

**Department of Health Care Services
Assembly Committee on Health Oversight Hearing**

- 1) **The standards the Department will be using for acceptable access and quality, including the specific performance measures that will be used to determine that the standards are being met for each population in each initiative. This should include Seniors and Persons with Disabilities (SPDs), dual-eligible persons, children converting from the Healthy Families Program (HFP) to Medi-Cal, and rural populations. Please also include the evaluation methodology and data collection process for each performance measure and for each initiative.**

Response:

DHCS includes both access and quality measures in its yearly quality and performance improvement program requirements for Medi-Cal managed care health plans (MCPs). The measures are selected after consultation with MCPs and with input from the External Quality Review Organization (EQRO) and other stakeholders. The list of measures for 2012 is available on the Department of Health Care Services (DHCS) website at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.PDF>.

Except for dual-eligible beneficiaries, all beneficiaries, including SPDs, Healthy Families, and rural expansion populations transitioning into Medi-Cal managed care, are required to be included, as applicable, in MCP reports for all measures. For the SPD transition, DHCS publically released an SPD Dashboard which can be located at:

http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf.

DHCS uses Healthcare Effectiveness Data and Information Set (HEDIS) measures. MCP report data is audited at the MCP level by DHCS' EQRO for accuracy and completeness. MCPs are required to meet minimum performance standards for each measure. All current measures are applicable across populations. For example, well child visits, immunizations, comprehensive diabetes care and annual monitoring of patients on persistent medications are just a few of the currently required HEDIS measures that apply equally to MCP beneficiaries, SPDs, Healthy Families, dual-eligibles, and rural expansion populations. For 2013, DHCS in collaboration with MCPs and the EQRO, developed a methodology by which to stratify several measures (comprehensive diabetes care, children and adolescent access to PCPs, annual monitoring for persistent medications, ambulatory care utilization, and all cause readmissions) into SPD and non-SPD groups.

Performance measurement results are reported and published annually and are used to rank MCPs and as a basis for required Quality Improvement Projects (QIPs). The evaluation methodology and data collection process for all measures is adherent to National Committee for Quality Assurance (NCQA) standards as assured by the EQRO during annual MCP audits to validate data accuracy and completeness prior to submission to the NCQA.

For Healthy Families, health plan metrics will include, but will not be limited to, child-only HEDIS measures indicative of performance in serving children and adolescents and existing Medi-Cal managed care performance metrics and standards including timely access, network adequacy, linguistic services and the use of surveys to measure beneficiary satisfaction and network adequacy post transition. These findings are publicly reported and posted on the DHCS website.

Dental plan metrics will include, but will not be limited to, provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and a survey of member satisfaction with plans and providers. All performance measures will be monitored for Dental Managed Care plans as well as Fee-for-Service (FFS), Denti-Cal. An annual report will be produced to represent the findings, similar to the current Healthy Families Quality Report. This report will be publicly reported and posted on the DHCS Denti-Cal website.

Further, for the Coordinated Care Initiative (CCI), acceptable access and quality standards are still being developed. These standards will reflect agreements with the Centers for Medicare & Medicaid Services (CMS) for the Dual-Eligible Demonstration Program (Demonstration), and input from stakeholders.

Under the Demonstration, the access standards will be a combination of Medicare and Medi-Cal requirements, network adequacy requirements for medical services to be determined by CMS, and network adequacy for Long-Term Services and Supports (LTSS) to be determined by the State. Through a joint readiness review process, CMS and the State will determine if MCPs meet those standards.

For the other components of CCI (mandatory enrollment in Medi-Cal managed care for dual-eligible beneficiaries and the inclusion of LTSS as Medi-Cal managed care benefits for dual-eligible beneficiaries and Medi-Cal only SPDs), DHCS will use the existing Medi-Cal access standards, plus the

LTSS network adequacy standards currently under development. Those LTSS standards are being developed through a stakeholder review process.

The quality standards for the Demonstration will reflect medical, LTSS, and behavioral health quality measures. These measures are currently being developed through a stakeholder review process. DHCS posted a list of over 90 measures for consideration, and is reviewing the stakeholder comments for those measures. Measures include HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), administrative data, as well as new measures for LTSS and behavioral health that will be developed in consultation with CMS, other state agencies, and stakeholders. The list and related materials can be viewed at <http://www.calduals.org/workgroup/quality/>. The revised list will be included in the Memorandum of Understanding (MOU) with CMS for the Demonstration, and the specific thresholds for the measures will be established in the individual MCP contracts.

For the other components of the CCI, DHCS is still considering which quality measures will be used, and how the quality measures for the Demonstration could be applied to the MCP activities outside of the Demonstration.

Dental Performance Measures

Both the Dental Managed Care (DMC) plans and Dental Fee-for-Service (Denti-Cal) program will be required to report on the following eleven performance measures. The DMC plans will provide encounter data and Denti-Cal will provide claims data. The data will be monitored on a monthly basis and publicly reported quarterly.

