Medi-Cal Managed Care Monitoring Overview

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I. Introduction

California's Medicaid program, Medi-Cal, administered by the California Department of Health Care Services (DHCS), currently provides health care to nearly 13 million beneficiaries. Approximately 80 percent of this population receives services through the managed care delivery system. California's three-linked goals focus on improving the beneficiary experience; improving health outcomes; and reducing total costs of care.

Medi-Cal managed care beneficiaries receive their care through one of 22 full risk Medi-Cal managed care health plans (MCPs) that contract with DHCS to deliver health care services in one or more of the state's 58 counties under six models of managed care. Each MCP is required to maintain a network of health care providers, in sufficient numbers, to serve the MCP's enrolled beneficiaries in a timely, effective, and appropriate manner. DHCS/MCP contracts require MCPs to maintain compliance with all applicable State and federal laws and regulations.

To ensure that all MCP beneficiaries are able to access timely, medically necessary covered services, DHCS maintains a comprehensive MCP Monitoring Plan ensuring MCP compliance with contractual requirements. The MCP Monitoring Plan provides a structure that DHCS utilizes to identify performance trends for individual MCPs, plan models, and on a statewide aggregate level. It provides to DHCS an understanding of MCP performance through a compilation of many different indicators. Components of the comprehensive monitoring plan occur at various frequencies throughout the year ranging from real time, to quarterly, to annually. Monitoring efforts address various components of plan activities including access, network composition, MCP audits and surveys, quality activities, grievance and appeals, transitions, continuity of care and required data.

DHCS monitoring initiatives are strengthened by cooperative partnerships. DHCS partners with the Department of Managed Health Care (DMHC), the primary governmental agency responsible for compliance with the Knox-Keene Health Care Service Plan Act of 1975, when monitoring MCPs. Efforts with DMHC are coordinated and made consistent whenever possible. Exchange of information between the two departments occurs regularly. The two departments leverage each others work to strengthen the overall monitoring system of MCPs.

DHCS provides technical assistance to MCPs regarding concerns and, when necessary, imposes corrective action, and may impose sanctions. This document provides a detailed overview of DHCS's monitoring efforts. It is important to note that DHCS is consistently strengthening and expanding its monitoring efforts and as such this document will be updated ongoing.

For a definition of terms used in the document see Section XI.

II. Network Access

Medi-Cal managed care health plans are contractually required to meet network adequacy standards including timely access and time and distance. In addition, they are responsible for ensuring access to all covered medically necessary services. These requirements include, but are not limited to:

Timely Access

- Appointments must be offered within the following timeframes:
    - Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
    - Urgent appointment for services that do require prior authorization – within 96 hours of a request;
    - Non-urgent primary care appointments – within ten (10) business days of request;
    - Appointment with a specialist – within fifteen (15) business days of request; and
    - Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) business days of request.

Time and Distance

- Primary care providers must be located within thirty (30) minutes or ten (10) miles of a beneficiary's residence unless the Contractor has a Department of Health Care Services approved alternative time and distance standard.

Measure 1: Network Certification

Are MCP networks adequate and able to meet the needs of all beneficiaries when accessing care prior to implementation? Are infrastructures in place to ensure network adequacy ongoing?

To ensure that Medi-Cal managed care health plan (MCP) networks are adequate to meet all covered medical necessary services for beneficiaries, the Department of Health Care Services (DHCS) conducts an initial network certification of MCPs prior to implementation and when one or more of the following occurs:

- Service area expansion;
- Mandatory and voluntary transition(s) of a beneficiary group, except when the population add is minimal, into managed care that previously held a voluntary status; and/or
- Benefit expansion.

These certifications are conducted by MCP service area which may include a single county or group of counties (dependent on service area as specified in the contract) and are conducted in

partnership with the Department of Managed Health Care for Knox Keene Act licensed MCPs (see Resources section for additional detail).

DHCS has established a certification tool which is used to capture all contractual obligations and confirms the network's ability to meet prerequisite conditions. The network certification process may be modified based on the reason for its completion, but at a minimum meets the requirements prescribed in Title 42, Part 438, of the Code of Federal Regulations. These requirements include verification of the: network's ability to meet medically necessary services needed for the projected enrollment and utilization, number and types of network providers, geographic location of providers relating to time and distance and timely access, hours of operation, service availability, physical accessibility, out of network access, right to a second opinion, provider credentialing, and policy and procedure requirements such as continuity of care and provider compliance.

DHCS sends a network certification letter for each MCP upon completion to the Centers for Medicaid and Medicare Services for review and approval when required.

Measure 2: Provider Network Report

MCP networks change ongoing due to many reasons, as this occurs, are sufficient providers still available and accepting new beneficiaries to allow for timely access to care for all beneficiaries?

The Department of Health Care Services (DHCS) receives a quarterly Provider Network Report produced by each Medi-Cal managed care health plan (MCP) summarizing changes in the provider network from the prior quarter. The report measures the impact to the network due to additions and deletions of primary care providers and is measured ongoing from the original network submission approved during the initial network certification of the plan.

DHCS reviews Provider Network Reports to determine MCP compliance with contract requirements based on any network changes. Specifically, time and distance standards, beneficiary assignment ratios ensuring timely access, are assessed.

DHCS verifies that each MCP has a comprehensive network of providers to ensure timely access to care for all beneficiaries for medically necessary services. DHCS systematically evaluates and engages an MCP to resolve any issues that are identified in the provider network reports. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

DHCS monitors trends across MCPs at the MCP model and statewide levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

Note: submission of this file will be eliminated in the future when DHCS's provider file project has been implemented to increase monitoring efficiency for DHCS and the MCPs.

Measure 3: Physician Ratio
Measure 4: Primary Care Provider Ratio

Are the number of physicians and PCPs in MCP networks sufficient to allow for timely access for all beneficiaries?

The Department of Health Care Services (DHCS) conducts monthly reviews of Medi-Cal managed care health plans (MCPs) provider data to monitor ratios of physicians and Primary Care Providers (PCP) to currently enrolled MCP beneficiaries. The physician and PCP ratio monitoring reviews use standards established in MCP contracts—one physician to 1,200 beneficiaries and one PCP to 2,000 beneficiaries.

Physician and PCP ratio monitoring ensures enough providers are available for all beneficiaries to maintain timely access to care. DHCS systematically evaluates and engages an MCP to resolve any issues that are identified. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan , or administering sanctions, respectively, until the issue is resolved.

DHCS monitors trends across MCPs at the MCP service, geographic, MCP model and statewide areas/levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

DHCS also utilizes provider ratio data shared by DMHC to determine MCP performance. DHCS provides technical assistance to MCPs regarding concerns and, when necessary, imposes corrective action, and may impose sanctions.

Measure 5: Timely Access

Are beneficiaries able to access care timely?

The Department of Health Care Services (DHCS) conducts annual medical audits of Medi-Cal managed care health plans (MCPs) – one component of these audits reviews timely access. Each audit reviews MCP compliance with timely access requirements including appointment wait time, standard policy and procedures, contract requirements, the MCP's communication methods used to communicate to its provider networks, and policies and procedures to monitor provider adherence to timely access standards. As a component of the annual medical audit, DHCS conducts an annual Appointment Wait Time Verification Study during which DHCS independently contacts provider offices and requests information about wait time to next, second, and third appointments.

Findings of non-compliance are compiled into an MCP audit report. DHCS utilizes this report to determine MCP compliance with timely access standards and imposes a Corrective Action Plan (CAP) for all findings which includes steps taken to resolve any finding, specific milestones, and timelines for completion. MCP audit report and CAP documents can be found here. Additional action in the form of sanctions and/or penalties may occur should the MCP not come into compliance with its CAP timely.

