



Medi-Cal Managed Care Program

QUALITY STRATEGY

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

Annual Assessment

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Department of Health Care Services
Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone: (916) 449-5000 Fax: (916) 449-5005
Internet Address: www.dhcs.ca.gov

Quality Strategy Annual Assessment

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EXECUTIVE SUMMARY

California's Medicaid system, Medi-Cal, provides health care services to more than 10 million beneficiaries through two distinct health care delivery systems: the managed care system and the traditional fee-for-service (FFS) system. The Medi-Cal Managed Care program currently provides health care services to nearly 10 million low-income Californians, including children, pregnant women, seniors, and persons with disabilities. The California Department of Health Care Services (DHCS) contracts with 23 full-scope managed care health plans and three specialty health plans to provide health care services to Medi-Cal enrollees in all 58 California counties.

DHCS developed its Medi-Cal Managed Care Quality Strategy 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 program costs. The present report builds on the framework of the *DHCS Strategy for Quality Improvement in Health Care*¹ (called the "overall DHCS Quality Strategy" in this report.) By designing objectives and interventions specific to the Medi-Cal managed care program, this report operationalizes the overall DHCS Quality Strategy, and will help DHCS make progress towards its seven priorities. The framework for this report also includes three commitments from the Department's Strategic Plan 2013-2017.²

Table 1. Framework of the *Medi-Cal Managed Care Quality Strategy, 2014-15*

	Focus areas	3 linked goals (triple aim)
Overall DHCS Quality Strategy priorities		
<ul style="list-style-type: none"> 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 	Maternal child health Postpartum care Immunizations Chronic disease Diabetes care Control of hypertension	<ul style="list-style-type: none"> Improve health Enhance quality of health care services Reduce DHCS per capita health care costs
<ul style="list-style-type: none"> Advance prevention Improve patient safety 	Tobacco cessation	
DHCS Strategic Plan commitments		
<ul style="list-style-type: none"> Treat whole person by coordinating, integrating services 		
<ul style="list-style-type: none"> Hold DHCS, Plans, providers and partners accountable for performance 		
<ul style="list-style-type: none"> Maintain effective, open communication 		

¹ http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2013.pdf

² <http://www.dhcs.ca.gov/Documents/DHCSStrategicPlan.pdf>

As the first annual assessment of the 2013 strategy, this document evaluates the performance of Medi-Cal managed care health plans (MCPs), lists measurable objectives for key indicators, includes interventions to improve performance, describes changes in service delivery and contractual standards, and outlines enhancements in DHCS oversight and monitoring of the Medi-Cal Managed Care program. In updating the 2013 strategy, this document follows the structure of the Centers for Medicare and Medicaid Services (CMS) Quality Strategy Toolkit to describe significant changes since 2013, and repeats broad outlines of the program only to provide context. For a detailed description of the Medi-Cal Managed Care program, the reader is referred to the 2013 strategy.³

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

- Maternal and child health: timely postpartum care, immunizations of 2 year olds
- Chronic disease management: hypertension control, diabetes care
- Prevention: tobacco cessation

These focus areas are specific examples of services that MCP members need to achieve the seven overall DHCS Quality Strategy priorities. The quality and coverage of each service is monitored by specific performance measures. For each of these measures, DHCS investigated causes for 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) data. DHCS also elicited MCP perspectives on the challenges they faced in engaging members 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 as the interventions are employed, and DHCS works with MCPs to set their own ambitious yet feasible targets.

DHCS views this 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. For 2013, MCP performance in assuring timely postpartum care declined nearly 5 percentage points from 2011. This statistically significant difference translates to an estimated 4,000 fewer postpartum women with timely visits in 2013 compared to 2011. In 2013, the proportion of women with live births who had timely postpartum care fell to 57%, which places California in the bottom 25% of all Medicaid managed care plans in the US. Section IV describes DHCS interventions to improve timely postpartum visits, including a Department-wide quality improvement collaborative and means to engage MCPs.

In 2013, immunization coverage for 155,000 two-year-old MCP members fell for a second

³http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/QualityStrategyRpt_2013.pdf.

consecutive year to 75%. This means that in 2013, 39,000 two-year olds lack one or more recommended immunizations, leaving them vulnerable to measles, pertussis, and other vaccine-preventable diseases that have been increasing during 2014 in California. To address this performance gap, DHCS is partnering with the California Department of Public Health (CDPH) to increase MCP provider use of the California Immunization Registry.

Chronic disease management. In 2013, MCP performance declined in key measures of diabetes care. The proportion of diabetes patients without documentation of blood glucose control rose to 44%. Among the 175,000 members with diabetes, 43,000 had uncontrolled blood glucose (HbA1c > 9%), and another 27,000 were either not tested or were missing the result. These patients are at increased risk for poor health outcomes, such as kidney failure, blindness, and lower extremity amputations. Section IV describes DHCS interventions to improve diabetes care, including a Department-wide quality improvement collaborative and venues to enlist MCP and stakeholder participation.

In 2013, MCPs reported controlling blood pressure in 56% of their members with hypertension. This leaves a major improvement opportunity for the remaining 77,000 members whose blood pressure is not controlled. Using the Archimedes model, DHCS predicted that a 15 percent average reduction in systolic blood pressure for each hypertensive member 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.⁴ To achieve these improvements, DHCS is participating in the CMS Prevention Learning Network to support implementation of the Million Hearts Initiative in Medi-Cal, which will include 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 US. Tobacco cessation services have been demonstrated to be clinically effective,⁵ with a return on investment of 3:1 for dollars spent on smoking cessation services in Medicaid populations.⁶ In the 2013 Medi-Cal Managed Care Consumer Assessment of Health Care Providers and Systems (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 members 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 didn't 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%). To expand tobacco cessation interventions, DHCS's interventions in State fiscal year (SFY) 2014-15 are to

⁴ 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.

⁵ 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>.

⁶ 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>.

increase referrals to the Quitline by setting Medi-Cal policy expectations for MCPs (see Policy Letter 14-006)⁷ and monitoring results.

Health inequities. Among their member populations, wide gaps persist in MCP performance by race and ethnicity. For example, Black members have a nearly 20% higher prevalence of hypertension than other race and ethnic groups (See Section IV B). Black women with recent births had the lowest postpartum visit rate of any race or ethnic group (Figure 2). To make these postpartum data actionable, DHCS evaluated timely postpartum visit rates among the Plans with >200 live births among Black women in 2012 (Table 4). To address these disparities, the DHCS postpartum collaborative will work with the highest performing MCPs to understand the reasons for their success in reaching Black women for timely postpartum visits and what interventions can be implemented by the MCPs with the least success reaching this group.

Overall performance. In 2013, MCP performance fell below the minimum contractually required performance for 21% of the 22 DHCS quality indicators in the 28 counties where MCPs were held to the Minimum Performance Level (MPL) last year. This means one in five Medi-Cal performance metrics was in the bottom 25% of all Medicaid-contracted health plans in the US. There continues to be wide variability in MCP performance. The six best performing plans (CalOptima, Inland Empire Health Plan, Kaiser North, Kaiser South, San Francisco Health Plan, and Santa Clara Family Health) performed above the minimum contractually required level in all their indicators and counties. At the other end of the spectrum, over one third of county-indicators in two MCPs (Anthem and Health Net) fell in the bottom 25 percent of Medicaid-contracted health plans in the US (Figure 1).

To address these challenges, DHCS is intensifying its engagement with MCPs and implementing rapid cycle quality improvement methods. DHCS is working with high-performing MCPs to define and spread best practices. For low-performing MCPs, DHCS has implemented a graded response depending on the persistence and pervasiveness of the performance problems. MCPs with a few indicators below the minimum performance level have initial submission requirements followed by twice yearly monitoring. MCPs with substandard performance on more measures are required to submit quarterly reports evaluating their most recent Plan-Do-Study act cycles. The lowest performing MCP is under a Corrective Action Plan with close DHCS monitoring.

* * *

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 first annual assessment reports on significant enhancements in the Medi-Cal Managed Care program since the 2013 Strategy.

⁷ <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-006.pdf>

SECTION I: INTRODUCTION

This document follows the structure of the CMS Quality Strategy Toolkit for states. It provides an update of the 2013 Medi-Cal Managed Care Quality Strategy by assessing progress and describing changes in DHCS's approaches to improving the quality of care and health of members of MCPs.

Managed Care Overview, Goals, Objectives

Overview

To meet the needs of MCP members with high-quality and appropriate health services, it is important to know their demographics, including age, gender, race-ethnicity, and aid code. There were approximately 6,961,000 MCP members as of March 1, 2014.^{8,9} Of this total, 55% (3.9 million) were children under age 18, and 45% (3.1 million) were adults. Girls comprised 49% of these children under age 18. Women comprised 53% of the 18 to 20 year olds, 63% of the 21 to 44 year olds, and 56%–63% of members aged 45 years and older. Of all MCP members, 51% were Hispanic, 19% were White, 10% were Black, 6% were Asian, 4% were South Asian/Pacific Islander, and 10% were Alaska Native, Native American, other, or of unknown race-ethnicity. By aid code groups, 63% (4.4 million) were families (parents and children in families with income up to 138% of the federal poverty level, FPL), 12% (approximately 800,000) were children (whose parents' income is 138% to 266% of FPL), 10% (approximately 600,000) were transitioned from the Low-Income Health Program (California's precursor to the Medicaid expansion), 9% (approximately 648,000) were seniors and persons with disabilities (SPDs) including children, and 6% (approximately 408,000) were dually eligible for Medi-Cal and Medicare.

DHCS contracted with 23 full-scope and 3 specialty managed care health plans to provide health care services to Medi-Cal enrollees in all 58 counties (Appendix A). There are currently six models of Medi-Cal Managed Care:

1. The County-Organized Health Systems (COHS) model operates as a single county-operated health plan that serves all eligible Medi-Cal beneficiaries in the county. This model does not offer Fee-for-Service (FFS) Medi-Cal. The COHS model serves about 1.76 million beneficiaries through six health plans in 22 counties.
2. The Two-Plan Model consists of a commercial health plan and a local initiative health plan. The local initiative health plan is governed by a County Board of Supervisors. The Two-Plan Model serves about 4.9 million beneficiaries through 12 health plans in 14 counties.
3. The Geographic Managed Care (GMC) Model allows for two or more commercial health plans to operate and provide services in a county. The GMC model has six health plans that serve more than 790,000 beneficiaries in Sacramento and San Diego counties.

⁸ will be posted at: <http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>

⁹ For more recent overall enrollment data, see Appendix A

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 200,000 beneficiaries in 18 counties.
5. The Imperial Model operates in Imperial County with two commercial health plans, similar to the Regional Model. It serves more than 51,000 Medi-Cal beneficiaries.
6. The San Benito Model operates in San Benito County, and provides services to beneficiaries through a commercial health plan or FFS Medi-Cal. The San Benito Model serves more than 6,000 beneficiaries. San Benito is California's only county where enrollment into managed care is not mandatory.

Quality Goals and Priorities

Three linked goals form the foundation of the overall DHCS *Strategy for Quality Improvement in Health Care*.¹⁰

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

This annual assessment of the 2013 Medi-Cal Managed Care Quality Strategy operationalizes the overall DHCS Quality Strategy to specifically improve the health of MCP members. The framework for the present report is based on the seven priorities of the overall DHCS Quality Strategy, as well as three commitments from the Department's Strategic Plan 2013-2017.¹¹ (See Table 1)

Medi-Cal Managed Care Program 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).

