Medi-Cal Managed Care

QUALITY STRATEGY

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

Annual Assessment

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Quality Strategy Annual Assessment

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EXECUTIVE SUMMARY

California's Medicaid system, Medi-Cal, provides health care services to almost 13 million beneficiaries through two distinct health care delivery systems: managed care and traditional fee-for-service (FFS). Medi-Cal Managed Care has grown tremendously. In 2013, it served about 6 million beneficiaries. That number has grown, and Medi-Cal managed care currently provides health care services to nearly 10 million low-income Californians, including children, pregnant women, and Seniors and Persons with Disabilities (SPDs). The California Department of Health Care Services (DHCS or Department) contracts with 23 full-scope Medi-Cal managed care health plans (MCPs) and three specialty health plans (SHPs) to provide health care services to Medi-Cal enrollees in all 58 California counties.

DHCS developed its *Medi-Cal Managed Care Quality Strategy Report*[1] in 2013 to address the Department's three linked goals: improve the health of all Californians, enhance quality, including the patient care experience, and reduce DHCS per-capita health care costs. The 2014 *Medi-Cal Managed Care Quality Strategy Annual Assessment*[2] built on the framework of the 2014 *DHCS Strategy for Quality Improvement in Health Care (DHCS Quality Strategy)*[3] by designing objectives and interventions specific to Medi-Cal Managed Care, operationalizing the overall DHCS Strategic Plan, and helping DHCS make progress towards its seven priorities within the framework of the commitments from the *DHCS Strategic Plan* 2013-2017.[4]

As the second annual assessment of the 2013 *Medi-Cal Managed Care Quality Strategy Report*, this document evaluates the performance of MCPs, updates progress toward measurable objectives for key indicators, assesses past interventions to improve performance, includes future interventions, describes changes in service delivery and contractual standards, and outlines enhancements in DHCS oversight and monitoring of Medi-Cal Managed Care. For a detailed description of Medi-Cal Managed Care, the reader is referred to the 2013 *Medi-Cal Managed Care Quality Strategy Report*.

This report focuses on performance in three areas critical for the health of MCP beneficiaries:

- Maternal and child health: timely postpartum care, immunizations of two-year olds
- Chronic disease management: hypertension control, diabetes care
- Prevention: tobacco cessation

These focus areas are specific examples of services that MCP beneficiaries need to achieve the seven overall DHCS Quality Strategy priorities of improving patient safety; delivering effective, efficient, and affordable care; engaging persons and families in their health; enhancing communication and coordination of care; advancing prevention; fostering healthy communities; and eliminating health disparities. The quality and coverage of each service is monitored by specific performance measures. For each of these measures, DHCS investigated causes for

[1] http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/QualityStrategyRpt_2013.pdf
[2] http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/MgdCareQualityStrategy2015.pdf
[3] http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2014.pdf
[4] http://www.dhcs.ca.gov/Documents/DHCSStrategicPlan.pdf

the performance gaps by analyzing aggregated data that MCPs reported to the National Committee for Quality Assurance (NCQA), encounter data MCPs reported to DHCS, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) MCP data. DHCS also elicited MCP perspectives on the challenges they faced in engaging beneficiaries and providers. DHCS then worked with stakeholders to develop interventions to address the gaps and set targets for improvement. These initial targets will be revisited in this report as the interventions have been employed, and DHCS continues to works with MCPs to set their own ambitious, yet feasible targets.

DHCS views this assessment as a living document and tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help achieve the Department's mission to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health and substance use disorder services, and long-term services and supports.

Maternal and child health.

In Measurement Year (MY) 2014, the proportion of women with live births who had timely postpartum care improved slightly from 57% to 59%, which places California above the bottom of the national Medicaid 25th percentile. As a result of growth in Medi-Cal Managed Care, over 12,000 more women were due for a postpartum visit in MY 2014 compared to MY 2013. As previously reported, in MY 2013 MCP performance in assuring timely postpartum care had declined nearly 5 percentage points from 2011 to 57%, which placed California below 25th percentile of all Medicaid managed care plans in the US for 2013. Section III describes DHCS interventions to improve timely postpartum visits, including a Department-wide quality improvement collaborative and means to engage MCPs.

In MY 2014, immunization coverage for two-year-old MCP beneficiaries fell again from 75% to 74%, leaving about 46,000 two-year olds without one or more recommended immunization. Medi-Cal Managed Care served almost 20,000 more two-year olds in MY 2014 compared to 2013. As previously reported for MY 2013, immunization coverage for two-year-old MCP beneficiaries had decreased for two prior consecutive years to 75%. The continuing decline in immunization rates means more children are vulnerable to measles, pertussis, and other vaccine-preventable diseases that increased during MY 2014 in California.

Section III describes DHCS interventions to improve immunization coverage for two-year-old MCP beneficiaries. To address the performance gap, DHCS is continuing to partner with the California Department of Public Health (CDPH) to increase MCP providers' use of the California Immunization Registry (CAIR), which will be aided by the upcoming release of the new, single, statewide immunization registry system, CAIR 2.0. Implementation is expected to begin in Fall 2016. CAIR is also working with MCPs to offer reports that will assist MCPs with better understanding which of their provider sites are signed up to use CAIR and which provider sites are actively uploading information to CAIR. DHCS will also be focusing on strategies to improve immunization rates for children as part of a National Governors Association (NGA) grant that DHCS received in 2015. The grant work will initially focus on three MCPs in Sacramento County where rates have been decreasing over the past two years, with the intent of expanding

successful interventions to other MCPs statewide. Additionally, DHCS has made improving rates of immunizations for two-year olds as one of the four topics the MCPs may choose for their DHCS-Priority Performance Improvement Projects (PIPs), and will work with the external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG). HSAG will facilitate quarterly collaborative discussions with the MCPs to provide technical assistance and a forum to discuss barriers and lessons learned in this quality improvement effort. In addition, HSAG will provide individual technical assistance to all MCPs that choose immunizations for two year olds as the topic for their DHCS-Priority PIP.

Chronic disease management.

In MY 2014, MCP performance improved on key measures for chronic disease management. The proportion of diabetic patients who received blood glucose control testing rose from 83% to 86% and the proportion of diabetic patients with glycosylated hemoglobin (HbA1c) levels above 9% (poor diabetes control) decreased from 44% to 39%. With the Medi-Cal Managed Care expansion, MCPs served more than 80,000 more beneficiaries living with diabetes in MY 2014 compared to 2013. These patients are at increased risk for poor health outcomes, such as kidney failure, blindness, and lower extremity amputations. As previously reported for MY 2013, MCP performance had shown a decline in key measures of diabetes care; improvement in MY 2014 reflects numerous joint efforts by both DHCS and the MCPs. Section III describes DHCS interventions to improve diabetes care, including a Department-wide quality improvement collaborative and venues to enlist MCP and stakeholder participation.

In MY 2014, MCPs reported controlling blood pressure in 61% of their beneficiaries with hypertension, an increase of 5 percentage points from 2013, when the rate was 56%. With the expansion of Medi-Cal Managed Care, MCPs served more than 100,000 more beneficiaries living with hypertension in MY 2014 compared to MY 2013. Using the Archimedes model, DHCS predicted that a 15 percent average reduction in systolic blood pressure for each beneficiary with hypertension would lead to the following outcomes over the next 20 years: 19,879 additional quality-adjusted life years, 3,894 fewer major adverse cardiac events, 1,786 fewer strokes, and 1,158 fewer deaths.[5] Section III describes DHCS interventions to achieve and sustain these improvements, including continued participation in the Centers for Medicare & Medicaid Services (CMS) Prevention Learning Network to support implementation of the Million Hearts Initiative in Medi-Cal, which includes working with MCPs to set MCP-specific targets for controlling high blood pressure.

Tobacco cessation.

Tobacco is the leading cause of preventable death in the U.S. Tobacco cessation services have demonstrated to be clinically effective,[6] with a return on investment of 3:1 for dollars spent

[5] Schlessinger L, Eddy DM. Archimedes: a new model for simulating health care systems-the mathematical formulation. *J Biomed Inform*. 2002; 35 (1): 37–50. doi: 10.1016/S1532-0464(02)00006-0.
[6] 2008 US Public Health Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence," http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html.

on smoking cessation services in Medicaid populations.[7] In the 2013 Medi-Cal Managed Care CAHPS survey, a median of 18.2% of respondents reported current smoking (range of 10% to 27% among MCPs). This means that an estimated 413,000 MCP beneficiaries are smokers. A median of 71% (range 58% to 80%) of smokers indicated they received advice from a health care provider to quit smoking. This leaves an estimated 120,000 smokers who did not recall being counseled to quit in the prior 6 months, which shows that improvements are needed in MCPs tobacco cessation counseling. The median for smokers who responded that their providers discussed cessation medications was only 40% (range 27 to 60%).

The CAHPS survey will be repeated in 2016, and DHCS will evaluate progress towards goals of reducing smoking prevalence and increasing the percentage of beneficiaries reporting receiving advice to quit smoking from their health care provider. Additionally, DHCS is exploring opportunities to monitor progress towards tobacco cessation goals by utilizing alternative metrics. Section III describes DHCS efforts to expand tobacco cessation interventions such as increasing referrals to the Quitline, and identifying and tracking tobacco users, per Policy Letter 14-006.[8]

Health Inequities.

Among their beneficiary populations, wide gaps were found in MCP performance by race and ethnicity in MY 2013. For example, African-American or Black beneficiaries had a nearly 20% higher prevalence of hypertension than other race and ethnic groups. Additionally, African-American or Black women with recent births had the lowest postpartum visit rate of any race or ethnic group. To make these postpartum data actionable, DHCS evaluated timely postpartum visit rates among MCPs with more than 200 live births among African-American or Black women in MYs 2012, 2013, and 2014. To address these disparities, the DHCS postpartum collaborative is working with the highest performing MCPs to understand the reasons for their success in reaching African-American or Black women for timely postpartum visits and identifying interventions that can be implemented by the MCPs that have had the least success reaching this group.

Overall Performance.

In MY 2014, MCP overall performance improved from MY 2013. Of the MCP reporting units where MCPs were held to the Minimum Performance Levels (MPLs), 82% performed above the MPLs in MY 2014, as compared to MY 2013 where 79% performed above the MPLs. While this is an improvement since the prior year, there continues to be variability in MCP performance. In MY 2014, 11% of the indicators were above the High Performance Level (HPL). The six best performing MCPs (CalOptima, Inland Empire Health Plan, Kaiser North, Kaiser South, San Francisco Health Plan, and Santa Clara Family Health Plan) performed above the contractually-required MPLs for all their indicators for all reporting units in MYs 2013 and 2014. At the other end of the spectrum, more than one third of reporting unit-indicators in two MCPs (Alameda Alliance for Health and Molina Healthcare) were below DHCS's MCP MPL requirements.

[7] Patrick, R. West K, Ku L, "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts," PLOS One, January 6, 2012, http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0029665.
[8] http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-006.pdf

To address these challenges, DHCS is intensifying its engagement with MCPs and continuing rapid-cycle quality improvement methods. DHCS is working with high-performing MCPs to define and spread evidence-based strategies and best practices. MCPs with indicators with rates below the MPLs are required to submit quarterly Plan-Do-Study-Act cycles and evaluate the effectiveness of their interventions. The lowest performing MCP from MY 2013 continues to be under a Corrective Action Plan (CAP) with close DHCS monitoring. This MCP has seen improvement in performance and has successfully achieved milestones that were set for MY 2014. DHCS instituted a CAP for three additional MCPs, effective Fall 2015, based on poor MY 2014 performance.

SECTION I: INTRODUCTION

Each state that enters into contracts with managed care organizations must develop a written quality strategy per Title 42 Code of Federal Regulations (CFR), Section (§) 438.202. This second annual assessment, reports on significant enhancements in Medi-Cal Managed Care since the 2013 *Medi-Cal Managed Care Quality Strategy Report* by assessing progress and describing changes in the California DHCS approach to improving the quality of care and health of beneficiaries of Medi-Cal MCPs.

This document follows the structure of the CMS Quality Strategy Toolkit for states.

Managed Care Overview, Goals, Objectives

Overview

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 8,993,000 MCP beneficiaries as of December 1, 2014.[9] This is an increase in membership of almost 3 million beneficiaries since the same time in 2013. Of this total, 46% (4.1 million) were children under age 18, and 54% (4.9 million) were adults. Girls comprised 49% of these children under age 18. Women comprised 52% of the 18 to 20 year olds, 59% of the 21 to 44 year olds, and 55%–63% of beneficiaries aged 45 years and older. Of all MCP beneficiaries, 47% were Hispanic, 21% were White, 9% were Black, 12% were Asian/ Pacific Islander, and 11% were other/ unknown race-ethnicity. By aid code groups, 51% (4.5 million) were families (parents and children in families with income up to 138% of the federal poverty level [FPL]), 11% (approximately 960,000) were children (whose parents' income is 138% to 266% of FPL), 7% (approximately 666,000) were seniors and persons with disabilities (SPDs) including children, 7% (approximately 644,000) were dually eligible for Medi-Cal and Medicare, and 24% (approximately 2.2 million) were Affordable Care Act (ACA) expansion population. Medi-Cal Managed Care membership continues to grow in 2015. As of August 4, 2015, there were approximately 9,728,000 MCP beneficiaries. Detailed information regarding the breakdown of membership by MCP can be found in in the Medi-Cal Managed Care Enrollment Reports.[10]

DHCS contracts with 22 full-scope MCPs and three SHPs to provide health care services to Medi-Cal enrollees in all 58 counties. For this report, and in other quality of care reports, DHCS has reported on Kaiser Foundation Health Plan as two entities, Kaiser North and Kaiser South. For purposes of continuity, DHCS will continue refer to 23 full-scope MCPs in this report.

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

1. 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

[9] Posted at: http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx
[10] http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

implemented in 22 counties and operates as a single county-operated health plan. This model does not offer FFS Medi-Cal. The COHS model serves about 1.94 million beneficiaries through six health plans in 22 counties; six of those counties were added in 2013.

2. 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 5.71 million beneficiaries through 16 health plans in 14 counties.

3. In the Geographic Managed Care (GMC) model, DHCS allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county). The GMC model has six health plans that serve more than 940,000 beneficiaries in Sacramento and San Diego counties.

4. 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. The Regional Model was implemented in November 2013, bringing Medi-Cal Managed Care to counties that historically offered only FFS Medi-Cal. The Regional Model serves more than 320,000 beneficiaries in 18 counties.

5. The Imperial Model operates in Imperial County with two commercial health plans. It serves more than 60,000 Medi-Cal beneficiaries.

6. 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 7,000 beneficiaries. San Benito is California's only county where enrollment into managed care is not mandatory.

