Medi-Cal Managed Care Quality Strategy Report

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Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule)

Requires each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities in that state.

- Managed Care Plans (MCPs)
- County Mental Health Plans (MHPs)
- Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Dental Managed Care (DMC)

Quality Strategy Report Timeline

- DHCS published Draft Report on March 28, 2018
- Stakeholder and tribal comment period ended April 27, 2018
- DHCS is currently reviewing public comments
- Final report will be submitted to CMS by July 1, 2018

DHCS Quality Strategy Reports

	DHCS Strategy for Quality Improvement in Health Care	Managed Care Plans: Medi-Cal Managed Care Quality Strategy	DHCS Medi-Cal Managed Care Quality Strategy Report
Delivery Systems	Managed Care & Fee for Service	Managed Care Plans	All Managed Care Delivery Systems: MCPs, MHPs, DMC-ODS, and DMC plans.
Topics	Describes the goals, priorities, guiding principles, and specific DHCS program activities related to quality improvement. Supports the DHCS Strategic Plan commitments and aligns with national efforts, such as the National Quality Strategy.	Per Code of Federal Regulations 438.202(a), States that have contracts with managed care organizations must have a written strategy for assessing and improving the quality of managed care services offered by **all Medi-Cal managed care health plans.** (superseded by 438.340)	Complies with Code of Federal Regulations 438.340, which requires each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by **all Medicaid managed care entities** in that state.

Quality Strategy Report Requirements

- Network adequacy standards
- Goals and objectives for continuous quality improvement, a description of the quality metrics, performance targets, and performance improvement projects
- Arrangements for annual, external independent reviews, through contracts with External Quality Review Organizations (EQROs)
- Transition of care policy, known as Continuity of Care at DHCS
- Plan to identify, evaluate, and reduce health disparities
- Policies regarding sanctions for plan non-compliance
- Definition of ‘‘significant change‘‘ for future reporting

Network Adequacy Standards

- Initially published in July 2017
- Amended in March 2018 as a result of Assembly Bill 205 (Chapter 738, Statutes of 2017), which codified and amended Medi-Cal network adequacy requirements
- Updates include:
  - Time and distance standards now reflect **county population density**
  - County categories now reflect population density groupings rather than population size
  - Dental pediatric timely access standards for specialist appointments are adjusted from **30 business days to 30 calendar days**
  - Timely access standards for Skilled Nursing Facilities and Intermediate Care Facilities for small and rural counties are adjusted from **14 business days to 14 calendar days**

Quality Goals: Managed Care Plans

Seven Focus Areas for Quality Improvement (QI):

- Postpartum care
- Childhood immunizations
- Diabetes care
- Control of hypertension
- Tobacco cessation
- Reducing health disparities
- Fostering healthy communities

Performance Improvement Projects (PIP)

- DHCS requires MCPs to conduct and/or participate in two PIPs annually
- First PIP topic aligns to one of four DHCS pre-selected priority focus area
- Second PIP topic selected by the MCPs

Quality Goals: Mental Health Plans

Two focus areas for quality improvement:

- Specialty Mental Health Services (SMHS) penetration rate
- Time between inpatient discharge and step down service

Performance Improvement Projects

- Each MHP is required to conduct two PIPs, one clinical and one non-clinical. MHPs have flexibility in selecting their PIPs.

Quality Goals: Drug Medi-Cal Organized Delivery System

DMC-ODS Focus Areas for Quality Improvement

- DHCS is developing quality measures for DMC-ODS and a two-part process to improve data collection
  - Develop relevant data collection and reporting system
  - Beneficiary initiation engagement in SUD treatment

Performance Improvement Projects

- Pilot counties are developing PIPs, which may be combined with MHP QI Plans in some counties

Quality Goals: Dental Managed Care Plans

Three focus areas for quality improvement

- Improve oral health of all beneficiaries.
- Increase utilization of dental visits, particularly preventive dental services among children.
- Reduce incidence of caries/tooth decay among all beneficiaries.

Performance Improvement Projects

- DHCS requires each DMC plan to maintain two Quality Improvement Projects (QIPs) per year. Current QIPs include beneficiary and provider outreach efforts, and community education.