DHCS monitors trends across MCPs at the MCP model and statewide levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

DHCS also utilizes timely access data shared by the Department of Managed Health Care to provide technical assistance to MCPs regarding concerns and, when necessary, imposes corrective action, and may impose sanctions.

Measure 6: Seniors and Persons with Disabilities Network Adequacy Assessment
Measure 7: Rural Expansion Network Adequacy Assessment

Are MCP networks adequate to ensure timely access to care for newly transitioned populations to managed care?

The Department of Health Care Services (DHCS) has entered into three Interagency Agreements with the Department of Managed Health Care (DMHC) to perform a quarterly network adequacy assessment on behalf of DHCS for each reviewed population in which a Medi-Cal managed care health plan (MCP) operates a line of business by county as applicable. The assessments measure network adequacy for defined categories of beneficiaries that have been mandatorily enrolled into an MCP under the Bridge to Reform waiver. The beneficiaries include Seniors and Persons with Disabilities for all MCPs, and beneficiaries residing in rural expansion counties.

MCPs submit quarterly detailed provider networks to DHCS for review by DMHC including primary care providers, specialists, hospitals, medical groups and physician extenders. DMHC assesses MCP provider networks against DHCS contractual network requirements including:

- Beneficiary enrollment and changes in enrollment since the previous quarter;
- Changes to the network for the previous quarter;
- Capacity of providers;
- Capacity of telehealth providers;
- Geographic access to Primary Care Providers and specialists;
- Availability of traditional and safety-net providers;
- Providers not accepting new patients;
- Indicator data such as grievances and appeals and DMHC Help Center and the Medi-Cal Managed Care program's Office of the Ombudsman call center reports; and
- Verification of a current Memorandum of Understanding between the MCP and each county where the MCP operates for the delivery of county-based behavioral health and substance use services.

DMHC and DHCS collaborate to send a letter to each MCP following each quarterly assessment. Signed by both departments, the letter identifies any potential network adequacy concerns and includes either a network approval or request for additional information pertaining to any areas of concern. MCP responses are utilized to determine MCP compliance and

necessary next steps. Depending on the severity of noncompliance, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

DHCS monitors trends across MCPs at the MCP service, geographic, MCP model and statewide areas/levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

III. Network Composition

The Department of Health Care Services (DHCS) requires Medi-Cal managed care health plans (MCPs) meet the following network composition standards:

- Maintain an adequate number of inpatient facilities, service sites, professional, allied, and specialist and supportive paramedical personnel to provide all medically necessary services to beneficiaries; and
- Ensure, to the extent possible, that the composition of the provider network meets the ethnic, cultural, and linguistic needs of all assigned beneficiaries on a continuous basis.

Measure 8: Monthly Provider File

What is the composition of each MCP's network?

The Department of Health Care Services (DHCS) requires Medi-Cal managed care health plans (MCPs) to submit a monthly provider file per as set forth in All Plan Letter guidance. This information provides DHCS with a list of all contracted providers offering services within the MCP networks and includes delegated entities.

Monthly provider files include contracted provider level network information for each MCP by county or Health Care Plan (HCP) number, which is a unique three digit code for each plan by county. Each file undergoes a quality check to confirm that it meets basic standards The basic standards are applied to specific data elements such as National Provider Identifier, provider service location, and provider specialty.

DHCS uses the data collected through the provider files in conjunction with other data sources such as encounter and timely access data to monitor total provider volume, assess provider utilization against reported networks, and monitor ratios of providers to beneficiaries.

DHCS systematically evaluates and engages an MCP to resolve any issues that are identified in the monthly provider file. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

DHCS monitors trends across MCPs at the MCP model and statewide levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

This file is utilized to measure compliance with other MCP network requirements as described below.

Measure 9: Special Populations Detailed Provider Network Report

What is the composition of each MCP's network for newly transitioned populations to managed care?

The Detailed Provider Network Report contains data on primary care providers, physician extenders, specialists, mental health providers, clinics, and hospitals, it is submitted quarterly. The Department of Health Care Services has partnered with the Department of Managed Health Care to conduct quarterly network reviews. This report is utilized to monitor network adequacy for certain beneficiary population categories that have been mandatorily transitioned into a Medi-Cal managed care health plan under the Bridge to Reform waiver including Seniors and Persons with Disabilities and beneficiaries from rural counties (see Measures 6 and 7 for additional detail).

Note: submission of this file will be eliminated in the future when DHCS's provider file project is implemented – strengthened and more efficient monitoring will be implemented instead.

Measure 10: Managed Care Health Plan Subcontractors Report

What do Medi-Cal managed care plan's subcontractor networks look like?

The Medi-Cal managed care health plan (MCP) Subcontractors Report is submitted to the Department of Health Care Services (DHCS) quarterly. This reports contains the names of all direct subcontracting provider groups including, but not limited to, Health Maintenance Organizations (HMOs), Independent Physician Associations (IPAs), medical groups, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), pharmacies, and Federally Qualified Health Centers (FQHCs) as well as their subcontracting HMOs, IPAs, medical groups, SNFs, HHAs, and FQHCs.

The report must be sorted by subcontractor type, indicating the county or counties in which MCP beneficiaries are served. In addition, the report also indicates where relationships or affiliations exist between direct and indirect subcontractors. DHCS reviews the report for compliance with the contract. DHCS systematically evaluates and engages an MCP to resolve any issues.

Measure 11: Provider Directory

Is the information that beneficiaries use to choose a provider accurate?

The Provider Directory enables each beneficiary to make an informed choice when choosing a provider to access care through. The Provider Directory contains, at a minimum, a listing of Medi-Cal managed care health plan (MCP) in-network provider names, numbers, address and telephone number of each service location (i.e., hospitals, Primary Care Providers (PCP), specialists, pharmacies, skilled nursing facilities, urgent care facilities, clinics, and American-Indian health programs). In the case of a medical group/foundation or Independent Practice Association (IPA), the medical group/foundation or IPA name, provider number, address and telephone number are included for each physician provider. The Directory includes hours and days of operation; services and benefits available; identification of , if any, non-English; languages spoken; the telephone number to call after normal business hours, physical accessibility symbols; and identification of providers that are not accepting new patients. The Department of Health Care Services (DHCS) reviews the Medi-Cal managed care health plans (MCPs) Provider Directory on a semi-annual basis to validate that it contains accurate and complete information about providers available to MCP beneficiaries. This is facilitated through the use of random sampling techniques.

DHCS systematically evaluates and engages an MCP to resolve any issues identified in the Provider Directory. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan , or administering sanctions, respectively, until the issue is resolved.

DHCS monitors trends across MCPs at the MCP model and statewide levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

Measure 12: MCP Initial Facility Site Reviews
Measure 13: MCP Subsequent Facility Site Reviews
Measure 14: DHCS Facility Site Reviews
Measure 15: Facility Site Review Aggregate Data

Are MCP providers in compliance with quality assurance requirements?

All Medi-Cal managed care health plan (MCP) network providers must demonstrate compliance with requirements through a Facility Site Review (FSR) prior to the provision of any services to beneficiaries. The Department of Health Care Services (DHCS) conducts FSRs on MCP providers prior to implementation and the addition of a new coverage population or benefit. MCPs are also required to conduct FSRs as set forth in the contract and All Plan Letter guidance.

Prior to implementation in a new service areas or the addition of a new population for coverage, DHCS conducts an FSR at a sample of the total MCP network providers to ensure that MCP provider sites have sufficient capacity to provide appropriate primary health care services, carry

out processes that support continuity and coordination of care, maintain patient safety standards and practices, and operate in compliance with all contractual requirements.