Performance Measure Name	Description	Numerator	Denominator
Annual Dental Visits	The percentage of beneficiaries under 21 who had at least one (1) dental visit during the measurement year.	Number of Members enrolled in the same plan for at least eleven (11) of the past twelve (12) months who received any dental procedure (D0100-D9999) ¹ during that period.	Number of Members continuously enrolled in the same plan for at least eleven (11) of the past twelve (12) months.
Continuity of Care	The percentage of beneficiaries under 21 continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year.	Number of Members in the denominator who also received a comprehensive or periodic oral evaluation (D0120, D0150) ¹ or a prophylaxis (D1110, D1120) ¹ in the measurement year.	Number of Members continuously enrolled in the same plan for two (2) years with no gap in coverage who received a comprehensive oral evaluation (D0150) ¹ or a prophylaxis (D1110, D1120) ¹ in the year prior to the measurement year.
Use of Preventive Services	The percentage of beneficiaries under 21 who received any preventive dental service during the past year.	Number of Members enrolled in the same plan for at least eleven (11) of the past twelve (12) months who received any preventative dental service (D1000-D1999) ¹ in the measurement year.	Number of Members continuously enrolled in the same plan for at least eleven (11) of the past twelve (12) months.
Use of Sealants	The percentage of beneficiaries ages 6-9 and 10-14 who received a dental sealant on at least one permanent molar tooth during the past year.	Number of Members ages 6-9 and 10-14 enrolled in the same plan for at least eleven (11) of the past twelve (12) months who received a dental sealant (D1351) ¹ .	Number of Members ages 6-9 and 10-14 enrolled in the same plan for at least eleven (11) of the past twelve (12) months.

¹ Current Dental Terminology 2011-2012 (CDT 11-12) Codes

Performance Measure Name	Description	Numerator	Denominator
Sealant to Restoration Ratio (Surfaces)	The ratio of occlusal surfaces of permanent first and second molars receiving dental sealant to those receiving restoration among beneficiaries ages 6-9 and 10-14 during the past year.	Number of occlusal surfaces of permanent first molars (Tooth Number = 3, 14, 19, 30) in 6-9 and 10-14-year-olds and of permanent second molars (Tooth = 2, 15, 18, 31) in 10-14-year-olds receiving dental sealant (D1351) ¹ among Members in those age groups enrolled in the same plan for at least eleven (11) of the past twelve (12) months.	Number of occlusal surfaces of permanent first molars (Tooth Number = 3, 14, 19, 30) in 6-9 and 10-14-year-olds and of permanent second molars (Tooth = 2, 15, 18, 31) in 10-14-year-olds receiving a restoration (D2000-D2999) ¹ among Members in those age groups enrolled in the same plan for at least eleven (11) of the past twelve (12) months.
Treatment/Prevention of Caries	The percentage of beneficiaries under 21 who received either treatment for caries or a caries-preventive procedure during the past year.	Number of Members enrolled in the same plan for at least eleven (11) of the past twelve (12) months who received a treatment for caries (D2000-D2999) ¹ or a caries-preventative procedure (D1203-D1206, D1310, D1330, D1351) ¹ during the past year.	Number of Members continuously enrolled in the same plan for at least eleven (11) of the past twelve (12) months.
Exams/Oral Health Evaluations	The percentage of beneficiaries who received a comprehensive or periodic oral health evaluation or, for beneficiaries under 3 years of age, who received an oral evaluation and counseling with the primary care giver, during the past year.	Number of Members enrolled in the same plan for at least eleven (11) of the past twelve (12) months who received a comprehensive or periodic exam (D0120 or D0150) ¹ or, for Members under three (3) years of age, who received an oral evaluation and counseling with the primary caregiver (D0145) ¹ , during the past year.	Number of Members continuously enrolled in the same plan for at least eleven (11) of the past twelve (12) months.

Performance Measure Name	Description	Numerator	Denominator
Overall Utilization of Dental Services	The percentage of beneficiaries under 21 continuously enrolled for 1, 2, and 3 years who received any dental service during those periods.	Number of Members continuously enrolled in the same plan for 1, 2, and 3 years with no break in eligibility who received any dental service (D0100-D9999) ¹ during those periods.	Number of Members continuously enrolled in the same plan for 1, 2, and 3 years, respectively.
Usual Source of Care	The percentage of beneficiaries under 21 who received any dental service each year for two (2) consecutive years.	Number of Members continuously enrolled in the same plan for 2 consecutive years who received at least 1 dental service in each of those years.	Number of Members continuously enrolled in the same plan for 2 consecutive years.
Use of Dental Treatment Services	Percentage of beneficiaries under 21 who received any dental treatment service during the past year.	Number of Members enrolled in the same plan for at least eleven (11) of the past twelve (12) months who received any dental treatment service (D2000-D9999) ¹ in the measurement year.	Number of Members continuously enrolled in the same plan for at least eleven (11) of the past twelve (12) months.
Preventive Services to Filling	Percentage of beneficiaries under 21 who received one (1) or more fillings in the measurement year who also received preventive services (topical fluoride application, sealant, preventive resin restoration, education) in the measurement year.	Number of Members enrolled in the same plan for at least eleven (11) of the past twelve (12) months who received one (1) or more fillings (D2000-D2999) ¹ in the measurement year and who also received one (1) or more topical fluoride applications (D1203, D1204 or D1206) ¹ , dental sealants (D1351) ¹ , preventive resin restorations (D1352) ¹ or education to prevent caries (D1310 or D1330) ¹ in the measurement year.	Number of Members continuously enrolled in the same plan for at least eleven (11) of the past twelve (12) months who receive one (1) or more fillings (D2000-D2999) ¹ in the measurement year.

2) **With regard to SPDs:**

a) *The plan to monitor and ensure continuity of care,*

Response:

The methodologies used by DHCS to monitor and ensure continuity of care for SPDs include MCP submission of SPD specific deliverables which require MCPs to do the following:

- Develop and maintain a Quality Improvement (QI) system that includes SPDs and assures the provision of case management and coordination and continuity of care.
- Provide MCP beneficiaries with comprehensive case management including coordination of care services and person-centered planning.
- Monitor and report on extended continuity of care requests, and MCP approvals and denials of transitional SPDs for continued access to FFS providers.

