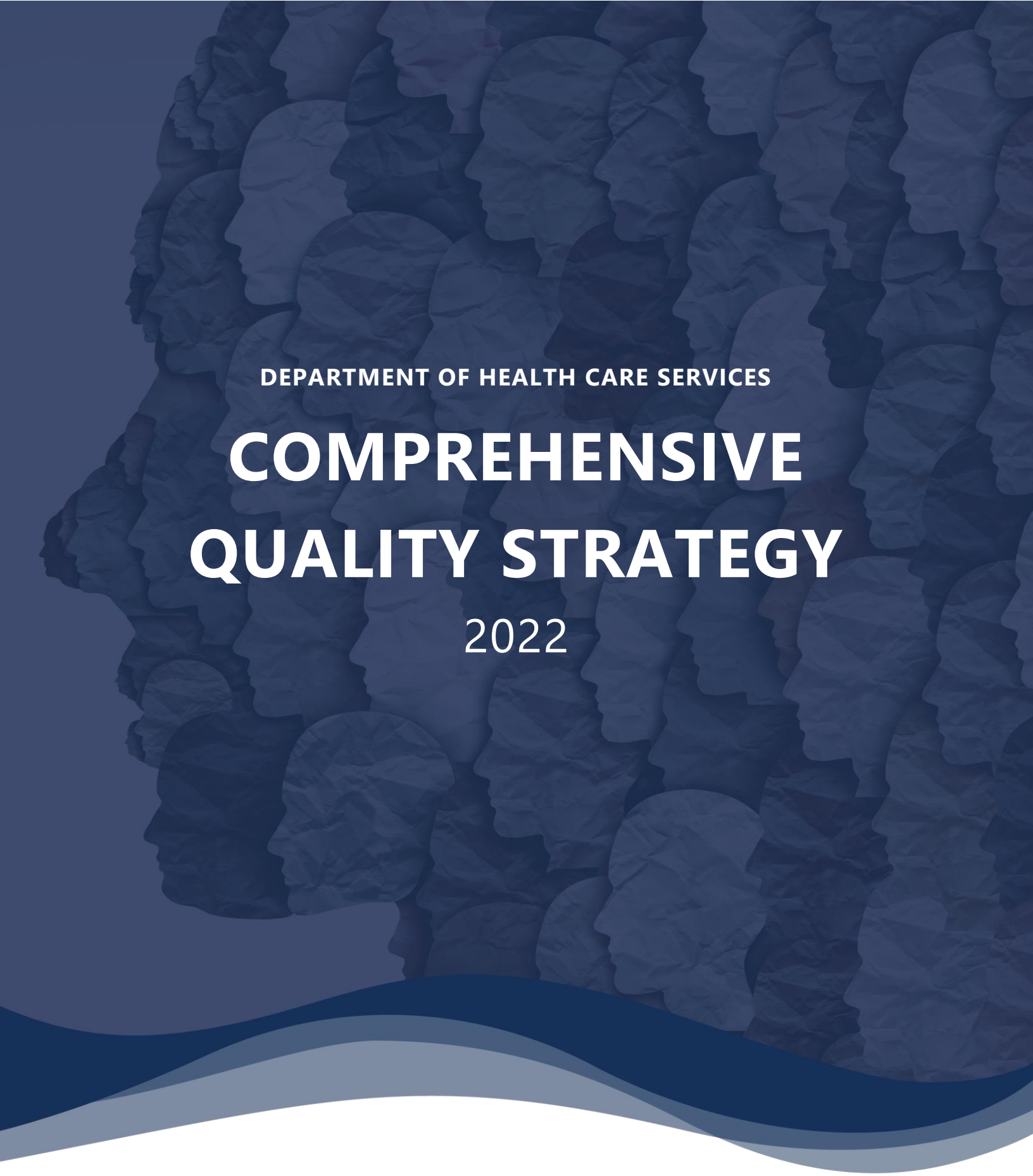


DEPARTMENT OF HEALTH CARE SERVICES

COMPREHENSIVE QUALITY STRATEGY

2022

DEPARTMENT OF HEALTH CARE SERVICES

Table of Contents

EXECUTIVE SUMMARY

The Department of Health Care Services' (DHCS) ten-year vision for the Medi-Cal program is that the people served by Medi-Cal should have longer, healthier, and happier lives. In this whole-system, person-centered, and population health approach to care, health care services are only one element of supporting better health in the population. Partnerships with Medi-Cal beneficiaries, communities, community-based organizations (CBO), schools, public health agencies, counties, and health care systems will be essential to preventing illness, supporting health care needs, addressing health disparities, and reducing the impact of poor health.

The COVID-19 public health emergency (PHE) has made DHCS' vision more relevant than ever. The pandemic's impacts, including a reduction by one and a half years in national life expectancy in 2020 (almost three years for Black and Latino communities), schools shifting to virtual instruction, job losses, risks for essential workers, and enormous stresses on public health and health care delivery systems, have been devastating. And yet, the pandemic also fostered unprecedented collaborations across silos, demonstrating the power of partnerships, especially in implementing COVID-19 testing, vaccination, and community education and outreach efforts. These partnerships can serve as models to help achieve DHCS' ten-year vision for Medi-Cal.