MCPs must conduct an initial FSR as part of the credentialing process for every network provider and subsequently through recredentialing every three years, at a minimum, thereafter. Providers cannot offer services until after the initial FSR is completed and requirement compliance is demonstrated. MCPs impose Corrective Action Plans (CAPs) regarding deficiencies. In addition, MCPs are required to remove a provider with a FSR non-passing score and/or when corrective action is not completed within the established CAP timelines as an available provider in the MCP network. FSR data is submitted to DHCS for review and to assist DHCS with determining MCP compliance with requirements. MCP FSR data is utilized to assess similar provider deficiencies across MCP networks.

DHCS also conducts ongoing FSRs on a sample of Primary Care Provider sites within a MCP network to verify that the sites have capacity to support the safe and effective provision of primary care clinical services to MCP beneficiaries. DHCS imposes a CAP for any identified deficiencies on the provider through the MCP. If a MCP fails to come into compliance with the CAP, depending on the severity, DHCS may begin a formal process of administering sanctions until the issue is resolved.

DHCS monitors trends across MCP providers within a service, geographic, MCP model, and statewide areas/levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

Measure 16: American-Indian Health Facility

Are MCPs in compliance with requirements pertaining to the inclusion of American-Indian Health Facilities in network?

The Department of Health Care Services (DHCS) monitors Medi-Cal managed care health plans (MCPs) on an annual basis to verify that MCPs are contracting or are attempting to contract with participating American-Indian Health Facilities as is required under the DHCS/MCP contract. If an MCP is not contracting with an American-Indian Health Facility within their service area, DHCS will engage the MCP to determine the reason.

If the MCP is determined to be out of compliance, DHCS systematically evaluates and engages the MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

DHCS monitors trends across MCPs within a service, geographic, MCP model, and statewide areas/levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

Measure 17: Suspended and Ineligible Providers

Are suspended and ineligible providers included in MCP networks?

Medi-Cal managed care health plans (MCPs) are required by contract to check the suspended and/or ineligible providers list monthly to ensure providers on the list are not in the MCP's network. These providers are not eligible for Medi-Cal dollars and may not be in network. The Department of Health Care Services (DHCS) verifies MCP compliance with this requirement through a validation process which runs the monthly provider file against the Suspended and Ineligible Provider Report to determine if providers are in MCP networks that are not allowable.

Pursuant to contractual requirements, any provider of health care services is excluded from participation in Medi-Cal when the individual or entity has:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reason;
- Lost or surrendered a license, certificate, or approval to provide health care; and/or
- Breached a contractual agreement with DHCS that explicitly specifies inclusion on this list as a consequence of the breach.

DHCS systematically evaluates and engages an MCP to resolve any issues identified when reviewing MCP networks to determine the inclusion of unallowable providers. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 18: Facility Decertification

How does DHCS ensure that decertified facilities are not in MCP networks?

The California Department of Public Health has regulatory authority to certify and decertify facilities in California as does the Centers for Medicare and Medicaid Services ; both entities may issue decertification notices of non-compliance to California facilities. Upon the issuance of a notice of decertification from Medi-Cal, the Department of Health Care Services (DHCS) immediately contacts Medi-Cal managed care health plans (MCPs) and provides applicable information. DHCS advises MCPs of the termination and provides a copy of the notice, which includes the effective date of the decertification.

In response to a final notification of decertification by DHCS, an MCP must immediately take required action to ensure that no Medi-Cal funds are paid to the provider past the specified action date, provide beneficiary notification, and provide for the safe transition of beneficiaries to a new provider.

DHCS closely monitors the transition of beneficiaries, maintains ongoing communication with MCPs regarding beneficiary transition plans, and oversees the safe transition of all beneficiaries to alternative providers.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 19: Termination of Subcontractor Relationships

When individual providers, provider groups, or other entities, responsible for serving a significant number of beneficiaries are to be terminated from the network, is the MCP appropriately noticing the Department, following all requirements, and transitioning beneficiaries appropriately?

All Medi-Cal managed care health plans (MCPs) must notify the Department Health Care Services (DHCS) regarding changes in the availability or location of covered services when over 500 beneficiaries are affected.

At least sixty days prior to the proposed effective termination date, MCPs must provide notice to the Department of Health Care Services (DHCS) that details contract terminations with Independent Practice Associations , medical groups, hospitals, clinics, Primary Care Providers , and other subcontracted providers. DHCS requires submission of notices and beneficiary transition plans for approval to ensure beneficiaries are properly noticed and no gaps in care occur.

MCPs are required to provide written notice to affected beneficiaries with "significant" provider changes at least thirty days prior to the intended effective date of the change. In emergencies or other unforeseen circumstances that make compliance with these requirements impossible, MCPs must provide notice to DHCS of the emergency or unforeseen circumstances as soon as possible.

DHCS systematically evaluates and engages an MCP to resolve any issues relating to MCP termination of providers and/or beneficiary transition to new providers to obtain covered services. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan , or administering sanctions, respectively, until the issue is resolved.

IV. Audits and Surveys

The Department of Health Care Services (DHCS) conducts medical surveys and audits to monitor Medi-Cal managed care health plans (MCPs) compliance with DHCS/MCP contracts. Information from these audits and surveys are utilized together to understand the overall performance of MCPs.

Measure 20: Medical Performance Audit

Are MCPs in compliance with DHCS/MCP contractual requirements?

The Department of Health Care Services (DHCS) performs annual medical audits of all contracting Medi-Cal managed care health plans(MCPs) under Welfare and Institutions Code, Section 14456, utilizing nationally recognized audit standards and criteria. Through the use of a formal audit tool, these medical audits review compliance with the DHCS/MCP contract and All Plan and Policy Letters.

The Medical Audit evaluates six categories of performance:

- Utilization Management;
- Continuity of Care;
- Access and Availability;
- Beneficiary's Rights and Responsibilities;
- Quality Improvement System; and
- Organization and Administration of the MCP.

Findings of non-compliance are compiled into an MCP audit report. DHCS utilizes this report to determine MCP compliance with requirements and imposes a Corrective Action Plan (CAP) for all findings which includes steps taken to resolve any finding, specific milestones, and timelines for completion. MCP audit report and CAP documents can be found here. Additional action in the form of sanctions and/or penalties may occur should the MCP not come into compliance with its CAP timely.

DHCS monitors trends across MCPs at the MCP model and statewide levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

DHCS also utilizes medical survey data shared by the Department of Managed Health Care to determine MCP performance. DHCS provides technical assistance to MCPs regarding concerns and, when necessary, imposes corrective action, and may impose sanctions.

Measure 21: Ad Hoc Audit or Focused Reviews

When alerted to a systemic issue with a plan, is there a mechanism to investigate the issue?

When a significant area of concern has been identified, the Department of Health Care Services (DHCS) can conduct ad hoc audits or focused reviews of contracting Medi-Cal managed care health plans . The focused review or ad hoc audit takes an in-depth look at the identified area of concern. Should findings be identified, DHCS imposes a Corrective Action Plan. If identified deficiencies are not corrected within appropriate timeframes, DHCS may administer sanctions, respectively, until the issue is resolved.

Measure 22: Seniors and Persons with Disabilities Medical Performance Survey
Measure 23: Rural Expansion Medical Performance Survey

When a population transitions into managed care, how does DHCS ensure that the MCP is in compliance with contractual requirements as applicable to the transitional population?

Under Interagency Agreement, the Department of Managed Health Care (DMHC) conducts triennial medical surveys of contracted Medi-Cal managed care health plans (MCPs) for the following transitioning populations on behalf of the Department of Health Care Services (DHCS):

- SPD beneficiaries; and,
- Rural expansion beneficiaries.

The surveys monitor MCP compliance, through use of a formal survey tool, with DHCS/MCP contractual requirements pertaining to the aforementioned transitioning populations.