Quality Goals and Priorities

Three linked goals formed the foundation of the overall 2013 DHCS *Strategy for Quality Improvement in Health Care.*[11] These goals continue to be the following:

- To improve the health of all Californians
- To enhance quality, including the patient care experience, in all DHCS programs
- To reduce DHCS's per-capita health care costs

The 2014 *Medi-Cal Managed Care Quality Strategy Annual Assessment*[12] was the first annual

[11] http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2013.pdf
[12] http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/MgdCareQualityStrategy2015.pdf

assessment of the 2013 *Medi-Cal Managed Care Quality Strategy Report.*[13] This report operationalized the overall 2013 DHCS *Strategy for Quality Improvement in Health Care.*[14] The framework for the present report is based on the seven priorities of the overall *2013 DHCS Strategy for Quality Improvement in Health Care*, as well as three commitments from the *DHCS Strategic Plan* 2013–2017.[15] (See Table 1)

Medi-Cal Managed Care Objectives

The focus areas of this report were chosen because they reflect DHCS priorities, address large performance gaps, and have interventions readily available to improve the health of significant segments of the Medi-Cal Managed Care population. Using these criteria, DHCS has selected two chronic diseases (diabetes and hypertension), two services within maternal/child health (postpartum care and immunization of two year olds), and tobacco cessation (a key prevention strategy) as priority focus areas.

Table 1. Framework for the *Medi-Cal Managed Care Quality Strategy Annual Assessment, 2015-16*

Overall DHCS Quality Strategy priorities	Focus Areas	3 linked goals (Triple Aim)
• Deliver effective, efficient, and affordable care • Engage persons and families in their health • Enhance communication and coordination of care • Foster healthy communities • Eliminate health disparities • Advance prevention • Improve patient safety DHCS Strategic Plan commitments • Treat whole person by coordinating, integrating services • Hold DHCS, MCPs, providers and partners accountable for performance • Maintain effective, open communication	**Maternal child health** Postpartum care Immunizations **Chronic disease** Diabetes care Control of hypertension **Tobacco cessation**	• Improve health • Enhance quality of health care services • Reduce DHCS per capita health care costs

Listed below are the objectives for services to be provided in MY 2015. The targets were set for a 5 percentage point improvement, compared to the baseline year of MY 2013. In some instances, these targets were already achieved in MY 2014. In most other instances, progress

[13] http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/QualityStrategyRpt_2013.pdf
[14] http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2013.pdf
[15] http://www.dhcs.ca.gov/Documents/DHCSStrategicPlan.pdf

towards these targets has been achieved. Interventions listed in Section III were either implemented in 2014 and 2015, or will be implemented in 2015 and 2016. See Section III for an analysis of the scope of the challenges that must be addressed to reach and sustain these objectives.

A. Postpartum care

1. Increase the Medi-Cal weighted average for timely postpartum care to at least 62% for MY 2015.
    - Target for MY 2015: 62%
    - Baseline from MY 2013: 57%
    - Target reached in MY 2014: No; however, performance increased by 2 percentage points to a rate of 59%
    - Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average

2. Increase the percentage of Medi-Cal Managed Care reporting units meeting the MPL for timely postpartum care to at least 80% for MY 2015.

- Target for MY 2015: 80%
- Baseline from MY 2013: 61%
    - In updating the report for this current year, DHCS determined that the 2013 *Medi-Cal Managed Care Quality Strategy Annual Assessment* reported the baseline percentage of Medi-Cal managed care reporting units meeting the MPL for timely postpartum care as 75%, when in fact the correct baseline from 2013 was 61%. While this baseline is 14 percentage points lower than previously reported, DHCS has determined that while maintaining the original target of 80% for 2015 is ambitious, it is also in line with strategic goals, so the target has not been lowered.
- Target reached in MY 2014: No, however, performance increased by 9 percentage points to 70%.
- Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average

3. Increase the proportion of African-American or Black postpartum women with timely postpartum care to at least 50% for MY 2015.
    - Target for MY 2015: 50%
    - Baseline from MY 2012 : 45%
    - Target reached in MY 2014: No. Performance decreased slightly to a rate of 44% in MY 2013 and remained at 44% in MY 2014.
    - Baseline for MY 2012 was recalculated using a revised methodology. The revised methodology resulted in higher overall rates for all race/ethnicity groups, and resulted in an increase of the baseline of African-American women from 33% to 45% for MY 2012. While the rates increased across all demographic groups, the pattern of the differences between groups remained relatively the same. The

revised methodology was also used to determine the rates for MY 2013 and MY 2014. Please see Section III for more information on the revised methodology and analysis results.

- Source: statewide Medi-Cal managed care weighted average calculated by DHCS applying NCQ specifications to encounter data (administrative only, including global billing delivery codes) submitted by MCPs

B. Immunization of 2 year olds

4. Increase to at least 80% the proportion of MCP beneficiaries with up-to-date immunizations by their 2nd birthday during MY 2015.
    - Target for MY 2015: 80%
    - Baseline from MY 2013: 75%
    - Target reached in MY 2014: No. Performance decreased slightly to a rate of 74%.
    - Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average

C. Hypertension

5. Increase to 61% the proportion of MCP beneficiaries 18 to 85 years of age with hypertension whose blood pressure is adequately controlled during MY 2015.
    - Target for MY 2015: 61%
    - Baseline from MY 2013: 56%
    - Target reached in MY 2014: Yes. Performance improved to 61%.
    - Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average

D. Diabetes

6. Outcome objective: Decrease to 39% the proportion of MCP beneficiaries with diabetes who had HbA1c testing greater than 9% or unknown in MY 2015.
    - Target for MY 2015: 39%
    - Baseline from MY 2013: 44%
    - Target reached in MY 2014: Yes. Performance improved to 39%.
    - Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide Medi-Cal Managed Care weighted average

7. Process objective: Increase to 88% the proportion of MCP beneficiaries with diabetes who had HbA1c testing during MY 2015.
    - Target for MY 2015: 88%
    - Baseline from MY 2013: 83%
    - Target reached in MY 2014: No, however, performance increased by 3 percentage points to reach 86%. This improvement was statistically significant.

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

8. Process objective: Increase to 30% the proportion of health care providers participating in the Medi-Cal Electronic Health Records incentive program who report the percentage of adults with diabetes with HbA1c greater than 9%.
    - Target for MY 2015: 30%
    - Baseline from MY 2013: 25%
    - Target reached in MY 2014: Yes. Performance surpassed the target by reaching almost 39% of health care providers participating in the Medi-Cal Electronic Health Records incentive program reporting on the percentage of adults with diabetes who have HbA1c greater than 9%.
    - Source: data submitted by participating providers to DHCS

E. Tobacco cessation

9. Increase to 76% the median proportion of smokers who report being counseled to quit in the prior 6 months (proposed to be measured during 2016 CAHPS survey).
    - Target for MY 2016: 76%
    - Baseline from MY 2013: 71%
    - Target reached in MY 2014: Unknown. DHCS will repeat CAHPS survey in MY 2016.
    - Source: CAHPS survey

10. Increase to 45% the median proportion of smokers who report a provider discussed tobacco cessation medications in the prior 6 months (proposed to be measured during 2016 CAHPS survey).
    - Target for MY 2016: 45%
    - Baseline from MY 2013: 40%
    - Target reached in MY 2014: Unknown. DHCS will repeat CAHPS survey in MY 2016.
    - Source: CAHPS survey

The objectives above will help DHCS meet its overall Quality Strategy priorities of delivering effective, efficient, and affordable care; engaging persons and families in their health; enhancing communication and coordination of care; eliminating health disparities; fostering healthy communities; and advancing prevention. They also address a number of the Department's commitments to the people it serves. For objectives that DHCS has reached already, DHCS will continue efforts to sustain and surpass this improvement. For objectives that DHCS has not reached, DHCS will continue to work towards achieving the objectives.

Objectives 11–14, listed below, are additional commitments to MCP beneficiaries and the public from the DHCS *Strategic Plan 2013–2017*[16] and the overall 2013 *DHCS Strategy for Quality*

[16] http://www.dhcs.ca.gov/Documents/DHCSStrategicPlan.pdf

Improvement in Health Care.[17] In future years, these will also include measurable targets, but for this report are framed as broad goal statements.

11. Improve patient safety
12. Treat the whole person by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care
13. Hold ourselves and our providers, health plans, and partners accountable for performance
14. Maintain effective, open communication and engagement with the public, our partners, and other stakeholders

See Appendix A for the current status of Medi-Cal Managed Care objectives that were listed in the 2013 report.

Development and Review of Quality Strategy

This report was developed by staff throughout DHCS, and involved obtaining feedback from MCPs and DHCS advisory groups related to the focus areas, objectives, and interventions. DHCS will submit this 2015 *Medi-Cal Managed Care Quality Strategy Annual Assessment* to CMS for approval and make it available to the public via the DHCS website.

DHCS assesses the effectiveness of this strategy annually, and reviews its progress in implementing this strategy quarterly. DHCS has ongoing collaboration with stakeholders on initiatives described in this document through quarterly MCP All-Plan Chief Executive Officer Meetings, quarterly All-Plan Medical Director Meetings, and quarterly Managed Care Advisory Group Meetings.

Every three years, DHCS coordinates a comprehensive review and update of its quality strategy. In June 2013, DHCS submitted a comprehensive 2013 *Medi-Cal Managed Care Quality Strategy Report* to CMS, which approved the report. This is an annual assessment. The next comprehensive *Medi-Cal Managed Care Quality Strategy Report* will be developed and submitted to CMS in 2016.

State Standards

Contract provisions established for MCPs incorporate specific standards for the elements outlined in 42 CFR §438.204: access to care, structure and operations, and quality measurement and improvement. See the 2013 *Medi-Cal Managed Care Quality Strategy Report* for a full description of the current state standards.

[17] http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2013.pdf

SECTION II: ASSESSMENT

National Performance Measures

For MY 2014, MCPs reported performance on 15 measures consisting of 30 individual indicators. (See Appendix B, which indicates that 23 of the 30 are in the CMS Core Adult and Child Set).

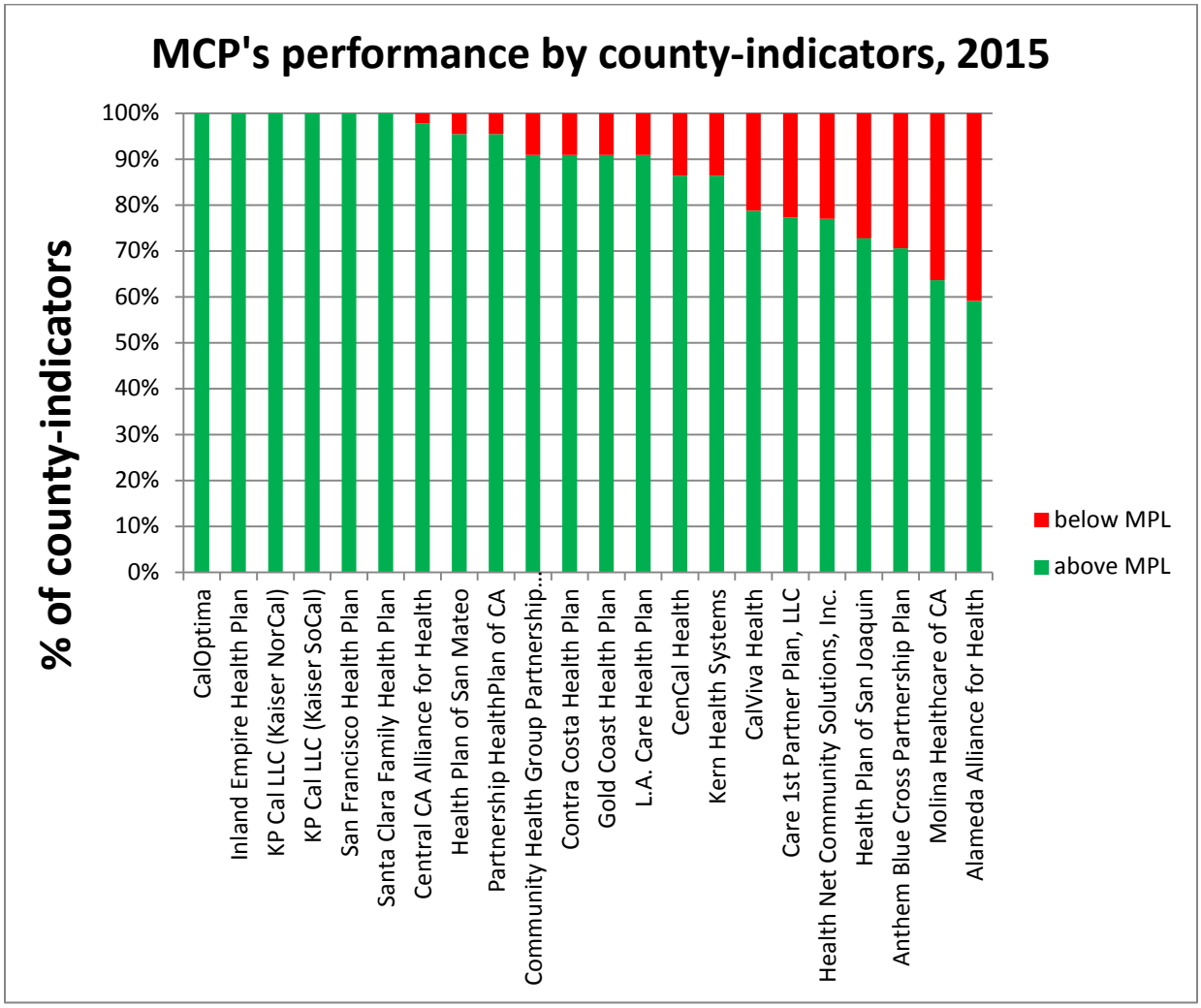
For 22 of these 30 indicators, DHCS holds MCPs accountable for performing at least as well as the national Medicaid 25th percentile. This is the MPL. DHCS defines HPL as performing as well as the national Medicaid 90th percentile.

For health care services provided in MY 2013, the MCPs exceeded the MPLs for 79% of the indicators. This left 21% of indicators falling below the MPLs. For the same MY, MCPs exceeded the HPL for 13% of the indicators. For health care services provided in MY 2014, the MCPs exceeded this MPL for 82% of the indicators where the MCPs were held to the MPL, demonstrating a 3% improvement from the prior year. Additionally in MY 2014, the MCPs exceeded the HPL for 11% of the indicators.[18]

Figure 1 shows the variability in MCP performance on these 22 indicators in MY 2014. Six MCPs fully met their contractual requirements across all their counties of operation; they had no indicators with rates below the minimum performance levels (CalOptima, Inland Empire Health Plan, Kaiser North, Kaiser South, San Francisco Health Plan, and Santa Clara Family Health Plan). However, 16 MCPs had indicators with rates below the MPLs in one or more of their reporting units of operation. The lowest performing MCP was Alameda Alliance for Health, with 41% of its indicators having rates below the MPLs; next was Molina with 36%; followed by Anthem Blue Cross, Health Plan of San Joaquin, Heath Net, Care1st and CalViva, with 29%–21% of indicators with rates below the MPLs.

[18] One of the 23 health plans operating in MY 2014 was new. Additionally, a total of nine of the reporting units for MY 2014 were considered new. New health plans and new reporting units are not held to the MPL until their second full year of operations.

Figure 1. MCP's performance by county-indicators, 2015



* The DHCS MPLs are set as the national Medicaid 25th percentile (except for CDC-H9 where a lower rate is better and the MPL is the national Medicaid 75th percentile). MCPs are not held to the MPL in a new county until their second full year of operations. See Appendix B for the measures included.

Performance on key maternal/child health, chronic disease, and tobacco cessation indicators are discussed in detail in Section III.