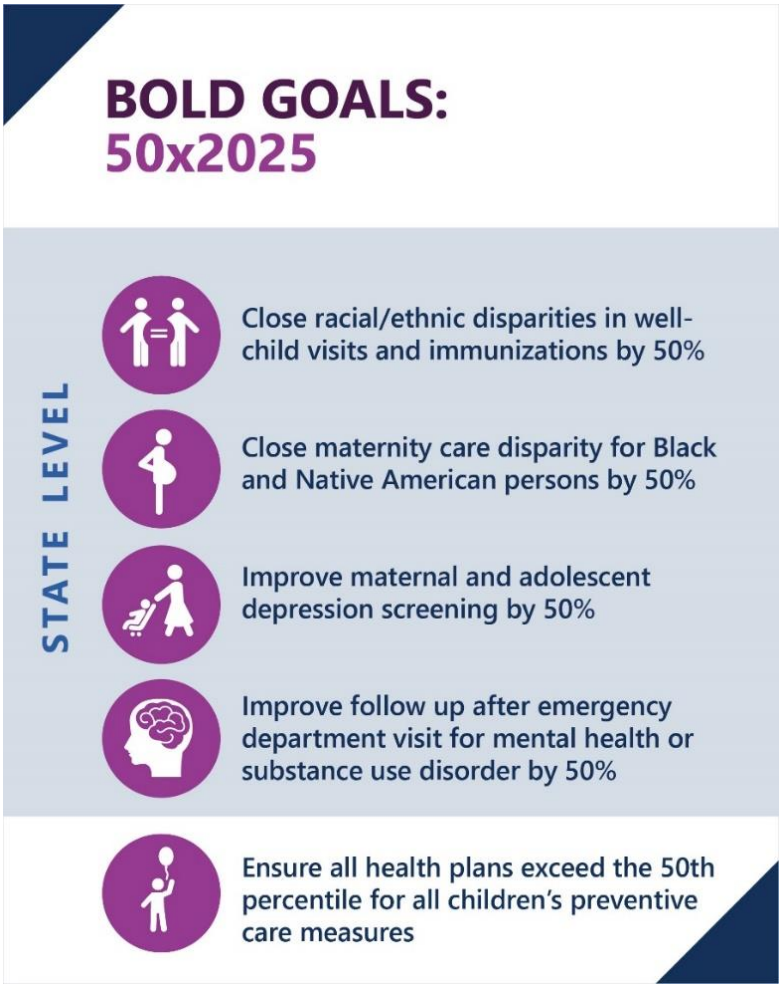
The 2022 DHCS Comprehensive Quality Strategy (CQS) lays out DHCS' quality and health equity strategy to support this vision. Section 1 of the CQS, in accordance with the Managed Care Final Rule, provides an overview of the Medi-Cal program and the quality management structure at DHCS, including the process for developing and reviewing the CQS.

Section 2 outlines DHCS' quality and health equity strategy. It incorporates and builds upon the policy framework outlined in CalAIM, and leverages the Home and Community-Based Services (HCBS) Spending Plan, upcoming Medi-Cal managed care procurement, and historic health investments in the fiscal year (FY) 2021-22 state budget to define a path for how we can ensure high-quality and equitable care for all Medi-Cal beneficiaries.

The CQS goals and guiding principles (summarized below) are built upon the Population Health Management (PHM) framework that is the cornerstone of CalAIM, and they stress DHCS' commitment to health equity, beneficiary involvement, and accountability in all of our programs and initiatives.

Section 2.3 of the CQS outlines the implementation of PHM, which aims to help all beneficiaries stay healthy via preventive and wellness services, identify and assess member risks to guide care management and care coordination needs, and identify and mitigate social drivers of health to reduce health care disparities. Coupled with PHM, the CQS outlines three clinical focus areas – children's preventive care, maternity care and birth equity, and behavioral health integration – that are designed to address the foundations of health (i.e., preventive efforts that have long-lasting impact from infants to seniors). Addressing child and maternal health and behavioral health for all populations will reduce chronic diseases and serious illnesses in the decades to come.

Section 2.4 of the CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' *Bold Goals: 50x2025* initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025. Additional high-priority goals with measurable targets are included for each managed care delivery system (Medi-Cal managed care, behavioral health, and dental). A complete set of all measures reported and tracked across Medi-Cal programs are available in **Appendix D**.



In order to achieve DHCS' vision of eliminating health care disparities, DHCS has defined needed improvements in data collection and stratification, workforce diversity and cultural responsiveness, and disparity reduction efforts. The Health Equity Roadmap in Section 2.5 shows DHCS' existing initiatives in each of these domains, and outlines gaps and questions that should only be answered with the involvement of Medi-Cal beneficiaries and communities most affected by health care disparities. DHCS will launch a Health Equity Roadmap co-design process in 2022 with individuals and communities to refine and build upon existing work, and to help DHCS complete a project plan for addressing key health disparities.

The CQS also introduces a set of priority clinical outcome metrics (a subset of its Medi-Cal managed care measures) that align with the priority areas of population health and clinical focus areas (colorectal cancer, high blood pressure, diabetes, prenatal and postpartum care, well-child visits, childhood and adolescent immunizations, and follow up for mental health and substance use disorder needs). These will also serve as health equity metrics, stratified by race and ethnicity, to inform disparity reduction efforts. Given that value-based payments (VBP) are an essential lever to support quality improvement and health equity efforts, these measures, along with member experience reviews and scores, will be incorporated into Medi-Cal managed care rates and

member-assignment algorithms in 2023. Additional VBP efforts are outlined in section 2.6 of the CQS and the 2024 managed care procurement Request for Proposal.

Lastly, Section 3 of the CQS outlines significant changes at DHCS in terms of its quality management structure and managed care monitoring and oversight activities. Specifically, DHCS is centralizing and elevating core quality and health equity functions under its new Quality and Population Health Management (QPHM) Program. It will also align and standardize managed care policies, as possible, across delivery systems, and institute standard, proactive monitoring strategies (including user-friendly public dashboards) to support transparency and accountability.