Reducing Health Disparities

- MCPs have begun to identify and address certain disparities such as racial disparities in hypertension and maternal care.
  - Each MCP is required to complete a PIP focused on a plan-specific health disparity, and the EQRO is completing a comprehensive health disparities analysis to more accurately identify health inequities and better target the neediest beneficiaries.
- Each county MHP and Substance Use Disorder program is required to develop and implement a Culturally and Linguistically Appropriate Services (CLAS) Plan that include objectives for reducing health disparities using culturally, linguistically, and ethically appropriate strategies.
- DMC plans are leveraging pilot programs within the Dental Transformation Initiative to create data systems to identify and address racial and ethnic disparities in pediatric dental populations.

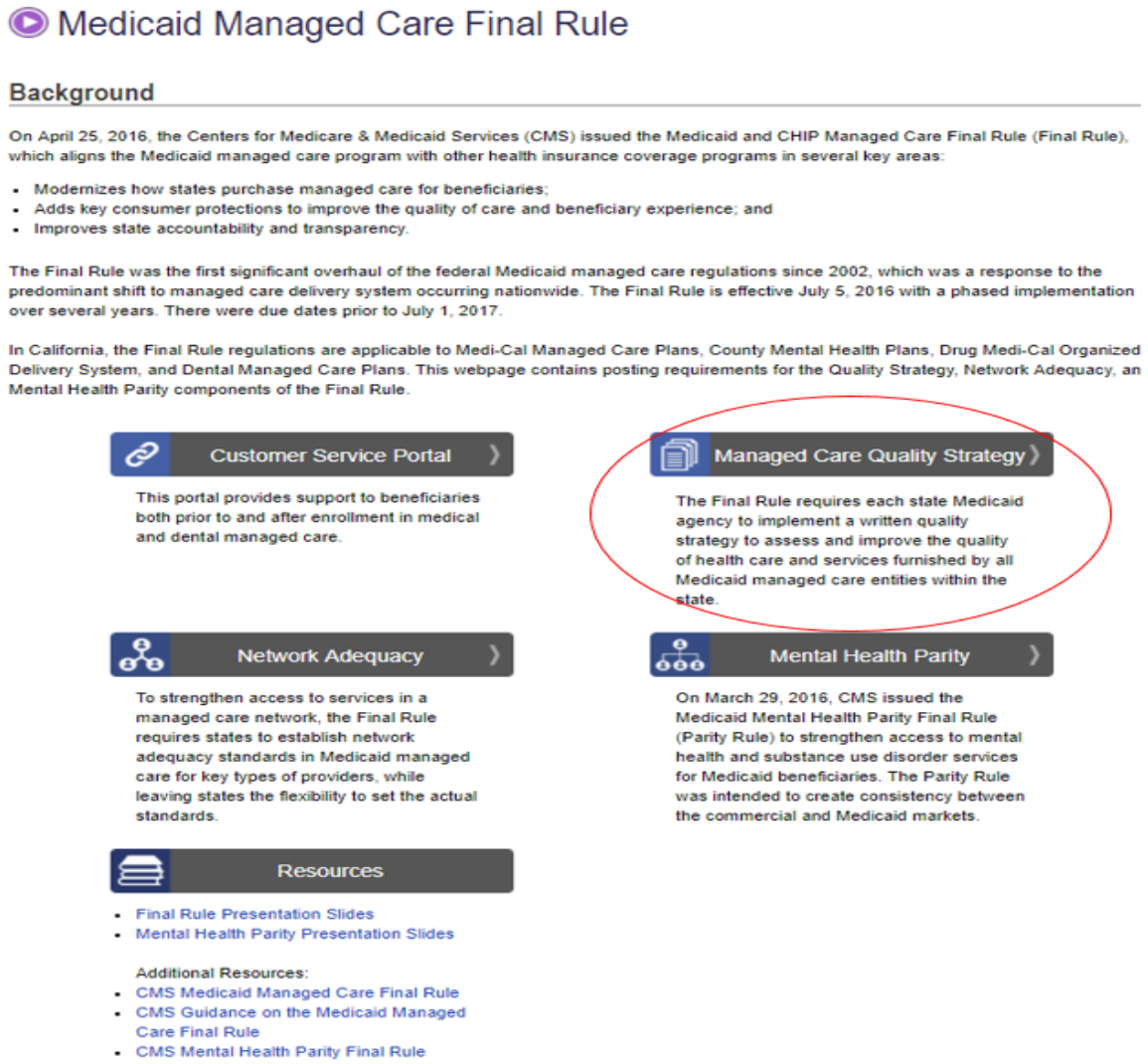
Quality Strategy Report: Stakeholder Feedback