They evaluate the following elements:

- Utilization Management (referrals and authorizations);
- Continuity of Care;
- Availability and Accessibility;
- Beneficiary Rights; and
- Quality Management.

Findings of non-compliance are compiled into an MCP survey report. DHCS utilizes this report to determine MCP compliance with requirements and imposes a Corrective Action Plan (CAP) for all findings which includes steps taken to resolve any finding, specific milestones, and timelines for completion. MCP survey report and CAP documents can be found here. Additional action in the form of sanctions and/or penalties may occur should the MCP not come into compliance with its CAP timely.

DHCS monitors trends across MCPs at the MCP model and statewide levels. Should a systemic trend be identified, DHCS engages with MCPs and provides technical assistance to address areas of concern.

DHCS also utilizes medical audit data (see aforementioned section) to determine MCP performance. DHCS provides technical assistance to MCPs regarding concerns and, when necessary, imposes corrective action, and may impose sanctions.

V. Quality and External Quality Review

The Department of Health Care Services (DHCS) contracts with an External Quality Review Organization (EQRO) to conduct annual Healthcare Effectiveness Data and Information Set (HEDIS®) audits of Medi-Cal managed care health plans (MCPs). Performance measurement validation such as HEDIS®, is a federally mandated External Quality Review activity.

The EQRO auditor validates MCP HEDIS® rates and utilizes HEDIS® standards and criteria established by the National Committee on Quality Assurance (NCQA). NCQA establishes national benchmarks (25th, 50th, 75th, and 90th percentile), from which DHCS creates its MCP Minimum Performance Level (MPL: 25th percentile) and High Performance Level (HPL: 90th percentile). This information is reported annually by DHCS in the annual HEDIS® Aggregate Report.

DHCS uses the annual HEDIS® rates and HEDIS® Aggregate Reports produced by the EQRO as a standardized tool for verifying and comparing the ability of each MCP to provide, quality, accessible, and timely health care services to its beneficiaries. DHCS provides technical assistance at the individual MCP, plan model, and statewide levels. DHCS imposes an Improvement Plan on any MCPs that does not meet the MPL for any HEDIS® measures.

In addition to using an external organization, DHCS conducts other reviews of MCP quality of care. DHCS has established an implemented a formal Quality Corrective Action Plan process which includes specific milestones and timelines generally over a multiple year period.

Measure 24: Improvement Plans

How does DHCS ensure improvement in areas of performance deficiency for HEDIS® rates?

The Department of Health Care Services (DHCS) contracts with an External Quality Review Organization (EQRO) to conduct annual validation of Improvement Plans (IPs) regarding specific areas of health care quality of Medi-Cal managed care health plans (MCPs). MCPs must implement an IP for each HEDIS® measure that is below the Minimum Performance Level. IPs are an opportunity for MCPs to focus on an area of quality improvement with increased technical assistance support from DHCS and the EQRO. The choice of intervention and target population for the IP is made through MCP data analysis.

DHCS's contracted EQRO places emphasis on improving both healthcare outcomes and processes through the integration of quality improvement science under the IP process. The EQRO guides the plans through a process using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility for adjustments throughout the improvement process. By piloting on a smaller scale, plans have an opportunity to determine the effectiveness of several changes prior to expanding the successful interventions to a larger scale.

The EQRO, in consultation with DHCS, provides technical assistance to MCPs throughout the IP process, with frequent contact and feedback to ensure that IPs are well-designed at the onset and provide opportunities for mid-course corrections. DHCS uses the findings to develop or modify quality related policies as well as to provide technical assistance and administer Corrective Action Plan to MCPs.

Measure 25: Managed Care Health Plan Quality Improvement Program Reports

What is the overall Quality Improvement plan for the MCP?

The Department of Health Care Services (DHCS) conducts medical performance audits of Medi-Cal managed care health plans (MCPs) and its contracted External Quality Review Organization (EQRO) includes the findings in its annual Medi-Cal Managed Care Technical Report.

DHCS collects Quality Improvement Program (QIP) reports from each MCP and provides them to the EQRO. Included in the QIP reports are three components: program description, program evaluation, and work plan. The program description lays out the purpose and goals of the MCP's utilization management program. The program evaluation determines if the program actually produced the intended result, evaluates the results of the quality of services provided, and measures the overall effectiveness of the program. The work plan outlines initiatives, activities, monitoring timeframes, and evaluation plans as they relate to the MCP's quality improvement goals and objectives.

The EQRO uses these QIP reports to augment DHCS's medical performance audits. In addition, the EQRO may use the QIP reports to substantiate an MCP's response to EQRO and/or DHCS recommendations. DHCS uses the findings to develop or modify quality related policies as well as to provide technical assistance and administer corrective action to MCPs when appropriate.

Measure 26: Performance Improvement Projects

Are MCPs focusing quality improvement efforts on identified areas of concern?

The Department of Health Care Services (DHCS) contracts with an External Quality Review Organization (EQRO) to conduct annual validation of Performance Improvement Projects (PIPs) regarding specific areas of health care quality of Medi-Cal managed care health plans (MCPs). Each MCP must be engaged in at least two PIPs at all times and can choose to engage in individual PIPs and small group (more than two MCPs) collaborative PIPs. PIPs are an opportunity for MCPs to focus on an area of quality improvement with increased technical assistance support from DHCS and the EQRO. The choice of type of PIP including target population and intervention is made through MCP data analysis.

DHCS's contracted EQRO places emphasis on improving both healthcare outcomes and processes through the integration of quality improvement science under the PIP process. The EQRO guides the plans through a process using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility for adjustments throughout the improvement process. By piloting on a smaller scale, plans have an opportunity to determine the effectiveness of several changes prior to expanding the successful interventions to a larger scale.

The EQRO, in consultation with DHCS, provides technical assistance to MCPs throughout the PIP process, with frequent contact and feedback to ensure that PIPs are well-designed at the onset and provide opportunities for mid-course corrections. DHCS uses the findings to develop

or modify quality related policies as well as to provide technical assistance and administer corrective action plans to MCPs.

Measure 27: Encounter Data Validation

Does the provider medical record match what is being reported by the MCP in encounter data?

The Department of Health Care Services (DHCS) contracts with an External Quality Review Organization (EQRO) to conduct an annual validation of encounter data reported by Medi-Cal managed care health plans (MCPs).

DHCS's contracted EQRO focuses on the following aspects for validation of encounter data submitted by MCPs: review of State requirements, analysis of electronic encounter data, and review of medical records to evaluate the completeness and accuracy of encounter data.

The EQRO produces a report that summarizes statewide and MCP-specific results regarding the focus of the specific encounter data validation activity. DHCS and its contracted EQRO, provide technical assistance to MCPs based on the findings and recommendations for quality improvement in the reports.

Measure 28: Focused Studies

Additional areas of focus that can to be studied relating to quality improvement.

The Department of Health Care Services (DHCS) contracts with an External Quality Review Organization to perform Focused Studies.

Concepts for a Focused Study are developed by DHCS to target relevant quality and administrative areas for improvement or exploration of Medi-Cal managed care health plan (MCP) clinical and non-clinical services. DHCS uses Focused Studies to develop current and future strategies for improvement and to assist DHCS in implementation and evaluation of quality improvement strategies. The Department utilizes Focused Studies to monitor performance in priority areas and to identify opportunities for improved quality of, and access to, care. DHCS uses the findings to develop or modify quality related policies as well as to provide technical assistance and administer corrective action plans to MCPs.

Measure 29: Managed Care Health Plan Consumer Assessment of Healthcare Providers and Systems Survey
Measure 30: Children's Health Insurance Program Specific Consumer Assessment of Healthcare Providers and Systems Survey

What is the beneficiary experience when accessing care?