DHCS is unwaveringly committed to addressing quality and health equity in Medi-Cal, as described in this strategy. However, as the COVID-19 pandemic and national awakening to racial injustice have demonstrated, incremental improvements are insufficient. The transformative investments in Medi-Cal through California Advancing and Innovating Medi-Cal (CalAIM) and the FY 2021-22 state budget, coupled with the disruption of COVID-19 and a society-wide desire for change, offer us a unique opportunity to transform Medi-Cal and achieve high-quality, equitable health care for all. This will not be an easy journey. It will require significant transformation and partnerships at all levels, and in different ways than have been attempted before, to achieve the ambitious goals we have outlined in this strategy. We invite you to join us.

INTRODUCTION

1.1 Scope

The CQS provides a summary of the extensive work being done to assess and improve the quality and equity of health care covered by DHCS, as well as its vision for the future of quality and health equity in Medi-Cal. The CQS also provides a foundational Health Equity Roadmap for DHCS, which will be revised and strengthened through a public co-design process in 2022 to ensure that health equity is embedded in all DHCS activities, with measurable targets for reducing health disparities across all programs.

The CQS serves as an update to the 2018 Medi-Cal Managed Care Quality Strategy Report, which was limited to quality in managed care programs. The revised 2022 CQS serves as a broader quality strategy to encompass all DHCS quality activities, while meeting the requirements of 42 Code of Federal Regulations (CFR) 438.340, as amended, under the Managed Care Final Rule. The revised strategy:

- Provides an overview of all DHCS health care, including managed care, fee-for-service (FFS), and other programs.
- Includes overarching quality and health equity goals, with program-specific objectives.
- Reinforces DHCS' commitment to health equity in all program activities.
- Provides a review and evaluation of the effectiveness of the 2018 Managed Care Quality Strategy (see **Appendix E**), which provided the foundation for many of the changes and revised approach described in the 2022 CQS.

The CQS has also been significantly revised since the previous draft that was posted for public comment in November 2019 as a result of the COVID-19 PHE. While the State of California enacted one of the nation's earliest stay-at-home orders that helped to substantially curb COVID-19 transmission, DHCS, its managed care plans, and the health care delivery system needed to quickly pivot to meet the COVID-19 related needs of members and modify its programs to prioritize access and safety. With the help of several federal COVID-19 PHE regulatory waivers and additional resources, the Medi-Cal program was able to: provide COVID-19 testing, treatment, and vaccine coverage and services; launch a $350 million COVID-19 Vaccination Incentive Program; and provide flexibilities (including telehealth payment parity) to improve access to medical and behavioral health treatment, ensure Medi-Cal coverage, and increase support for Medi-Cal home and community-based programs. The COVID-19 PHE has fundamentally

altered how DHCS envisions health equity, quality, and health policy moving forward, and these changes are reflected in this strategy.

Also incorporated in the CQS' Quality Improvement section are details about the CalAIM initiative, which encompasses broader delivery system, program, and payment reform across the Medi-Cal program. While conceived with extensive stakeholder engagement prior to the COVID-19 PHE, CalAIM's goals are even more relevant as we emerge from the pandemic. The goals have been strengthened with support from additional historic investments in the 2021-22 state budget and the HCBS Spending Plan.[1] This transformational work will support DHCS' efforts to drive quality outcomes and reduce health disparities, and it is woven into our CQS.

