 25 Months–6 Years	Administrative	RCHSD	No
14	CAP-711	Children and Adolescents' Access to Primary Care Practitioners: 7–11 Years	Administrative	RCHSD	No
15	CAP-1219	Children and Adolescents' Access to Primary Care Practitioners: 12–19 Years	Administrative	RCHSD	No
16	CCW-MMEC	Contraceptive Care—All Women Ages 15–20: Most or Moderately Effective Contraception	Administrative	RCHSD	No

	MEASURE ACRONYM	MEASURE	MEASURE TYPE METHODOLOGY	PSP	HELD TO MPL?
17	CCW-LARC	Contraceptive Care—All Women Ages 15–20: LARC	Administrative	RCHSD	No
18	CCW-MMEC	Contraceptive Care—All Women Ages 21–44: Most or Moderately Effective Contraception	Administrative	AHF	No
19	CCW-LARC	Contraceptive Care—All Women Ages 21–44: LARC	Administrative	AHF	No
20	HVL	Human Immunodeficiency Virus (HIV) Viral Load Suppression	Administrative	AHF	No
21	COB	Concurrent Use of Opioids and Benzodiazepines	Administrative	AHF, SCAN	No
22	OHD	Use of Opioids at High Dosage in Persons Without Cancer	Administrative	AHF, SCAN	No
23	CDF	Screening for Depression and Follow-Up Plan	Administrative	AHF, SCAN	No

Performance Measures for Managed Long-Term Services and Supports Plans (MLTSSPs) Measurement Year 2019 | Reporting Year 2020

	MEASURE ACRONYM	MEASURE	MEASURE TYPE METHODOLOGY	HELD TO MPL?
1	AMB-ED	Ambulatory Care: ED Visits	Administrative	No
2	PCR	Plan All-Cause Readmissions	Administrative	No

[i] Stratified by Seniors and Persons with Disabilities (SPD).
[ii] Final decision on whether DHCS holds MCPs to the Minimum Performance Level (MPL) for PCR will be determined upon release of NCQA's 2019 Quality Compass.
[iii] Measure is part of both the CMS Adult and Child Core Sets. Though MCPs will report the "Total" rate, data will be collected stratified by the child and adult age groups.
[iv] MCPs held to the MPL on the total rate only.