¹⁰ http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2013.pdf

¹¹ <http://www.dhcs.ca.gov/Documents/DHCSStrategicPlan.pdf>

Table 1. Framework for the *Medi-Cal Managed Care Quality Strategy, 2014-15*

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Overall DHCS Quality Strategy priorities		
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<ul style="list-style-type: none"> • Advance prevention 	Tobacco cessation	
<ul style="list-style-type: none"> • Improve patient safety 		
DHCS Strategic Plan commitments		
<ul style="list-style-type: none"> • Treat whole person by coordinating, integrating services 		
<ul style="list-style-type: none"> • Hold DHCS, Plans, providers and partners accountable for performance 		
<ul style="list-style-type: none"> • Maintain effective, open communication 		

Listed below are the objectives for services to be provided in 2015. As a starting point, targets have been set for a 5 percentage point improvement, compared to the baseline year of 2013. Interventions listed in Section IV are being implemented in 2014 and 2015. As DHCS works with MCPs on implementation, these preliminary targets will be adjusted to ensure they are ambitious but feasible. (See Section IV for an analysis of the scope of the challenges that must be addressed to reach these objectives.)

A. Postpartum care

1. Increase the Medi-Cal weighted average for timely postpartum care to at least 62% for measurement year 2015.
 - Target for measurement year 2015: 62%
 - Baseline from 2013 measurement year: 57%
 - Source: reported as aggregate data by MCPs and audited by the Department's External Quality Review Organization (EQRO), which calculated the statewide weighted Medi-Cal Managed Care average
2. Increase the percentage of Medi-Cal Managed Care counties meeting the minimum performance level for timely postpartum care to at least 80% for measurement year 2015.
 - Target for measurement year 2015: 80%
 - Baseline from 2013 measurement year: 75%

- Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide weighted Medi-Cal Managed Care average
3. Increase the proportion of Black postpartum women with timely postpartum care to at least 38% for measurement year 2015.
 - Target for measurement year 2015: 38%
 - Baseline from 2012 measurement year: 33%
 - Source: statewide Medi-Cal managed care average calculated by DHCS applying National Committee for Quality Assurance (NCQA) specifications to encounter data (administrative only) submitted by MCPs

B. Immunization of 2 year olds

4. Increase to at least 80% the proportion of MCP members with up-to-date immunizations by their 2nd birthday during measurement year 2015 (to be reported in 2016).
 - Target for measurement year 2015: 80%
 - Baseline from 2013 measurement year: 75%
 - Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide weighted Medi-Cal Managed Care average

C. Hypertension

5. Increase to 61% the proportion of MCP members 18 to 85 years of age with hypertension whose blood pressure is adequately controlled during measurement year 2015 (to be reported in 2016).
 - Target for measurement year 2015: 61%
 - Baseline from 2013 measurement year: 56%
 - Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide weighted Medi-Cal Managed Care average

D. Diabetes

6. Outcome objective: Decrease to 39% the proportion of MCP members with diabetes who had HbA1c > 9% in measurement year 2015 (to be reported in 2016).
 - Target for measurement year 2015: 39%
 - Baseline from 2013 measurement year: 44%
 - Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide weighted Medi-Cal Managed Care average
7. Process objective: Increase to 88% the proportion of MCP members with diabetes who have had HbA1c testing during measurement year 2015 (to be reported in 2016).
 - Target for measurement year 2015: 88%
 - Baseline from 2013 measurement year: 83%

- Source: reported as aggregate data by MCPs and audited by the Department's EQRO, which calculated the statewide weighted Medi-Cal Managed Care 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 on the percentage of adults with diabetes who have HbA1c > 9%.
- Target for measurement year 2015: 30%
 - Baseline from 2013 measurement year: 24.58%
 - 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 measurement year 2016: 76%
 - Baseline from 2013 measurement year: 71%
 - 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 measurement year 2016: 45%
 - Baseline from 2013 measurement year: 40%
 - 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.

Objectives 11–14 are additional commitments to MCP members and the public from the DHCS *Strategic Plan, 2013–2017*¹² and the overall DHCS Quality Strategy. In future years, these will also include measurable targets, but for this report are framed as broad goal statements.

11. Improve patient safety (See Section IV)
12. Treat the whole person by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care (See Section V)
13. Hold ourselves and our providers, health plans, and partners accountable for performance (See Section IV)

¹² <http://www.dhcs.ca.gov/Documents/DHCSStrategicPlan.pdf>

14. Maintain effective, open communication and engagement with the public, our partners, and other stakeholders (See Section V)

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

Development and Review of Quality Strategy

This report was developed by staff and managers throughout the Department and included two Department-wide Quality Improvement (QI) collaboratives initiated as part of the Adult Medicaid Quality Grant. MCP staff (including medical directors, health educators, and quality directors) and two of the DHCS advisory groups (which include members and their advocates) provided feedback on the focus areas, objectives, and interventions. DHCS will submit this *Quality Strategy 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 Medi-Cal Managed Care Division (MMCD) All-Plan CEO meetings, quarterly MMCD All-Plan Medical Directors meetings, and quarterly MMCD Advisory Group meetings.

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

SECTION II: ASSESSMENT

National Performance Measures

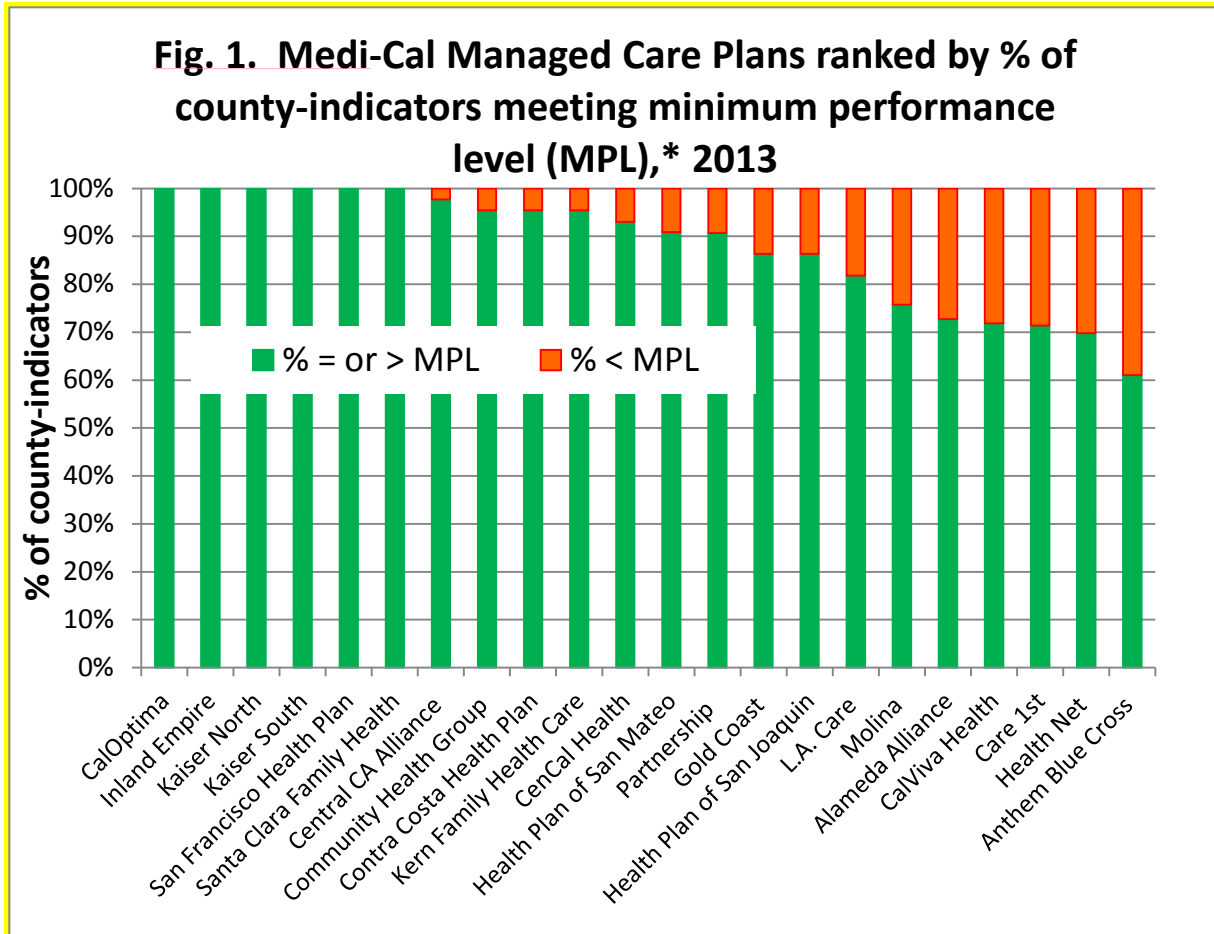
For measurement year 2014, MCPs will report performance on 15 measures consisting of 30 individual indicators. (See Appendix C, which indicates that 23 of the 30 are in the CMS Core Adult and Child Set).

For 22 of these 30 indicators, DHCS contracts hold MCPs accountable for performing at least as well as the lowest performing 25% of Medicaid-contracted managed care health plans in the US. This is the minimum performance level. DHCS defines high performance level as performing as well as the top 10% of Medicaid Plans in the US.

For health care services provided in 2013, the 23 full service health plans exceeded this minimum performance level for 79% of the indicators across their 28 counties of operation.¹³ However, this leaves 21% of indicators falling below the minimum performance level. Interventions to address these challenges are described in below (as well as in Section IV).

Figure 1 shows the wide variability in MCP performance on these 22 indicators. Six MCPs fully met their contractual requirements across all their counties of operation; they had no indicators below the minimum performance level (CalOptima, Inland Empire Health Plan, Kaiser North, Kaiser South, San Francisco Health Plan, and Santa Clara Family Health Plan). However, 16 MCPs fell below minimum performance levels for a total of 186 indicators in one or more of their counties of operation. The lowest performing MCP was Anthem Blue Cross, where 39% of its indicators fall below the minimum contract requirement; next was Health Net with 35%; followed by Care 1st, CalViva, Alameda Alliance, Molina, and Health Plan of San Joaquin with 29%–23% of indicators below the MPL.

¹³ One of the currently operating 23 health plans is new; new health plans (and existing health plans beginning operations in a new county) are not held to the MPL until their second full year of operations.



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

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

Monitoring and Compliance

Rapid Cycle Quality Improvement

In an effort to quickly raise MCP performance, DHCS initiated the following approaches to the 15 MCPs not meeting minimum contractual performance standards for one or more indicators in measurement year 2013:

- DHCS has reduced time lags in identifying and addressing poor performance, so there is still time for intervention before the measurement year ends. In 2014, DHCS identified poor performing MCPs in July, right after MCPs reported their finalized results to NCQA. DHCS also shortened the timeframe from 90 to 60 days for MCPs to submit Improvement Plans (IPs) to address their first two performance gaps.

- DHCS developed instructions and a template for developing objectives using interim outcomes to facilitate use of Plan-Do-Study-Act (PDSA) methods.
- DHCS is requiring MCPs with substandard performance to conduct quarterly evaluations of their Plan-Do-Study-Act cycles, with DHCS engagement throughout the year to monitor progress, provide technical assistance, and share lessons learned across MCPs.

Rapid cycle QI methods have also been implemented in Quality Improvement Projects (see next section).

Quality Improvement Projects (QIPs)

DHCS requires MCPs to conduct and/or participate in two QIPs annually. One is the statewide collaborative project on reducing readmissions, and the other is an MCP-specific QIP.

As of August 1, 2014, 23 full-scope MCPs were working on 27 MCP-specific QIPs (see Appendix D). Each QIP includes 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 two indicators). These 27 QIPs fall into the following topic areas:

- Diabetes care (9 QIPs)
- Prenatal/postpartum (7 QIPs)
- Immunization (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).

QIPs on one topic encompass all of the counties within multi-county health plans; except for Partnership Health Plan whose three QIPs encompass different county groupings.

Of the total of 27 QIPs, 16 QIPs (in 15 health plans) included HEDIS measures and have progressed to the stage where improvement can be assessed. Of these 16, four (20%) achieved statistically significant improvement from measurement year 2012. All four are among Medi-Cal's higher performing MCPs.