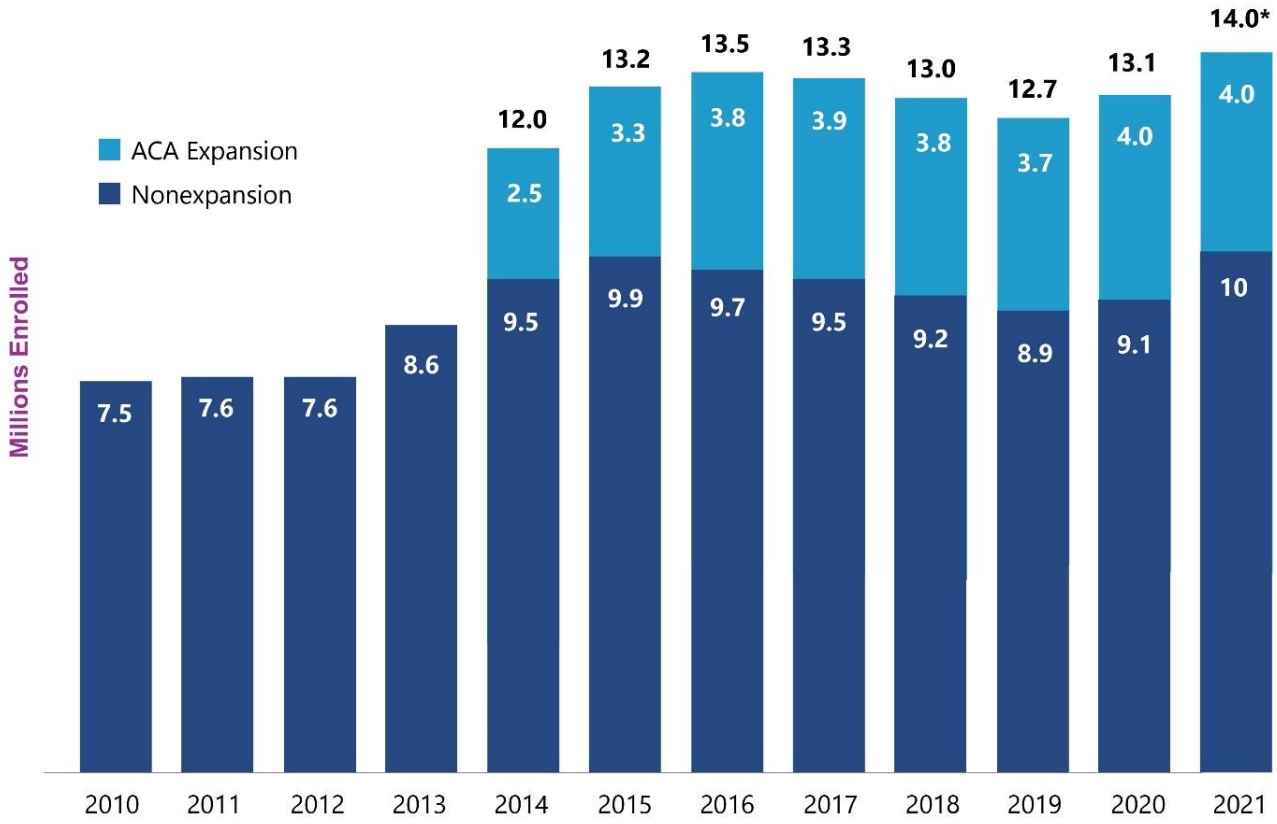
1.2 Medi-Cal Program Overview

DHCS is the single state agency responsible for the administration of Medi-Cal, California's Medicaid and Children's Health Insurance Program (CHIP), which provides comprehensive health care coverage at no or low cost for approximately 14 million low-income individuals, or one in three Californians. With an annual budget of approximately $129 billion, DHCS is the largest health care purchaser in California.

DHCS also provides state-funded full-scope Medi-Cal to young adults and children under age 26 who would otherwise be ineligible for full-scope Medi-Cal because of their immigration status. Beginning in May 2022, DHCS will expand full-scope Medi-Cal coverage to adults 50 years of age and older who would otherwise be ineligible for full-scope Medi-Cal because of their immigration status. Thanks to the Affordable Care Act's Medicaid expansion and these other policy changes, Medi-Cal enrollment has steadily grown over the last decade (see Figure 1), dramatically reducing the number of uninsured Californians. Details of this expansion, by specific groups and federal requirements, is outlined in Figure 2.

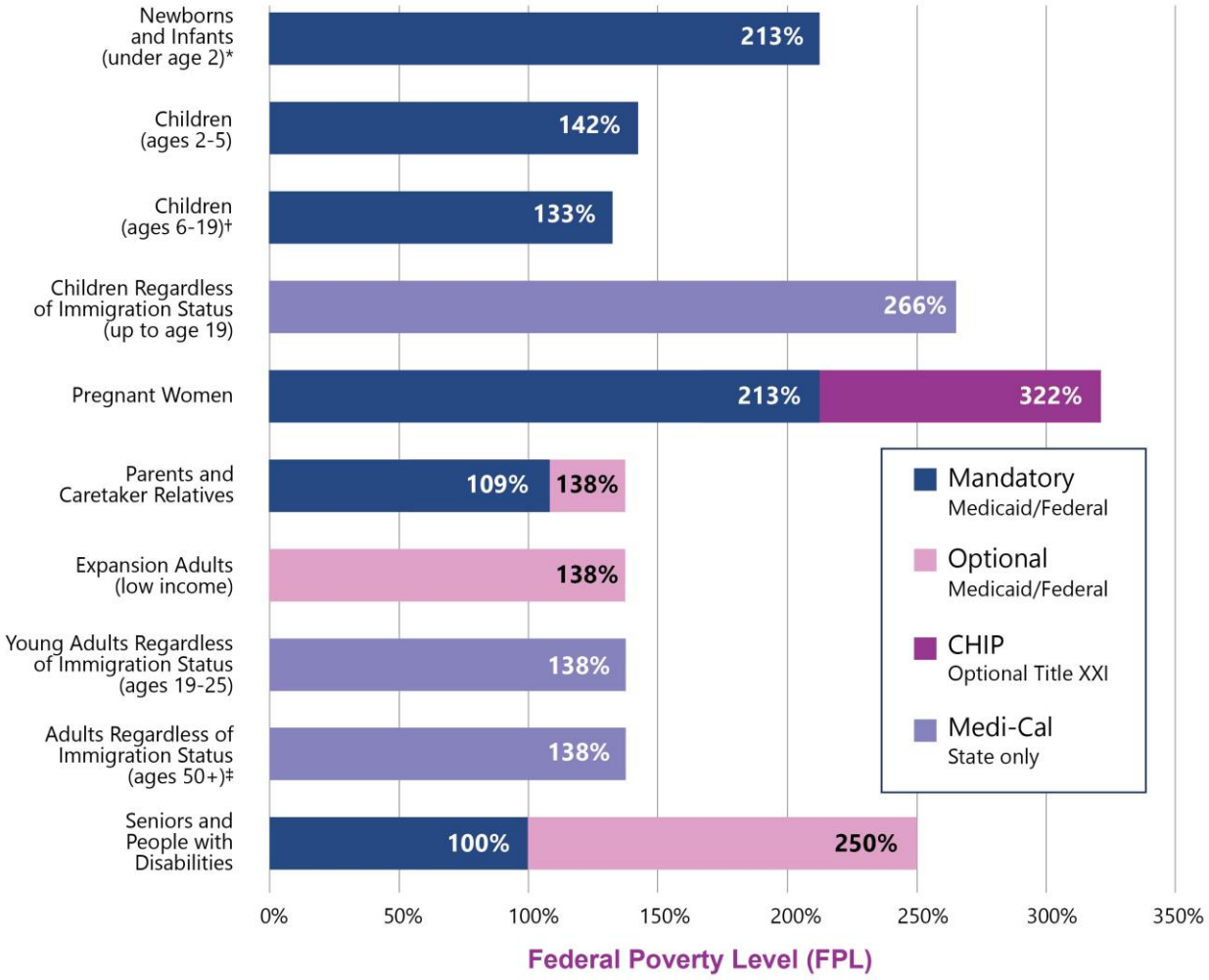
[1] Policy details of CalAIM and the HCBS Spending Plan are not required to be included in the CQS by 42 CFR 438.340, as amended, under the Managed Care Final Rule, but are incorporated given their vital role in the Medi-Cal program and impact on quality and health equity.