Monitoring and Compliance

Rapid Cycle Quality Improvement

In an effort to raise MCP performance, DHCS initiated and continued the following approaches for the MCPs not meeting minimum contractual performance standards for one or more indicators in MY 2014:

- To ensure time for intervention, DHCS continued to work to reduce time lags in identifying and addressing poor performance. In July 2015, DHCS identified poor performing MCPs, as soon as MCPs submitted their final, audited rates to NCQA.

- In 2014, DHCS initiated a new approach to quality improvement projects that focuses on rapid cycle quality improvement. Based on lessons learned from the process, DHCS has determined that a focus on rapid-cycle improvement and implementation of Plan-Do-Study-Act (PDSA) cycles can increase the potential for improved outcomes. As a result, DHCS will continue to focus on rapid cycle quality improvement methods for MCPs with indicators with rates below the minimum performance levels in 2015 and 2016.

- DHCS continued to use instructions and a template for developing objectives using interim outcomes to facilitate use of PDSA methods.

- DHCS continued to require MCPs with substandard performance to conduct quarterly evaluations of their PDSA cycles, with DHCS engagement throughout the year to monitor progress, provide technical assistance, and share lessons learned across MCPs.

- DHCS continues to hold a quarterly Quality Improvement Learning Collaborative which provides a forum for MCPs to receive technical assistance, learn about additional tools and resources, and share evidence-based strategies.

Rapid cycle quality improvement methods were also implemented in Quality Improvement Projects (QIPs) and will continue to be utilized for the new PIPs.

Performance Improvement Projects (PIPs)

As of July 1, 2015, QIPs will be referred to as PIPs by DHCS in order to align with CMS terminology. DHCS requires MCPs to conduct and/or participate in two PIPs annually. In 2014, MCPs were required to continue to participate in a statewide collaborative project to fulfill one of these requirements. The statewide collaborative focused on reducing All-Cause Readmissions (ACR),

For the ACR statewide collaborative, MCPs reported baseline rates for ACR in MY 2012 and remeasurement occurred in MY 2013. Each MCP set its own target to achieve in MY 2013 a statistically significant decrease in the proportion of readmissions compared to MY 2012. The ACR Medi-Cal Managed Care weighted average for all beneficiaries, SPDs, and non-SPDs improved from MY 2012 to 2013. For all beneficiaries, improvement was seen from 14.43% to 14.17%. For SPDs improvement was seen from 17.04% to 16.27% and for non-SPDs improvement was seen from 9.35% to 9.18%. The statewide collaborative concluded June 2015, though MCPs continue to report rates for the ACR measure. In MY 2014 the ACR Medi-Cal Managed Care weighted average for all beneficiaries worsened from 14.17% to 17.72%. From MY 2013 to 2014, 12 MCPs saw worsening in their ACR rate, 7 MCP rates were unchanged, and small improvements were seen in only 3 MCPs covering 5 reporting units: Partnership Health Plan (Southeast), Alameda Alliance for Health, and Anthem Blue Cross (Santa Clara & Contra Costa). While this statewide collaborative may not have clearly achieved its original objective and this collaborative has now concluded, DHCS remains confident that new approaches as described using rapid-cycle quality improvement methods will help lead to broader improvements in all measures including ACR. DHCS will continue to work with its

EQRO to conduct more detailed analyses of these results to determine the statistical significance of the statewide efforts.

In addition to this statewide collaborative project, in 2014 23 full-scope MCPs were conducting 27 MCP-specific QIPs. Each QIP included one or more indicators within a topic, such as diabetes (which may include up to 6 indicators) or prenatal/postpartum care (which may include one or both of these indicators). These 27 QIPs fell into the following topic areas:

- Diabetes care (9 QIPs)
- Prenatal/postpartum care (7 QIPs)
- Immunizations (3 QIPs)
- Controlling high blood pressure (2 QIPs)
- Child and Adolescent access to primary care practitioners (2 QIPs)
- Other (1 QIP each on the topics of well-child visits, asthma medication adherence, monitoring persistent medications, and rating providers and quality of care).

These QIPs concluded in June 2015. Of the 27 QIPs, five (18.5%) achieved statistically significant improvement from baseline, and two sustained improvement for at least one subsequent measurement period. Additionally, one achieved statistically significant improvement in the most recent measurement period from the previous measurement period. MCPs submitted an annual status report for each QIP and quarterly progress reviews. DHCS also instituted procedures to intensify technical assistance to each MCP, as needed.

Beginning in September 2015, MCPs will embark on a new PIP process. The new process places a greater emphasis on improving outcomes using quality improvement science. The new approach guides MCPs through the process using rapid-cycle improvement methods to pilot small changes. The EQRO developed a series of five modules which follow a framework that represents a modified version of The Institute for Healthcare Improvement's Model for Improvement. The EQRO will provide technical assistance throughout the process with frequent contact and feedback. PIPs will last 18 months with the first topic being one of four preselected DHCS topics that align with the identified priority areas of improving childhood immunization rates, timely postpartum visit care, diabetes care, and control of high blood pressure. Of the 23 full-scope MCPs, five selected the topic of improving childhood immunization rates, nine selected the topic of timely postpartum visit care, eight selected the topic of diabetes care, and two selected the topic of controlling of high blood pressure. Of the 3 SHPs, one selected diabetes care, one selected controlling high blood pressure, and one selected a separate topic due to the preselected topics not being appropriate for the SHP's specialized population.

The PIP second topic will be selected by the MCPs. Under the guidance of DHCS and the EQRO, MCPs will provide information supporting their choice of topic and will be encouraged to select an area where they have a demonstrated need for improvement. It is expected that the MCPs will begin their second PIP in January 2016.

Corrective Action Plans

DHCS updated the Quality of Care CAP process in September 2015 and shared the process with MCPs. A CAP is triggered if an MCP meets any of the following criteria:

1) Three or more of the same External Accountability Set (EAS) indicators have rates below the MPLs in the same reporting unit for the last three or more consecutive years; or

2) More than 50% of the total number of EAS indicators for any reporting unit have rates below the MPLs in the most recent MY; or

3) Non-submission of encounter data by an Alternative Health Care Service Plan to a contracted MCP results in the rates for the MCP's EAS indicators not meeting the MPLs or HPL; and/or,

4) DHCS determines that the imposition of a CAP is necessary because the MCP is out of compliance with HEDIS requirements as set forth in its DHCS/MCP contract.

DHCS will impose sanctions for MCPs under a CAP that do not meet established milestones, which may include financial penalties.

In September 2014, DHCS re-initiated a CAP with its lowest performing MCP due to persistent substandard performance across many of its counties of operation. This CAP is effective through 2017 and, on a quarterly basis, the MCP submits status updates to DHCS for review.

In September 2015, DHCS evaluated the need for new CAPs with additional MCPs due to persistent substandard performance across three or more indicators for three or more years in the same reporting unit, as well to address data collection and reporting difficulties experienced by MCPs. DHCS is currently instituting new CAPs for three MCPs.

Public Reporting of Performance Results

DHCS publically reports audited performance results for each MCP on its website and in frequent presentations to stakeholders. DHCS continues to produce the Medi-Cal Managed Care Performance Dashboard (Dashboard). This Dashboard displays data pertaining to enrollment and demographics, financial strength of care plans, health care service utilization, grievances and State Fair Hearings, Continuity of Care and Medical Exemption Requests, and managed care plan Healthcare Effectiveness Data and Information Set (HEDIS®[19]) and CAHPS rates. The Dashboard is continuing to evolve based on the program needs and input from MCPs and stakeholders.

DHCS has also taken other steps to increase public reporting of data. In March 2015, DHCS joined the California Health and Human Services (CHHS) Open Data Portal, which facilitates public access to non-confidential health and human services data. The goal is to make publishable state data open and freely available in accessible formats for the public to reuse and redistribute. DHCS is dedicated in publishing high quality data with comprehensive metadata and documentation to foster interoperability and maximize public understanding of the

[19] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

data. DHCS has provided unprecedented user-friendly access to publicly available data on Medi-Cal and other DHCS programs and continues to add data on a quarterly basis.

Monitoring Network Adequacy
In 2014, DHCS began the Network Monitoring Project. This project is intended to strengthen the Department's oversight of MCP network adequacy by improving current and developing new monitoring procedures. The project is comprised of over 50 mini-projects each addressing a different way of measuring network adequacy, all of which will be rolled out for implementation during 2016.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
DHCS has been using the results of the tobacco questions from the 2013 CAHPS® survey to inform tobacco cessation interventions and monitoring. DHCS uses the CAHPS surveys to assess beneficiary experience of care, and publishes results in the Consumer Guide to help inform beneficiaries' decisions on choosing an MCP.

Quality and Appropriateness of Care

Reducing Disparities in Health Care
The *Let's Get Healthy California Task Force Final Report*[20] *(LGHCTF)* noted that racial and ethnic disparities continue to widen across many health outcomes. The report makes clear that eliminating health disparities is an over-arching goal and that health equity is vital to achieving improvements in health.

Eliminating disparities is also a priority of the DHCS Quality Strategy. As part of the DHCS quality improvement collaboratives on diabetes and postpartum care (see Section III), DHCS has previously analyzed encounter data to determine disparities in key indicators by race and ethnicity. Actionable results are described in Section III, along with interventions to address the disparities.

DHCS is also participating in a CMS Prevention Learning Network with the goal of aligning DHCS services, programs, delivery systems, and partnerships to support the Million Hearts Initiative in Medi-Cal. After reviewing national and Medi-Cal data, DHCS elected to place a priority on increasing hypertension control among MCP beneficiaries and to reduce health disparities in this clinical area. See Section III for a description of the quality improvement project to increase hypertension control.

In 2013, DHCS developed a series of fact sheets, titled *Health Disparities in the Medi-Cal Population.* The fact sheets, which reflect the same indicators used by the *LGHCTF,* characterize identifiable health disparities in the Medi-Cal population.[1] In State Fiscal Year (SFY) 2014–15, DHCS worked with stakeholders and partners to develop aggressive intervention plans to eliminate addressable disparities and inequities and will continue these collaborations in the future. In 2015, DHCS developed a second set of fact sheets based on the quality indicators from the Centers from Medicaid and Medicare Adult Medicaid Quality Grant

[20] http://www.chhs.ca.gov/Documents/Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf
[1] http://www.dhcs.ca.gov/dataandstats/reports/Pages/HealthDisparities.aspx

(AMQG). As part of the partnership, DHCS maintains an interagency agreement with the Office of Health Equity within CDPH to optimize effectiveness and efficiency in shared efforts to eliminate health disparities and inequities.

Enrollee Race, Ethnicity, and Primary Language Data

DHCS contracts with an enrollment broker to enroll beneficiaries into an MCP. The DHCS enrollment broker uses Medi-Cal Eligibility Data System (MEDS) information to generate and send enrollment packets to newly eligible Medi-Cal beneficiaries in Two-Plan Model, Regional, Imperial, San Benito, and GMC model counties. Self-reported race, ethnicity, and language information for each new beneficiary is transmitted to the appropriate MCP based on MCP enrollment files, as required by 42 CFR §438.204(b)(2). DHCS currently uses 13 threshold languages, including English. DHCS uses the threshold language data to determine the languages into which enrollment and informing materials in each county must be translated and which languages must be available to interpret conversations between Medi-Cal enrollees/beneficiaries and enrollment customer service representatives. In addition, MCPs must use the threshold language criteria to determine the languages into which informing materials must be translated. MCPs must also arrange for appropriate cultural and linguistic support to limited English proficient beneficiaries, including interpreter services in provider offices.

External Quality Review

The most recent EQRO recommendations for DHCS (from the 2013-14 EQRO Technical Report) are listed below, along with DHCS responses.

1. Report outcomes achieved through strategies outlined in the *Medi-Cal Managed Care Quality Strategy Report,* and indicate whether strategies will be expanded, modified, or eliminated to achieve improvement in key focus areas.

   DHCS response: Outcomes achieved through strategies in the previous Quality Strategy Report are outlined in this report, and this report indicates which strategies are being continued, expanded, modified or eliminated to achieve improvement in the key focus areas.

2. Explore with the EQRO a redesigned QIP process that supports the MCPs in conducting QIPs using rapid-cycle techniques and a validation process that facilitates greater technical assistance to the MCPs and feedback throughout the rapid-cycle QIP process.

   DHCS response: See Monitoring and Compliance in Section II above which describes the redesigned PIP process, formally referred to as QIPs.

SECTION III: IMPROVEMENT and INTERVENTIONS

Initiatives to Improve the Quality of Care

This section describes initiatives to improve the quality of health care services provided to MCP beneficiaries in the following areas:

- Maternal and child health (postpartum care, immunizations)
- Chronic disease management (diabetes care, control of hypertension)
- Prevention (tobacco cessation)

These initiatives respond to important gaps in care that have large consequences on individual and population health, as well as on the Medi-Cal budget. While the objectives in the 2014 *Medi-Cal Managed Care Quality Strategy Annual Assessment* proposed a modest five percentage point improvement from MY 2013 to 2015, the interventions implemented in 2014 assisted with achievement of some of these goals before MY 2015, and the interventions listed below should better equip DHCS and MCPs to maintain and surpass these already achieved goals and to accelerate progress toward the rest of the three linked goals. These areas are a subset of all the health needs of MCP beneficiaries. Focusing on these three areas for the next year should strengthen organizational structures and capacity to enable DHCS and its contracted MCPs to make improvements in the overall quality of health care services.

In Table 2, the health interventions for the three areas are listed in descending order by the estimated number of beneficiaries impacted.

Table 2. Estimated impact of MCP performance: beneficiaries documented to have received appropriate care ("served") vs. not "served," 2014

Performance measure	Growth in number of beneficiaries impacted from MY 2013 to 2014	Number of beneficiaries impacted total in MY 2014	Percentage of beneficiaries "served"	Numbers of beneficiaries not documented to receive appropriate care
Tobacco Cessation+				
• Advised to quit	Not Applicable (NA)*****	413,000 adults who smoke	71% recalled being counseled to quit	120,000 smokers not recalling being counseled to quit
• Discussed medication to quit	NA*		40% recalled discussing cessation medications	248,000 smokers not recalling discussing medication to quit
Controlling blood pressure	106,427 more adults with hypertension (HTN)	281,629 adults with HTN	61.22% with controlled HTN	92,139 HTN patients with blood pressure not controlled
Diabetes Care				
• HbA1c testing	83,313 more adults with diabetes	242,588 adults with diabetes	85.81% tested in past year	34,430 diabetes patients with no HbA1c test result
• Blood glucose control			60.65% whose last HbA1c was < 9%^ or unknown	95,456 diabetes patients whose HbA1c was > 9% (not controlled) or unknown
Immunization coverage	19,105 more two year olds	174,341 two year olds	73.84% up to date on immunizations **	45,606 two year olds incompletely immunized
Postpartum care	12,439 more women who gave birth	94,427 women who gave birth	59.35% had a timely postpartum visit**	38,384 mothers without a timely postpartum visit

Notes: numbers rounded to nearest 1000.

* New data not available for number of adults who smoke in 2014 to compare to 2013.

+ Estimated impact for Tobacco Cessation continues to be based on rates reported in the 2014 *Medi-Cal Managed Care Quality Strategy Annual Assessment* and reflects the 2,268,493 Medi-Cal managed care beneficiaries 18 years of age and older. as of

December 2013.