Through an interagency agreement, the Department of Managed Health Care (DMHC) currently conducts health plan medical surveys on behalf of DHCS to ensure that enrollees affected by the SPD transition are assisted and protected under California's strong patient rights laws. DMHC's medical surveys evaluate utilization management (UM), continuity of care, availability and accessibility, member rights, and quality management.

b) *The evaluation methodology and plans for data collection, in addition to the use of anecdotal reports or complaints, such as audits, spot checks, etc.,*

Response:

DHCS submits monthly reports to CMS consisting of plan-level data as well as the SPD Dashboard which can be located at:

http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf.

The data comes from both internal and external data sources including: Health Care Options (HCO), the Medi-Cal Managed Care Division's (MMCD) Office of the Ombudsman (OMB), MMCD's Medical Monitoring Unit and Performance Measurement Unit, MCPs, and DMHC. Data variables collected include enrollment, extended continuity of care, Medical Exemption Requests (MERs), risk stratification and risk assessment, OMB calls, fair hearing and member grievance data, DMHC help center calls, and network adequacy. Most of this data is reported to CMS at the MCP and State level, as appropriate.

DHCS reviews data on a monthly, quarterly, and annual basis to determine areas that require further exploration. In addition, DHCS convenes a quarterly Stakeholder Advisory Committee (SAC) (specific to the DHCS' Section 1115 Demonstration Waiver) and a Managed Care Advisory Group (AG) during which DHCS looks to stakeholders and advocates to provide anecdotal information to DHCS relative to the SPD population. DHCS also checks in with advocates and stakeholders informally on an on-going basis. Finally, reports related to grievances and appeals and OMB call data are reviewed to identify any trends related to the SPD transition.

c) *Information on the process for contract monitoring, including standards and objective measures of an adequate network of qualified specialists and ancillary providers that you are applying,*

Response:

Under the Medi-Cal managed care contract, DHCS requires its MCPs to:

- In addition to DMHC's Knox-Keene network adequacy standards, maintain an adequate provider network, including SPDs, in the proposed county and to provide the full scope of Medi-Cal benefits.
- Provide DHCS with quarterly provider network reports.
- Ensure and monitor an appropriate provider network, including PCPs, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and service sites within each service area.

In addition, DHCS conducts periodic medical audit reviews which include evaluations of MCP network adequacy. Beginning January 1, 2013, these medical audit reviews will be conducted on an annual basis. On a quarterly basis, DMHC, on behalf of DHCS, performs network adequacy assessments which focus on the impact of MCP networks and enrollment changes pertaining to the ability of MCPs to continue meeting the health care needs of their SPD members. These network assessments focus on the following areas:

- MCP's current enrollment and changes since the last quarter.
- Changes to a MCP's network since it was reported for the previous quarter to DMHC and/or DHCS.
- Current geographical access for beneficiaries.
- Availability of traditional and safety-net providers.
- Network providers who are not accepting new patients.
- Access related member feedback, such as grievance reports and calls to DMHC and/or OMB.

MCPs are obligated to ensure and monitor an appropriate provider network, including PCPs, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and service sites within each service area. MCPs ensure that networks continuously satisfy the following full-time equivalent provider to member ratios: 1) PCPs: 1:2,000 and 2) Total Physicians: 1:1,200

d) Information on complaints about difficulties in arranging for an enrollee to continue to see a particular provider, the numbers of complaints by plan and by type, how they are responded to, and the dispute resolution process,

Response:

DHCS requires all MCPs to report SPD related grievance data on a quarterly basis pertaining to:

- Physical accessibility.
- Out of network provider requests.
- Access to primary care.
- Access to specialists.
- All other SPD related grievances.
- Overall total of SPD related grievances.

DHCS also collects data internally pertaining to:

- Call volume to the DHCS Office of the Ombudsman pertaining to access, SPD mandatory enrollment and overall volume.
- State Fair Hearing requests by SPDs related to access.
- DMHC Help Center calls.

The data outlined in in the previous two bullet point sets is available on the DHCS website through the SPD Dashboard report:

http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf

DHCS contractually requires MCPs to implement and maintain a member grievance system in accordance with Title 28, California Code of Regulations (CCR) Sections 1300.68 and 1300.68.01, and Title 22 CCR Section 53858. Each MCP is required to respond, resolve each grievance, and provide notice to the beneficiary as quickly as the beneficiary's health condition requires, or within 30 calendar days from the date the MCP receives the grievance.

Please see responses to 2(a), pertaining to continuity of care, and 2(b), pertaining to appeals/grievance reporting, for additional information

- e) *The mechanisms you are employing to assure that an enrollee who has lost access to a pre-transfer provider is able to receive services from a qualified specialist or ancillary provider,***

Response:

Prior to the SPD transition, DHCS conducted a provider network certification for each MCP that would be enrolling SPDs. The network certification included PCPs, specialists, and ancillary providers. The certification was approved by CMS. Ongoing monitoring of a MCP's provider network is completed through quarterly and annual reporting requirements. Additionally, DMHC monitors MCPs' provider networks to ensure that timely access standards are met.

Following the enrollment of a SPD, MCPs are contractually required to conduct a Health Risk Assessment (HRA) and stratification process. The risk stratification mechanism or algorithm to identify newly enrolled SPDs with higher-risk and more complex health care needs is required to be completed within 44 days. Based on the results of the health risk stratification, the MCP is required to administer the DHCS approved HRA survey within 45 days for SPDs deemed to be a higher health risk, and 105 days for those determined to be a lower health risk. The health risk stratification and assessment are conducted in accordance with Welfare and Institutions Code (W&I Code) Sections 14182 (c)(11) to (13) and MMCD Policy Letter (PL) 11-007.