Figure 1: Medi-Cal Enrollment, 2010-2021



*2021 enrollment data reflects enrollment through June 2021.
Note: Enrollment month is November of each year.
Sources: Month of Eligibility, Aid Category by County, Medi-Cal Certified Eligibility, DHCS, November 25, 2020; and Medi-Cal Enrollment Update, DHCS, April 8, 2021

Figure 2: Medi-Cal Income Thresholds



Note: CHIP is the Children's Health Insurance Program, which is part of the Medi-Cal program.
* Medicaid requires mandatory coverage of newborns and infants up to age 1 and up to 213% FPL. Title XXI allows states the option to cover newborns and infants under age 2 and up to 322% FPL.
† 5% income disregard doesn't apply.
‡ Effective in 2022.
Sources: "California Medicaid Eligibility Groups by Medi-Cal Aid Code," California Health & Human Services Agency, accessed October 22, 2020; All County Letter Welfare Letter 20-03 (PDF), DHCS, February 5, 2020; Program Eligibility by Federal Poverty Level for 2021, Covered California, accessed October 18, 2020; and "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," Kaiser Family Foundation (KFF), March 26, 2020.

Nearly 12 million individuals are covered through Medi-Cal's managed care delivery system[2], which consists of:

- Medi-Cal Managed Care (MCMC)
- Cal MediConnect (CMC) Financial Alignment Initiative
- Dental Managed Care (Dental MC)
- Specialty Mental Health Services (SMHS) Program
- Drug Medi-Cal Organized Delivery System (DMC-ODS)

As a part of CalAIM, on June 30, 2021, DHCS submitted a 1915(b) waiver renewal to CMS to consolidate Medi-Cal managed care delivery system programs currently authorized under California's Medi-Cal 2020 Section 1115(a) demonstration—MCMC, Dental MC, and DMC-ODS—with SMHS under the 1915(b) waiver in 2022. Also, as a part of CalAIM, DHCS will transition the CMC initiative, currently in seven counties, to a Dual Eligible Special Needs Plan (D-SNP) Exclusively Aligned Enrollment structure in 2023. Alignment of all managed care authorities will enable DHCS to simplify California's Medi-Cal managed care delivery system and advance the goal of improving health outcomes and reducing health disparities for Medi-Cal beneficiaries, as well as lay the groundwork for full integration plans that offer integrated physical, behavioral, and dental health benefits. Full details of each managed care plan are provided in **Appendix B**.

In addition to managed care, Medi-Cal members also receive care through FFS Medi-Cal, Indian Health Services, and several 1915(c) HCBS waiver programs tailored to meet specific population needs. DHCS has also developed additional focused programs to meet specific health care needs of complex and vulnerable populations, including California Children's Services (CCS), which serves children with complex medical conditions, the Program of All-Inclusive Care for the Elderly (PACE), and In-Home

[2] For purposes of the Managed Care Final Rule requirements, MCMCs and Dental MC plans are Managed Care Organizations (MCO), and SMHS and DMC-ODS plans are Prepaid Inpatient Health Plans (PIHPs). COHS plans are considered Health Insuring Organizations (HIO), but are held to the same requirements as MCOs per the DHCS/MCMC contract.

Supportive Services (IHSS). Collectively, these programs are designed to meet the full spectrum of member needs. These programs are described below.

Medi-Cal Managed Care (MCMC)

MCMC is the foundational delivery system that provides coverage for physical health and non-specialty mental health services for approximately 84 percent of the Medi-Cal population through Medi-Cal managed care plans. MCMC operates in all 58 counties in the state through six MCMC models that vary by county or region (two of these models, Imperial and San Benito, will sunset in 2023).

- **County Organized Health System (COHS) or Single Plan Model:** Beneficiaries are served by a single plan that is created and administered by a county board of supervisors or a local health authority.
- **Two-Plan:** Beneficiaries choose between a single publicly run entity, known as a local initiative plan, and a single commercial plan.
- **Geographic Managed Care (GMC):** Beneficiaries choose from multiple commercial plans.
- **Regional:** Beneficiaries choose between two or more commercial plans operating in two or more contiguous counties as one service area.
- **Imperial:** Beneficiaries in Imperial County choose between two commercial plans.
- **San Benito:** Beneficiaries choose between a single commercial plan and Medi-Cal FFS.

DHCS is currently restructuring the MCMC contract, and will release a Request for Proposal (RFP) for commercial MCMCs statewide in February 2022. The managed care procurement and updated standard contract demonstrates a shift in expectations for the MCMCs and will be a primary vehicle by which DHCS will ensure quality, transparency, and accountability in the managed care program. The implementation date for new commercial health plan contracts is January 1, 2024. In addition, effective January 1, 2024, DHCS will move from multiple model contracts to one standard model contract for all MCMCs, including Local Initiatives and COHS. Using the same restructured contract for all plan models will better enable DHCS to standardize requirements and monitoring processes across all counties and for all managed care

plan model types.[3] Seventeen counties have currently been conditionally approved to move forward to change their county MCMC model. If these conditional approvals meet DHCS requirements and contracts are successfully executed, DHCS anticipates four county plan models to be in effect on January 1, 2024: Regional (expansion); COHS; Two-Plan; and GMC, with a majority of counties in COHS. Previously, most Medi-Cal children, pregnant people, and parents/caretaker relatives were required to enroll in MCMC to access services. As of January 2022, all other non-duals[4] across the Medi-Cal populations will be mandatorily enrolled into MCMC (mandatory enrollment is authorized under a 1915b waiver). American Indian and Alaska Native beneficiaries, individuals eligible for Medicare and Medi-Cal (dual eligibles) in certain counties (until 2023), foster children and foster youth in non-COHS counties, and all beneficiaries in San Benito County (until 2024) have the option, but are not required, to enroll in MCMC (voluntary enrollment).