The Department of Health Care Services (DHCS) contracts with an External Quality Review Organization to perform the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

The CAHPS survey is a nationally standardized survey instrument developed by the National Committee for Quality Assurance designed to capture adult and child beneficiary perspectives of healthcare quality. The intent of CAHPS is to obtain information directly from the person receiving care by using survey results to track and improve beneficiary satisfaction and demonstrate quality improvement.

The main measures of satisfaction with various aspects of care are: access (receiving needed care and receiving care quickly), interpersonal care (how well doctors' communicate and how courteous and helpful office staff is), and plan administrative services (customer service). In addition, the CAHPS survey provides overall ratings of care provided by personal doctor, nurse, or specialist seen on regular basis.

The survey is conducted triennially for the Medi-Cal managed care population and annually for the Children's Health Insurance Program population.

DHCS systematically evaluates and engages a Medi-Cal managed care health plan to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 31: Health Education, Cultural, and Linguistic Group Needs Assessment Report and Update

Are MCPs analyzing and implementing care based on the diversity of and cultural and linguistic needs of their beneficiary population?

The Department of Health Care Services (DHCS) collects a Health Education, Cultural, and Linguistic Group Needs Assessment (GNA) from all Medi-Cal managed care health plans (MCPs).

MCPs are required to conduct GNAs to identify: the needs of its beneficiaries, the available health education and cultural and linguistic programs and resources, and the gaps in services. The special needs of Seniors and Persons with Disabilities, children and adults with special healthcare needs, beneficiaries with limited English proficiency, and beneficiaries from diverse cultural and ethnic backgrounds must be specifically addressed in the GNA findings. The GNA findings are used to plan and implement culturally competent and linguistically appropriate services. MCPs must use multiple reliable data sources, methodologies, techniques, and tools to conduct the GNA.

MCPs prepare a GNA Report and electronically submit an Executive Summary of their GNA Report every five years.

DHCS requires that MCPs prepare a GNA update and submit it annually when a full GNA Report Executive Summary is not submitted. The GNA update addresses demographic changes, new health disparities or changes in health outcomes, changes in HEDIS®, CAHPS, other survey

findings, new health education, quality improvement and cultural and linguistic programs and resources, and new program needs and how they will be addressed.

DHCS monitors the timeliness and content of the GNA Executive Summaries and GNA updates, and reviews the GNA reports to assess MCP beneficiary needs and MCP activities to address those needs. DHCS uses the findings to develop or modify quality related policies as well as to provide technical assistance and administer corrective action plans to MCPs when appropriate.

VI. Grievances and Appeals

The Department of Health Care Services (DHCS) monitors beneficiary grievances and appeals, State Medi-Cal Fair Hearings (SFH), and Independent Medical Reviews (IMR) as a method of measuring Medi-Cal managed care health plan (MCP) beneficiary experience. These data are also utilized to identify areas on MCP non-compliance. DHCS contractually requires that MCPs develop, implement, and maintain written policies that address the beneficiary rights and responsibilities and communicate them to beneficiaries, providers, and, upon request, potential beneficiaries. Amongst the many rights that beneficiaries have, they have the right to:

- Voice grievances, either verbally or in writing, about the organization or the care received; and/or
- Request a SFH, including information on the circumstances under which an expedited fair hearing is possible.

In addition, when a beneficiary receives a Notice of Action from a Knox Keene licensed MCP informing a beneficiary that a medical service has been denied, deferred, or modified, the beneficiary has the right to request an IMR. Together the grievances and appeals, SFHs, and IMRs provide a holistic view of how MCPs are delivering care and allowing the beneficiaries voices to be heard.

Measure 32: Quarterly Grievance Report

What is the beneficiary experience when accessing care?

The Department of Health Care Services (DHCS) collects quarterly grievance data from Medi-Cal managed care health plans (MCPs). DHCS requires MCPs to submit a Quarterly Grievance Report detailing the grievances data at the beneficiary level including the resolution of each grievance.

DHCS utilizes its data warehouse to link the unique beneficiary information of each reported grievance to obtain demographic data such as ethnicity, age, gender, language, geographic area, and service population group types. DHCS uses the Grievance Report as a monitoring tool to measure the: experience of the beneficiary when accessing services, ability of the MCPs to provide quality health care services, effectiveness of utilization control policies, and overall performance of the MCPs in providing health care benefits to its beneficiaries. DHCS analyzes quarterly grievance data and reports summarized findings on the Medi-Cal Managed Care Performance Dashboard.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan , or administering sanctions, respectively, until the issue is resolved.

Measure 33: State Fair Hearings

What is the beneficiary experience when accessing care?

The Department of Health Care Services (DHCS) collects, analyzes, and reports data on Medi-Cal State Fair Hearings (SFHs). DHCS utilizes SFH data as a monitoring tool to measure the: experience of the beneficiary when accessing services, ability of the Medi-Cal managed care health plans (MCPs) to provide quality health care services, effectiveness of utilization control policies, and overall performance of the MCPs in providing health care benefits to its enrollees. DHCS analyzes SFH data quarterly and reports data publicly on the Medi-Cal Managed Care Performance Dashboard. The Department also creates produces a quarterly Independent Medical Review (IMR) and SFH report.

The SFH Report identifies requests statewide by:

- Category; and
- Outcome.

Quarterly reports are compared to prior quarters to identify ongoing trends. When trends are identified at the individual MCP, plan model, or statewide level, DHCS engages in technical assistance with MCPs. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved with an MCP.

Measure 34: Independent Medical Reviews

What is the beneficiary experience when accessing care?

The Department of Health Care Services (DHCS) receives Independent Medical Review (IMR) data from the Department of Managed Health Care (DMHC) on a quarterly basis. DHCS analyzes the IMR data and produces a quarterly report that includes IMR and State Fair Hearing data.

The IMR Report identifies trends and highlights MCPs with the highest:

- IMR cases per 1,000 beneficiaries;
- Number of IMR cases overturned;
- IMR cases reversed by MCP; and
- IMR denials upheld.

Quarterly reports are compared to prior quarters to identify ongoing trends. When trends are identified at the individual MCP, plan model, or statewide level, DHCS engages in technical assistance with MCPs. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan , or administering sanctions, respectively, until the issue is resolved with an MCP.

VII. Data

The Department of Health Care Services (DHCS) collects data from and pertaining to its contracted Medi-Cal managed care health plans (MCPs). This data gives DHCS a snapshot in time of the performance of partner MCPs and can potentially point to beneficiary concerns. DHCS conducts data analysis on received data to further DHCS's goal of improving the quality of health care services provided to Medi-Cal Managed Care and related populations.

Measure 35: Encounter Data

Measure 36: Encounter Data Quality Report Cards

Are encounter data reported by MCPs complete, accurate, reasonable, and timely?

The Department of Health Care Services (DHCS) monitors Medi-Cal managed care health plan (MCP) contractual compliance regarding submittal of complete, accurate, reasonable, and timely encounter data on a monthly basis for all services for which they are financially liable.

Encounter Data is the administrative information that describes health care interactions between beneficiaries and providers. DHCS utilizes encounter data for many reasons, including but not limited to, oversight of MCPs, analysis of Medi-Cal beneficiary populations and health care delivery.

DHCS oversees the submission of high quality MCP encounter data as defined by DHCS contractual requirements and policy guidance. DHCS monitors and tracks encounter data submissions from the MCPs to the DHCS data warehouse.

Further, DHCS measures Medi-Cal managed care encounter data for quality and assesses Medi-Cal managed care health plan (MCP) performance on encounter data reporting. The quality measurements and performance assessment of each MCP regarding encounter data reporting are used by DHCS to create the Encounter Data Quality Report Cards.