^This table uses the complement of the HEDIS® CDC-H9 rate (i.e., 1 minus .39). To qualify for the numerator for this rate, a beneficiary would either have a HbA1c test value greater than 9 or a test value unknown.

** no improvement from MY 2013

Tobacco (row 1): proportions are medians from the 2013 CAHPS survey. Impacted population is estimated by applying the median proportions to the adult Medi-Cal Managed Care enrollees as of December 2013

http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD_Dashboard_Q4_2013.pdf

Rest of rows: proportions are statewide weighted averages derived from the rates MCPs submit to NCQA. The source for column 2 is the total population eligible for the HEDIS® rate calculation, as reported by MCPs to NCQA. These are minimum estimates, since NCQA specifications exclude certain patients (such as those not continuously enrolled in the MCP for 12 months).

The populations served and not served both grew, as would be expected with almost 3 million additional beneficiaries served through Medi-Cal Managed Care. The growth in membership through the expansion of Medi-Cal can be seen most in adult beneficiaries with chronic diseases such as diabetes or hypertension. DHCS saw improvement in a number of key areas, even with this tremendous growth of new membership. The Medi-Cal statewide average for Controlling Blood Pressure, Diabetes HbA1c testing, Diabetes HbA1c >9, and Postpartum Care have all improved from MY 2013 to 2014. The statewide weighted average for Controlling High Blood Pressure and Diabetes HbA1c >9 met the goal of improvement by five percentage points early by meeting that goal in MY 2014. Additionally, the statewide weighted average for Diabetes HbA1c testing improved by three percentage points, and the statewide weighted average for Postpartum Care improved by two percentage points after declining in the previous year.

While DHCS found a number of areas with successes, the Medi-Cal statewide weighted average for Immunizations of two year olds declined from 77% to 75% from MY 2012 to 2013. It fell again slightly in MY 2014 to 74%. Additionally, while areas of success were found, it is important for DHCS to see these successes sustained and surpassed in MY 2015. DHCS implemented or plans to implement the following interventions to address the causes of poor performance and to reach or surpass improvement objectives for MY 2014 that are listed in Section I.

DHCS Interventions from SFY 2014–15 and SFY 2015–16

1. Intensify engagement with targeted MCPs
   a. DHCS has worked to understand and address the causes of lower performance, current MCP activities, successes and challenges, lessons learned, and technical assistance needs. For each indicator, DHCS focused on:

- MCPs with the largest numbers of beneficiaries not served (where interventions are needed to raise the statewide weighted average).
- MCPs with substandard performance (to ensure minimum quality of care in all counties) and use rapid cycle Quality Improvement (QI) methods.
- MCPs with largest number of beneficiaries in underserved race-ethnic groups (to address health inequities).

b. DHCS assisted MCPs in setting MCP-specific targets for one or more of the objectives in this document, and included action plans to meet the targets in their required annual quality improvement reports.

In addition to continuing the above interventions, DHCS plans to continue to intensify engagement with the MCPs. DHCS will utilize technical assistance teams consisting of members of DHCS staff with clinical, research, analytic, and quality improvement backgrounds for MCPs with the greatest demonstrated need for improvement. This team will work in conjunction with the EQRO and will focus on providing increased technical assistance and oversight of MCPs with substandard performance that may be at risk for a CAP in future years if improvement is not achieved. The team's focus will be to ensure that the MCPs are successful in applying the concepts of quality improvement and will assist the MCPs with ensuring targets and interventions are evidence based.

2. Convene a statewide QI Collaborative
   a. DHCS brought together MCP staff (Quality Directors, Medical Directors, Health Educators) with DHCS staff with regular, action-oriented teleconferences for MCPs to share challenges and lessons learned, identify and resolve state and local barriers, and receive/provide technical assistance. Four Quality Improvement Collaboratives were established, including a Diabetes Quality Improvement Collaborative, Hypertension Quality Improvement Collaborative, Postpartum Quality Improvement Collaborative, and the Quality Improvement Learning Collaborative. This organizational structure was used to enlist MCPs to adapt and implement:

      i. The Million Hearts Initiative

      ii. The postpartum and diabetes interventions in this document

      iii. Four Quality Improvement concepts for rapid cycle quality improvement

   b. DHCS established a SharePoint site for posting/exchanging evidence based strategies and best practices and resources. DHCS will be continuing the above collaboratives, as this was found to be a great opportunity to share evidence based strategies and best practices and to support statewide improvement. DHCS saw improvement in each of these areas based on the statewide Medi-Cal weighted average for key quality indicators in these areas. DHCS plans to modify the collaborative by bringing in the support of the EQRO and will continue to solicit and utilize MCP feedback in the design of these collaboratives. Additionally, DHCS and the EQRO will initiate a similar collaborative focused on Childhood Immunizations, an area where the state has not seen improvement over the past year. The first set of PIPs that MCPs will conduct will be around four key priority areas: Diabetes, Hypertension, Postpartum Visits, and

Childhood Immunizations of two-year-olds. MCPs participating in these PIPs will participate in one of the correlated four Quality Improvement Collaboratives, though the group will not be limited to just those MCPs as all MCPs may find benefit from participation.

3. Optimize provider education, feedback, incentives for QI
   a. DHCS continues to work to define strategies used by the most successful MCPs to engage their provider groups for performance feedback and peer comparison, patient registries and population management, care management and patient outreach in order for DHCS to establish and implement standards of practice.

DHCS continues to support MCP efforts to establish provider incentive programs. These programs can be drivers of quality improvement, can help focus providers on key priority areas for improvement, and can complement efforts around other beneficiary incentives.

DHCS has developed a Care Coordination Collaborative with its MCP partners to assist the MCPs with improving care coordination for beneficiaries both within the plan and integration of services outside of the plan. The Collaborative, which is composed of DHCS staff and various staff from each of the MCPs, will share evidence based strategies and best practices surrounding care coordination and also help to increase and improve communication between the MCPs and various outside agencies (e.g., Regional Centers, California Children's Services, County Mental Health, County Public Health, Substance Use Disorder Services, Dental, Subacute Nursing Facilities, hospitals, etc.), to better integrate care. The Collaborative held its first meeting at the end of July 2015 and will meet every two months.

   b. DHCS has continued to work with Integrated Healthcare Association (IHA) to identify successful elements and means to scale them up from its survey of MCP Pay-for-Performance programs and Medi-Cal MCP Pilot project (and Web Reporting Platform).

DHCS has continued to meet with IHA to learn from their survey of MCP Pay-for-Performance programs and their Medi-Cal MCP Pilot project (and Web Reporting Platform). DHCS continues to gather evidence based strategies and best practices from MCPs with successful Pay-for-Performance programs and successful provider report card programs.

   c. Within the Electronic Health Record (EHR) incentive program (Meaningful Use Stage 2):

- DHCS denoted HbA1c > 9% on the State Level Registry (SLR) as a recommended Clinical Quality Measure (CQM) and this was published on the SLR home page
- DHCS has provided data to MCPs on their providers participating in the EHR incentive program, which CQMs they report, and their level of performance.

DHCS identified HbA1c > 9% as a recommended CQM, which may have largely contributed to such a significant increase in providers reporting on this measure, from 25% in MY 2013 to 39% in 2014.

d. DHCS has provided evidence-based resources online for providers (such as the American Medical Group Foundation's *Measure Up Pressure Down Provider Toolkit to Improve Hypertension Control*[21]).

e. DHCS continues to evaluate obstetric payment arrangements (including global billing) and their impact on postpartum visit rates.

4. Optimize beneficiary engagement

a. DHCS continues to assess barriers to beneficiary engagement and determine which can most effectively be addressed by MCPs.

This is an ongoing topic during all the Quality Improvement Learning Collaboratives. DHCS continues to support MCPs learning from each other about barriers that have the greatest effect and thus the highest opportunity for high impact.

b. DHCS continues to describe MCP beneficiary education, outreach and incentives programs.

DHCS has determined that beneficiary incentive programs are being used for the vast majority of the MCPs to encourage beneficiaries to engage in healthy behaviors, such as screening for cervical cancer, establishing healthy eating habits or exercising. In addition, MCPs have developed beneficiary incentive programs that started, are ongoing, or ended in the past year. For example, gift cards are provided to beneficiaries with diabetes who complete their HbA1c test. Approximately eight MCPs are participating in diabetes incentive programs. Two MCPs have blood pressure monitoring incentive programs. Six MCPs have incentive programs for increasing postpartum visits. DHCS continues to monitor and approve beneficiary incentive programs and track the programs for the MCPs.

c. In updating the beneficiary incentive program process for MCPs, DHCS also will be providing guidance on MCP use of focus groups and beneficiary surveys. MCPs can gather information directly from beneficiaries through focus groups and surveys. This information can be translated into strategies to improve quality of care.

DHCS continues to explore avenues to increase opportunities to share evidence based strategies and best practices among MCPs. In addition to Quality Improvement Collaboratives and Medical Director Meetings, DHCS has instituted a new avenue to share evidence based strategies and best practices in 2015. DHCS has in the past given Quality Awards to high performing MCPs and MCPs that show the greatest improvement. In 2015, DHCS began a new Quality Award for Innovation. This award will be given to the MCP with the most innovative project or pilot project aimed at improving quality of care. The nomination and voting process for this award will provide an opportunity for MCPs to share evidence based strategies and best practices. The award announcement will include another opportunity for MCPs to review both the program that won as well as all programs that were nominated.

[21] American Medical Group Foundation, American Medical Group Association. *Measure Up Pressure Down Provider Toolkit to Improve Hypertension Control*. Alexandria, VA: American Medical Group Foundation; 2013. http://www.measureuppressuredown.com/HCProf/toolkit.pdf. Accessed July 24, 2014.

d. Implement a pilot program with selected MCP to offer free blood pressure monitors to Medi-Cal beneficiaries with hypertension.[22,23]

Home blood pressure monitors became a covered benefit effective August 2015 for all Medi-Cal and dual eligible beneficiaries for one MCP, San Francisco Health Plan. Monitors with a value up to $50 are covered, and each beneficiary is eligible for 1 monitor every 5 years.

e. DHCS continues to engage key MCPs to institutionalize Text4baby enrollment for all perinatal beneficiaries.

MCPs have developed direct collaborations with Text4baby. One MCP has contracted with Text4baby to jointly develop outreach materials while another is in the process of developing a contract. Two MCPs have signed contracts with Text4baby around building a custom service and exchanging data, while others are pursuing this option. Additionally, through CDPH, California Perinatal Service Program (CPSP) providers who enroll at least ten pregnant women into Text4baby are eligible for an incentive raffle.

f. Identify evidence-based strategies and best practices within MCP networks for timely notifications of pregnancies and deliveries.

DHCS continues to support efforts for MCPs to increase timely notifications of pregnancies and deliveries, and has utilized the Postpartum Quality Improvement Collaborative to further these discussions.

5. Improve and analyze encounter data to drive program improvement
   a. DHCS planned to perform an analysis of MCP performance on key indicators by race and ethnicity to evaluate progress toward eliminating health inequities in priority areas.

DHCS has performed an analysis of timely postpartum visit rates by race/ethnicity using data from MY 2013 and MY 2014. This analysis was done using a revised methodology, and to better understand trends in performance on this key indicator over time, DHCS repeated the analysis for MY 2012 data utilizing the new methodology.

While DHCS was not able to complete analysis of other key indicators by race and ethnicity in 2015, DHCS was able to produce Health Disparity Fact Sheets to highlight areas of disparity for ongoing focus. Additionally, DHCS is evaluating an option of using the EQRO to perform such analysis in future years. DHCS is working closely with the EQRO to develop a Health Disparities Report that will identify areas of disparities in rates by race/ethnicity, and other demographic factors. DHCS will begin requiring MCPs to submit beneficiary-level data to the EQRO for this analysis. Furthermore, DHCS will internally dive deeper into health inequities in postpartum care by looking beyond race and ethnicity to identify other beneficiary-level characteristics that influence care.

[22] Centers for Disease Control and Prevention. *Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners.* Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2013. http://millionhearts.hhs.gov/Docs/MH_SMBP.pdf. Accessed June 24, 2014.
[23] Uhlig K, Balk EM, Patel K, et al. *Self-Measured Blood Pressure Monitoring: Comparative Effectiveness.* 45 ed. Rockville, MD: Agency for Healthcare Research and Quality; 2012. http://www.ncbi.nlm.nih.gov/books/NBK84604/pdf/TOC.pdf. Accessed July 24, 2014.

b. Prioritize additional data analysis

DHCS elicited MCP input on data that would be most actionable for their QI efforts. DHCS has determined that timely birth data would enable MCPs to take better action in improving postpartum visit rates. DHCS is continuing to explore avenues to support MCPs efforts to improve timeliness of birth data.

Additionally, MCPs have identified the need for more timely data regarding services provided to beneficiaries outside of the MCP to ensure successful care coordination efforts and integration of services. DHCS has taken steps to provide timely access to data regarding medications that are covered outside the MCP, such as anti-psychotic medications, substance use disorder treatment medications, and medications to treat Human Immunodeficiency Virus. Reports for these medications will be provided to the MCPs on a monthly basis. The reports will provide information for the last 12 months to ensure data is as timely as possible while still providing opportunity to ensure data completeness over time due to expected data lags. MCPs have identified these new reports as a resource to improve the quality of care beneficiaries receive and will impact many aspects of care.

- DHCS continues to explore avenues to utilize pharmacy data (to assess prescription and adherence to anti-hypertensive medications, tobacco cessation drugs).

California was one of ten states chosen to participate in the Medicaid Incentives for the Prevention of Chronic Disease Program, created by the ACA. These states are studying the use of incentives to encourage Medicaid beneficiaries to make healthy choices. California's project is the Medi-Cal Incentives to Quit Smoking (MIQS). Eligible Medi-Cal beneficiaries who smoke could receive a $20 gift card if they call the Helpline and engage in counseling. They could also receive free nicotine patches sent to their home, in addition to free telephone counseling. Providers throughout the state were actively referring their Medi-Cal patients, and over 47,000 enrolled through the end of July 2015. MQIS was successful in meeting its goals to provide incentives and counseling services that help Medi-Cal beneficiaries quit smoking. All MCPs received data on their beneficiaries who called the California Smokers' Helpline and subsequently received free nicotine patches through this program.

With the end of the MIQS program, some MCPs are independently collaborating with the Helpline to continue this service. Some MCPs are also reviewing pharmacy data to get a sense of utilization of tobacco cessation drugs among their beneficiaries. An updated tobacco All Plan Letter (APL) will outline MCP options for assessing and tracking tobacco use and treatment.

- DHCS has discussed which CMS Core Child and Adult indicators it could calculate internally using encounter data.

DHCS has taken steps to evaluate the utilization of encounter data to calculate additional indicators. DHCS will continue to determine which measures could be calculated internally using encounter data related to the CMS Core Child and Adult quality measures. Additionally, DHCS is exploring opportunities to monitor progress towards tobacco cessation goals by utilizing alternative metrics. DHCS plans to utilize Focus Studies completed by the EQRO to determine if the methodology used for such measures is valid and if the degree of completeness and accuracy of data is such that DHCS can publicly report such measures with confidence. DHCS will also be exploring internal calculation of other quality metrics such as metrics related to palliative care quality, and plans to utilize the EQRO Focus Studies to similarly determine if the measures' rates are valid and reliable.

c. DHCS continues the Encounter Data Improvement Project, and is identifying other means to support MCPs to improve data collection and use.