MCMC covers most Medi-Cal State Plan services, including primary and specialty care, as well as non-SMHS for beneficiaries with mild-to-moderate functional impairments.[5] Services not covered under MCMC include SMHS, most substance use disorder (SUD) services, and, in some counties, long-term care (LTC). Effective January 1, 2022, San Mateo County members will receive dental services as a benefit delivered through the COHS health plan. As part of CalAIM, in 2023, LTC services and dually eligible beneficiaries (except those with non-LTC share of cost) will be covered under MCMC statewide. In 2026, the state intends to have the Dual Eligible Special Needs Plan (D-SNP) Exclusively Aligned Enrollment model available statewide, and by 2027, will transition to statewide managed long-term services and supports (MLTSS) to advance its goals of whole-person care and aligned managed care delivery systems.

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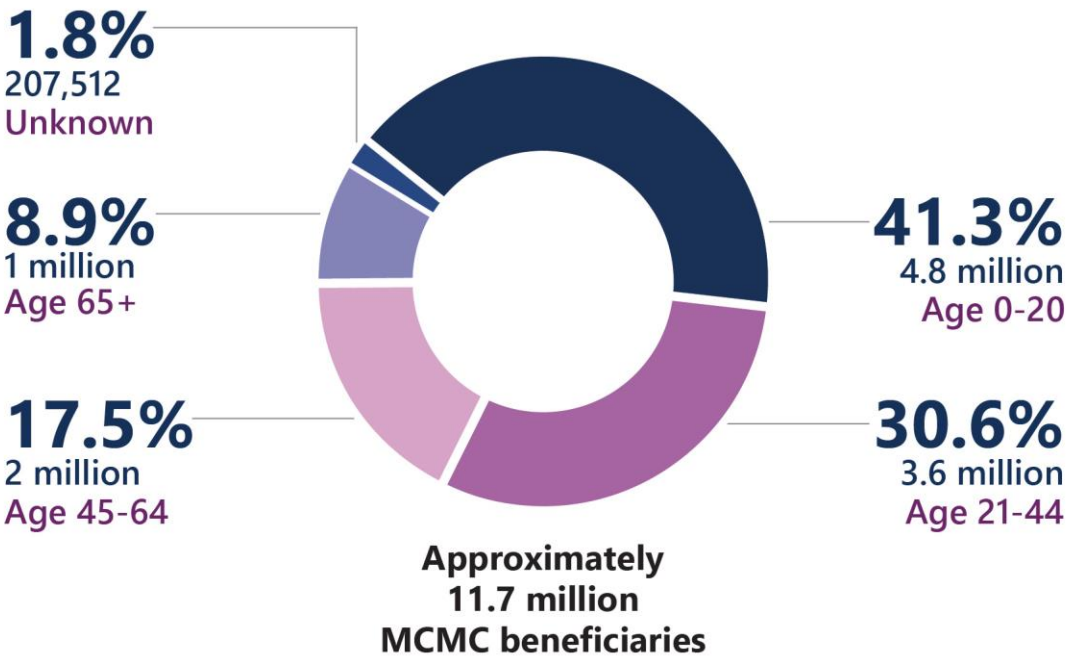
[3] MCMC boilerplate contracts are available on the MCMC Boilerplate Contracts webpage.
[4] This also includes other populations, such as Trafficking and Crime Victims Assistance Program (TCVAP), individuals enrolled in Accelerated Enrollment, and beneficiaries who were formerly in FFS that reside in rural zip codes and have other health care coverage.
[5] Pursuant to Executive Order N-01-19, the state is in the process of carving out pharmacy benefits from MCMCs as a component of the Medi-Cal Rx initiative.

As of June 2021, there were approximately 11.7 million MCMC beneficiaries.[6] This is an increase of almost 5.7 million beneficiaries since 2013. The demographic breakdown of the managed care population is summarized below in Figures 3, 4, 5, and 6. Detailed information regarding the breakdown of membership by MCMC is in the DHCS MCMC Enrollment Reports.[7]

Figure 3: Medi-Cal Managed Care Demographics—Children and Adults



[6] Medi-Cal Managed Care Performance Dashboard; Enterprise Performance Monitoring System-Managed Care Monitoring Excel Interface (Date Represented: April 2021)