MCPs submit an annual status report for each QIP. To foster year-round quality improvement efforts, this year DHCS began to require MCPs to conduct quarterly progress reviews. DHCS also recently instituted procedures to intensify technical assistance to each MCP, as needed, and continue the QIP until the MCP demonstrates statistically significant improvement and sustains it for at least one year.

Reducing all-cause readmissions (ACR) to the hospital is the aim of the statewide collaborative QIP. Last year (2013) was the first remeasurement year. Each MCP set its own target to achieve in 2013 a statistically significant decrease in the proportion of readmissions compared to 2012. While six Medi-Cal Managed Care-counties noted statistically significant decreases in readmissions (an improvement) compared to 2012, another six found statistically significant

increases (worsening), and the remaining 31 had no significant change. Overall, the Medi-Cal Managed Care weighted average for members who were not SPDs continued to fall from 10.3% in 2011, to 9.4% in 2012 (baseline year), to 9.1% in 2013, reflecting the national and statewide trend. The incidence of ACR for SPDs fluctuated between 16% and 17% during the same years without a clear trend.

DHCS will work with its external quality review organization (EQRO) to conduct more detailed analyses of these results to determine the statistical significance of the statewide improvement in the non-SPDs, which must be interpreted in light of patterns outside of Medi-Cal Managed Care. DHCS will also examine the contribution of the SPD population to the MCP-specific findings. To foster rapid cycle QI, for the first time MCPs will submit evaluations of a PDSA cycle as part of their annual reports (due 8/30/2014) on at least one intervention to decrease readmissions during 2014, the second remeasurement year. The collaborative will also discuss initial findings from the first remeasurement year.

Corrective Action Plans

DHCS formalized the Quality of Care Corrective Action Plan (CAP) process in June 2014. A CAP will be triggered if a Plan meets either or both of the following criteria: 1) Three or more of the same indicators are below the MPL in the same reporting unit for the last three or more consecutive years; or 2) more than 50% of the total number of indicators for any reporting unit is below the MPL in the most recent measurement year. DHCS reserves the right to make the final decision regarding imposing a CAP on an MCP apart from either of the aforementioned triggers being met. DHCS will impose sanctions for MCPs under a CAP that do not meet established milestones, which may include financial penalties.

In November 2013, 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 2016 and, on a quarterly basis, the MCP submits status updates to DHCS for review.

Public Reporting of Performance Results

DHCS publically reports audited performance results for each MCP on its website and in frequent presentations to stakeholders.

To improve program oversight and monitoring, MMCD has developed the Medi-Cal Managed Care Performance Dashboard (Dashboard). The third quarterly iteration was released in August 2014. 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^{®14}) and CAHPS rates. The Dashboard will continue to evolve based on the program needs and input from MCPs and stakeholders.

¹⁴ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The 2013 CAHPS® survey data have been analyzed. DHCS has begun using the results of the tobacco questions to inform tobacco cessation interventions and monitoring. DHCS uses the CAHPS surveys to assess member experience of care, and publishes results in the Consumer Guide to help inform members' 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*¹⁵ (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 IV), DHCS analyzed encounter data to determine disparities in key indicators by race and ethnicity. Actionable results are described in Section IV, 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 members and to reduce health disparities in this clinical area. See Section IV 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.¹⁶ In SFY 2014-15, DHCS will work with stakeholders and partners to develop aggressive intervention plans to eliminate addressable disparities. As part of the partnership, DHCS has developed an interagency agreement with the Office of Health Equity within the California Department of Public Health (CDPH) to optimize effectiveness and efficiency in shared efforts to eliminate health disparities.

Enrollee Race, Ethnicity, and Primary Language Data

DHCS contracts with an enrollment broker to ensure that Medi-Cal beneficiaries are enrolled into an MCP no later than 90 days from the date the beneficiary is shown in the Medi-Cal Eligibility Data System (MEDS). The DHCS enrollment broker uses 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. Race, ethnicity, and language information for each new member is transmitted to the appropriate MCP based on MCP enrollment files, as required by 42 CFR §438.204(b)(2).

¹⁵ <http://www.chhs.ca.gov/Documents/Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf>

¹⁶ <http://www.dhcs.ca.gov/dataandstats/reports/Pages/HealthDisparities.aspx>

In 2014, DHCS released a letter revising the method used to determine threshold languages.¹⁷ The letter included a chart that uses the new dataset for threshold languages and highlights the primary or preferred language of beneficiaries in each county. DHCS currently uses twelve threshold languages, including English. The MCPs must implement all their contracted language services in accordance with the updated dataset by January 1, 2015. 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 and to arrange for appropriate cultural and linguistic support to LEP members, including interpreter services in provider offices.

External Quality Review

The most recent EQRO recommendations for DHCS (from the SFY 2012-13 *Technical Report*)¹⁸ are listed below, along with DHCS responses.

1. Continue to implement new monitoring and oversight protocols to ensure that each MCP complies with all federal and State requirements, including that each MCP undergoes a comprehensive audit at least once within a three-year period.

DHCS response: The DHCS Medi-Cal Managed Care Division coordinates with the DHCS Audits and Investigative Division to conduct medical audits of MCPs. DHCS is working towards conducting annual audits and will do so beginning in 2015. DHCS also coordinates with the Department of Managed Health Care to conduct medical surveys of MCPs every three years.

2. Engage MCPs that display poor performance over consecutive years in intensive oversight (at least quarterly), and require these MCPs to develop formal correction action plans to address their poor performance.

DHCS response: See Monitoring and Compliance in Section II above.

3. Identify state-level barriers related to Medi-Cal managed care performance, and develop and implement strategies to address these barriers.

DHCS response: See examples in Section IV below for diabetes, postpartum care, immunization, and hypertension.

¹⁷ <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-008.pdf>

¹⁸ http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/TechRpt/CA2012-13_Technical_Report_F1.pdf

SECTION III: 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. Listed below are only those areas that have substantially changed since the 2013 Medi-Cal Managed Care Quality Strategy.¹⁹ See the latter document for a full description of the current state standards.

Access Standards

See the 2013 Medi-Cal Managed Care Quality Strategy.

Structure and Operations Standards

See the 2013 Medi-Cal Managed Care Quality Strategy.

Measurement and Improvement Standards

Practice Guidelines

DHCS has established clinical guidelines as contract requirements. In 2014, DHCS amended contracts to specify that MCPs ensure adherence to U.S. Preventive Services Task Force (USPSTF) A and B recommendations for adults, including tobacco cessation recommendations.

Quality Assessment and Performance Improvement Program

To select measures for MCP reporting in 2016, DHCS reviewed the CMS Core Child and Adult Core Sets using National Quality Forum criteria for evaluation of measures. DHCS developed a proposal to calculate some of the Core Set indicators by using encounter data submitted to DHCS, including oral health and assessment of developmental delays in children. In several stakeholder venues, DHCS presented its proposal to add new measures, and retire those deleted by NCQA. After several rounds of input from stakeholders, DHCS plans to add the tobacco cessation measures using CAHPS surveys.

The measures for MCPs to report in 2015 are listed in Appendix C. Measures of possible overutilization of services continue to include the following: ambulatory care (emergency department visits), all cause readmissions (adapted by California), avoidance of antibiotic treatment in adults with acute bronchitis, and use of imaging studies in low back pain. All the remaining measures in the DHCS External Accountability Set (EAS) shed light on possible underutilization of services.

Current Quality Improvement Plans for each MCP are listed in Appendix D.

Stakeholder Input/Workgroups

DHCS has various ongoing collaborative workgroups to ensure that stakeholders have ample opportunity to advise, provide input, and make recommendations regarding program services, operational issues, and areas for quality improvement. DHCS regularly utilizes the knowledge

¹⁹http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/QualityStrategyRpt_2013.pdf.

and expertise of our health plan partners to review and give input on Policy and All Plan Letters prior to finalization. The letters are available on the DHCS webpage.²⁰

²⁰ <http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx>

SECTION IV: 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 members 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 Section II propose a modest 5 percentage point improvement from 2013 to 2015, the interventions listed below should better equip DHCS and MCPs to accelerate progress toward the three linked goals in subsequent years. As noted above, these targets are a starting point, to be adjusted during implementation to ensure they are ambitious but feasible.

These areas are a subset of all the health needs of MCP members. 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. This will form the basis for yearly reassessments and revisions of this Quality Strategy.

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

Table 2. Estimated impact of Medi-Cal Managed Care Plan performance: members documented to have received appropriate care (“served”) vs. not “served,” 2013

Performance measure			
Tobacco cessation			
<ul style="list-style-type: none"> Advised to quit 	413,000 adults who smoke+	71% recalled being counseled to quit	120,000 smokers not recalling being counseled to quit
<ul style="list-style-type: none"> Discussed medication to quit 		40% recalled discussing cessation medications	248,000 smokers not recalling discussing medication to quit
Controlling hypertension (HTN)	175,000 adults with HTN	56% with controlled HTN**	77,000 HTN patients with blood pressure not controlled
Diabetes care			
<ul style="list-style-type: none"> HbA1c testing 	159,000 adults with diabetes	83% tested in past year**	27,000 diabetes patients with no HbA1c test result
<ul style="list-style-type: none"> blood glucose control 		56% ** whose last HbA1c was < 9%^	43,000 diabetes patients whose HbA1c was > 9% (not controlled)
Immunization coverage	155,000 two year olds	75% up to date on immunizations**	39,000 two year olds incompletely immunized
Postpartum care	82,000 women who gave birth	57% had a timely postpartum visit**	35,000 mothers without a timely postpartum visit

Notes: numbers rounded to nearest 1000.

* of the total December 2013 Medi-Cal Managed Care enrollment of 6,026,905 members.

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptDec2013.pdf

+18.2% of 2,268,493 Medi-Cal managed care members 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 .44)

** no improvement from 2012 measurement year

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 audited, statewide weighted averages reported by Plans to NCQA. The source for column 2 is the total population eligible for the HEDIS® rate calculation, as reported by Plans to NCQA. These are minimum estimates, since NCQA specifications exclude certain patients (such as those not continuously enrolled in the Plan for 12 months).

DHCS plans to implement the following interventions to address the causes of poor performance and to reach improvement objectives for measurement year 2015 that are listed in Section I.