- DHCS continues to investigate discrepancies in denominators from encounter data compared to other data sources such as the audited, aggregate data MCPs report to NCQA.

6. Measure, report and use MCP performance

a. DHCS has continued to update performance indicators on the Dashboard each quarter.

In the coming year, DHCS plans to utilize a new format for performance indicators on the Dashboard so that all indicators can be presented at one time once the rates are available, rather than only a select number over time.

b. Post annual performance results online promptly.

DHCS continues to work towards prompt public reporting. DHCS instituted new regulations regarding the safe release of data to ensure that beneficiary identification is protected. These new regulations led to some delays in public reports during 2015. However, as this process continues to be utilized and improved, DHCS will work to ensure delays do not occur.

c. Present to stakeholders.

DHCS continues to present information to stakeholders through a number of venues. In addition to the Dashboard and reports published online, DHCS presents information to the Medi-Cal Managed Care Advisory Group and other large stakeholder meetings.

d. DHCS continues to inform beneficiaries' choice of MCPs via the Consumer Guide rankings, developed by the Office of Public Advocate.

e. DHCS included the *Controlling High Blood Pressure* indicator in the auto-assignment algorithm, where MCPs with higher performance than other(s) operating in the same county are rewarded by receiving new beneficiaries who do not actively choose to enroll in a particular MCP

The addition of this indicator to the other measures involved in the auto-assignment algorithm (*Cervical Cancer Screening*, *Childhood Immunization Status*, *Timeliness of*

Prenatal Care, *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life*, *Comprehensive Diabetes Care*: *HbA1c Testing*, and now *Controlling High Blood Pressure*) has helped ensure MCPs with higher performance on key areas are rewarded.

f. DHCS continues to develop tobacco cessation indicators and targets (including the outcome of smoking prevalence and the process of calls to the Helpline) to implement and monitor Policy Letter 14-006)[24]

The DHCS Tobacco Subcommittee, comprised of health educators of the managed care health plans, was formed to assist in this endeavor. The Committee has met several times and helped develop metrics to identify tobacco users and to monitor their use. Methods identified include: electronic health records, International Classification of Disease (ICD) codes, California Smokers' Helpline data, as well as pharmacy data, Current Procedural Terminology codes, the Staying Healthy Assessment (SHA) and CAHPS. Additionally, DHCS is exploring opportunities to monitor progress towards tobacco cessation goals by utilizing alternative metrics.

7. Collaborate with CDPH
   a. DHCS has promoted partnerships between MCPs with local Maternal, Adolescent and Child Health (MCAH) programs. This has included providing a crosswalk for MCPs to access services and provider training from local MCAH programs through the Postpartum Quality Improvement Collaborative.

The MCAH programs have agreed to partner with the Postpartum Quality Improvement Collaborative and will be working with the county CPSP coordinators to build relationships between the coordinators and the MCPs.

DHCS also has partnerships between CDPH's Coordinated Chronic Disease Branch and the Hypertension Quality Improvement Collaborative. The Collaborative has connected MCPs with CDPH projects, including projects funded by the Centers for Disease Control and Prevention to prevent and better manage cardiovascular disease at the local level.

b. DHCS held a webinar to inform MCPs on the CAIR, specifically covering strategies for increasing provider use of the registry, uploading EHR, automation of monthly reports for MCPs to intervene in real time to reach children not yet immunized.

DHCS continues to work with the MCPs and CAIR to find ways to increase provider enrollment and utilization of CAIR. CAIR has agreed to run reports for MCPs of their network provider sites to determine if the sites are enrolled and utilizing the registry. MCPs can then use this information to target provider groups not utilizing the registry to provide education and technical assistance.

c. DHCS had planned to identify lessons learned from research project matching Medi-Cal with CAIR. However the research project was put on hold at CDPH.

DHCS plans to continue to communicate with CDPH and utilize the efforts of the research project when the project restarts. Additionally, DHCS has been collaborating with CDPH to

[24] http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-006.pdf

increase communication and collaboration between CAIR and MCPs. Furthermore, DHCS was awarded a NGA grant. The NGA Center for Best Practices is launching a learning collaborative to assist states in their efforts to improve access and quality of care for their maternal and child health populations, and DHCS in partnership with CDPH's MCAH and Immunization Branches, as well as other private sector partners will utilize this opportunity to focus on improving immunization rates of two-year-old MCP beneficiaries.

Each subsection below describes the importance of the health problem to MCP beneficiaries, the scope and nature of the performance gap, and its causes. These analyses provided the basis for selection of the interventions listed above as continued priority areas for improvement.

A. Postpartum Care

Timely postpartum visits are important for support of breastfeeding, screening for postpartum depression; follow up of conditions such as diabetes and hypertension, and family planning. The postpartum visit is a critical window for preconception health counseling and reproductive life planning to achieve optimal birth spacing and improve future pregnancy-related outcomes. DHCS contracts require MCPs to implement a comprehensive risk assessment tool comparable to American Congress of Obstetricians and Gynecologists and CPSP standards, administered at key pregnancy milestones including the postpartum visit.[25]

Postpartum care is measured by the percentage of women with live births who had timely postpartum care. The NCQA defines a timely postpartum visit as a visit to an obstetrics and gynecology practitioner or midwife, family practitioner or other primary care provider on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts and abdomen.
- Notation of postpartum care.

NCQA specifies that the eligible population for this measure is women continuously enrolled in a plan from 43 days prior through 56 days after delivery.[26]

Medi-Cal Managed Care Health Plan performance: audited, aggregate data reported by MCPs to NCQA. In MY 2014, the Medi-Cal Managed Care weighted average, a rate which is validated by the EQRO, rose to 59%, which is above the 25th percentile for Medicaid. Despite this increase, 38,000 women did not meet criteria for a timely postpartum visit. Some progress has been achieved when compared to MY 2013 where the Medi-Cal Managed Care weighted average fell to 57%, which was below the 25th percentile for Medicaid.

[25] DHCS Two Plan boilerplate contract, Exhibit A, attach 10, section 7. http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[26] NCQA guidelines do not specify whether continuous enrollment refers to continuous enrollment in a Managed Care Plan, or continuous enrollment in Medicaid. For all data presented in this report, "continuous enrollment" refers to continuous enrollment in a single Managed Care plan.

Demographics Methodology-Revised from Previous Year

DHCS utilized a revised methodology in analyzing postpartum disparities with data from MY 2013 and MY 2014. DHCS has chosen for the analysis of MY 2013 and MY 2014 data to include global delivery billing codes because DHCS was able to pull global billing codes in instances when the date of postpartum care is identified. This analysis aligns with the NCQA technical specifications. This allows for the inclusion of global delivery billing codes while avoiding the overestimation of rates that could have occurred if global delivery billing codes had been included in the methodology used last year. Inclusion of global delivery billing codes when the postpartum care date can be identified allows DHCS to look at rates of timely postpartum visits in a way that more closely aligns with the rates MCPs report to NCQA, which are audited by the EQRO yearly. For example, using the revised methodology, DHCS found that the statewide weighted average for timely postpartum visits occurring in MY 2013 was 55.37%. This rate is very close to the average statewide postpartum rate of 56.99% for MY 2013 that was derived from the rates MCPs submit to NCQA. Further, the rate developed using global delivery billing codes remained slightly under the audit EQRO statewide rate, therefore DHCS expects that the revised methodology did not result in an overestimation of postpartum visits but rather is more indicative of an accurate snapshot.

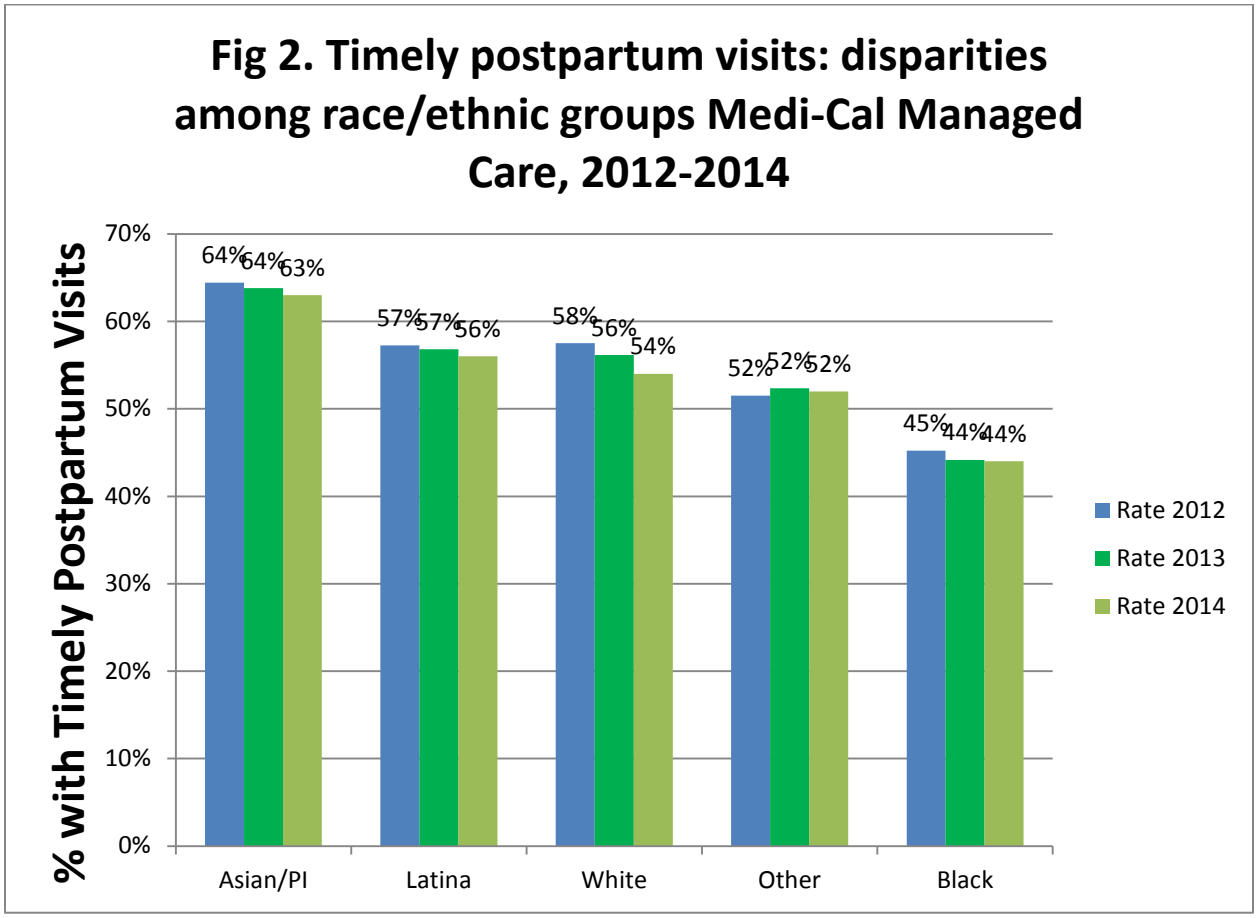
Demographics for MY 2012

In MY 2012, the majority of women who needed a postpartum visit were Latina (53%) followed by White women (19%), Black women (13%), and Asian/Pacific Islander women (8%). In order to better understand trends overtime, DHCS repeated an analysis of postpartum visit rates by race/ethnic group using the revised methodology to establish a new baseline for MY 2012. The application of the revised methodology to capture postpartum visits resulted in higher overall rates across all race/ethnicity groups; however, the pattern of the differences between groups remained relatively the same. Black women were found to have the lowest rates of timely postpartum visits compared to other race/ethnic groups at 45%. Asian/Pacific Islander women had the highest postpartum visit rate (64%), followed by White women (58%) and Latinas (57%).

Demographics for MY 2013

DHCS performed an analysis of postpartum visit rates by race and ethnicity utilizing data from MY 2013 (Figure 2). In MY 2013, the majority of women who needed a postpartum visit were Latina (51%) followed by White women (20%), Black women (12%), and Asian/Pacific Islander women (8%). Black women continue to have the lowest rates of timely postpartum visits compared to other race/ethnic groups at 44%. Asian/Pacific Islander women had the highest postpartum visit rate (64%), followed by Latinas (57%) and White women (56%).

Demographics for MY 2014



DHCS performed an analysis of postpartum visit rates by race and ethnicity utilizing data from MY 2012 - 2014. In MY 2014, the majority of women who needed a postpartum visit were Latina (49%) followed by White women (20%), Asian/Pacific Islander (PI) women (11%), and Black women (10%). Black women continue to have the lowest rates of timely postpartum visits compared to other race/ethnic groups at 44%. Asian/PI women had the highest postpartum visit rate (63%), followed by Latinas (56%) and White women (54%).

Key drivers. DHCS constructed a "Driver Diagram" after reviewing five postpartum-focused Improvement Plans (IPs) and one QIP submitted to DHCS,[27] as well as discussions from the June 19–20, 2014 Maternity Care Symposium[28] and the DHCS Quality Improvement Collaborative group on maternal care. Primary drivers were beneficiary characteristics (knowledge and resources); data completeness, accuracy, reasonableness and timeliness; providers and their characteristics (knowledge, engagement with the MCP, resources); MCP

[27] DHCS mandates that MCPs submit an IP when performance falls below the MPL for any indicator. QIPs, required for all MCPs, are more detailed and intensive improvement plans, and are validated by DHCS's External Quality Review Organization.
[28] California Health Care Foundation, UC Davis Institute for Population Health. http://www.dhcs.ca.gov/services/calendar/Pages/Symposium.aspx

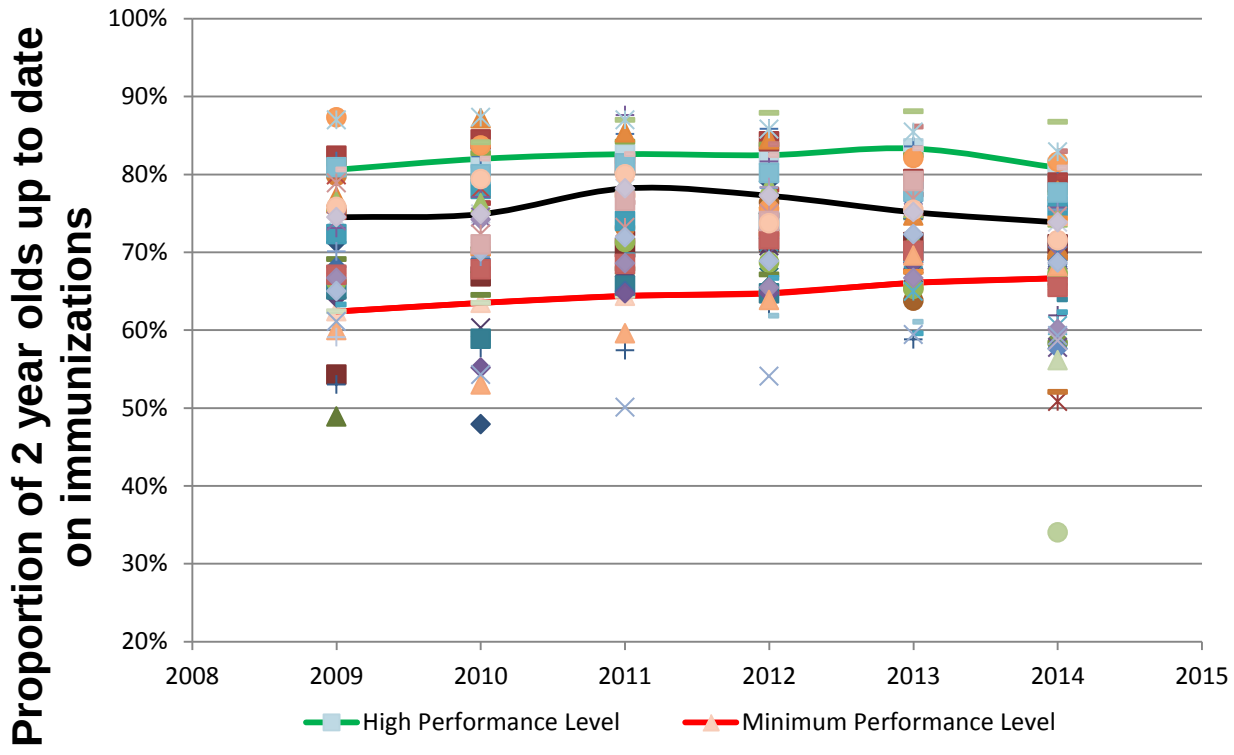
oversight, management, quality improvement; and DHCS payments, policies, oversight, and assistance. To develop the interventions listed above, an extensive list of secondary drivers was also constructed.