[7] Medi-Cal Managed Care Enrollment Report

Figure 4: Medi-Cal Managed Care Demographics—Gender

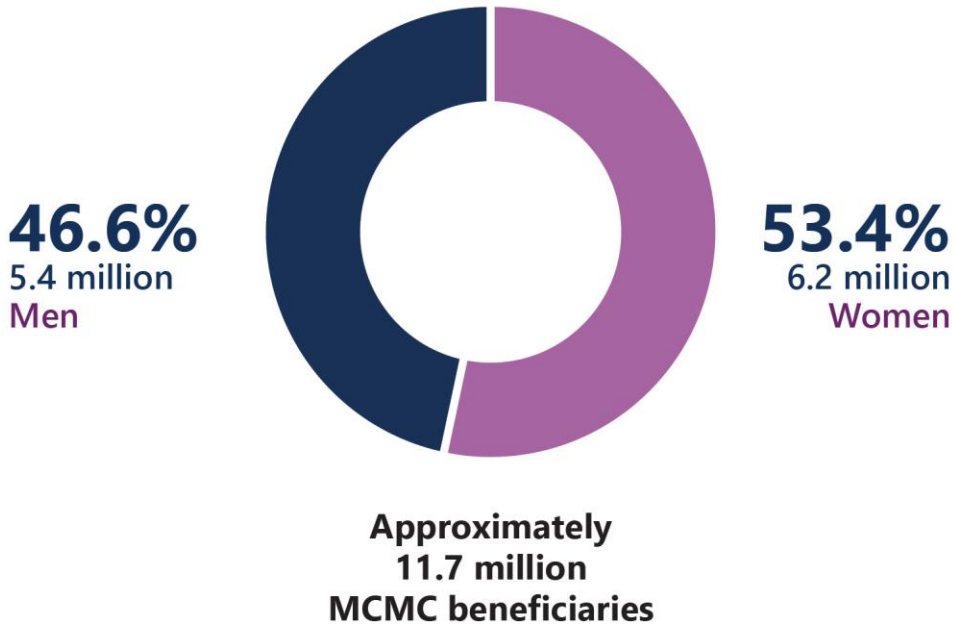


Figure 5: Medi-Cal Managed Care Demographics—Race/Ethnicity

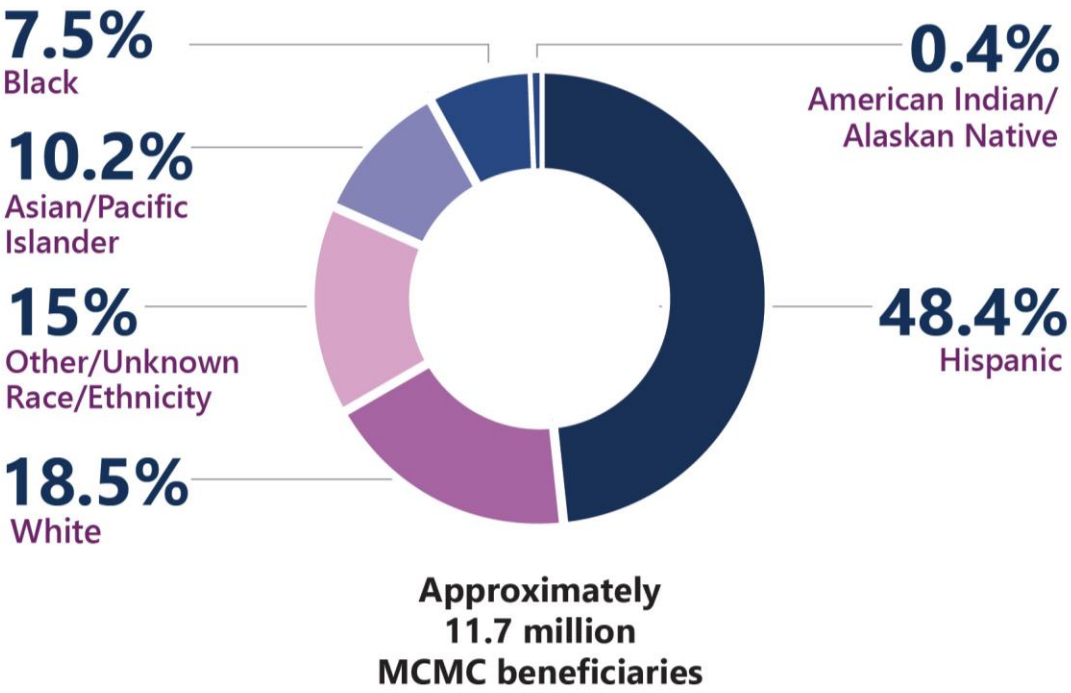
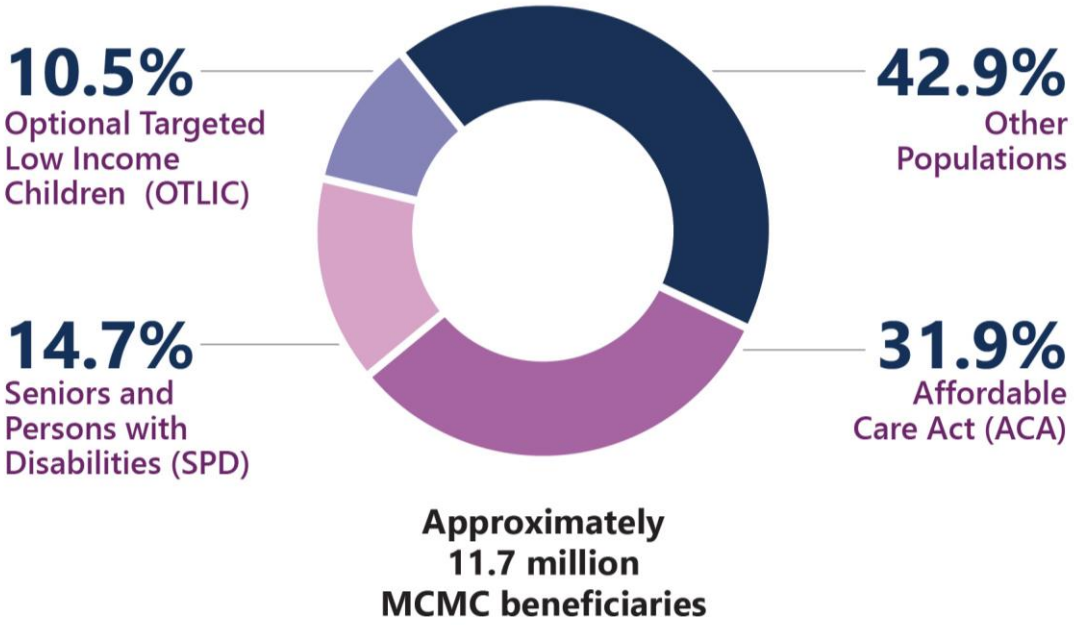