DHCS Interventions for SFY 2014-15 (to achieve the objectives in Section I covering one or more of the ten performance measures in maternal and child health, chronic disease, and prevention)

1. Intensify engagement with targeted MCPs
 - a. Understand and address the causes of lower performance, current MCP activities, successes and challenges, lessons learned, and technical assistance needed. For each indicator, DHCS will focus on:
 - MCPs with the largest numbers of members not served (where interventions are needed to raise the statewide average)
 - MCPs with substandard performance (to ensure minimum quality of care in all counties). Use rapid cycle QI methods (see Section II.)
 - MCPs with largest number of members in underserved race-ethnic groups (to address health inequities).
 - b. Assist MCPs in setting MCP-specific targets for one or more of the objectives in this document, and include action plans to meet the targets in their required annual QI reports (contract deliverables).
2. Convene a statewide QI Workgroup of MCP staff (Quality directors, Medical Directors, Health educators) and hold regular, action-oriented teleconferences for MCPs to share challenges and lessons learned, identify and resolve state and local barriers, receive/provide technical assistance.
 - a. Elicit Plan co-chairs as a means to develop MCP champions and leadership
 - b. Use this organizational structure to enlist MCPs to adapt and implement
 - the Million Hearts Initiative
 - the postpartum, diabetes, and tobacco cessation interventions in this document
 - c. Establish a SharePoint site for posting/exchanging best practices and resources
3. Optimize provider education, feedback, incentives for QI
 - a. Describe strategies used by the most successful Plans for engaging their provider groups for performance feedback and peer comparison, patient registries and population management, care management and patient outreach. Establish and implement standards of practice for MCP engagement with providers.
 - b. Work with Integrated Healthcare Association (IHA) to identify successful elements and means to scale them up from its:
 - Upcoming survey of MCP Pay-for-Performance programs
 - Medi-Cal MCP Pilot project (and Web Reporting Platform)
 - c. Within the Electronic Health Record (EHR) incentive program (Meaningful Use Stage 2):
 - Denote HbA1c > 9% on the State Level Registry (SLR) as a recommended Clinical Quality Measures (CQM) and publish on SLR home page

- Provide data to MCPs on their providers participating in the EHR incentive program, which CQMs they report, and their level of performance
 - d. Provide 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. Evaluate obstetric payment arrangements (including global billing) and their impact on postpartum visit rates
4. Optimize member engagement
- a. Assess barriers to member engagement and determine which can most effectively be addressed by MCPs
 - b. Describe MCP member education, outreach and incentives programs in each of the 3 areas
 - c. Define the elements most successful at improving performance; establish and implement standards of practice for MCPs to engage members for each of the three initiatives
 - d. Implement a pilot program with selected MCPs to offer free blood pressure monitors to Medi-Cal members with hypertension.^{22,23}
 - e. Engage key MCPs to institutionalize Text4baby enrollment for all perinatal members.
 - f. Identify best practices within Plan networks for timely notifications of pregnancies and deliveries.
5. Improve and analyze encounter data to drive program improvement
- a. Repeat analysis of Plan performance on key indicators by race and ethnicity to evaluate progress toward eliminating health inequities in postpartum care, immunization coverage, or diabetes care
 - b. Prioritize additional data analysis
 - Elicit MCP input on which data will be most actionable for their QI efforts
 - Pharmacy data (to assess prescription and adherence to anti-hypertensive medications, tobacco cessation drugs)
 - Consider which CMS Core Child and Adult indicators DHCS will calculate internally using encounter data

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/HCPProf/toolkit.pdf>. Accessed July 24, 2014.

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.

- c. Continue the Encounter Data Improvement Project, and identify other means to support Plans in improving data collection and use
 - Investigate discrepancies in denominators from encounter data vs. audited, aggregate data MCPs report to NCQA
6. Measure, report and use Plan performance
 - a. Update performance indicators in Dashboard each quarter
 - b. Post annual performance results online promptly
 - c. Present to stakeholders
 - d. Inform members' choice of Plans via Consumer guide, Office of Public Advocate rankings
 - e. Include the *Controlling High Blood Pressure* measure in the auto-assignment algorithm, where Plans with higher performance than other(s) operating in the same county are rewarded by receiving new members who do not actively chose to enroll in a particular Plan
 - f. Develop tobacco cessation indicators and targets (including the outcome of smoking prevalence and the process of calls to the Quitline) to implement and monitor Policy Letter 14-006)²⁴
7. Collaborate with CDPH
 - a. Promote partnerships between MCPs with local Maternal, Adolescent and Child Health programs; provide a cross walk for MCPs to access services and provider training from local MCAH programs
 - b. Hold a webinar to inform MCPs on the California Immunization Registry (CAIR), specifically covering strategies for increasing provider use of the registry, uploading of EHR, automation of monthly reports so MCPs can intervene in real time to reach children not yet immunized
 - c. Identify lessons learned from research project matching Medi-Cal with CAIR

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

A. Postpartum Care

Timely postpartum visits are important for support of breastfeeding, screening for depression, follow up of conditions such as diabetes and hypertension, and family planning. For women who wish to have future pregnancies, this 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

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

(ACOG) and Comprehensive Perinatal Services Program (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 National Committee for Quality Assurance (NCQA) defines a timely postpartum visit as a visit to an obstetric-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 Plan performance: audited, aggregate data reported by Plans to NCQA. In 2013, the Medi-Cal Managed Care weighted average fell to 57%, below the 25th percentile for Medicaid. This represents nearly a 5 percentage point drop from 2011 (binomial test, $p < 0.001$). This statistically significant difference translates to an estimated 4000 fewer postpartum women with timely visits in 2013 compared to 2011.

Note: the following sections use 2012 data for timely postpartum care, as it is the most recently available information for the analyses described below.

In 2012, 78,516 MCP members comprised the denominator for the postpartum measure reported to the NCQA. Of these women, 59% (46,020) were reported to have a timely postpartum visit. Of the remaining 32,496 women who did not have a timely postpartum visit, the largest share were members of LA Care (20% - 6,433), Health Net (13% - 4,280), Anthem (12% - 3,772) and Inland Empire Health Plan (12% - 4,047).

Of note, Medi-Cal Managed Care-counties in 2012 with high rates of timely prenatal care also had high rates of timely postpartum care (Pearson correlation coefficient 0.7). It is possible that interventions to improve early notification of pregnancy and engagement in prenatal care are associated with timely postpartum care as well. Alternatively, it may be that Medi-Cal Managed Care-counties with high prenatal rates are serving women who are more likely to return for postpartum visits.

MCP performance: individual level encounter data reported by MCPs to DHCS. The DHCS Medi-Cal Management Information System/Decision Support System (MIS/DSS) is a warehouse of encounter data reported by Plans, and provides valuable member-level data to

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.

analyze alongside the aggregate, audited data that Plans report to NCQA. Using encounter data in the MIS/DSS through 9/30/2013, the DHCS Office of Family Planning's Family Planning, Access, Care, and Treatment (Family PACT) evaluation team (under contract with University of California, San Francisco-UCSF) replicated the postpartum care rate for MCP members continuously enrolled in an MCP 43 days before to 56 days after delivery.

Timing of visit after delivery (Table 3). While the HEDIS[®] specifications define a timely postpartum visit as occurring on or between 21 and 56 days after delivery, some clinical recommendations suggest that postpartum care up to 90 days after delivery may be acceptable for certain women. By expanding the postpartum care timeframe to 21-90 days, the postpartum visit rate increased by 5.7 percentage points. When an additional week was added to the beginning to lengthen the timeframe to 14–90 days, the rate increased by an additional 3.1 percentage points. If this entire window is considered (14–90 days), the rate rises by a total of 8.3%, with Plans ranging from an increase of 4.5 to 30.2 percentage points.

Table 3. Comparison of timely postpartum visit rates by data source, visit intervals and global billing codes, Medi-Cal Managed Care, 2012

	% with postpartum visit		Comment
	Aggregate, audited data reported by MCPs to NCQA	Individual-level encounter data reported by MCPs to DHCS	
<ul style="list-style-type: none"> 21-56 days after delivery 	48.1 % (administrative data only) (59% with hybrid method using chart reviews)	42.2%	5.9 percentage points lower than the aggregate, audited data MCPs report to NCQA*
<ul style="list-style-type: none"> 21-90 days after delivery 	Not available (n/a)	47.9%	5.7 percentage points higher than the 42.2% within 21-56 days*
<ul style="list-style-type: none"> 14-56 days after delivery 	n/a	45.3%	3.1 percentage points higher than the 42.2% within 21-56 days*
<ul style="list-style-type: none"> 14-90 days after delivery 	n/a	50.5%	8.3 ^ percentage points higher*
If global billing codes included (see text on p. 5)	n/a	60.4%	18.2 percentage points higher than the 42.2% excluding global billing codes*

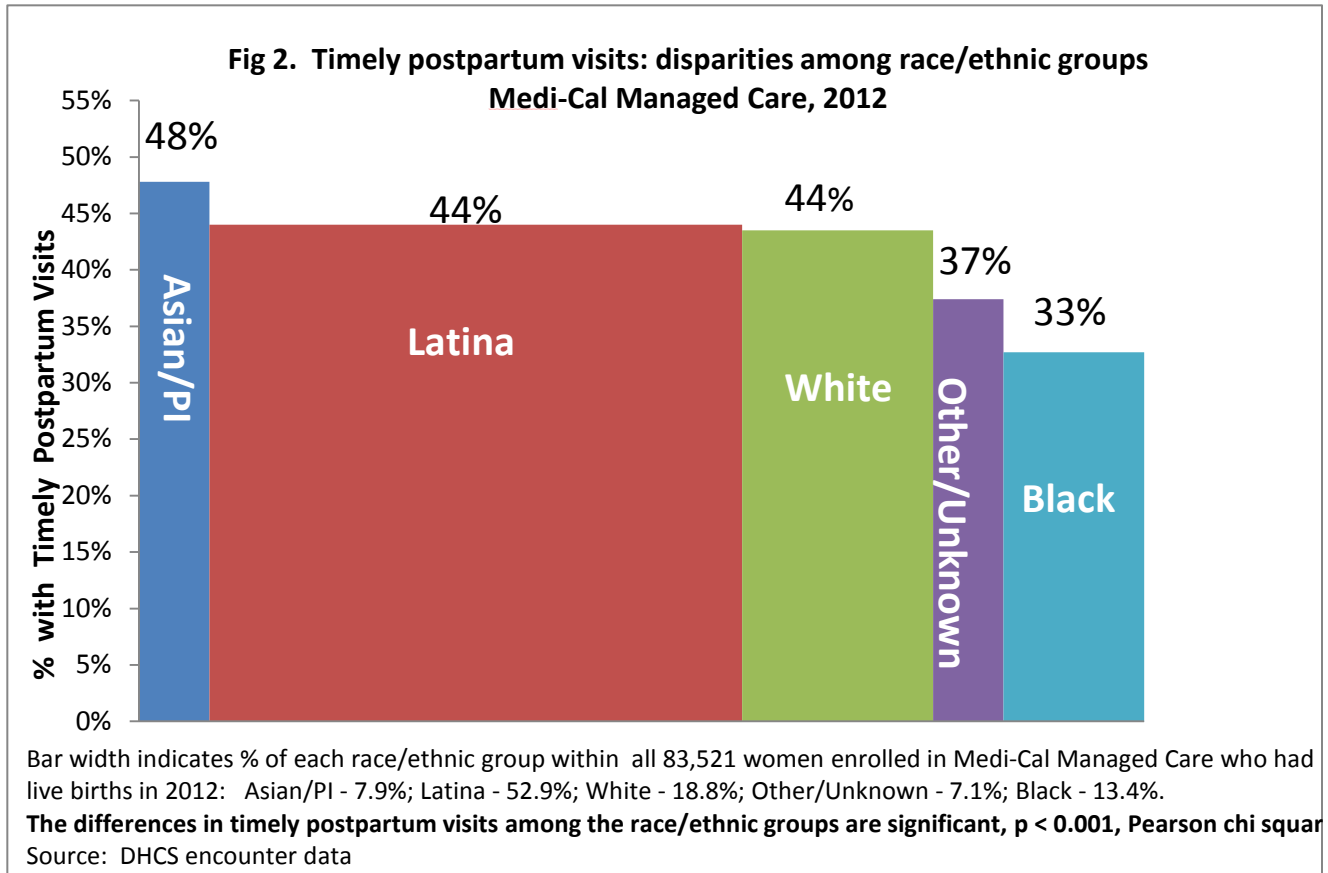
* Pearson chi square $p < 0.001$, when compared to rate for 21-56 days postpartum (derived from individual-level encounter data reported by MCPs to DHCS).

^ 5.7 and 3.1 in the 2 rows above do not sum to 8.8 since women with postpartum visits on the 21st day are counted in both the 21-90 and 14-56 intervals

Note: 5,890 more women in the individual level encounter data were found to meet the measure specifications compared to the aggregate, audited denominator. DHCS is evaluating encounter data reporting in three Plans that accounted for most of the discordance to see which source is closer to the actual number of women who delivered a live birth.

Demographics. The timely postpartum care rate was significantly different by primary language spoken. It was highest for women who spoke primarily Spanish (51.4%) compared to 46.7% among women with other/unknown primary language, and 40.5% among women who primarily spoke English. Women residing in rural/frontier zip codes had significantly higher rates of postpartum care (50.0%) than urban women (40.9%). There were no significant differences by age of the women. (Data not shown.)