- f) *The mechanisms that are in place to ensure that consumers know how and to whom to request continuity and where to appeal or complain,***

Response:

To ensure that SPD beneficiaries and stakeholders are fully aware of continuity of care rights, DHCS communicated the process to request continuity of care using the following methods:

- All MCPs are required to honor FFS treatment authorization requests (TARS) until the beneficiary is seen by the MCP PCP.
- A full-page continuity of care notice was inserted into the SPD enrollment packets.
- An in-person community presentation was conducted in each county impacted by the SPD transition.
- DHCS conducted five statewide webinars with stakeholder input, one of which is posted on the DHCS website (link below).

- A Frequently Asked Questions (FAQs) document was developed and posted to the DHCS website (link below).
- A continuity of care provider bulletin was developed and sent to all FFS providers, MCPs, and posted to the DHCS website (link below).
- DHCS participated in numerous provider, county, MCP, stakeholder, and local committee meetings to discuss the SPD process and provider education on beneficiary rights.
- A SPD-specific webpage and the above mentioned materials are posted to the webpage at: www.dhcs.ca.gov/spdinfo.

DHCS requires all MCPs to explain the procedure for how a beneficiary can file appeals and grievances. This is included as a requirement under the MCP's Medi-Cal managed care contract. DHCS reviews and approves policies and procedures relative to appeals and grievances to ensure that all MCPs are in compliance with all federal and state laws. MCPs are also required to submit any changes to these policies and procedures to DHCS for review prior to implementation.

The DHCS Office of the Ombudsman can be contacted at 1-888-452-8609 and the DMHC Help Center can be contacted at 1-888-466-2219.

g) The process the Department will employ to monitor for disturbing trends,

Response:

DHCS holds a conference call with DMHC prior to each of DMHC's MCP medical surveys to identify concerns that have been flagged through the review of data, monitoring tools, advocates and stakeholder statements, past findings, and other areas of concern related to the MCP being reviewed. These flagged areas are incorporated into the DMHC's review of the MCP.

Please also see the response to 2(b) for additional information related to monitoring and evaluation.

h) How you ensure that the plan has a liaison and how providers and enrollees are being informed of this, and,

Response:

DHCS amended its Medi-Cal managed care contracts to require MCPs to maintain a dedicated liaison to coordinate with each regional center operating within a MCP's service area to assist SPDs with developmental disabilities. This liaison assists SPDs with developmental disabilities in understanding and accessing services, and acts as a center point of

contact for questions, access and care concerns, and problem resolution as required by W&I Code Section 14182(c)(10).

Prior to the SPD transition, DHCS conducted MCP readiness reviews. These readiness reviews included the review and approval of the MCP's SPD-specific contractually required deliverables and the approval of its liaison policy and procedure. In addition, any changes to this policy and procedure by a MCP must be submitted to DHCS for review and approval.

- i) Information on the initial health risk assessment process for SPDs and how the Department is monitoring this process, including the results of any evaluations or oversight and any recommended changes or corrective actions plans.***

Response:

The HRA process for SPDs is described in All Plan Letter (APL) 12-004 which can be located on the DHCS website at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-004.pdf>.

DHCS reviews and approves the risk stratification mechanism or algorithm and the HRA survey tool, as well as all policies and procedures related to the health risk stratification and assessment for each MCP. MCPs are required to use any existing claim and utilization data supplied by DHCS, member self-reported information in the risk stratification process, and to contact members by phone or mail to complete the HRA within specified time periods.

As described in the PL mentioned above, MCPs are required to report the following, on a quarterly basis, for all newly enrolled SPDs: risk stratification results; results of attempts to contact; numbers of completed and declined risk assessment surveys; and the correlation between risk as determined by the risk stratification process and the HRA survey process. These results are published in a September 2012 report covering the first full year of implementation on the DHCS website at:
http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf.

The report includes baseline data, therefore, no changes or corrective actions have been recommended at this time.

- 3) With regard to utilization for all the initiatives, please provide the evaluation and data collection plans for all the populations. Specifically include benchmarks for institutionalizations, hospitalizations, pharmacy usage, primary care visits, and specialty care visits and how the**

Department will measure and monitor changes. Please include information on any comparisons or trend tracking that is planned.

Response:

SPDs:

With regards to SPDs, DHCS will begin submitting quarterly SPD Waiver Reports to CMS pertaining to utilization beginning in November 2012. Data reported and evaluated will include:

- Top 10 Diagnosis Codes.
- Top 10 Service Categories.
- Number of Prescription Claims.
- Number of Outpatient, Inpatient and Hospital Services.
- Number of Emergency Room Visits.

The data will be reported from DHCS' Management Information System/ Decision Support System (MIS/DSS). DHCS will review data on a monthly, quarterly, and annual basis to determine areas that require further exploration.

Dual-Eligibles-CCI:

To ensure beneficiaries receive high quality care through the CCI, a rigorous evaluation and quality monitoring program will be implemented. The State will partner on an evaluation with CMS. Upon CMS approval, the Demonstration will be included in the CMS evaluation conducted by a team of researchers under contract to the Research Triangle Institute (RTI). The evaluation team will measure, monitor, and evaluate the impact of the State's Demonstration on the cost, quality, and utilization of care received by dual-eligible beneficiaries. In addition, the evaluation will seek to understand how the initiatives operate, how they transform and evolve over time, and what impact they have on beneficiaries' perspectives and experiences. The key issues targeted by the evaluation include, but are not limited to:

- Beneficiary health status and outcomes as measured by metrics being developed with stakeholder input.
- Quality of care provided across care settings and delivery models.
- Beneficiary access to care across care settings and payers.
- Beneficiary satisfaction and experience as measured by metrics being developed with stakeholder input.
- Administrative and systems changes and efficiencies.
- Overall costs or savings for Medicare and Medicaid.