In its overall MCP monitoring efforts, DHCS issues Encounter Data Quality Report Cards to verify reliable, quality encounter data submissions from each MCP. In addition, DHCS uses the Encounter Data Quality Report Cards to hold each MCP accountable for reporting data that meets State and federal regulations and DHCS policies.

The quality measurements for the managed care encounter data evaluate completeness, accuracy, reasonability, and timeliness using the most recently published version of the Quality Measures for Encounter Data (QMED) document. The QMED document describes the purpose and specifications for each measure and the methodology for grading performance. DHCS calculates

MCP Encounter Data Quality Grades of "High-Performing," "Low-Performing," or "Non-Compliant," based on the most recent quarterly measurement results in relation to the results from previous consecutive quarters.

Encounter Data Report Cards are issued for each MCP on a quarterly basis. DHCS provides technical assistance to MCPs when its Encounter Data Quality Report Card grades are "Low-Performing" or "Non-Compliant." MCPs are required to remediate all identified deficiencies and resubmit the data. If MCPs do not remediate all identified deficiencies, depending on the severity, DHCS administers a Corrective Action Plan or sanctions, respectively, until the issue is resolved.

Measure 37: Managed Care Ombudsman Call Reports

What is the beneficiary experience when accessing care?

The Medi-Cal Ombudsman helps solve problems from a neutral standpoint to ensure that beneficiaries receive all medically necessary services for which plan are contractually responsible. They will not take sides in a compliant. They consider all information in an impartial and objective manner. On a daily basis the Office of Ombudsman monitors the number of voicemails in both English and Spanish, the number of unprocessed e-mails, the number of unprocessed fillable forms, and the case count per staff. The Office of Ombudsman reviews daily trends such as increased voicemail, e-mail, and online fillable forms and makes necessary adjustments to remedy these types of issues.

On a monthly basis, the Department of Health Care Services (DHCS) Office of the Ombudsman receives data about the total number and type of calls received. The call data is used to generate a monthly report, it includes nine elements that are used to create an Ombudsman Quarterly report.

Elements included in the Ombudsman Quarterly report are listed below:

- Total calls received (inbound) by the Ombudsman;
- Calls to the Ombudsman by create date monthly counts;
- Seniors and Persons with Disabilities (SPD) all calls by create date;
- Calls for access issues;
- Calls regarding mandatory enrollment;
- Calls to the Ombudsman by create date plan counts;
- SPD calls access issues with plan counts;
- SPD calls by create date with plan counts; and
- SPD calls regarding mandatory enrollment.

These data are mined to identify trends at the individual Medi-Cal managed care health plan, plan model, and statewide levels. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 38: Managed Care Health Plan Call Center Report

What is the beneficiary experience when accessing care? Are beneficiaries able to obtain assistance when calling MCPs?

The Department of Health Care Services (DHCS) requires Medi-Cal managed care health plans (MCPs) to submit quarterly Call Center Reports in accordance with contractual requirements. The Call Center Reports must include data on the number of calls received by call type (questions, grievances, access to services, request for health education, etc.); the average speed to answer MCP beneficiary services telephone calls with a live voice; and the MCP beneficiary services telephone calls abandonment rate.

DHCS analyzes and monitors the Call Center Reports to verify that MCPs are providing quality health care services and meeting the contractual requirements. DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 39: Benefit and Population Analysis

Adhoc analyses of MCP performance.

The Department of Health Care Services (DHCS) monitors Medi-Cal managed care health plans (MCPs) through data mining and the production of ad hoc analytic reports on enrollment, service utilization, and provider networks.

The ad hoc analytic reports may target new beneficiary populations transitioning to Medi-Cal MCPs or benefits that are new to MCPs. DHCS tracks and trends data to monitor safe transitions of beneficiary populations and to verify appropriate implementation of new Medi-Cal managed care benefits.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 40: Medi-Cal Managed Care Performance Dashboard

A quarterly snapshot of Medi-Cal managed care performance.

The Department of Health Care Services (DHCS) publishes the Medi-Cal Managed Care Performance Dashboard (Dashboard) on a quarterly basis.

The Dashboard contains data on a variety of measures including enrollment, population demographics, health care utilization, grievances and appeals, quality of care, and measures of satisfaction. Information contained in the Dashboard assists DHCS and stakeholders in understanding Medi-Cal managed care health plan (MCP) performance.

DHCS developed the Dashboard as a monitoring tool and to enhance transparency. DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 41: Pharmacy Formulary

Is the MCP's pharmacy formulary in compliance with contractual requirements?

Medi-Cal managed care health plans (MCPs) are required to submit to the Department of Health Care Services (DHCS) a complete pharmacy formulary for review and approval prior to the beginning of operations, annually thereafter, and upon request. The formulary is reviewed for compliance with DHCS policies.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

VIII. Population Transitions, New Benefits, Continuity of Care, Stakeholder Concerns, and Additional Monitoring

The Department of Health Care Services (DHCS) closely monitors new benefits and/or transitions involving certain populations whose needs are specialized or may involve complex challenges. Because encounter and other data sources are not available immediately, DHCS has implemented the collection of adhoc/temporary data collection from Medi-Cal managed care health plans (MCPs) to assist with understanding how MCPs are performing and what the beneficiary experience is. DHCS utilizes these types of data collection when enforcing changes in policies and procedures.

Measure 42: Stakeholder Input

What are we hearing from external persons/entities?

The Department of Health Care Services (DHCS) receives input for stakeholders via different venues including emails, meetings, phone calls, and others. DHCS follows up on each inquiry or report immediately, resolves them if resolution is needed, and utilizes any identified issues for monitoring purposes. All inquiries are monitored for trending, analysis, and reporting.

DHCS systematically evaluates and engages a Medi-Cal managed care health plan to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 43: Seniors and Persons with Disabilities Transition

How are MCPs performing relative to the transition of Seniors and Persons with Disabilities (SPDs)? What is the SPD experience when accessing care?

The Department of Health Care Services (DHCS) monitors the transition of Senior and Persons with Disabilities (SPDs) from voluntary to mandatory enrollment into a Medi-Cal managed care health plan (MCP). DHCS requires MCPs to submit quarterly data on the SPD including enrollment, grievances and appeals, utilization of services, and continuity of care requests. In addition to these data, DHCS reviews SPD specific data from other areas such as the Ombudsman, State Fair Hearings , Health Risk Assessments, and Medical Exemption Requests . DHCS reviews and analyzes all of the different data to provide a full perspective on MCP performance and beneficiary experience.

DHCS also utilizes network adequacy and medical survey analyses conducted on behalf of DHCS by the Department of Managed Health Care relative to SPDs.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 44: Rural ExpansionTransition

How are MCPs performing relative to the transition of beneficiaries to managed care in the rural expansion counties? What is the rural expansion beneficiary experience when accessing care?

In 2013 the Department of Health Care (DHCS) expanded managed care to 28 additional counties, referred to as the rural expansion of the Medi-Cal managed care delivery system. The additional counties include: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

DHCS monitors the transition of beneficiaries in these rural expansion counties from fee-for-service (FFS) to mandatory enrollment into a Medi-Cal managed care health plan (MCP). DHCS requires MCPs to submit quarterly data on the rural expansion including Primary Care Provider (PCP) assignment and changes in assignment, provider network, continuity of care, consumer satisfaction, grievances, and fraud and abuse. In addition to these data, DHCS reviews rural expansion specific data from other areas such as the Ombudsman, State Fair Hearings and Independent Medical Reviews. DHCS reviews and analyzes all of the different data to provide a full perspective on MCP performance and beneficiary experience.

DHCS also utilizes network adequacy and medical survey analyses conducted on behalf of DHCS by the Department of Managed Health Care relative to the rural expansion.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 45: Behavioral Health Treatment Services

How are MCPs performing relative to the transition of the responsibility of Behavioral Health Treatment (BHT) services from Regional Centers to MCPs? What is the beneficiary experience when accessing care when accessing BHT services?