There were statistically significant differences among postpartum rates by race/ethnicity. Asian/Pacific Islander women had the highest postpartum visit rate (47.8%), followed by Latinas (44.0%) and White women (43.5%). Women with other/unknown race ethnicity (37.4%) and Black women (32.7%) had the lowest rates.



To find opportunities to diminish the inequity in postpartum care for Black women, OFP/UCSF conducted further analysis. Among the 13 MCPs with 200 or more Black women delivering live births in 2012, the proportion of Black women with timely postpartum care ranged from 25% in Health Net LA, LA Care and Inland Empire, to 50% in CalViva Fresno (Table 4).

In 2012, there were 11,158 Black women who met the NCQA specifications, comprising 13.4% of all MCP members included in the measure. Forty five percent (45%) of these women were in three MCPs: LA Care, Health Net LA, and Inland Empire Health Plan. For comparison, these MCPs contributed 50% of the 7,507 African-American women in California who did not have documented receipt of timely postpartum care.

Table 4. Black women with timely postpartum visits, Medi-Cal Managed Care Plans with > 200 deliveries to Black women in 2012

		# Live Births	% Timely Postpartum Visits
CalViva Health	Fresno	483	50.1
Partnership Health Plan	Solano/Napa/Yolo	323	46.7
Kern Health Systems	Kern	377	42.4
Alameda Alliance for Health	Alameda	723	42.0
Contra Costa Health Plan	Contra Costa	325	40.3
Health Plan of San Joaquin	San Joaquin	373	37.3
Anthem	Alameda	225	36.9
Community Health Group	S Diego	251	31.1
Health Net	Sacramento	329	30.7
Anthem	Sacramento	546	29.3
Inland Empire Health Plan	Riverside/S Bernardino	1,557	25.4
LA Care	Los Angeles	2,444	24.9
Health Net	Los Angeles	1,050	24.5
<i>Subtotal in 13 Plan-counties above</i>		8,523	
Total (all 46 Plan-counties)		11,158	32.7

Source: individual level encounter data reported by MCPs to DHCS

Note: ranked in descending order by % with timely postpartum care

Diabetes. Of the women delivering live births in 2012, diagnosis codes for diabetes were found in encounter data for 11.9% of women (3.9% with preconception diabetes²⁷ and 8.0% with gestational diabetes).²⁸ Women with gestational diabetes had a higher postpartum care rate (48.6%) than women with preconception diabetes (44.4%) or no diabetes (41.5%, $p < 0.0001$). The difference remains statistically significant when women with any diabetes are grouped together. However, over half of women with any type of diabetes had no record of a postpartum visit. It is possible that they had follow-up with an endocrinologist, but if they saw a primary care practitioner, the basic elements of a postpartum visit were not done or not documented.

Global billing. Global billing allows providers who render total obstetrical care to receive a bundled payment consisting of antenatal care, delivery and postpartum care. Per NCQA technical specifications, globally billed obstetric care cannot be included in the numerator unless the date of postpartum care can be identified, or evidence of a postpartum visit was found in chart review.²⁹ When global billing codes were included in rates calculated by UCSF using individual-level encounter data, the postpartum visit rate increased by 18.2 percentage points (42.2% without global codes compared to 60.4% with global codes) (Table 3). Inclusion of

²⁷ Preconception diabetes: ICD-9 code 648 (DM complicating pregnancy, childbirth or the puerperium) within 56 days of estimated delivery.

²⁸ Gestational diabetes: ICD-9 code 648.8 (abnormal glucose tolerance (gestational diabetes) complicating pregnancy, childbirth or the puerperium) or V12.21 (personal history of gestational diabetes) within 56 days of estimated delivery

²⁹ NCQA. HEDIS® technical specifications, Volume 4, 2014. p. 244 and 246.

global codes is an overestimation of actual postpartum visit rate, as some women may not have returned for a postpartum visit within 21-56 days of delivery, or may not have returned at all.

Key drivers. DHCS constructed a “Driver Diagram” after reviewing five current postpartum-focused Improvement Plans (IPs) and one Quality Improvement Project (QIP) submitted to DHCS,³⁰ as well as discussions from the June 19-20, 2014 Maternity Care Symposium³¹ and the DHCS Quality Improvement Collaborative group on maternal care. Primary drivers were member characteristics (knowledge and resources); Data completeness, accuracy, reasonableness and timeliness; Providers and their characteristics (knowledge, engagement with the MCP, resources); MCP oversight, management, quality improvement; and DHCS payments, policies, oversight, assistance. To develop the interventions listed above, an extensive list of secondary drivers was also constructed.

B. Immunization Coverage of Two Year Olds

In 2013, immunization coverage of 155,000 two-year old MCP members 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.

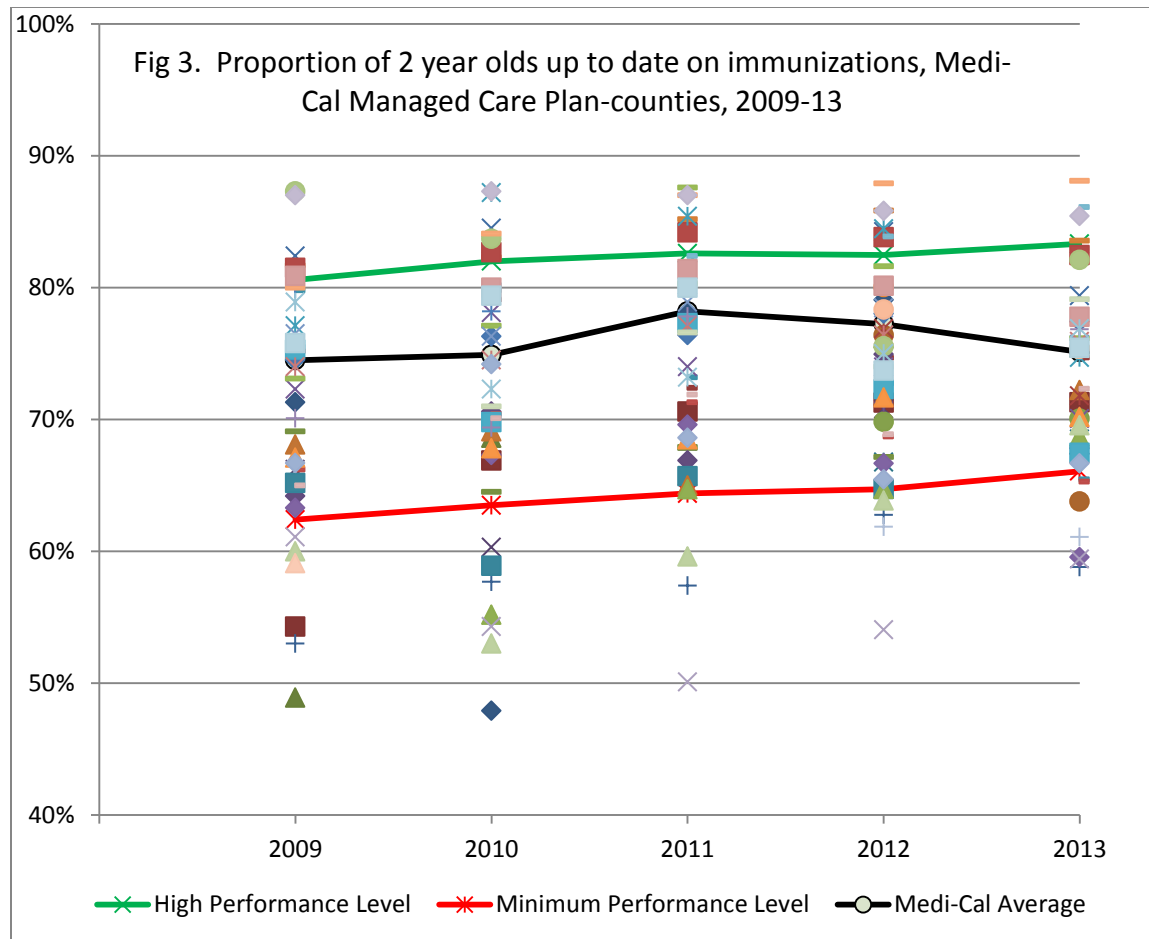
Immunization coverage declined by 3 percentage points from 2011 to 2013 (binomial test, $p < 0.0001$). This statistically significant difference translates to an estimated 4700 fewer two year olds with up to date immunizations in 2013 compared to 2011.

In 2013, four MCPs exceeded the high performance level by fully immunizing over 83% of their two year old members. However, immunization coverage in 8 counties (operated by five other MCPs) fell to below the minimum performance level of 66%.

Figure 3 shows a 2011-2013 decline in Medi-Cal Managed Care performance (black line) in the face of improving Medicaid performance nationwide (with rising 25th and 90th percentiles in the red and green lines). However, the variability across Medi-Cal Managed Care-counties has decreased, with fewer MCPs below the Medicaid 25th percentile (red line). DHCS is conducting more in depth analysis to better understand the causes of these trends, so interventions can be designed and implemented.

³⁰ 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 External Quality Review Organization.

³¹ California Health Care Foundation, UC Davis Institute for Population Health.
<http://www.dhcs.ca.gov/services/calendar/Pages/Symposium.aspx>



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 percent and 5.8 percent of deaths.³²

The Medi-Cal claims and encounter dataset offers opportunities to explore hypertension among various subpopulations. As expected, age was a significant factor in hypertension rates. Sixty percent of MCP members 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.³³

As shown in Table 2 above, there were 175,000 MCP members identified with hypertension in 2013. Table 5 shows that more than half of the MCP members diagnosed with hypertension were represented by six MCPs.

³² 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.

³³ Medi-Cal MIS/DSS and Symmetry EBM Groupers, Version 8.2; January 1, 2013 – December 1, 2013.

Table 5. Six Plans Serve More than Half of Medi-Cal Managed Care Members Diagnosed with Hypertension, 2013.³⁴

MCPs	Medi-Cal Managed Care Members with Hypertension According to Plan Audited Data (n=175,202)	
	No.	%
LA Care	33,613	19.2%
Inland Empire – San Bernardino/Riverside	16,802	9.6%
CalOptima – Orange	13,707	7.8%
Alameda Alliance for Health	9,596	5.5%
Health Net – LA	8,701	5.0%
CalViva Health – Fresno	6,387	3.6%
Sub-Total	88,806	50.7%

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 SBP over 140 mm Hg or 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 member could achieve a 15 percent reduction in their SBP. Assuming that 175,202 hypertensive MCP members 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 members 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.³⁵