B. Immunization Status of Two Year Olds

In MY 2013, immunization coverage of 155,000 two-year-old MCP beneficiaries fell for a second consecutive year to 75%. This means 39,000 two year olds lack one or more recommended immunizations, which leaves them vulnerable to measles, pertussis and other vaccine-preventable diseases that have been increasing during 2014 in California. Immunization coverage declined by 3 percentage points from MY 2011 to 2013 (binomial test, $p < 0.0001$). This statistically significant difference translates to an estimated 4700 fewer two year olds with up-to-date immunizations in MY 2013 compared to 2011.

In MY 2014, immunization coverage of two-year-old MCP beneficiaries fell for a third consecutive year (Figure 3) to 74%, leaving 46,000 two year olds with incomplete immunizations. Variation among MCP performance remained high. As in MY 2013, in MY 2014 four MCPs exceeded the high performance level by fully immunizing more than 81% of their two-year-old beneficiaries in 2014. However, immunization coverage in 9 reporting units (operated by five other MCPs) fell to below the minimum performance level of 67% in MY 2014. One reporting unit was an outlier with only 34% of its two year olds being up to date on immunizations. This reporting unit was in its first baseline year of reporting. DHCS does not hold reporting units accountable to meet the MPLs during their first baseline year of reporting as performance on quality metrics may be tied to difficulties obtaining accurate and complete data in the first reporting year. Such factors may have contributed to this reporting unit having performed at a level distinctly lower than all other reporting units.

Figure 3. Proportion of 2 year olds up to date on immunizations, MCP reporting units, MY 2009-14



C. Controlling High Blood Pressure

In 2010, heart disease and stroke were the first and third leading causes of death among Californians, respectively, accounting for 24.9% and 5.8% of deaths.[29]

The Medi-Cal claims and encounters dataset offers opportunities to explore hypertension among various subpopulations. As expected, age was a significant factor in hypertension rates. Sixty percent of MCP beneficiaries older than 65 years of age had hypertension, compared to 50% of 55 to 64 year olds, 30% of 45 to 54 year olds, 15% of 35 to 44 year olds, and 3% of 18 to 34 year olds. After adjusting for age, females had significantly higher rates than males, and African-Americans had nearly 20% higher rates than other race/ethnic groups.[30]

In MY 2013, there were 175,000 MCP beneficiaries identified with hypertension, and more than half of the MCP beneficiaries diagnosed with hypertension were represented by six MCPs. In MY 2014, the number of beneficiaries identified with hypertension grew to over 280,000 and about half of the MCP beneficiaries diagnosed with hypertension were represented by four MCPs (Table 3).

[29] California Department of Public Health. Thirteen leading causes of death by race/ethnic group and sex, California, 2010. http://www.cdph.ca.gov/data/statistics/Documents/VSC-2010-0508.pdf Web site. Published October 3, 2012. Accessed July 22, 2014.
[30] Medi-Cal MIS/DSS and Symmetry EBM Groupers, Version 8.2; January 1, 2013 – December 1, 2013.

Table 3. Four MCPs Serve Approximately Half of Medi-Cal Managed Care Beneficiaries Diagnosed with Hypertension, MY 2014.[31] (Medi-Cal Managed Care Beneficiaries with Hypertension According to MCP Audited Data (n=281,629))

MCP – Reporting Unit(s)	Number	Percentage
L. A. Care-Los Angeles	53,672	19%
Health Net- Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare	34,958	12.5%
Inland Empire – San Bernardino/Riverside	26,438	9.4%
CalOptima – Orange	22,881	8.1%
Sub-Total	137,949	49%

Using the Archimedes simulation tool, DHCS estimated the potential health benefits and cost savings of controlling blood pressure among the hypertensive Medi-Cal Managed Care population. The simulation included people aged 18 to 59 with systolic blood pressure (SBP) over 140 mm Hg or diastolic blood pressure (DBP) over 90 mm Hg and people aged 60 to 85 with SBP over 150 mm Hg or DBP over 90 mm Hg. The model provided costs and health outcomes assuming that each simulated beneficiary could achieve a 15 percent reduction in their SBP. Looking at the number of hypertensive beneficiaries in MY 2013, if 175,202 hypertensive MCP beneficiaries received the intervention, the model estimated improvements in health outcomes, namely 19,879 additional quality-adjusted life years, 3,894 fewer major adverse cardiac events, 1,786 fewer strokes, and 1,158 fewer deaths over a 20-year period. The model also illustrated that DHCS could save 523 million inflation-adjusted dollars during the same time period.

This translates to the following outcomes over the next 20 years per 1,000 MCP beneficiaries with hypertension: nearly 3 million inflation-adjusted dollars in savings, 113 additional quality-adjusted life years, 22 fewer major adverse cardiac events, 10 fewer strokes, and 7 fewer deaths.[32]

Medi-Cal Managed Care Health Plan performance: audited, aggregate reporting. The *Controlling High Blood Pressure* measure is used to assess the percentage of beneficiaries 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the MY. The specifications for this measurement changed for MY 2014, so that beneficiaries over age 65 who did not have diabetes had a higher target blood pressure that was considered acceptable to meet criteria for this measure. This change in the specification used for calculating the measure slightly relaxed the numerator compliance criterion for Medicaid beneficiaries aged 65–85 without a diagnosis of diabetes. However, the

[31] 2014 HEDIS Rates with Extra Data: Total Population validated EQRO
[32] Schlessinger L, Eddy DM. Archimedes: a new model for simulating health care systems-the mathematical formulation. *J Biomed Inform*. 2002; 35 (1): 37–50. doi: 10.1016/S1532-0464(02)00006-0.

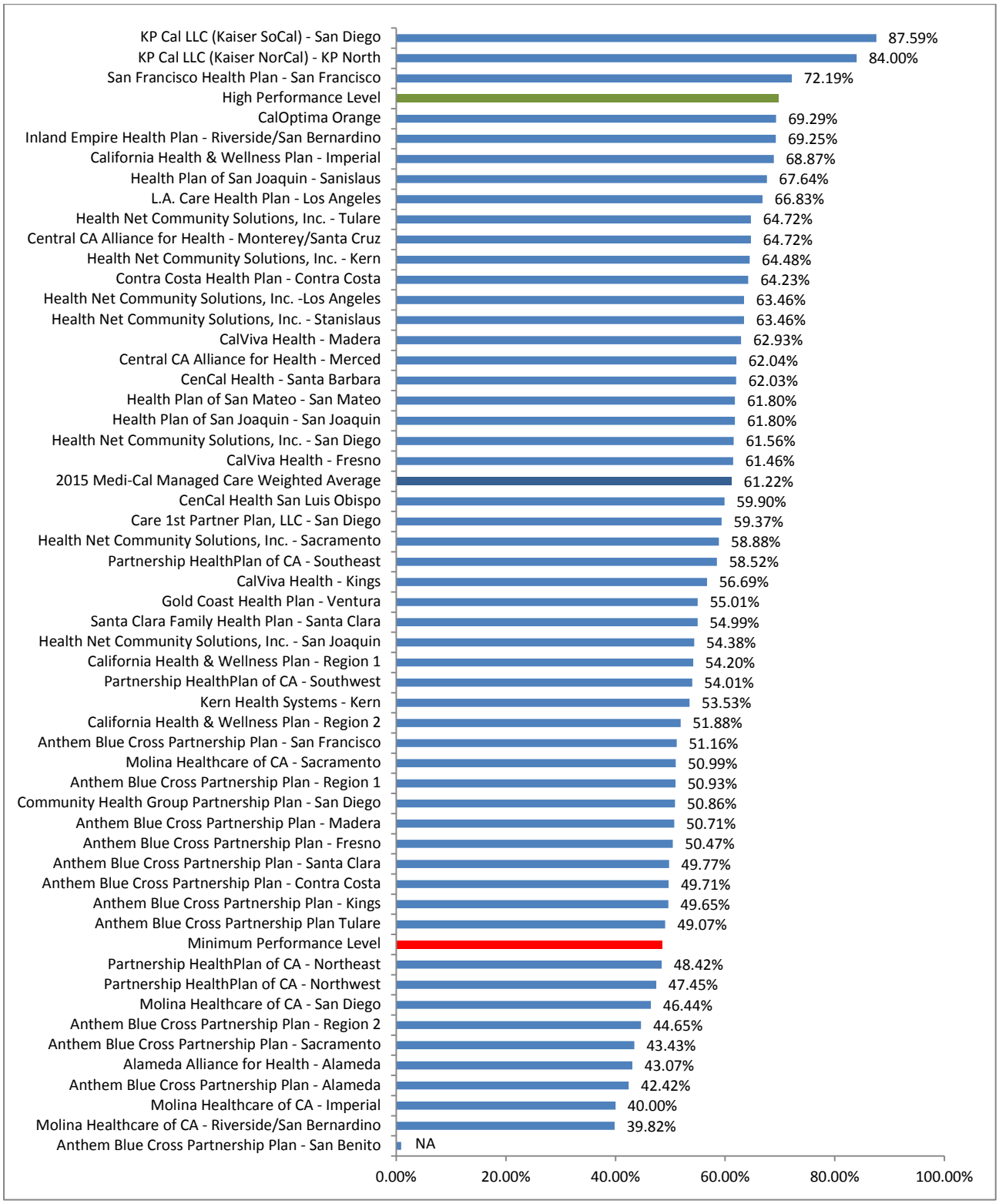
differences seen in MY 2014 compared to 2013 may not be primarily due to the changes in the specifications for the following reasons:

- This change in specification applies to a subset of the eligible population (possibly a small subset). The magnitude of difference observed for some MCPs appears to be much larger than would be expected for the subset.

- The difference from MY 2013 to 2014 goes in both directions for different MCPs. Some MCPs have positive changes; others have negative changes. If the difference was largely driven by specification changes, the rate of change will likely be unidirectional.

In the MY 2013, the MCPs varied widely in their performance on this measure, with Kaiser-San Diego reporting 86.37% and Health Plan of San Mateo reporting 29.93%. In 2014 (Figure 4), MCPs continued to see a wide range in performance with Alameda Alliance for Health reporting 40.39% of its beneficiaries having controlled blood pressure, while Kaiser-San Diego reported 86.34% of its beneficiaries were controlled. Overall, the weighted average for Medi-Cal improved 5 percentage points to reach 61%.

Figure 4. Medi-Cal Managed Care Performance: Controlling High Blood Pressure by MCP Reporting Unit, Measurement Year 2014



Green bar: DHCS HPL is HEDIS®2014 National Medicaid 90th Percentile, representing MY 2013

data. Red bar: DHCS MPL is HEDIS® 2014 National Medicaid 25th Percentile, representing MY 2013 data.

D. Diabetes

One in seven adult Californians (13.8%) has diabetes.[33] The prevalence of diabetes increases with age. One out of every six adult Californians aged 65 and over has type 2 diabetes. Diabetes rates are also higher among ethnic/racial minorities. Compared with non-Hispanic Whites, Hispanics and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from their disease.[34] The number of MCP beneficiaries with diabetes is expected to continue to rise significantly as California expands coverage to childless adults, and their diabetes care needs are greater since many were underserved.

Measurement of MCP performance. The HbA1c blood test is the standard biomarker for the adequacy of glycemic management; it reflects average blood glucose levels over the prior 2- to 3-months. The test plays a critical role in the management of people with diabetes, since high HbA1c predicts both microvascular and, to a lesser extent, macrovascular complications. Increasing rates of HbA1c testing among those with diabetes is key to better disease management and to improving outcomes.

MCP performance: audited, aggregate reporting. In MY 2013, 159,275 MCP beneficiaries met the HEDIS® specifications to comprise the denominator for the diabetes measures reported to NCQA. This is a minimum estimate of the number of adult MCP beneficiaries with diagnosed diabetes. That number rose to close to 243,000 MCP beneficiaries in MY 2014. Of these 243,000 beneficiaries with diabetes, 86% were reported to have an HbA1c test in MY 2014, up from 83% in the prior year.

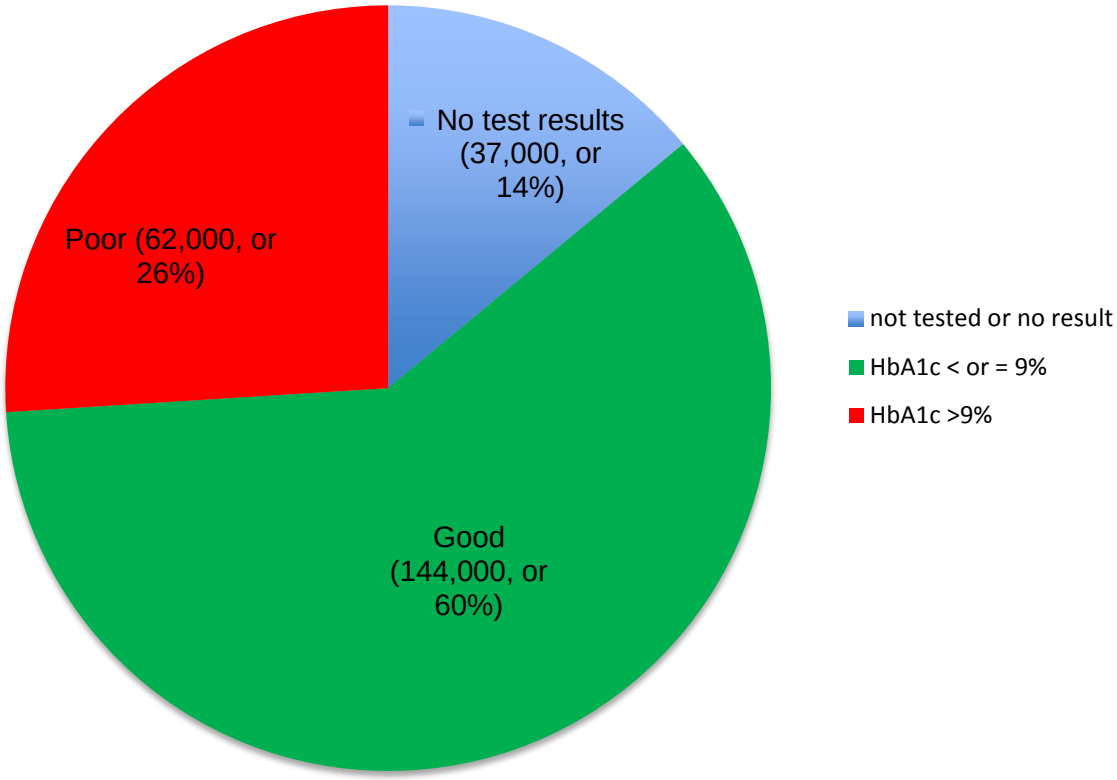
In MY 2014, seven Medi-Cal Managed Care reporting units tested only 74% to 79% of their diabetes patients' HbA1c levels, placing them in the national Medicaid 25th percentile: Anthem in two counties (Kings and Sacramento); Health Net in two counties (Sacramento and San Diego); Cal Viva in one county (Kings), Health Plan of San Joaquin (San Joaquin) and Molina Healthcare (Sacramento). By contrast, Kaiser (in San Diego and Sacramento) tested 95–96% of its beneficiaries with diabetes, which places this MCP in the top of the national Medicaid 90th percentile.