The CMS evaluation methods will use qualitative and quantitative approaches, including the following:

- Conducting site visits, qualitative analysis of program data, focus group and key informant interviews.
- Tracking changes in utilization, cost, and quality measures.
- Evaluating the impact of the Demonstration on cost, quality, and utilization measures.
- Calculating savings attributable to the Demonstration.

The California-led approach to measuring and monitoring quality of care and services provided under the Demonstration is being developed by DHCS with significant stakeholder input. DHCS is working closely with the University of California Davis (UCD) Institute for Population Health Improvement directed by Kenneth W. Kizer, MD, MPH, Distinguished Professor, UCD School of Medicine and the Betty Irene Moore School of Nursing. Dr. Kizer and associates will provide technical assistance in both evaluation design/implementation as well as program interventions, including a rapid cycle QIP that will enable DHCS to monitor and collect data to perform needed program adjustments that ensure high quality health care delivery. The State evaluation will align with the national evaluation, and as much as possible, the State will use the national evaluation metrics to allow for an "apples to apples" comparison.

Healthy Families:

The evaluation and data collection plans for the Healthy Families population are still under discussion; however, DHCS will begin with current MCP measures and adjustments will be made as the population dictates.

DHCS and DMHC are tasked with assessing health and dental plan provider network adequacy and continuity of care efforts. DHCS will have the lead responsibility on ensuring that Medi-Cal health and dental plans meet DHCS/Medicaid contractual network adequacy requirements and DMHC will have the lead responsibility for ensuring that plans meet Knox-Keene licensure network adequacy requirements.

The departments will be evaluating health plan networks against established Knox Keene network and access standards and standards set forth in the DHCS health plan contracts. These reviews include, at a minimum:

- Assessing steps the health plan (Plan) will take to preserve continuity of care to ensure a smooth transition. The Plan's transition process relating to continuity of care, including communications to members and providers.
- How the Plan will ensure access to specialist(s) and prescription medication so that there is no disruption in services for children with special health care needs and those receiving specialty services such as autism treatment services or mental health services.

- The Plan's outreach and communication process that explains the Primary Care Provider (PCP) reassignment process to enrollees.
- Efforts the Plan made to contract with HFP providers who are not currently in the Plan's Medi-Cal network.
- The Plan steps taken to review its out-of-network authorization process to ensure that, under circumstances where a patient cannot be transitioned to a new provider, the Plan is able to preserve continuity of care for transitioning HFP members whose treating providers are not in the Plan's network.
- Steps the Plan has taken to ensure that individuals moving to new providers as a result of the HFP transition will have timely access to their new provider and will not have a disruption in services.
- Any changes in the Plan's network to ensure there are no disruptions in services as a result of the transition.
- Any administrative changes the Plan has made to ensure there are no disruptions in services as a result of the transition (e.g. care management staff, expedited utilization management services, etc.).
- Steps the Plan has taken to evaluate whether its current Medi-Cal contracted providers will continue to contract and treat the Medi-Cal enrollees after the transition of HFP enrollees.
- Steps the Plan has taken to evaluate whether its current Medi-Cal contracted provider groups will remain financially solvent with the addition of HFP lives into the Medi-Cal product.

Health plan metrics will include, but will not be limited to, child-only HEDIS measures indicative of performance in serving children and adolescents and existing Medi-Cal managed care performance metrics and standards including timely access, network adequacy, linguistic services, and the use of surveys to measure beneficiary satisfaction and network adequacy post transition. These findings are publicly reported and posted on the DHCS website.

Dental plan metrics will include, but will not be limited to, provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and a survey of member satisfaction with plans and providers. All performance measures will be monitored for Dental Managed Care plans as well as Fee-for-Service, Denti-Cal. An annual report will be produced to represent the findings, similar to the current Healthy Families Quality Report. This report will be publicly reported and posted on the DHCS Denti-Cal website.

Additional information on this transition plan is available on the DHCS website at:

<http://www.dhcs.ca.gov/services/Documents/Healthy%20Families%20Program%20Transition%20to%20Medi-Cal%20Strategic%20Plan.pdf>

Rural Populations:

The evaluation and data collection plans for the rural county expansion populations are still under discussion; however, DHCS will begin with current measures for MCPs and adjustments will be made as the population and the geography of the regions(s) dictates.

Dental:

Dental utilization will be monitored through monthly reports reported quarterly. Beneficiary populations on the reports will be split out so utilization of beneficiaries in the Medi-Cal Targeted Low Income FPL for Children Program can be compared to utilization of all other beneficiaries in Medi-Cal Dental Program as well as the past data reported for the Healthy Families Program. Question number one provides additional detail on the standards the Department will be using for acceptable access and quality, including the specific performance measures that will be used to determine that the standards are being met for each population in each initiative.

- 4) Information on what HEDIS measures are being collected and what other quality measures the Department is collecting, how quality measures are being used by the Department, and how they are or will be reported to the Legislature and public, including information on any quality improvement initiatives.**

Response:

On an annual basis, DHCS collaborates with stakeholders to develop the final set of HEDIS measures which MCPs are required to report to DHCS during the subsequent Calendar Year (CY). These collaborations include a survey of MCP medical directors, in-person and by phone discussions with MCP medical directors and other relevant key stakeholders, and a presentation to MMCD's AG of the proposed draft measures which DHCS is considering for use.

Following approval, the final set of HEDIS measures is outlined in an annual APL which is intended to clarify the Quality and Performance Improvement Program requirements for MCPs. All MCPs are contractually required to report annual performance measurement results, participate in a consumer satisfaction survey, and conduct ongoing QIPs.