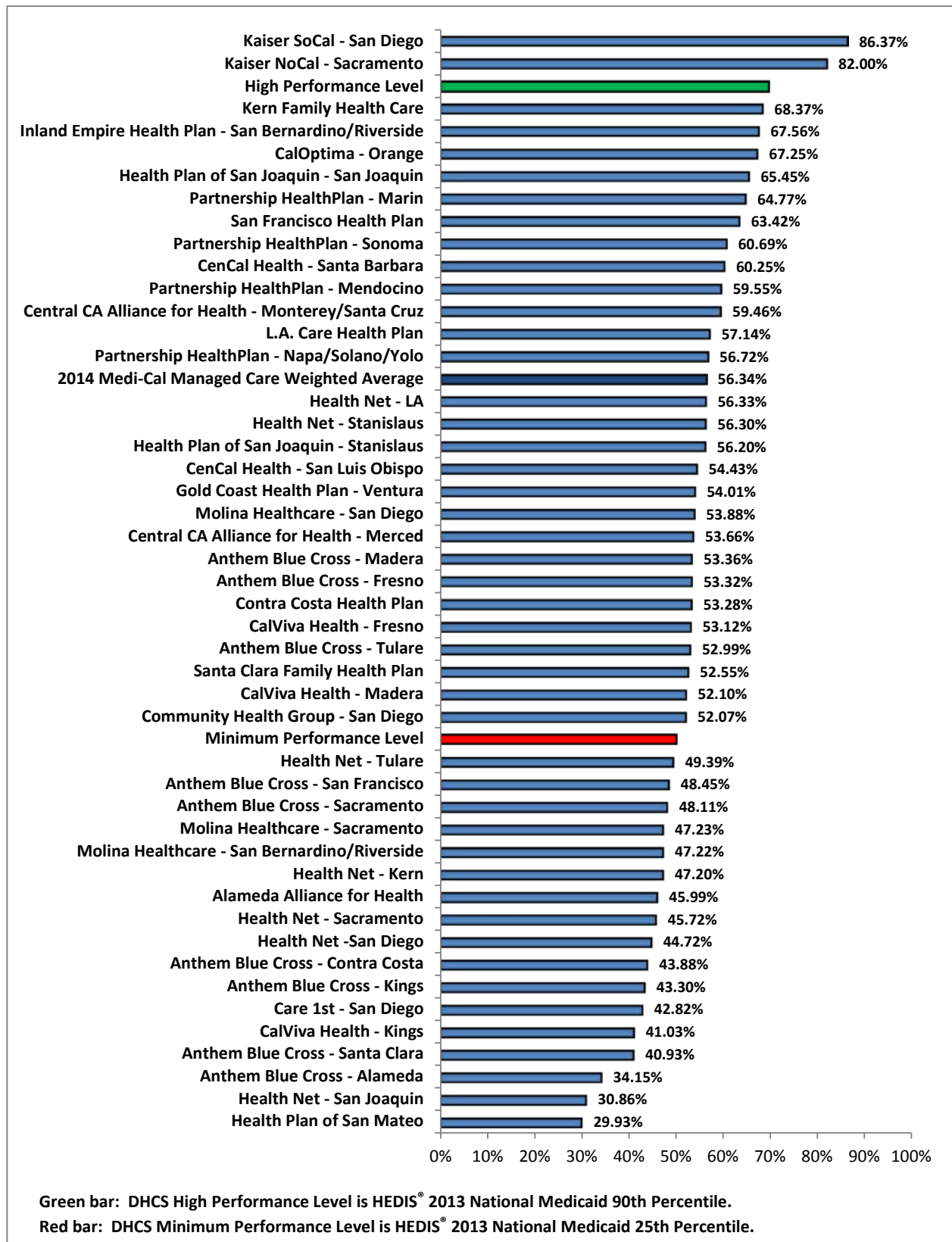
Medi-Cal Managed Care Plan performance: audited, aggregate reporting. The *Controlling High Blood Pressure* measure (NQF #0018) is used to assess the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (blood pressure less than 140/90 mm Hg) during the measurement year.

As shown in Figure 4 for 2013 measurement year, the MCPs varied widely in their performance on this measure, with Kaiser-San Diego reporting 86 percent and Health Plan of San Mateo reporting 30 percent. The DHCS high performance level is 70%, while the minimum performance level is 50 percent of patients with hypertension under control. The weighted average for the Medi-Cal managed care population is closer to the minimum performance level, which demonstrates significant opportunities for improvement.

³⁴ Medi-Cal MIS/DSS and Symmetry EBM Groupers, Version 8.2; January 1, 2013 – December 1, 2013.

³⁵ 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.

Fig 4. Medi-Cal Managed Care Performance: Controlling High Blood Pressure by Plan, 2013



D. Diabetes

One in 7 adult Californians (13.8%) has diabetes.^{36,37} The number of MCP members with diabetes is expected to rise significantly as California expands coverage to childless adults, and their diabetes care needs great since many were previously underserved.

Measurement of MCP performance. The hemoglobin (Hb) A1C 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 2013, 159,275 MCP members met the HEDIS® specifications to comprise the denominator for the diabetes measures reported to National Committee on Quality Assurance (NCQA). (This is a minimum estimate of the number of adult MCP members with diagnosed diabetes.)

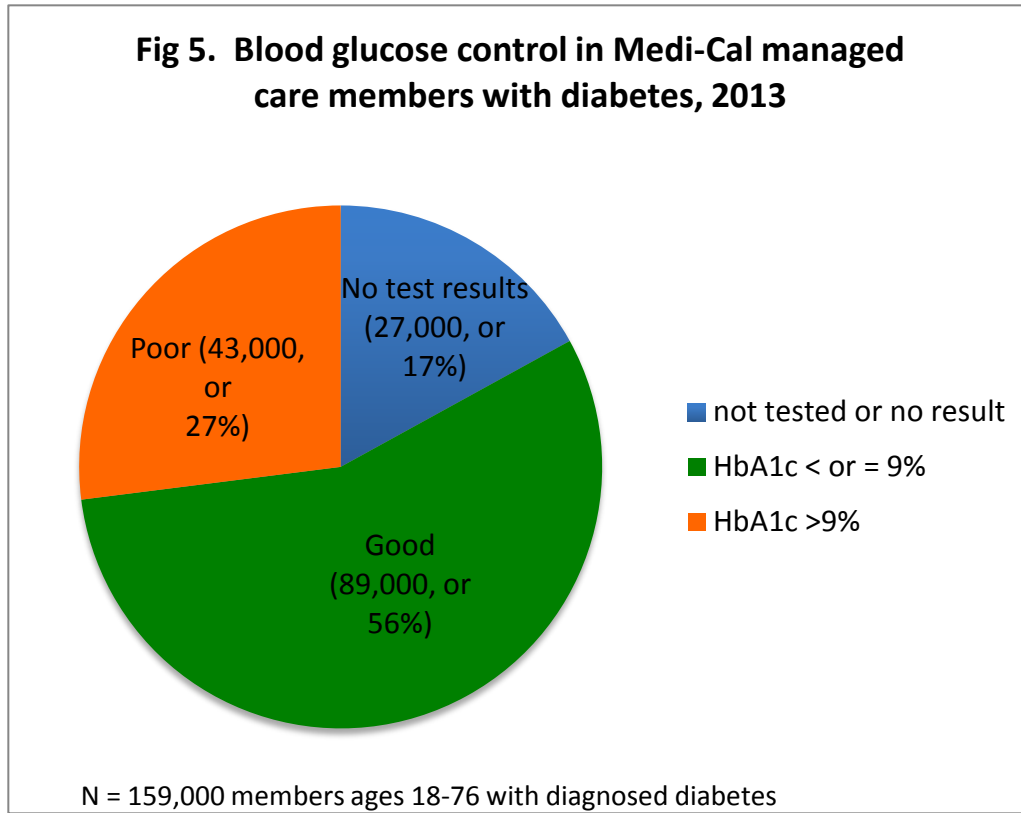
Of these 159,275 members with diabetes, 83% were reported to have a HbA1c test in 2013, a proportion that has not improved between 2010 and 2013. For HbA1c testing in 2013, 10 Medi-Cal Managed Care-counties tested only 73% to 79% of their diabetes patients, placing them in the bottom 25% of Medicaid-contracted health plans in the US: Anthem in four counties (Alameda, Contra Costa, Kings, and Sacramento); Health Net in four counties (Kern, Sacramento, San Diego and San Joaquin); Cal Viva in one county (Kings), and Health Plan of San Joaquin (San Joaquin). By contrast, Kaiser (in San Diego and Sacramento) tested 95–97% of its members with diabetes, which places this MCP in the top 10% of Medicaid-contracted health plans in the US.

Applying the 83% to the 159,275 members in the diabetes measure in 2013, one can estimate that 132,198 had an HbA1c test, leaving approximately 27,077 without testing in the prior 12 months (Figure5).

Once HbA1c test results are available, individuals with diabetes can be treated to maintain or improve blood glucose control. In 2013, 43,000 diabetes patients (or 27% of all diabetes patients) were documented to have poor glycemic control (HbA1c > 9%) (Figure 5). (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 extremity amputations, and renal failure.

³⁶ Estimates provided by California Diabetes Program using data from Behavioral Risk Factor Surveillance System, 2001-2010, National Health and Nutrition Examination Survey, 2007-2008, California

³⁷ California Diabetes Program. California Diabetes Fact Sheet, 2012, Technical Notes. www.caldiabetes.org. 2012.



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

Other essential components of diabetes care are examinations for retinal and renal disease so they can be detected early and treated. In 2013, only 51% of members with diabetes were documented to have a retinal exam. The only diabetes measure that improved in 2013 was the proportion of diabetes patients with an evaluation for kidney disease, which rose to 83%.

MCP performance: encounter level data reporting. The DHCS MIS/DSS is a warehouse of encounter data reported by MCPs, and provides valuable individual member-level data to analyze alongside the aggregate HEDIS[®] data reported by MCPs. For the analysis of measurement year 2012 data below, DHCS replicated the HEDIS[®] specifications for HbA1c testing.

MCP members with diabetes were significantly less likely to have received a HbA1c test in 2012 if they were African-American (compared to other race-ethnic groups), ages 18–64 (compared to 65–75), urban residents (compared to rural), English speaking (compared to Spanish), and not receiving Supplemental Security Income (SSI), (compared to receiving SSI). There was no significant difference by gender.

Just over half of African-American members with diabetes were tested (55.4%, 95%CI 54.7–56.1%), compared to 64%–65% in Hispanics and Asians, and 59% in Whites. Further analyses revealed that there were 17,688 African-Americans meeting the HEDIS[®] specifications for diabetes in 2012, or 12% of the total number of members with diabetes included in the HEDIS[®] measure that year. Of these individuals, 7,891 (45%) were not tested. More than half of the African-American members with diabetes who were untested were members of LA Care, Community Health Group of San Diego, and Health Net LA.

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), member lack of disease knowledge and difficulty adhering to medication or lifestyle changes, and lack of provider awareness or systems for tracking members needing services.

E. Tobacco Use

Tobacco is the leading cause of preventable death in the US. Tobacco cessation services have been demonstrated to be clinically effective and cost effective,³⁸ with a return on investment of 3:1 for dollars spent on smoking cessation services in Medicaid populations.³⁹ In the 2013 Medi-Cal Managed Care Consumer Assessment of Health Care Providers and Systems (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.⁴⁰

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 MMCD quality strategies. DHCS is currently updating the most recent (September 2013) 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

³⁸ 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>.

³⁹ 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>.

⁴⁰ These results are limited to those with >100 respondents in the denominator.

from local codes and file formats to HIPAA-compliant formats, DHCS is focused on capacity and use of the centralized MIS/DSS, DHCS's centralized data repository and analytic platform. Improvements include: incorporation of reference data that will improve capabilities to analyze population characteristics, care delivery models and quality measures; training for and upgrades to diagnosis grouping software that supports calculation of preventable quality indicators; and data quality reports that are used by program areas to work with data providers to improve quality. DHCS has also begun the process to re-procure the MIS/DSS support contract, which will provide specific opportunities to increase MITA maturity and support the DHCS Quality Strategy.

Encounter Data Validation and Improvement

Over the past couple of 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 goal of the study is to examine the extent to which encounter data submitted by MCPs to DHCS are complete and accurate. In year 1 of the EDV study, the EQRO compared the administrative records in the MCPs' claims-processing systems to the encounter records in the DHCS Management Information System/Decision Support System (MIS/DSS) database. In addition to the comparative analyses of administrative data, the EQRO reviewed the MCPs' information systems and processes pertaining to claim processing and encounter-data submission to assess the MCPs' capabilities to collect and submit accurate and complete encounter data. The EQRO provided to DHCS MCP-specific audit reports and an aggregated report to present comparative analysis findings of each MCP under study and statewide average results.

In year 2 of the EDV study, the EQRO procured medical records for comparison with the encounter records of MIS/DSS. The EQRO will use the results of this analysis to assess record and data element completeness, as well as data element accuracy between the medical record and the encounter record contained within the MIS/DSS. As with year 1 of the EDV study, the EQRO will develop MCP-specific audit reports as well as an aggregated report for statewide analysis. DHCS will work with the EQRO to develop the year 3 EDV study which will have a different focus and scope than years 1 and 2.