- **Quality Goals**
  - Further develop quality improvement measures and implementation processes for DMC-ODS and MHPs
  - Stratify populations in quality goals
    - Pregnant women, individuals with disabilities, people living with HIV, American Indians and Alaskan Natives etc.
  - Develop inter-system care coordination strategy
  - Align and merge data collection and quality improvement across delivery systems

Quality Strategy Report: Stakeholder Feedback

- **Evidence-Based Clinical Practice Guidelines**
  - Improve use of evidence-based clinical practice guidelines for all managed care entities
- **Reducing Health Disparities**
  - Integrate health disparities reduction in all aspects of report
  - Increase measures for maternal health
  - Provide clarification on how CLAS plans will address disparities

DHCS Website



Medicaid Managed Care Final Rule

Background

On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid and CHIP Managed Care Final Rule (Final Rule), which aligns the Medicaid managed care program with other health insurance coverage programs in several key areas:

- Modernizes how states purchase managed care for beneficiaries;
- Adds key consumer protections to improve the quality of care and beneficiary experience; and
- Improves state accountability and transparency.

The Final Rule was the first significant overhaul of the federal Medicaid managed care regulations since 2002, which was a response to the predominant shift to managed care delivery system occurring nationwide. The Final Rule is effective July 5, 2016 with a phased implementation over several years. There were due dates prior to July 1, 2017.

In California, the Final Rule regulations are applicable to Medi-Cal Managed Care Plans, County Mental Health Plans, Drug Medi-Cal Organized Delivery System, and Dental Managed Care Plans. This webpage contains posting requirements for the Quality Strategy, Network Adequacy, an Mental Health Parity components of the Final Rule.

Customer Service Portal

This portal provides support to beneficiaries both prior to and after enrollment in medical and dental managed care.

Managed Care Quality Strategy

The Final Rule requires each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities within the state.

Network Adequacy

To strengthen access to services in a managed care network, the Final Rule requires states to establish network adequacy standards in Medicaid managed care for key types of providers, while leaving states the flexibility to set the actual standards.

Mental Health Parity

On March 29, 2016, CMS issued the Medicaid Mental Health Parity Final Rule (Parity Rule) to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Rule was intended to create consistency between the commercial and Medicaid markets.

Resources

- Final Rule Presentation Slides
- Mental Health Parity Presentation Slides

Additional Resources:

- CMS Medicaid Managed Care Final Rule
- CMS Guidance on the Medicaid Managed Care Final Rule
- CMS Mental Health Parity Final Rule

http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx

DHCS Website

Medi-Cal Managed Care Quality Strategy

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The Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule), at 42 Code of Federal Regulations 438.340, requires each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities in that state.

The Department of Health Care Services (DHCS) intends to provide an updated Managed Care Quality Strategy Report on an annual basis to capture any significant changes within a twelve month period. **DHCS is currently seeking public comment on the draft report. Questions and comments should be submitted to** publicinput@dhcs.ca.gov **no later than April 27, 2018**. Please note that any letters or feedback received may be posted on this webpage.

Proposed Medi-Cal Managed Care Quality Strategy Report **(Released March 28, 2018)**

This report describes California's Medicaid quality strategy, and how it meets the following requirements of the federal regulations:

- The State-defined network adequacy standards
- The State's goals and objectives for continuous quality improvement, a description of the quality metrics, performance targets, and performance improvement projects
- Arrangements for annual, external independent reviews
- A description of the State's transition of care policy
- The State's plan to identify, evaluate, and reduce health disparities
- Policies regarding sanctions and
- The State's definition of "significant change."

From 2004 through 2017, DHCS has published Managed Care Quality Strategy Reports for Medi-Cal managed care plans (MCPs) that are available on the Medi-Cal Managed Care – Quality Improvement & Performance Measurement Reports webpage. Beginning in 2018, the report encompasses quality strategies across all of California's Medicaid managed care delivery systems, including: i) MCPs; ii) County Mental Health Plans; iii) Drug Medi-Cal Organized Delivery Systems; and iv) Dental Managed Care plans.

http://www.dhcs.ca.gov/formsandpubs/Pages/ManagedCareQSR.aspx

Questions?