In addition, DHSC has recently developed the *Strategy for Quality Improvement in Health Care (Quality Strategy)*, which is a blueprint to

improve the health of Californians, improve the quality of all DHCS programs, and reduce the Department's per capita health care costs. The *Quality Strategy* and a multi-year implementation plan, which is currently under development, will emphasize the use of measures, including HEDIS and other quality metrics from the Agency for Healthcare Research and Quality and the National Quality Forum, to guide the establishment and measurement of quality improvements efforts department-wide.

Current HEDIS measures reported by MCPs are available on the DHCS website in APL 11-021 which can be located at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.pdf>.

DHCS is currently finalizing this year's APL which will describe HEDIS performance requirements for CY 2013. In addition to 14 HEDIS measures, it will include one customized measure for determining rates of hospital readmissions within 30 days of discharge, and a methodology for stratifying several measures into separate populations including SPDs and non-SPDs.

DHCS also contracts to perform CAHPS through its EQRO. This survey is an optional Medicaid external quality review activity to assess managed care members' satisfaction with their health care services. CAHPS are administered to both adult members and parents or caretakers of child members at the county level. The survey is administered every three years and was most recently conducted in 2010. A summary of the findings from the report is available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Reports/CAHPS2009-10.pdf.

HEDIS results are used by DHCS for "pay-for-performance" (e.g. the default algorithm) and, with CAHPS results, to guide MCP and DHCS quality improvement activities. MCPs scoring below a pre-determined minimum for HEDIS measures are required to submit Improvement Plans to DHCS for those measures. MCPs are also required to have two QIPs underway at all times. One of these QIPs is the Statewide Collaborative (MCPs are currently focusing on a Hospital Readmissions QIP, see below for additional information). DHCS reviews and approves QIP proposals based on needs related to poor performance in HEDIS and CAHPS.

DHCS provides quarterly reports to the Legislature about HEDIS performance measures and the Statewide Collaborative QIP. Additionally, an annual aggregate HEDIS report is published. The quarterly reports on the status of all MCP QIPs and the annual HEDIS report can be located at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>.

There is only one dental HEDIS performance measure, Annual Dental Visits for ages 2-18. It will be reported annually to the public in the report with the rest of the dental performance measures.

Statewide Collaborative Quality Improvement Project

In July of 2011, DHCS began meeting with MCPs and DHCS' EQRO, Health Services Advisory Group (HSAG), to begin a new Statewide Collaborative QIP titled "Reducing All Cause Hospital Readmissions." The Guiding Principles Subcommittee developed a set of principles for conducting MCP meetings for the collaborative process. The Measure Specifications Subcommittee developed specifications for customizing the selected HEDIS measure, titled "Plan All-Cause Readmissions," specific to the Medi-Cal population.

A hospital readmission is a preventable or avoidable hospital admission that occurs within 30 days after discharge from the first or index admission. MCPs submitted collaborative QIP proposals in March of 2012. Subsequently, MCPs submitted QIP study design phase data in September of 2012. MCPs are now conducting a barrier analysis and designing interventions to be implemented in January 2013.

Over the next three years, the goals for the Statewide Collaborative are to: 1) understand the reasons why Medi-Cal members 21 years of age and older are readmitted to the hospital, and 2) identify and implement effective strategies to reduce hospital readmission rates.

5) Information on the last time the default algorithm was revised, the quality measures that are used for the default algorithm, the history of the results over time with regard to each plan and future plans for updates.

Response:

In 2005, or Program Year (PY) 1, the Auto Assignment Incentive Program (also known as the default algorithm), was implemented in Medi-Cal managed care in both Geographic Managed Care (GMC) and Two-Plan Model (TPM) counties for all beneficiaries being auto assigned in the service area of these managed care models. Initially HEDIS performance measures and two safety net measures were used to develop quality scores for MCPs in each county to determine what percentage of the default enrollment would go to each MCP. Additional HEDIS measures were added in PYs 3 and 6, and the use of appropriate medications for people with asthma HEDIS measure was dropped in PY 6.

The default algorithm percent distribution is annually recalculated based on the approved performance measures for the applicable PY. Currently, the algorithm is being recalculated for CY 2013.

The Auto Assignment Incentive Program Stakeholder Workgroup meets annually to discuss and make recommendations to DHCS regarding which HEDIS performance measures should be used for the upcoming PY. This stakeholder group met this year on October 3rd. One of the six measures currently used, adolescent well-care visits, is no longer reported by the MCPs. Thus, the number of measures currently used was reduced to five. The group made the recommendation to DHCS that the same five measures be used during the upcoming PY. DHCS agreed with this recommendation.

A description of the manner in which the default algorithm is calculated and current measures used can be located at:

<http://www.dhcs.ca.gov/provgovpart/Documents/MMCDAAPerfIncentiveOrvw.pdf>.

A history of the Auto Assignment Incentive Program default percentages by MCP can be located at:

http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_DefaultRatesYears1-7.pdf.

A report showing TPM county enrollment for 2011 can be located at:

http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_2PlanGMCNewEnrolTotalsCY2011.pdf.

6) With regard to the Healthy Families Program:

a) The transition plan and how the Department plans to ensure that there is no disruption in service delivery and provider access.