In September 2012, DHCS began the EDIP. To fulfill one of EDIP's objectives, DHCS created the Encounter Data Quality Unit (EDQU). The EDIP and EDQU are focused on improving the quality of encounter data in the domains of completeness, accuracy, reasonableness, and timeliness through enhanced measurement, tracking, and reporting mechanisms. These mechanisms will strengthen DHCS's ability to impose corrective action plans and financial penalties on MCPs when they do not meet minimum data quality requirements.

The enhanced measurement, tracking and reporting mechanisms, however, rely on a new Encounter Data Capture and Transmission (EDCT) system which is currently under development by DHCS's Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance (OHC). To ensure that business needs are met, MMCD is working closely with

OHC on the development of this system. DHCS is also working closely with the MCPs as they transition to EDCT, with a transition deadline of October 1, 2014. At this time, all MCPs are actively submitting test files to the new system. The transition to EDCT will allow all MCPs to submit encounter data directly to DHCS in a uniform manner and in HIPAA-compliant industry standard transaction formats.

Adoption of Electronic Health Records

To support advancements of HIT in the clinical care environment experienced by Medi-Cal beneficiaries, DHCS has implemented the Medicaid Electronic Health Record (EHR) Incentive Program. This program provides incentives to providers serving Medi-Cal beneficiaries when the providers adopt a certified EHR and use it in a meaningful way, as specified in CMS regulations. As of August 1, 2014, over 14,000 eligible professionals and eligible hospitals had received over \$974-million 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 clinical quality measures (CQMs) to Medi-Cal. DHCS plans to leverage existing technical capacities in support of the MITA to receive the CQMs. In stage two of the incentive program, the CQMs specifically align with the National Quality Strategy.

DHCS has worked closely with other Health Information Technology for Economic and Clinical Health (HITECH) grantees to support providers in the implementation of EHRs. Grantees included California Health and Human Services Agency (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 members. DHCS has received funding that supports the implementation of a new California Immunization Registry (CAIR 2.0), which will support meaningful-use requirements, will be run by CDPH at the State level (as opposed to the current model with 10 regional registries), and will support DHCS efforts to increase immunization rates among the Medi-Cal population.

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

Patient Safety

Several indicators that DHCS requires MCPs to report each year shed light on patient safety: use of imaging in 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 is evaluating findings of a Robert Wood Johnson-funded white paper with recommendations on reducing overuse and misuse of services, and is participating in the California Maternal Quality Care Collaborative, where objectives include reducing early elective delivery and unnecessary C-sections. Finally, the Department is developing procedures for reporting Provider Preventable Conditions, and exploring possible interventions in reducing opiate misuse.

Intermediate Sanctions

See Section 2 under Monitoring and Compliance.

SECTION V: 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 Assessment

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

DHCS has begun a new stage of work to assess and plan for implementation of an ACA Section 2703 Health Homes program. California enacted AB 361 in 2013, which authorized DHCS to implement a Health Home 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 Home program(s). Currently, DHCS is doing preliminary assessment work. DHCS will engage stakeholders when it has developed fresh assessment information to share; program development begins in fall 2014. When available, DHCS will provide updates on Health Home program developments and stakeholder engagement through the DHCS Stakeholder Update ListServ. Interested stakeholders can subscribe to this ListServ at the following web link:

<http://www.dhcs.ca.gov/Pages/DHCSListServ.aspx>.

DHCS is also coordinating with the Health and Human Services Agency California State Innovations Model (CalSIM) Planning and Testing Grant process. The CalSIM plan includes a multi-payer Health Home proposal, which includes ACA Section 2703 Health Homes in Medi-Cal. Information about the CalSIM plan and process is available at this web link:

<http://www.chhs.ca.gov/pages/pritab.aspx>.

Healthy Families Program Transition into Medi-Cal Managed Care

DHCS began transitioning beneficiaries of the Healthy Families Program (HFP), California's version of Children's Health insurance Program (CHIP), to the Medi-Cal Managed Care program on January 1, 2013. Between January 1, 2013 and April 1, 2013 California transitioned over 555,300 children to Medi-Cal Managed Care.

By fall 2013, DHCS transitioned another 155,000 children.

DHCS required MCPs to meet specified performance standards and comply with all existing performance standards and measurements required by the law prior to the transition of any HFP beneficiaries. DHCS required all MCPs to submit the necessary provider network data to ensure that their networks met the required network adequacy standards prior to the transition of HFP beneficiaries. A thorough review of their networks was completed and submitted to CMS for approval prior to implementing the HFP children transition. The majority of the children that have transitioned have been able to maintain access to the same primary care provider

(PCP) they were seeing while in the HFP. Through a monthly monitoring report submitted to CMS, DHCS is able to keep both CMS and stakeholder groups informed on how the transition is going and address any concerns that become apparent during the transition.

The final two phases of the Healthy Families transition were implemented in August and September 2013. The transitions involved Healthy Families members without any MCP affiliation who were required to choose a new MCP. DHCS sent beneficiaries a notice 90 days prior to their transition date, informing them of the upcoming changes, and providing them with the necessary tools to choose a new MCP in their county of residence. This phase included COHS MCPs, and was implemented with a minimum of disruption of services. By the end of 2013, almost all HFP members had been transitioned to MCPs. The health plans continued to report weekly and monthly on issues regarding the transition (member and provider grievances, continuity of care issues, call center activity) until June 2014.

Statewide Expansion of Medi-Cal Managed Care

California's SFY 2012-13 budget called for the extension 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, 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 Anthem Blue Cross or FFS Medi-Cal.

To ensure a smooth transition, DHCS has set up performance metrics and monitoring activities that focus on how MCPs are meeting the needs of the transitioned beneficiary population. DHCS reviewed collected data and analyzed it to ensure that beneficiaries had access to providers and continuity of care. MCPs have been reporting the following information:

- Health Plan Grievances/Appeals Related to Access to Care – This information includes grievances made to both (Department of Managed Health Care (DMHC) 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 PCPs (Geo Access) – This information is used as a component of each MCP's provider network adequacy review.
- Member Rights and Program Integrity Audits – DHCS performs annual audits on its Plans regarding how well each MCP fulfills its obligations to its members regarding

providing access to services and providers, responding to grievances, and supplying information.

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

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

- 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 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 is employing a passive enrollment process for the Cal MediConnect Program. Beneficiaries scheduled to be enrolled into a Cal MediConnect Plan receive an advance notification at least 90 days prior to the date they are scheduled to be enrolled. This letter explains that the beneficiary may opt-out or make another enrollment decision prior to the enrollment's effective date. If the beneficiary does not make an active enrollment choice, the beneficiary will be passively enrolled into the Cal MediConnect Plan that was identified in the notice that they receive 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, members with health assessments and care plans within specified timeframes, and member grievances related to their demonstrated inability to get an appointment with a PCP. The passive enrollment measures will be fully defined in the three-way contracts for the Cal MediConnect Program.

Passive enrollment for the Cal MediConnect program began in April 2014 in San Mateo County. In July, passive enrollment expanded to four more counties. The remaining three counties participating in the Cal MediConnect program will be transitioning in January and July of 2015. As of August 2014, approximately 42,000 dual eligibles have enrolled in the program, with a

projected total enrollment of approximately 74,000 by September 2014.⁴¹ 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 (MLTSS). The figures as of July 2014 show that about 30% of those scheduled to be passively enrolled are opting-out of the Cal MediConnect program.

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 a series of forums with a wide variety of stakeholders, MMCD has collaborated with the Mental Health Services Division to develop and implement an expanded outpatient mental health services program to members 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 members 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 (DSM). These services, described in All Plan Letter 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 Memoranda of Understanding (MOUs) with the county mental health plans (MHPs) that provide the SMHS to ensure care coordination as beneficiaries are referred between the two systems (described in All Plan Letter 13-018). These MOUs are currently being submitted and reviewed. MMCD will be monitoring the implementation of the new services through special reports submitted by the MCPs, as well as through analysis of encounter data.

DHCS is currently developing a process for implementing the new Behavioral Health Treatment (BHT) benefit that became effective July 7, 2014.

In addition to the expanded mental health services, MMCD has implemented a new alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit effective January 1, 2014 (described in All Plan Letter 14-004) for members ages 18 and older. Each member 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 Staying Health

⁴¹ http://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx

Assessment (SHA). Providers who offer SBIRT services must refer Plan members who may have an alcohol use disorder to the county or other community services for further evaluation and treatment. In spring 2013, DHCS, in collaboration with the University of California Los Angeles, offered a series of SBIRT webinar trainings for providers. A series of in-person SBIRT trainings are being offered from August 2014 to May 2015 through a special grant.

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 members, starting with children.

SECTION VI: CONCLUSIONS and OPPORTUNITIES

DHCS programs now serve nearly 11 million Californians. One in five 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 more than \$70 billion in public funds to provide health care services for low-income families, children, pregnant women, 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 March 1, 2014, the number of enrollees in Medi-Cal Managed Care increased to 6.96 million, or 69% of all Medi-Cal beneficiaries. The Medi-Cal Managed Care program has now expanded to all 58 counties, enrolled new members (including childless adults) and added new benefits (including mental health and substance use services).

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 program 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 VII: APPENDICES

- A. Medi-Cal Managed Care Health Plan Enrollment (August 2014)
- B. Status of 2013 Medi-Cal Managed Care Program Objectives
- C. External Accountability Set Measures: 2015
- D. Managed Care Plan Quality Improvement Projects (as of August, 2014)
- E. Acronyms

APPENDIX A: MEDI-CAL MANAGED CARE HEALTH PLAN ENROLLMENT (August 2014)

Medi-Cal Managed Care Enrollment Report - August 2014			
Plan Type	County	Plan Name	Totals
Two-Plan	Alameda	Alameda Alliance for Health	207,378
		Anthem Blue Cross	54,537
	Contra Costa	Contra Costa Health Plan	131,407
		Anthem Blue Cross	20,746
	Fresno	CalViva Health	228,399
		Anthem Blue Cross	90,446
	Kern	Kern Family Health	170,506
		Heath Net	67,398
	Kings	CalViva Health	20,525
		Anthem Blue Cross	16,144
	Los Angeles	LA Care	1,433,546
		Health Net	756,124
	Madera	CalViva Health	28,392
		Anthem Blue Cross	16,557
	Riverside	Inland Empire Health Plan	412,370
		Molina Healthcare	60,889
	San Bernardino	Inland Empire Health Plan	447,701
		Molina Healthcare	75,363
	San Francisco	San Francisco Health Plan	102,572
		Anthem Blue Cross	19,531
	San Joaquin	Heath Plan of San Joaquin	174,246
		Health Net	16,950
	Santa Clara	Santa Clara Family Health	203,811
		Anthem Blue Cross	54,974
Stanislaus	Heath Plan of San Joaquin	82,666	
	Health Net	69,125	
Tulare	Anthem Blue Cross	81,493	
	Health Net	83,002	
Total Two-Plan Enrollment			5,126,798
Imperial	Imperial	Molina Healthcare	12,287
		CA Health & Wellness	40,541
San Benito	San Benito	Anthem Blue Cross	6,502
Total Enrollment Imperial/San Benito			59,330

APPENDIX A: MEDI-CAL MANAGED CARE HEALTH PLAN ENROLLMENT (August 2014)