Once HbA1c test results are available, individuals with diabetes can be treated to maintain or improve blood glucose control. In MY 2013, 43,000 diabetes patients (or 27% of all diabetes patients) were documented to have poor glycemic control (HbA1c > 9%). In MY 2014 (Figure 5) the statewide Medi-Cal Managed Care weighted average for poor glycemic control improved to 26% (lower rate is better) but that still left 92,000 diabetic patients without documented poor control. (Note that the NCQA indicator called CDC-H9 is comprised of patients with HbA1c > 9% plus those who had no test result). These patients are at increased risk of blindness, lower

[33] California Diabetes Program. California Diabetes Fact Sheet, 2012, Technical Notes. www.caldiabetes.org. 2012.
[34] California Department of Public Health Chronic Disease Control Branch. Burden of Diabetes in California. September 2014. https://www.cdph.ca.gov/programs/cdcb/Documents/FINAL%20Rpt%20(1877)%20DM%20burden%202014_9-04-14MNR3.pdf

extremity amputations, and renal failure.

Figure 5. Blood glucose control in MCP beneficiaries with diabetes, MY 2014



About 240,000 beneficiaries ages 18-75 years old with diagnosed diabetes

Controlling blood pressure in individuals with diabetes is critical to reducing the risk of heart attack and stroke. In MY 2013, only 60% of MCP beneficiaries with diabetes had adequate blood pressure control, the lowest proportion since at least 2009. This means more than 1 in 3 beneficiaries with diabetes have uncontrolled blood pressure, which places them at high risk for cardiovascular complications. In MY 2014, this proportion rose to 63%.

Other essential components of diabetes care are examinations for retinal and renal disease. In MY 2013, only 51% of beneficiaries with diabetes were documented to have a retinal exam. This improved to 53% in MY 2014. The proportion of diabetes patients with an evaluation for kidney disease rose from 83% in MY 2013 to 84% in MY 2014.

Barriers and challenges articulated by MCPs. The most common barriers to diabetes care

identified by MCPs were poor data quality (such as missing laboratory reports), beneficiary lack of disease knowledge, difficulty adhering to medication or lifestyle changes, and lack of provider awareness or systems for tracking beneficiaries needing services.

E. Tobacco Use

Tobacco is the leading cause of preventable death in the U.S. Tobacco cessation services have been demonstrated to be clinically cost effective,[35] with a return on investment of 3:1 for dollars spent on smoking cessation services in Medicaid populations.[36] In the 2013 Medi-Cal Managed Care CAHPS survey, a median of 18.2% of respondents reported current smoking (range of 10% to 27% among MCPs). A median of 71% (range 58% to 80%) of smokers indicated they received advice from a health care provider to quit smoking. However, the median for smokers who responded that their providers discussed cessation medications was only 40% (range 27 to 60%). Similarly, a median of only 37% of smokers (range 28% to 56%) indicated their health care provider discussed cessation methods and strategies.[37]

Health Information

DHCS recognizes the role that health information technology (HIT) plays in improving the quality of health care provided to beneficiaries, preventing medical errors, reducing health care costs, increasing administrative efficiencies, decreasing paperwork, and expanding access to affordable health care.

In accordance with 42 CFR §438.204(f), DHCS information systems directly support the departmental and Managed Care Quality and Monitoring Division's (MCQMD) quality strategies. DHCS has recently completed the annual state self-assessment of its Medicaid Information Technology Architecture (MITA). As part of the annual MITA state self-assessment, DHCS has developed a strategic vision. This vision will enable DHCS to address HIT components that are necessary to advance its information architecture, including data-collection methods; data management and storage; metadata; and the data models and analytics capabilities necessary to support quality measurement, reporting, and transparency. In addition to improvements expected through Encounter Data Improvement Project (EDIP) and transformations as part of the conversions from local codes and file formats to Health Insurance Portability and Accountability Act compliant formats, DHCS is focused on capacity and use of the centralized Management Information System/Decision Support System (MIS/DSS), DHCS's centralized data repository and analytic platform. Improvements include: incorporation of reference data that will improve capabilities to analyze population characteristics; care delivery models and quality measures; training for and upgrades to diagnosis grouping software that supports calculation of preventable quality indicators; and data quality reports that are used by program areas to work with data providers to improve quality. DHCS has completed the re-procurement of the MIS/DSS support contract, which will provide specific opportunities to increase MITA maturity and support the DHCS Quality Strategy.

[35] 2008 US Public Health Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence," http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html.
[36] Patrick, R. West K, Ku L, Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts, PLOS One, January 6, 2012, http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0029665.
[37] These results are limited to those with >100 respondents in the denominator.

Encounter Data Validation and Improvement

Over the past few years, DHCS has focused on improving encounter data received from the MCPs. DHCS recognizes the importance of this data to be able to assess utilization, outcomes, disparities, and quality both by DHCS and CMS.

In 2012, DHCS signed a three-year contract with its EQRO to conduct an annual Encounter Data Validation (EDV) study. The studies included a review of the MCPs' capabilities to collect and submit accurate and complete encounter data, comparative analysis on MCP electronic encounter data for accuracy and completeness, a comparative analysis on medical records to DHCS electronic encounter data for accuracy and completeness, and an MCP survey to assess plan implementation of new DHCS encounter data reporting requirements issued in late 2014. The EQRO provided to DHCS MCP-specific audit reports and an aggregated report to present findings of each MCP and statewide average results. DHCS utilizes these reports to target areas of concern for data quality improvement.

In 2015, DHCS successfully transitioned MCPs to national standard formats and moved to a new Post Adjudicated Claims and Encounters System to receive and process the data. Through this change, DHCS was able to standardize data reporting, enhance the dataset, and improve data management. DHCS also imposed data quality requirements on MCPs and established the Quality Measures for Encounter Data. DHCS has created mechanisms to measure, track, and report on encounter data quality and continues to enhance its monitoring processes. In addition, DHCS has heightened its technical assistance efforts to MCPs to provide multiple venues for collaboration and support.

Adoption of Electronic Health Records

To support advancements of HIT in the clinical care environment experienced by Medi-Cal beneficiaries, DHCS has implemented the Medicaid EHR Incentive Program. This program provides incentives to providers serving Medi-Cal beneficiaries when the providers adopt a certified EHR and use it in a meaningful way, as specified in CMS regulations. As of August 1, 2015, 16,744 eligible providers received payments for a total of $419,713,047.61 of incentive payments through the EHR Incentive Program. Over the same time period, 275 eligible hospitals received a total of $652,431,102.23 in incentive payments through the EHR Incentive Program.

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

DHCS has worked closely with other Health Information Technology for Economic and Clinical Health grantees to support providers in the implementation of EHRs. Grantees included CHHS, which is responsible for the Health Information Exchange Cooperative Agreement, the four Regional Extension Centers, the Beacon Program in San Diego, the Workforce Program, and the California Telehealth Network. This group of grantees worked in partnership with lead coordination by CHHS to assist in the adoption of EHRs and the implementation of

infrastructure necessary to connect EHRs with each other and with the ancillary services necessary to support meaningful use.

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

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

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

Patient Safety

Several indicators that DHCS requires MCPs to report each year shed light on patient safety: use of imaging for low back pain (which can lead to unnecessary back surgery), avoidance of antibiotics in adults with acute bronchitis (not clinically indicated and leads to antibiotic resistance), and monitoring renal function in patients receiving diuretics and other drugs (to avoid adverse medication effects). DHCS has partnered with the California Maternal Quality Care Collaborative (CMQCC), where objectives include reducing early elective delivery and unnecessary C-sections. In 2014, DHCS held webinars in partnership with CMQCC and the Integrated Healthcare Association to encourage MCPs to highlight the benefits of using CMQCC's maternal data center and to encourage public reporting of maternal quality of care measures. DHCS has also developed an internal Collaborative aimed at reducing preventable deaths due to opioid overdose and reduce opioid misuse as well as joining an interagency collaborative with similar goals. DHCS works to increase access to buprenorphine treatment for addiction and naloxone treatment to reverse overdose. DHCS continues to discuss opioid misuse with MCPs and assist MCPs with sharing innovative strategies.

Intermediate Sanctions

See Section 2 under Monitoring and Compliance.

SECTION IV: DELIVERY SYSTEM REFORMS

One of the Department's commitments is to design delivery systems and payment strategies to drive improved quality and outcomes (Strategy 4.1 in the DHCS Strategic Plan, 2013–2017). Below are updates on the most recent delivery system reforms implemented by DHCS.

Health Homes

Section 2703 of the ACA provides states the option to provide comprehensive care coordination through health homes for individuals with complex conditions. The ACA supports the implementation of this program by providing states an enhanced Federal Medical Assistance Percentage equal to 90% of a state's payments for two years with no deadline to apply or implement the activity.

DHCS continues its efforts on assessing and planning for implementation of an ACA Section 2703 Health Homes program. California enacted Assembly Bill (AB) 361 in 2013, which authorized DHCS to implement a Health Homes program if DHCS determines that such a program would be operationally viable, produce positive health outcomes, and be at least cost neutral. AB 361 requires stakeholder engagement for the development of a Health Homes program(s). Currently, DHCS is engaging stakeholders during the developing phase of the program. When available, DHCS provides updates on Health Homes program developments and stakeholder engagement through the DHCS Health Homes Program Stakeholder ListServ. Interested stakeholders can subscribe to this ListServ by sending a subscription request to the program's e-mail box: HHP@dhcs.ca.gov. A Draft-Final concept paper was released on December 14, 2015 for stakeholder comment. The State Plan Amendment is anticipated to be submitted to CMS early 2016.

Statewide Expansion of Medi-Cal Managed Care

California's SFY 2012–13 budget called for the expansion of Medi-Cal Managed Care statewide starting in September 2013.

The regional expansion into the 28 remaining FFS counties was implemented over two phases. The eight northernmost California counties that chose to affiliate with Partnership Health Plan, a COHS Model, transitioned in September 2013. In November 2013, the Regional Model was initiated in 18 rural counties with two health plans: California Health and Wellness and Anthem Blue Cross. At the same time, Imperial County started managed care services with California Health and Wellness and Molina Health Plan. In San Benito County, beneficiaries were provided a choice of either Anthem Blue Cross or FFS Medi-Cal.

To ensure a smooth transition, DHCS set up performance metrics and monitoring activities that focused on how MCPs are meeting the needs of the transitioned beneficiary population. DHCS reviewed collected data and analyzed it to ensure that beneficiaries in all areas, including the regional expansion areas, had access to providers and continuity of care. MCPs reported and continue to report the following information:

- Health Plan Grievances/Appeals Related to Access to Care – This information includes grievances made to both the Department of Managed Health Care and/or to DHCS.

DHCS evaluates the data based on significant increases in such activities beyond current trends once the transition begins.

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

- Time and Distance Requirements for Primary Care Providers (PCPs) (Geo Access) – This information is used as a component of each MCP's provider network adequacy review.

- Beneficiary Rights and Program Integrity Audits – DHCS performs annual audits on its MCPs regarding how well each MCP fulfills its obligations to its beneficiaries regarding providing access to services and providers, responding to grievances, and supplying information.

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

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

- Network adequacy for MCPs
- Primary care assignments for MCP providers
- Ombudsman inquiries for MCPs
- Beneficiary/Provider call-center inquiries for health services
- Continuity-of-care referrals and outcomes
- Grievances and appeals
- Beneficiary satisfaction phone survey
- Telemedicine utilization

The data collection, reports, and analysis ensure that DHCS is sufficiently monitoring the expansion of managed care and that MCPs are meeting the needs of the transitioned beneficiary population.

Cal MediConnect Program: Passive Enrollment Measures

DHCS has phased in enrollment into the Cal MediConnect program for beneficiaries who are dually eligible for Medicare and Medi-Cal via a passive enrollment process which has concluded for all counties but Orange and Santa Clara. During this process, beneficiaries scheduled to be enrolled into a Cal MediConnect Plan received an advance notification at least 90 days prior to the date they were scheduled to be enrolled. This letter explained that the beneficiary may opt-out or make another enrollment decision prior to the enrollment's effective date. If the beneficiary did not make an active enrollment choice, the beneficiary was passively enrolled into

the Cal MediConnect Plan that was identified in the notice that they received 60 days prior to their enrollment date.

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

Passive enrollment for the Cal MediConnect program began in April 2014 in San Mateo County. In July 2014, passive enrollment expanded to four more counties (Los Angeles, San Bernardino, San Diego, and Riverside). The remaining two counties, Santa Clara and Orange, participating in the Cal MediConnect program began passive enrollment in January and July of 2015, respectively. As of August 2015, approximately 117,449 dual eligibles were enrolled in the program. Because this is a passive enrollment process, duals eligibles have the option of requesting to switch from the Cal MediConnect plan to an MCP to receive coverage of Managed Long-Term Services and Supports. The figures as of August 2015 show that about 46% of those eligible for passive enrollment have opted-out of the Cal MediConnect program. DHCS and CMS are working collaboratively to analyze the higher than expected opt-out percentage, particularly among the Los Angeles county and IHSS populations.