Response:

Transition Plan:

The California Health and Human Services Agency (Agency) worked collaboratively with DHCS, DMHC, the Managed Risk Medical Insurance Board (MRMIB), and stakeholders in developing the Healthy Families Program Transition to Medi-Cal Strategic Plan and submitted it to the Legislature on October 2, 2012. Throughout the four phases of the Transition, DHCS, in partnership with Agency, DMHC, and MRMIB, is committed to continue to request and consider input from consumers, stakeholders, and legislative staff. Please see the transition plan and attachments for detail on the Transition. It includes information on the

specific implementation timeline, including a breakdown of the 4 Phases of the transition, a discussion of consumer and stakeholder outreach and input, network adequacy determination, data tracking and ongoing monitoring, and federal approval. The Strategic Plan and other information on the Transition are available at:

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

- b) *How children will continue to receive services or treatments for ongoing or chronic conditions such as asthma, diabetes, attention deficit hyperactivity disorder, or myopia without interruption,***

Response:

For Phase 1, Parts A and B, there should no disruption in services since the Healthy Families child will remain with the same health plan. Further, each MCP is required to ensure there is not a disruption in services, and that provider/patient relationships are maintained either in the MCP's provider network, or for up to 12-months for continuity of care with a provider who is out-of-network if an agreement regarding payment can be reached. Please see Attachment II, Qualitative Data Elements, of the Strategic Plan for information that DMHC and DHCS requested from plans regarding continuity of care.

- c) *Whether new authorizations and referrals have to be obtained,***

They do not need to be obtained for Phase 1.

For Phase 1, new authorizations and referrals are not required since the Healthy Families child is remaining with the same MCP. For Phase 2-4, it is not the intention of the Department to disrupt authorizations and referrals, but processes are currently being developed to meet this goal.

Prior authorizations for treatment to the transitioning HFP population will be honored by the Medi-Cal Dental Program if the service is a Medi-Cal Dental benefit. There will be no need to receive a new authorization.

- d) *For HFP providers not enrolled into Medi-Cal and, as applicable, the Vaccine for Children program, how provider enrollment will be completed prior to transitioning children, and,***

Response:

For Medi-Cal managed care, provider enrollment is conducted at the MCP level. MCPs have been actively contacting HFP provides for contracting purposes. Prior to the transition, the Department will conduct a full

provider network review to ensure that MCP provider networks are sufficient to serve HFP membership.

For the Vaccines for Children program (VFC), providers will need to fill out a set of enrollment forms which can be found at www.eziz.org. The VFC office will review the enrollment forms for completeness, verifies medical license information and then sends the package to the local VFC field representative. The VFC rep contacts the office to schedule a site visit. During the site visit, the provider's vaccine storage units are checked and all of the VFC requirements are reviewed. If all requirements are met, the VFC office issues then a provider identification number and the provider can begin ordering vaccines.

The VFC program will be discussing provider outreach strategies at an advisory group meeting scheduled for November 7, 2012.

e) *The plan for the dental and vision transition and continuity plans.*

Response:

The Medi-Cal Dental program is performing provider outreach to encourage Healthy Families Program (HFP) providers to enroll in the Medi-Cal Dental program so they can continue treatment of their HFP beneficiaries when they transition to Medi-Cal. Outreach activities include, but are not limited to, provider call campaigns, survey, education, and streamlining the enrollment process. Please see the Strategic Plan for descriptions of each activity.

Vision coverage transition also coincides with the medical coverage transition. As children transition from HFP to Medi-Cal based on the phases, they will move out of their HFP vision plan and will receive their vision services under the managed health care plan or in Medi-Cal fee-for-service, as applicable. The Medi-Cal managed care plans will coordinate with the Prison Industry Authority for the fabrication of optical lenses. Please see the Strategic Plan for descriptions of each activity.

7) With regard to the Coordinated Care Initiative:

a) *Status of CMS approval and any requirements for access, quality, and evaluation they have imposed,*

Response:

DHCS is currently in discussions with CMS and stakeholders to develop the MOU for the Demonstration which will specify access, quality, and evaluation for the Demonstration. DHCS has made substantial progress in its. DHCS has had many conference calls and meetings with CMS on

the MOU and DHCS has been working collaboratively with the other departments implementing the CCI (i.e., the California Department of Aging, the Department of Social Services, the Department of Managed Health Care, and the Department of Rehabilitation) on the MOU. DHCS anticipates that the MOU will likely be finalized in November.

As noted in responses to Question's 1 and 3 above, upon CMS approval, the Demonstration will be included in the CMS evaluation conducted by a team of researchers under contract to RTI. The quality standards for the Demonstration will reflect medical, LTSS, and behavioral health quality measures. These measures are currently being developed through a stakeholder review process. DHCS posted a list of over 90 measures for consideration, and is reviewing the stakeholder comments for those measures.

b) Measures for plan readiness and the results of network adequacy review.

Response:

CMS is preparing a National Readiness Review Tool, which will be used to develop the State's plan-specific readiness review tool for the Demonstration. California's state-specific tool is still being developed, and will be tailored to the Demonstration parameters outlined in SB 1008 and SB 1036 (Chapter 45, Statutes of 2012), the MOU between the State and CMS, and the experience of the MCPs.

The state-specific edits will reflect, among other things, the State's operational standards for health assessments, care coordination, and LTSS readiness for the Demonstration that are currently being developed in consultation with stakeholders. Further, the State intends to work with CMS to incorporate readiness criteria specific to delegated models, to allow the State and CMS to review how MCPs will execute, carry out, and monitor delegated models.

The state-specific tool cannot be finalized until a MOU for the Demonstration is fully executed, although the State intends to continue working with stakeholders to discuss the standards that will be incorporated into the readiness tool prior to the signing of the MOU.

c) Plans for evaluation of the demonstration project sites, CMS evaluation and performance requirements and the timeline, and,

Response:

As discussed in responses for Questions 1 and 3, DHCS is working with CMS and stakeholders to develop a plan for evaluation, quality, and performance measures.

d) A description of how the utilization, particularly hospitalizations, and Long Term Services and Supports data will be collected, analyzed and reported.

Response:

As part of the development of quality measures for the CCI, DHCS is currently reviewing process measures that will be used to monitor the Demonstration and the CCI. These process measures will include utilization, hospitalization, and LTSS.