Medi-Cal Managed Care Enrollment Report - August 2014			
Plan Type	County	Plan Name	Totals
Regional Model	Alpine	Anthem Blue Cross	123
		CA Health & Wellness	112
	Amador	Anthem Blue Cross	3,697
		CA Health & Wellness	1,145
		Kaiser	31
	Butte	Anthem Blue Cross	20,843
		CA Health & Wellness	25,486
	Calaveras	Anthem Blue Cross	2,550
		CA Health & Wellness	4,509
	Colusa	Anthem Blue Cross	3,173
		CA Health & Wellness	1,874
	El Dorado	Anthem Blue Cross	7,302
		CA Health & Wellness	12,962
		Kaiser	683
	Glenn	Anthem Blue Cross	3,110
		CA Health & Wellness	3,823
	Inyo	Anthem Blue Cross	1,538
		CA Health & Wellness	1,748
	Mariposa	Anthem Blue Cross	2,011
		CA Health & Wellness	961
	Mono	Anthem Blue Cross	1044
		CA Health & Wellness	715
	Nevada	Anthem Blue Cross	8,199
		CA Health & Wellness	5,174
	Placer	Anthem Blue Cross	22,172
		CA Health & Wellness	8,598
		Kaiser	2,586
	Plumas	Anthem Blue Cross	1,580
		CA Health & Wellness	1,429
	Sierra	Anthem Blue Cross	272
		CA Health & Wellness	191
	Sutter	Anthem Blue Cross	15,521
		CA Health & Wellness	9,690
	Tehama	Anthem Blue Cross	7,192
		CA Health & Wellness	8,238
	Tuolumne	Anthem Blue Cross	3,543
CA Health & Wellness		5,031	
Yuba	Anthem Blue Cross	9,769	
	CA Health & Wellness	7,467	
Total Enrollment Regional Model			215,092

APPENDIX A: MEDI-CAL MANAGED CARE HEALTH PLAN ENROLLMENT (August 2014)

Medi-Cal Managed Care Enrollment Report - August 2014				
Plan Type	County	Plan Name	Totals	
GMC	Sacramento	Anthem Blue Cross	128,362	
		Health Net	103,597	
		Kaiser Foundation	58,128	
		Molina Healthcare	48,221	
	San Diego	Care 1st Health Plan	52,237	
		Community Health Group	199,909	
		Health Net	53,688	
		Kaiser	36,429	
			Molina Healthcare	137,299
	Total GMC Enrollment			817,870
COHS	Marin	Partnership Health Plan of CA	30,623	
	Mendocino		30,731	
	Napa		24,161	
	Solano		93,009	
	Sonoma		92,564	
	Yolo		41,416	
	Del Norte		9,975	
	Humboldt		39,920	
	Lake		23,615	
	Lassen		6,125	
	Modoc		2,550	
	Shasta		57,247	
	Siskiyou		14,139	
	Trinity		3,847	
	Merced	Central California Alliance for Health	106,229	
	Monterey		121,132	
	Santa Cruz		55,551	
	Santa Barbara	CenCal	93,879	
	San Luis Obispo		46,290	
	Orange	CalOptima	623,612	
	San Mateo	Health Plan of San Mateo	101,516	
	Ventura	Gold Coast Health Plan	163,251	
Total COHS Enrollment			1,778,382	
Subtotal for Two-Plan, Regional Model, GMC and COHS			7,938,142	
PCCM	Los Angeles	AIDS Healthcare Foundation	855	
	San Francisco	Family Mosaic	-13	
	Total PHP Enrollment		842	
All Models Total Enrollments			7,938,984	

Source: CAPMAN Capitation Report

APPENDIX B: STATUS OF 2013 MEDI-CAL MANAGED CARE PROGRAM OBJECTIVES

#	Objective and Status
1.	<p>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.</p> <p>Status: Through our contracts with Medi-Cal Managed Care Plans, DHCS requires that Medi-Cal members are assigned to a primary care physician/clinic (PCP) and the PCP serves as the member's medical home. On November 1, 2013, DHCS completed the expansion of Medi-Cal managed care plans to the 28 rural counties where Medi-Cal members did not previously have access to managed care.</p>
2.	<p>Objective: Implement one-or-more performance standards and measures that would require plans to evaluate and improve SPD health outcomes by Healthcare Effectiveness Data and Information Set (HEDIS®)⁴² reporting year 2013.</p> <p>Status: For services provided in calendar year 2012 and 2013, Plans reported (in 2013 and 2014), five HEDIS® performance measures stratified for the SPD and non-SPD populations (see Appendix B for list of required HEDIS® measures and stratification).</p>
3.	<p>Objective: Complete the COHS Plan contract revisions, and align them with Two-Plan and GMC contracts that require enhanced case management and coordination-of-care services for SPD members identified as high-risk and a process for MMCD to monitor plan compliance by August 2013.</p> <p>Status: COHS contract revisions were completed in September 2013 for Partnership Health Plan and November 2013 for rest of the COHS plans. All plans 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.</p>
4.	<p>Objective: Continue a statewide collaboration with Plans through calendar year (CY) 2015 to reduce "All Cause Readmissions" by addressing continuity of care and care transitions for adults 21-years and older, including SPDs and dual eligibles.</p> <p>Status: See Statewide Collaborative Quality Improvement Project <i>All-Cause Readmissions Baseline Report</i> June 2013 – May 2014: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2013-14_QIP_Coll_ACR_Baseline_Report_F1.pdf</p>
5.	<p>Objective: Administer the 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)⁴³ survey to all Plans, with results available in early 2014.</p> <p>Status: Results have been analyzed and the report is currently under review. Tobacco use questions are described in Section IV of this report.</p>
6.	<p>Objective: Establish a process by June 2013 for timely notification of Plans that ensures that Plans contact beneficiaries who have recently received a denial of their Medical Exemption Requests (MERs) for care coordination and to address any special needs.</p> <p>Status: On April 3, 2014, DHCS released All Plan Letter 13-013 that established continuity of care requirement for beneficiaries transitioning to a managed care plan that had a Medical Exemption Request (MER) denied for clinical reasons. DHCS provides all health plans with a weekly data file that identifies the impacted beneficiaries, their provider, and the ICD-9 code.</p>

⁴² HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁴³ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

APPENDIX B: STATUS OF 2013 MEDI-CAL MANAGED CARE PROGRAM OBJECTIVES

#	Objective and Status
7.	<p>Objective: Coordinate activities that focus on the collection, analysis, and reporting for 16 of the <i>Initial Core Set of Adult Health Care Quality Measures for Medicaid-Eligible Adults</i> as part of the Adult Medicaid Quality Grant (AMQG).</p> <p>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 members. 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. MMCD has been an important partner in AMQG activities including data analysis and participation in the two quality improvement projects.</p>
8.	<p>Objective: Reduce the smoking rate among Medi-Cal managed care Plan members. In line with the DHCS's Quality Strategy, by 2014, the Medi-Cal Managed Care program will make available the full complement of effective tobacco-use treatments, adapt clinical systems to assess all patients for tobacco use, strongly advise those who smoke about the importance of quitting, refer smokers to evidence-based treatments, train Plan providers on evidence-based tobacco use treatment strategies, and strengthen monitoring.</p> <p>Status: DHCS developed an All Plan Letter (APL) detailing enhancements to tobacco use treatment in Managed Care Plans (MCP). The new policy requires plans to:</p> <ul style="list-style-type: none"> o Assess each member's tobacco use through the Individual Health Education Behavioral Assessment and the Staying Healthy Assessment; o Cover all seven Food and Drug Administration (FDA)-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); o Ensure that individual, group and telephone counseling is offered to Members who wish to quit smoking, whether or not those Members 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 <i>Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update</i>. <p>DHCS will monitor MCP smoking prevalence trends using data collected from tobacco questions in the CAHPS survey.</p>
9.	<p>Objective: Continue to consistently review our process to engage stakeholders and advocates in policy development</p> <p>Status: Ongoing</p>

APPENDIX C: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: Measurement Year 2014/Report 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:+ <ul style="list-style-type: none"> 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):+ <ul style="list-style-type: none"> ACE inhibitors or ARBs 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
7.	CAP-1224* CAP-256* CAP-711* CAP-1219*	Children & Adolescents' Access to Primary Care Practitioners (4 indicators):+ <ul style="list-style-type: none"> 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): <ul style="list-style-type: none"> 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 	Hybrid measure	No	Yes, for <i>HbA1c Testing only</i>
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

APPENDIX C: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: Measurement Year 2014/Report Year 2015

#	Acronyms	Measure	Measure Type Methodology	SPD	
11.	MMA-50 MM A- 75	Medication Management for Asthma+ (2 indicators for each age group: 5-11 years, 12-18, 19-50, and 51-64)*** <ul style="list-style-type: none"> Medication Compliance 50% Medication Compliance 75% 	Administrative measure	No	No
12.	PPC -Pre PPC -Pst	Prenatal & Postpartum Care (2 indicators): <ul style="list-style-type: none"> Timeliness of Prenatal Care+ Postpartum Care+ 	Hybrid measure	No	Yes, for <i>Prenatal only</i>
13.	LBP	Use of Imaging Studies for Low Back Pain	Administrative measure	No	No
14.	WCC-BMI WC C-N WC C	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents+ <ul style="list-style-type: none"> BMI percentile Counseling for nutrition Counseling for physical activity 	Hybrid measure	No	No
15.	W-34	Well-Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life+	Hybrid measure	No	Yes
Total Number of Measures			8 Hybrid + 7 Admin measures		

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

*MCPs will not be held to a minimum performance level (MPL) for measures shaded in gray

**Seniors and Persons with Disabilities (SPD)

*** Same age bands that Plans 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 members 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 members 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 (CANS) outcome/assessment tool during the measurement period.

SCAN

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

APPENDIX D: MANAGED CARE PLAN QUALITY IMPROVEMENT PROJECTS (QIPs) as of August 1, 2014

See accompanying document "Appendix D for QSR 8.27.14 draft v1.docx" for the list of Plan-specific QIPs and their status as of 8/1/14.

The statewide collaborative to reduce readmissions to the hospital is discussed in Section II.

APPENDIX E: ACRONYMS

ABA	Applied Behavioral Analysis	MMCD	Medi-Cal Managed Care Division
ACA	Affordable Care Act	MOU	Memorandum of Understanding
ACR	All-Cause Readmissions	NCQA	National Committee for Quality Assurance
ACOG	American College of Obstetricians and Gynecologists	PCCM	Primary Care Case Management
AHRQ	Agency for Healthcare Research and Quality	PCP	Primary Care Provider
AMQG	Adult Medicaid Quality Grant	PHP	Prepaid Health Plans
CAP	Corrective Action Plan	Plan	Medi-Cal Managed Care Plan
CAHPS	Consumer Assessment of Healthcare Providers and Systems	QI	Quality Improvement
CCI	Coordinated Care Initiative	QIP	Quality Improvement Projects
CCS	California Children's Services	SBIRT	Screening, Brief Intervention and Referral to Treatment
CDPH	California Department of Public Health	SPD	Seniors and Persons with Disabilities
CFR	Code of Federal Regulations	T-MSIS	Transformed Medicaid Statistical Information Systems
CHHS	California Health and Human Services Agency	USPSTF	U.S. Preventive Services Task Force
CHIP	Children's Health Insurance Program	§	Section
CMS	Centers for Medicare and Medicaid Services		
COHS	County Organized Health Systems		
CPSP	Comprehensive Perinatal Services Program		
CQM	Clinical Quality Measures		
DHCS	Department of Health Care Services		
DMHC	Department of Managed Health Care		
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		
FMAP	Federal Medical Assistance Percentage		
GMC	Geographic Managed Care		
HEDIS	Healthcare Effectiveness Data and Information Set		
HFP	Healthy Families Program		
HIPAA	Health Insurance Portability and Accountability Act		
HIT	Health Information Technology		
HITECH	Health Information Technology for Economic and Clinical Health		
IP	Improvement Plan		
LTSS	Long-Term Services and Supports		
MCP	Medi-Cal Managed Care Plan		
MEDS	Medi-Cal Eligibility Data System		
MIS/DSS	Management Information System/Decision Support System		
MIQS	Medi-Cal Incentives to Quit Smoking Project		
MITA	Medicaid Information Technology Architecture		
MLTSS	Managed Long-Term Services and Supports		
MPL	Minimum Performance Level		