The Department of Health Care Services (DHCS) expanded the Medi-Cal managed care health plans' (MCPs) responsibility for the provision of Early and Periodic Screening, Diagnosis and Treatment Services for beneficiaries 0 to 21 years of age to include medically necessary Behavioral Health Treatment (BHT) services effective September 15, 2014. BHT is defined as professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, which develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. These services were previously provided by Regional Centers and as such beneficiaries receiving services prior to September 15, 2014 will have responsibility for their services transferred to their MCP in early 2016.

DHCS is monitoring the provision of BHT services in MCPs. DHCS and the Center for Medicare and Medicaid Services (CMS) will certify MCP networks to ensure all contractual requirements are met. The Department currently collects monthly data from MCPs about the number of beneficiaries accessing services, Comprehensive Diagnostic Evaluations completed, and number of assessments completed. DHCS also reviews State Fair Hearing, Independent Medical Review, Ombudsman, and other types of data regularly. The Department will monitor the transition of beneficiaries currently receiving BHT services from Regional Centers. In addition, to the aforementioned efforts, MCPs will report quarterly data including detailed continuity of care requests and outcomes, the number of treatment plans developed and services hours used by age groups, and grievances and appeals.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 46: Mental Health Benefit

What is the experience of beneficiaries when accessing mild to moderate mental health benefits in MCPs? How is coordination with County Specialty Mental Health Plans occurring?

In January 2014, the Department of Health Care Services (DHCS) implemented mild to moderate mental health as a benefit in Medi-Cal. As a result, DHCS requires Medi-Cal managed care health plans (MCPs) to submit mental health data on a quarterly basis. The data includes number and category of referrals and grievances, as well as approved and denied beneficiary

continuity of care requests. DHCS uses the data to monitor the implementation of outpatient mental health services for MCP beneficiaries as well as coordination of services between MCPs and County Specialty Mental Health Plans.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 47: Wheelchairs and Seating and Positioning Components

Are MCPs in compliance with new/clarified policies and procedures?

The Department of Health Care Services (DHCS) implemented new guidelines relating to the Wheelchairs and Seating and Positioning Components benefit in July of 2015. DHCS monitors implementation of new guidelines when necessary.

DHCS is monitoring Medi-Cal managed care health plan (MCP) compliance by reviewing data from the Ombudsman, State Fair Hearings, Independent Medical Reviews, quarterly grievance reports, stakeholder input, secret shopper surveys and other through other monitoring indicators. DHCS will be collecting plan policy and procedures and issuing a reporting template.

MCPs are notified by DHCS if deficiencies are identified regarding this benefit coverage. DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 48: Medical Exemption Request – Continuity of Care

Are MCPs following Medical Exemption Request (MER) automatic continuity of care requirements?

Certain beneficiaries who are required to mandatorily enroll in Medi-Cal managed care health plans (MCPs) who were previously in fee-for-service (FFS) may request a Medical Exemption Request (MER) be approved from the Department of Health Care Services (DHCS). MCPs are provided a denied MER data file weekly and these denials are considered to be automatic continuity of care requests. The following conditions must be met for continuity of care to be offered, the:

- MCP is able to determine that the beneficiary has an ongoing relationship with the provider;
- Provider shares treatment information with the MCP;
- Provider is a State Plan approved provider;
- Provider is willing to accept the higher of the MCP's contract or FFS rates; and
- Provider meets the MCP's applicable professional standards and does not have any disqualifying quality of care issues.

DHCS conducts quarterly reviews of MCP reported and DHCS data to verify that MCPs are offering continuity of care to beneficiaries on the data file.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 49: The Department of Health Care Services Response Team

What are our external partners reporting that can be used for monitoring purposes?

The Department of Health Care Services (DHCS) establishes a Response Team when implementing a new population for coverage or benefit. The DHCS Response Team investigates and resolves areas of concern identified by external persons and/or entities. It coordinates outreach and education, case management, and care coordination with Medi-Cal managed care health plans to provide technical assistance and/or resolve any identified issues.

All cases are monitored for trending analysis and reporting.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 50: Secret Shopper Surveys

What is the beneficiary experience when accessing services?

The Department of Health Care Services (DHCS) conduct secret shopper surveys of Medi-Cal managed care health plan (MCP) call centers and providers to measure compliance with policies and procedures and contractual requirements. Secret shopper calls are made on an adhoc basis which may include when DHCS receives an external complaint, benefit changes are implemented, beneficiary transitions are occurring, and/or when other DHCS monitoring process indicates that an issue might exist.

MCPs are notified by DHCS if deficiencies are identified. DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 51: Managed Long-Term Services and Supports

How does DHCS ensure that MLTSS is transitioned appropriately into managed care?

The Department of Health Care Services (DHCS) enacted the Coordinated Care Initiative, which included Managed Long-Term Services and Supports as a Medi-Cal managed care benefit for Seniors and Persons with Disabilities (SPD) beneficiaries who are eligible for either Medi-Cal

only or SPD dual-eligibles. DHCS requires MCPs to submit quarterly reports containing the following MLTSS monitoring items: continuity of care, call center data pertaining to MLTSS, provider changes, community and facility placement, beneficiary risk assessment reports.

DHCS systematically evaluates and engages an MCP to resolve any issues. Depending on the severity, DHCS will begin a formal process of providing technical assistance, imposing a Corrective Action Plan, or administering sanctions, respectively, until the issue is resolved.

Measure 52: Corrective Action Plans

DHCS utilizes Corrective Action Plans (CAPs) when MCPs are out of compliance with requirements.

The Department of Health Care Services (DHCS) monitors Medi-Cal managed care health plans (MCPs) to ensure that they are providing quality and timely health care. DHCS administers Corrective Action Plans (CAPs) to MCPs to address deficiencies and non-compliance with contractual requirements.

A CAP is a step by step plan of action that the MCPs must develop to achieve targeted outcomes for resolution of identified errors in an effort to:

- Identify the most cost-effective actions that can be implemented to correct error causes;
- Develop and implement a plan of action to improve processes or methods so that; outcomes are more effective and efficient;
- Achieve measureable improvement in the highest priority areas; and,
- Eliminate repeated deficient practices.

CAPs vary depending on if they are for quality, encounter data, contract compliance, medical audit/survey, or other. DHCS has established specific CAP processes in some cases such as quality.

DHCS uses the data collected from the audits, surveys, and CAPs to identify developing trends in the administration and provision of health care services for Medi-Cal Managed Care beneficiaries. DHCS monitors developments through this process and helps align DHCS policy with its mission of providing quality healthcare to beneficiaries. If identified deficiencies are not corrected within appropriate timeframes, DHCS may administer sanctions until the issue is resolved.

Measure 53: Deliverable and Submission Review

Are MCP policies and procedures in compliance with contract requirements?

The Department of Health Care Services (DHCS) reviews submissions and deliverables from Medi-Cal managed care health plans (MCPs) as needed to determine MCP contractual compliance. Examples of deliverables and submissions that DHCS reviews include marketing events materials, updated policies and procedures, Evidence of Coverage (EOC), and beneficiary

letters. DHCS reviews specific deliverables on an annual basis, before marketing events, when a MCP is awarded a new contract, and on an ad hoc basis. DHCS provides technical assistance when MCP deliverables and submissions do not meet requirements. If identified deficiencies are not corrected within appropriate timeframes, DHCS may administer a Corrective Action Plan or sanctions, respectively, until the issue is resolved.