8) With regard to all initiatives, a description of the process for developing, or any existing action plans, to address deficiencies identified during and after the transition for each initiative, under what circumstances the Department will delay or halt the transition and how stakeholders will be involved in identifying and addressing deficiencies and development of action plans.

Response:

DHCS will monitor grievances and complaints made to the DHCS' OMB the MCPs. DHCS will seek input from the MMCD AG, which is composed of a wide array of stakeholders, in identifying problems and appropriate remedies to deficiencies.

If DHCS finds that at any given point, the health or safety of a transitional population is in jeopardy, and that delaying or halting the transition would resolve the issue, DHCS will consider those options.

Add in a couple sentences about DMHC IAs and readiness reviews as applicable.

Medi-Cal Dental

During and after implementation of the HFP transition to the Medi-Cal Dental Program, any deficiencies found in reports from dental plans will be analyzed and action plans will be developed accordingly by the program. As in the Immediate Action Expectations the Department will notify the dental plan or FFS program that there is a deficiency and develop specific actions, milestones and benchmarks to ensure the proper steps are being taken to correct the deficiency. Depending on the deficiency and the severity corrective action plans can take up to one year.

- 9) **A description of the stakeholder process for each initiative, including opportunities to ask questions and provide comments. A description of how the Department will incorporate comments, with specific examples of how comments have influenced or modified Departmental planning or implementation of the transitions to date. Also include how the Department intends to seek input from the Legislature and inform the Legislature of progress.**

Response:

SPDs:

- DHCS posted the original 1115 Demonstration Waiver Proposal for comment which included a SPD transition component in 2009.
- A Waiver SAC was formed and included representatives across a broad spectrum of stakeholder representatives. The Advisory Committee list can be located at:
<http://www.dhcs.ca.gov/provgovpart/Documents/SAC%202012%20members%207-16-12.pdf>.
- DHCS created a SPD Technical Workgroup specific to the SPD transition. Information pertaining to the workgroup can be located at:
<http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupSPDs.aspx>.
- Multiple stakeholders meetings have been held since 2009 and are ongoing.
- Legislative staff is provided notice of each scheduled meeting, with the applicable attachments, and are provided the summary documents.
- DHCS seeks input from stakeholders at SAC meetings, SPD technical workgroup meetings, MMCD AG meetings, informal discussions with stakeholders, and other.
- The stakeholder process has had a significant impact on DHCS' efforts to link beneficiaries and MCPs through coordination of care efforts, identifying an appropriate list of stratification and risk-assessment requirements for MCPs when transitioning SPDs, provider and staff training requirements relative to the population, and notices that were sent to beneficiaries.

Dual-Eligibles-CCI:

Starting in April 2010:

- DHCS supported a broad stakeholder engagement process to inform them of the design and implementation of the CCI and the Demonstration.
- DHCS has organized numerous opportunities to learn directly from beneficiaries about their health care experiences, needs, preferences and reactions to proposed system changes.
- DHCS has organized dozens of stakeholder meetings focused on specific topics pertaining to the CCI.

- DHCS' Legislative and Governmental Affairs staff relayed all critical information to key legislative staff members.
- DHCS released save-the-date meeting announcements, meeting invitations, and other related meeting materials via an email distribution list and also utilized the DHCS website www.dhcs.ca.gov. DHCS also posted this information on an additional website, www.calduals.org. This stakeholder distribution list has grown throughout the process, as DHCS received numerous requests from individuals interested in the issues. As of late September 2012, over 2,300 individuals and organizations are on the Cal Duals email distribution list.
- Various policies have been revised to reflect stakeholder feedback, particularly the populations included in the CCI, provider policies, and structure of In-Home Supportive Services (IHSS) as a managed care benefit.

DHCS will continue to incorporate stakeholder feedback in the implementation of the CCI.

Healthy Families:

- Throughout the transition, DHCS will continue to request and consider input from consumers, stakeholders, and legislative staff.
- DHCS has multiple efforts underway in order to reach a variety of stakeholders which include weekly planning meetings with the California Health and Human Service Agency, the Department of Finance, the Managed Risk Medical Insurance Board, and DMHC and twice monthly meetings with CMS.
- The CMS meetings are designed to provide technical assistance on key components of the transition including necessary federal approvals (State Plan and 1115 Demonstration Waiver amendments), health and dental plan contract approvals, eligibility provisions, and cost sharing requirements.
- Additionally, MMCD, the Medi-Cal Eligibility Division, and Dental Managed Care conduct meetings with key partners who have operational roles in the transition.
- MMCD conducts the following activities:
 - Weekly phone calls with MCPs.
 - Quarterly Meetings with the MMCD AG.
 - Bi-weekly meetings with DMHC.
 - Joint reviews of the Medi-Cal managed care provider network with DMHC.

Rural Populations:

DHCS released a Request for Interest to determine health plan interest in the 28 rural expansion counties in April 2012.

- The initial stakeholder list was made up of health plans and a combination of other DHCS stakeholder lists.
- DHCS has an expansion webpage and can be located at:
<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDRuralExpansion.aspx>.
The webpage contains all current and past information. DHCS is actively adding new stakeholder information as requested.
- Two stakeholder meetings have been held (July and August 2012). The third is set for late October and the meetings will continue through at least March 2013.
- Legislative staff are provided notice prior to each scheduled stakeholder meeting, with the applicable attachments, and are provided the summary documents following the meetings.
- Stakeholders were provided a copy of the procurement document, or Request for Application (RFA) that will be released in mid-October for comment and input.
- DHCS evaluated the stakeholder comments and updated the RFA. Updates included, but were not limited to, the removal of the Knox-Keene requirement for plans not currently required to have one, the request for increased health plan input on coordination for behavioral health services, and special consideration for the seven northern California counties.