Integration of Mental Health and Alcohol Use Disorder Services

Pursuant to the passage of Senate Bill 1 of the First Extraordinary Session (Hernandez, Chapter 4, Statutes of 2013), which added sections 14132.03 and 14189 to the Welfare and Institutions Code, and as a result of a series of forums with a variety of stakeholders, MCQMD in collaboration with the Mental Health Services Division developed and implemented an expanded outpatient mental health services program to beneficiaries of all ages. Effective January 1, 2014, MCPs are responsible to cover and pay for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition defined by the current Diagnostic and Statistical Manual of Mental Disorders. These services, described in APL 13-021, are provided by the mental health professionals in the MCPs' networks (outside of the primary care physician's scope of practice) and include:

1. Individual and group mental health evaluation and treatment (psychotherapy);
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and
5. Psychiatric consultation

The eligibility for Medi-Cal specialty mental health services (SMHS) provided by county MHPs has not changed pursuant to this new policy. MCPs are required to enter into a Memoranda of Understanding (MOUs) with the county mental health plans (MHPs) that provide SMHS to ensure care coordination as beneficiaries are referred between the two systems (described in APL 13-018). These MOUs are nearly complete; all but 5 of the 98 MOUs have been submitted and reviewed. DHCS is monitoring the implementation of the new services through special reports submitted by the MCPs, as well as through analysis of encounter data. MCPs are required to submit mental health data reports on grievances, continuity of care, and referrals to the MHPs. DHCS continues to review this data to ensure that the expanded services are in place and that beneficiaries are accessing these services. In addition, DHCS has also organized a collaborative meeting between the MCPs and the MHPs which meets quarterly. The first meeting occurred at the end of August 2015. Agenda items focus on access, coordination of care, management of the "moderate" diagnosis, and management of complex diagnoses, such as eating disorders. DHCS has also convened a Care Coordination Collaborative with the MCPs, to assist MCPs with improving care coordination both within the plan and with agencies outside of the MCP, including the Regional Centers and county MHPs. This Collaborative met for the first time at the end of July 2015 and will meet every two months. Finally, DHCS convened a Delivery System Dispute Resolution Workgroup comprised of the MCPs and association representatives from the County Behavioral Health Directors' Association and the California Association of Health Plans. The purpose of the workgroup was to develop a dispute resolution process to ensure that beneficiaries are not juggled between the MCPs and the MHPs and that no beneficiary falls through the cracks. Based on stakeholder input, DHCS finalized a dispute resolution process at the state level when issues cannot be resolved at the local level between MCPs and MHPs. Additional information can be found in APL 15-007, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-007.pdf

In addition to the expanded mental health services, DHCS has implemented a new alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit effective January 1, 2014 (described in APL 14-004) for beneficiaries ages 18 and older. Each beneficiary is eligible for one expanded screening per year (using the Alcohol Use Disorder Identification Test, the Alcohol Use Disorder Identification Test—Consumption or another validated tool) and three brief intervention sessions per year (which can be combined) to address risky alcohol use. The expanded screening is longer than the initial, brief screening in the SHA. Providers who offer SBIRT services must refer MCP beneficiaries who may have an alcohol use disorder to the county or other community services for further evaluation and treatment. Expanded Substance Use Disorder benefits will continue to be provided through the current delivery systems: Medi-Cal FFS or county administered Drug Medi-Cal, depending on the benefit.

Behavioral Health Treatment Services

DHCS has implemented the new Behavioral Health Treatment (BHT) benefit for autism spectrum disorders (ASD) that became effective September 15, 2014. BHT services, including applied behavioral analysis and other evidence-based behavioral intervention services that

develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD, are a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD (described in APL 14-011). DHCS is preparing to transition beneficiaries who are currently receiving BHT services at the Regional Centers to the MCPs. This transition is expected to occur in early 2016.

Coordination of Dental Health Services

DHCS divisions responsible for Medi-Cal Managed Care and dental services are coordinating efforts to assess and improve oral health of MCP beneficiaries, starting with children. DHCS plans to utilize the newly established Care Coordination Collaborative as one avenue to improve the integration of dental and physical health services. DHCS has also developed policies to guide MCPs on the appropriate use of general anesthesia for dental procedures and provided additional information regarding how to best coordinate these requests with dental procedure approval from dental services.

SECTION V: CONCLUSIONS and OPPORTUNITIES

DHCS programs now serve nearly 13 million Californians. One in three people in the State receives health care services financed or organized by DHCS, making the department the largest health care purchaser in California. DHCS invests almost $100 billion in public funds to provide health care services for low-income families, children, pregnant women, and seniors and persons with disabilities, while helping to maintain the health care delivery safety net.

The Department has seen a significant increase in Medi-Cal enrollment and responsibility for coverage. As of December 1, 2014, the number of enrollees in Medi-Cal Managed Care increased to 9 million, or 75% of all Medi-Cal beneficiaries. Medi-Cal Managed Care has expanded to all 58 counties, enrolled new beneficiaries (including childless adults) and added new benefits (including behavioral health therapy).

This annual assessment—with its focus on three critical areas of maternal/child health, chronic disease management, and prevention—reflects the continued emphasis by DHCS on quality and outcomes. This report also reflects the DHCS commitment to the three linked goals of the Department's overall Quality Strategy: improve the health of all Californians, enhance the quality health care delivered (including the patient experience), and reduce per-capita health care costs.

Developing this report required DHCS to collaborate with stakeholders to set priorities and measurable objectives, assess the causes of suboptimal performance, and identify interventions to address these challenges. This process has created a living document and tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help achieve the Department's mission to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long-term services and supports.

SECTION VI: APPENDICES

A. Status of 2013 Medi-Cal Managed Care Objectives

B. External Accountability Set Measures: 2015

C. Acronyms

APPENDIX A: STATUS OF 2013 MEDI-CAL MANAGED CARE OBJECTIVES

#	Objective and Status
1.	**Objective**: Establish a process by December 2013 to ensure that all beneficiaries enrolled in Medi-Cal Managed Care have access to a medical home and to increase access to medical homes through geographic managed care expansion into currently FFS-only counties. **Status**: Through our contracts with MCPs, DHCS requires that Medi-Cal beneficiaries are assigned to a PCP/clinic and the PCP serves as the beneficiary's medical home. On November 1, 2013, DHCS completed the expansion of MCPs to the 28 rural counties where Medi-Cal beneficiaries did not previously have access to managed care.
2.	**Objective**: Implement one-or-more performance standards and measures that would require plans to evaluate and improve SPD health outcomes by HEDIS®[38] reporting year 2013. **Status**: For services provided in MY 2014 MCPs reported 9 HEDIS® performance indicators and 1 non HEDIS® performance indicator stratified for the SPD and non-SPD populations (see Appendix B for list of required HEDIS® measures and stratification).
3.	**Objective**: Complete the COHS MCP contract revisions, and align them with Two-Plan and GMC contracts that require enhanced case management and coordination-of-care services for SPD beneficiaries identified as high-risk and a process for MCQMD to monitor plan compliance by August 2013. **Status**: COHS contract revisions were completed in September 2013 for Partnership Health Plan and November 2013 for rest of the COHS MCPs. All MCPs were included in the expansion of outpatient mental health and substance use disorder benefits starting in January 2014. This was reflected in contract amendments in December 2013.
4.	**Objective**: Continue a statewide collaboration with MCPs through MY 2015 to reduce "All Cause Readmissions" by addressing continuity of care and care transitions for adults 21-years and older, including SPDs and dual eligibles. **Status**: See Section II Assessments – Performance Improvement Projects of this report.
5.	**Objective**: Administer the 2013 CAHPS®[39] survey to all MCPs, with results available in early 2014.

[38] HEDIS® is a registered trademark of the National Committee for Quality Assurance.
[39] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

#	Objective and Status
	Status: Results have been analyzed and reported. Tobacco use questions are described in Section IV of this report. The next CAHPS® will be completed in 2016.
6.	**Objective**: Establish a process by June 2013 for timely notification of MCPs that ensures that MCPs contact beneficiaries who have recently received a denial of their Medical Exemption Requests for care coordination and to address any special needs. **Status**: On April 3, 2014, DHCS released APL 13-013 that established continuity of care requirement for beneficiaries transitioning to a managed care health plan that had a Medical Exemption Request denied for clinical reasons. DHCS provides all MCPs with a weekly data file that identifies the impacted beneficiaries, their provider, and the ICD-9 code.
7.	**Objective**: Coordinate activities that focus on the collection, analysis, and reporting for 16 of the *Initial Core Set of Adult Health Care Quality Measures for Medicaid-Eligible Adults* as part of the AMQG. **Status**: In January 2014, DHCS submitted its AMQG annual report to CMS. As part of the annual report, DHCS reported on 16 of the Initial Core Set of Adult Health Care Quality measures, including pertinent data stratification and updates on the two quality improvement projects: improving the post-partum care rate and improving diabetes care among Medi-Cal beneficiaries. In July 2014, DHCS submitted its second semi-annual report to CMS which provided further updates on measure collection and analysis as well as quality improvement project updates. MCQMD has been an important partner in AMQG activities including data analysis and participation in the two quality improvement projects.
8.	**Objective**: Reduce the smoking rate among MCPs beneficiaries. In line with the DHCS's Quality Strategy, by 2014, Medi-Cal Managed Care will make available the full complement of effective tobacco-use treatments, adapt clinical systems to assess all patients for tobacco use, strongly advise those who smoke about the importance of quitting refer smokers to evidence-based treatments, train MCPs providers on evidence-based tobacco use treatment strategies, and strengthen monitoring. **Status**: DHCS developed an APL detailing enhancements to tobacco use treatment in MCPs. The new policy requires MCPs to: o Assess each beneficiary's tobacco use through the Individual Health Education Behavioral Assessment and the Staying Healthy Assessment; o Cover all seven Food and Drug Administration approved tobacco cessation medications: bupropion SR, Varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch for adult who smoke or use other tobacco products (at least one must be available without prior authorization);

#	Objective and Status
	o Ensure that individual, group and telephone counseling is offered to Beneficiaries who wish to quit smoking, whether or not those Beneficiaries opt to use tobacco cessation medications; o Cover two independent quit attempts per year with no minimum break in between; o Provide services to pregnant women consistent with the ACA requirements; and require MCPs to inform and educate clinicians regarding effective tobacco use treatment strategies consistent with the U.S. Department of Health and Human Services, Public Health Service *Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update.* DHCS will monitor MCP smoking prevalence trends using data collected from tobacco questions in the CAHPS survey.
9.	**Objective**: Continue to consistently review our process to engage stakeholders and advocates in policy development **Status**: Ongoing

APPENDIX B: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: Reporting Year 2015

#	Acronyms	Measure	Measure Type Methodology	SPD Stratification** Required	Auto**** Assignment Algorithm
1.	ACR*	All-Cause Readmissions+	Administrative (non-NCQA) measure, defined by ACR collaborative	Yes	No
2.	AMB-OP* AMB-ED*	Ambulatory Care:+ • Outpatient visits • Emergency Department visits (**Children)***** • Emergency Department visits **(Adults)** • Emergency Department visits **(Total)**	Administrative measure	Yes	No
3.	MPM-ACE MPM-DIG* MPM-DIU	Annual Monitoring for Patients on Persistent Medications (3 indicators):+ • Angiotensin Converting Enzyme Inhibitors or Angiotensin Receptor Blockers • Digoxin • Diuretics	Administrative measure	Yes	No
4.	AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative measure	No	No
5.	CCS	Cervical Cancer Screening+	Hybrid measure	No	Yes
6.	CIS-3	Childhood Immunization Status – Combo 3+	Hybrid measure	No	Yes

#	Acronyms	Measure	Measure Type Methodology	SPD Stratification** Required	Auto**** Assignment Algorithm
7.	CAP-1224* CAP-256* CAP-711* CAP-1219*	Children & Adolescents' Access to Primary Care Practitioners (4 indicators):+ • 12-24 Months • 25 Months – 6 Years • 7-11 Years • 12-19 Years	Administrative measure	Yes	No
8.	CDC-E CDC-HT CDC-H9 CDC-H8 CDC-N CDC-BP	Comprehensive Diabetes Care (6 indicators): • Eye Exam (Retinal) Performed • HbA1c Testing+ • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attention for Nephropathy • Blood pressure control (<140/90 mm Hg)	Hybrid measure	No	Yes, for *HbA1c Testing* **only**
9.	CBP	Controlling High Blood Pressure+ < 140/90 mm Hg (except < 150/90 mm Hg for ages 60-85 without diabetes)	Hybrid measure	No	Yes
10.	IMA-1	Immunizations for Adolescents+	Hybrid measure	No	No

Note: Information about tobacco cessation measures will be provided at a later date.

*MCPs will not be held to a MPL for measures shaded in gray
** SPD
*** Same age bands that MCPs already report to NCQA
**** Data from 2014 measurement year will be used in 2015 auto-assignment algorithm. Subsequent years to be determined.
+ included in the Core CMS Child and/or Adult Set

Performance Measures Required for Specialty Plans Reporting Year 2015

AHF Healthcare Centers

- Colorectal Cancer Screening
- Controlling High Blood Pressure

Family Mosaic Project

- *Out-of-Home Placements:* The percentage of Medi-Cal managed care beneficiaries enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.
- *School Attendance:* The number of capitated Medi-Cal managed care beneficiaries enrolled in Family Mosaic with a 2 or 3 in school attendance on both the *initial and most recent* Child and Adolescent Needs and Strength outcome/assessment tool during the measurement period.

SCAN

- Breast Cancer Screening
- Osteoporosis Management in Women Who Had a Fracture

APPENDIX C: ACRONYMS

AB Assembly Bill
ACA Affordable Care Act
ACR All-Cause Readmissions
AMQG Adult Medicaid Quality Grant
APL All Plan Letter
ASD Autism Spectrum Disorder
BHT Behavioral Health Treatment
CAP Corrective Action Plan
CAHPS Consumer Assessment of Healthcare Providers and Systems
CAIR California Immunization Registry
CDPH California Department of Public Health
CFR Code of Federal Regulations
CHHS California Health and Human Services Agency
CMS Centers for Medicare & Medicaid Services
COHS County Organized Health Systems
CPSP Comprehensive Perinatal Services Program
CQM Clinical Quality Measures
CQMCC California Maternal Quality Care Collaborative
DBP Diastolic Blood Pressure
DHCS Department of Health Care Services
EAS External Accountability Set
EDIP Encounter Data Improvement Project
EDV Encounter Data Validation
EHR Electronic Health Record
EQRO External Quality Review Organization
FFS Fee-for-Service Medi-Cal
FPL Federal Poverty Level
GMC Geographic Managed Care
HbA1c Glycosylated Hemoglobin
HEDIS Healthcare Effectiveness Data and Information Set
HIT Health Information Technology
HPL High Performance Level
HSAG Health Services Advisory Group
HTN Hypertension
ICD International Classification of Disease
IHA Integrated Healthcare Association
IP Improvement Plan
LGHCTF Let's Get Healthy California Task Force Final Report
LI Local Initiative
MCAH Maternal, Adolescent and Child Health
MCP Medi-Cal Managed Care Health Plan
MCQMD Managed Care Quality and Monitoring Division
MEDS Medi-Cal Eligibility Data System
MHP Mental Health Plans
MIS/DSS Management Information System/Decision Support System
MIQS Medi-Cal Incentives to Quit Smoking
MITA Medicaid Information Technology Architecture
MPL Minimum Performance Level
MOU Memorandum of Understanding
MY Measurement Year
NA Not Applicable
NCQA National Committee for Quality Assurance
NGA National Governors Association
PCP Primary Care Provider
PDSA Plan-Do-Study-Act
PIP Performance Improvement Project
QI Quality Improvement
QIP Quality Improvement Projects
SBIRT Screening, Brief Intervention and Referral to Treatment
SBP Systolic Blood Pressure
SFY State Fiscal Year
SHA Staying Healthy Assessment
SHP Specialty Health Plan
SLR State Level Registry
SMHS Specialty Mental Health Services
SPD Seniors and Persons with Disabilities
§ Section