IX. Abbreviations and Acronyms

BHT	Behavioral Health Treatment
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBAS	Community-Based Adult Services
CCI	Coordinated Care Initiative
CDPH	California Department of Public Health
CHIP	Children's Health Insurance Program
CMS	Centers for Medicaid and Medicare Services
COC	Continuity of Care
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQRO	External Quality Review Organization
FFS	Medi-Cal Fee-For-Service Program
FQHC	Federally Qualified Health Centers
FSR	Facility Site Review
GNA	Health Education, Cultural, and Linguistic Group Needs Assessment
HCP Number	Health Care Plan Number
HEDIS®	Healthcare Effectiveness Data and Information Set
HHA	Home Health Agency
HMO	Health Maintenance Organization
IMR	Independent Medical Review
IPA	Independent Practice Association
Knox-Keene Act	Knox-Keene Health Care Service Plan Act of 1975
MCP	Medi-Cal managed care health plan
MLTSS	Managed Long-Term Services and Supports
MMP	Medicare-Medicaid Plan
NCQA	National Committee on Quality Assurance
NPI	National Provider Identifier
PCP	Primary Care Providers
PIP	Performance Improvement Program
SFH	State Fair Hearing
SNF	Skilled Nursing Facility
SPDs	Seniors and Persons With Disabilities

X. Appendix

Managed Care Monitoring Outline Summary

Measure #	Description	Frequency
	Network Access	
1	Network Certification	Ad Hoc
2	Provider Network Report	Quarterly
3	Physician Ratio	Monthly
4	Primary Care Provider Ratio	Monthly
5	Timely Access Study	Annually
6	Seniors and Persons with Disabilities Network Adequacy Assessment	Quarterly
7	Rural Expansion Network Adequacy Assessment	Quarterly
	Network Composition	
8	Monthly Provider File	Monthly
9	Special Populations Detailed Provider Network Report	Quarterly
10	Managed Care Health Plan Subcontractors Report	Quarterly
11	Provider Directory	Semi-Annually
12	Managed Care Health Plan Facility Site Reviews	Triennially
13	Managed Care Health Plan Subsequent Facility Site Reviews	Triennially
14	DHCS Facility Site Reviews	Triennially
15	Facility Site Review Aggregate Data	Triennially
16	American Indian Health Facility	Semi-Annually
17	Suspended and Ineligible Providers	Monthly
18	Facility Decertification	Ad Hoc
19	Termination of Subcontractor Relationships	Ad Hoc
	Audits and Surveys	
20	Medical Performance Audit	Annually
21	Ad Hoc Audit or Focused Reviews	Ad Hoc
22	Seniors and Persons with Disabilities Medical Performance Survey	Triennially
23	Rural Expension Medical Performance Survey	Triennially
	Quality and External Quality Review	
24	Improvement Plans	Annually
25	Managed Care Health Plan Quality Improvement Program Reports	Annually
26	Performance Improvement Projects	Annually
27	Encounter Data Validation	Annually
28	Focused Studies	Annually
29	Managed Care Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	Annually

30	Children's Health Insurance Program Specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	Annually
31	Health Education, Cultural, and Linguistic Group Needs Assessment Report and Update	Quinquennially
	Grievance and Appeals	
32	Quarterly Grievance Report	Quarterly
33	State Fair Hearings	Quarterly
34	Independent Medical Review	Quarterly
35	Encounter Data	Ongoing
36	Encounter Data Quality Report Cards	Quarterly
37	Managed Care Ombudsman Call Reports	Quarterly
38	Managed Care Health Plan Call Center Report	Quarterly
39	Benefit and Population Analysis	Ad Hoc
40	Medi-Cal Managed Care Performance Dashboard	Quarterly
41	Pharmacy Formulary	Annually
	Population Transitions, New Benefits, Continuity of Care, Stakeholder Concerns, and Additional Monitoring	
42	Stakeholder Input	Quarterly
43	Seniors and Persons with Disabilities Transition	Quarterly
44	Rural Expansion Transition	Quarterly
45	Behavioral Health Treatment Services	Quarterly
46	Mental Health Benefit	Quarterly
47	Wheelchairs and Seating and Positioning Components	Monthly
48	Medical Exemption Request - Continuity of Care	Monthly
49	The Department of Health Care Services Response Team	Ad Hoc
50	Secret Shopper Surveys	Ad Hoc
51	Managed Long-Term Services and Supports	Quarterly
52	Corrective Action Plans	Ad Hoc
53	Deliverable and Submission Review	Ad Hoc

Resources

Knox Keene Health Care Service Plan Act of 1975
HEDIS® Aggregate Report
Medical Audits and Surveys Corrective Action Plan
Medi-Cal Managed Care All Plan, Policy, and Dual Plan Letters
Medi-Cal Managed Care Boilerplate Contracts
Medi-Cal Managed Care Monitoring
Medi-Cal Managed Care Quality Improvement & Performance Measurement Reports
Suspended and Ineligible Provider List
Six Models of Managed Care

XI. Definitions

1. **Block transfer -** A transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.
2. **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey** - The CAHPS survey is a nationally standardized survey instrument developed by the National Committee for Quality Assurance (NCQA) designed to capture adult and child beneficiary perspectives of healthcare quality. The intent of CAHPS is to obtain information directly from the person receiving care by using survey results to track and improve member satisfaction and demonstrate quality improvement.
3. **Full risk Medi-Cal managed care health plans (MCPs)** - A Med-Cal managed care health plan that is obligated to cover all of the beneficiaries' cost of care. Beneficiaries will not be charged for any care regardless of the cost.
4. **Healthcare Effectiveness Data and Information Set (HEDIS®)** - A tool used by more than 90 percent of health plans in the United States to measure performance on important dimensions of care and service. HEDIS consists of 81 measures across 5 domains of care and is standardized in order to give regulators, payors, and consumers the ability to compare health plans to each other.
5. **Health Care Plan (HCP) Number** - A unique three digit number that demarcates each plan by each county in which the plan operates.
6. **Improvement Plans (IP)** - MCPs must submit an IP for each measure of the Healthcare Effectiveness Data and Information Set (HEDIS®) that does not meet the DHCS-established minimum performance level or is given an audit result of "Not Reportable." IPs must include new targeted interventions, justify including interventions from the prior year if applicable, include prioritization of barriers and interventions, and include a mechanism for evaluating interventions. DHCS expects MCPs to incorporate a rapid cycle/continuous quality improvement process to guide "course corrections" and achieve desired IP outcomes. As part of this approach, MCPs should perform real-time tracking of their interventions and conduct, at minimum, quarterly evaluations of their interventions.
7. **Interagency Agreement** - A contract between two (2) or more California State agencies.
8. **Knox Keene Act** - The Knox-Keene Health Care Service Plan Act of 1975, as amended, is the set of laws passed by the State Legislature and administered by the Department of Managed Healthcare (DMHC) to regulate Managed Care Plans within the state. It is designed to promote the delivery and quality of health and medical care to the people of California.
9. **The Provider Application and Validation for Enrollment (PAVE)** - PAVE transforms provider enrollment from a manual paper-based process to a web-based portal that providers use to complete and submit their application, verifications, and to report changes. PAVE affords providers on-line instructions; secure log-in; increased accuracy; application fee payment; document uploading capability; electronic signature; application progress tracking; and reduced processing time.

10. **Physician extenders** - A health care provider who is not a physician but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.
11. **Performance Improvement Projects (PIPs)** - A concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention.
12. **Safety net provider** - A provider offering free or reduced-cost care to low-income and uninsured patients.
13. **Technical assistance** - The providing of assistance and/or training.
14. **Telehealth** - The delivery of health-related services and information via telecommunications technologies. Telehealth could be as simple as two health professionals discussing a case over the telephone or as sophisticated as doing robotic surgery between facilities at different ends of the globe.