Figure 6: Medi-Cal Managed Care Demographics—By Aid Code Groups



Additionally, as a part of CalAIM, DHCS' 1915(b) waiver renewal submission seeks to:

- Require additional populations to enroll in MCMC (as described above and including nearly all dual eligibles in 2023).
- Further standardize benefits offered across California's managed care delivery system.[8]

These enrollment changes are the foundation of the CQS, as reduced administrative complexity, integrated whole person care, and improved care coordination through managed care are key drivers for quality and health equity efforts. This transition is

[8] DHCS intends to carve out the Multipurpose Senior Services Program (MSSP), which is currently carved in to MCMC in Coordinated Care Initiative (CCI) counties, to FFS effective 2022, and SMHS from the MCMC benefit package for certain Medi-Cal members enrolled in Solano and Sacramento counties no sooner than July 2022. DHCS intends to carve in to the MCMC benefit package statewide major organ transplants by 2022 and institutional LTC services (e.g., skilled nursing facilities, pediatric/adult subacute care, and disabled/rehabilitative/nursing services) by 2023.

particularly important for the vulnerable coverage groups that currently lack adequate case management and care coordination services in the FFS delivery system. The standardization of benefits will ensure that regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have access to the same set of benefits through MCMC, a critical change to ensure continuity of health care, especially as beneficiaries switch plans or move across county lines. In particular, the managed care carve-in of long-term care (LTC), as well as the enrollment in Medi-Cal managed care of dually eligible beneficiaries in the remaining 31 rural, Bay Area, and Central Valley counties (LTC is already available in 17 counties), will promote DHCS' goals related to improved coordination of care, health outcomes, and quality of care.

Cal MediConnect (CMC) and Dual Eligible Special Needs Plan (D-SNP) Exclusively Aligned Enrollment

Implemented in 2014, CMC is a state-federal partnership to provide dually eligible Medicare-Medicaid enrollees with a coordinated, person-centered care experience across both programs.

Under CMC, DHCS and the Centers for Medicare & Medicaid Services (CMS) contract with Medicare-Medicaid Plans (MMP) to coordinate the delivery of and be accountable for covered Medicare and Medicaid services for approximately 115,000 participating dually eligible enrollees in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Dually eligible members not enrolled in CMC navigate multiple sets of rules, benefits, insurance cards, and providers (Medicare Parts A and B, Part D, and Medicaid). Many dually eligible members suffer from multiple or severe chronic conditions and could benefit from better care coordination and management of health and long-term supports and services. Under CMC, MMPs are responsible for providing a comprehensive assessment of Medicare-Medicaid enrollees' medical, behavioral health, long-term services and supports, functional, and social needs. Medicare-Medicaid enrollees and their caregivers work with an interdisciplinary care team to develop person-centered, individualized care plans. CMC is designed to offer opportunities for beneficiaries to self-direct services, be involved in care planning, and live independently in the community.

As of January 1, 2023, CMC enrollees will transition to Medicare D-SNPs and affiliated MCMC plans in a D-SNP Exclusively Aligned Enrollment approach that DHCS is

developing with CMS and stakeholders. The D-SNP Exclusively Aligned Enrollment approach is similar to CMC in that one entity is financially responsible for both Medicare and Medi-Cal benefits, with integrated member materials, benefit coordination, and beneficiary and provider communication. DHCS intends to expand the D-SNP Exclusively Aligned Enrollment approach to additional counties in 2026.

Dental Managed Care (Dental MC)

Dental services have been provided through Dental MC in two California counties since 1995—Sacramento (mandatory enrollment, authorized under an 1115 waiver) and Los Angeles (voluntary enrollment, authorized under a 1915(a) waiver). Members have the option of choosing from three Dental MC plans in each county. In the remaining counties, dental services are available through FFS. Members receive dental services from dentists within the plan's provider network, and are eligible for the same scope of benefits as members who access services through the dental FFS delivery system. As of July 2021, approximately 885,682 Medi-Cal members are enrolled in Dental MC.[9]

Specialty Mental Health Services (SMHS) Program

SMHS are currently provided by 56 county mental health plans (MHP) covering all 58 counties, including two joint-county arrangements in Sutter/Yuba and Placer/Sierra. This model has been in place since 1995 under the authority of a 1915(b) waiver. County MHPs are required to provide or arrange for the provision of SMHS to adult and children beneficiaries in their counties who meet SMHS criteria, consistent with beneficiaries' mental health treatment needs and goals. The SMHS boilerplate contract is available on the DHCS website. The SMHS program has evolved through numerous renewals to the state's current 1915(b) waiver for SMHS and other policy changes, as described in the current renewal application.

County MHPs must provide outpatient services in the least restrictive community-based settings.

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[9] Source: DHCS Data Warehouse Dental Dashboard July 2021 Update. Enrollment includes Medi-Cal members continuously enrolled for at least three months within the same plan during CY 2020.

SMHS include:[10]

- Medication Support Services
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment
- Crisis Residential Treatment Services
- Psychiatric Health Facility Services
- Intensive Care Coordination
- Intensive Home-Based Services
- Therapeutic Foster Care Services
- Therapeutic Behavioral Services
- Targeted Case Management
- Psychiatric Inpatient Hospital Services
- Peer Support Specialist Services (as of July 2022)

Nearly 260,000 children and youth received SMHS between July 2019 and June 2020. The demographics of these children and youth are summarized below in Figures 7, 8, and 9:

[10]Certain SMHS are not Medicaid State Plan Services, as services provided through Medicaid Early and Periodic Screening, Diagnostic, and Treatment are covered whether or not they are included in the Medicaid State Plan. Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Foster Care Services, and Therapeutic Behavioral Services are available to Medi-Cal beneficiaries up to age 21 if medically necessary and not included in the State Plan.

Figure 7: Medi-Cal SMHS—Children by Age

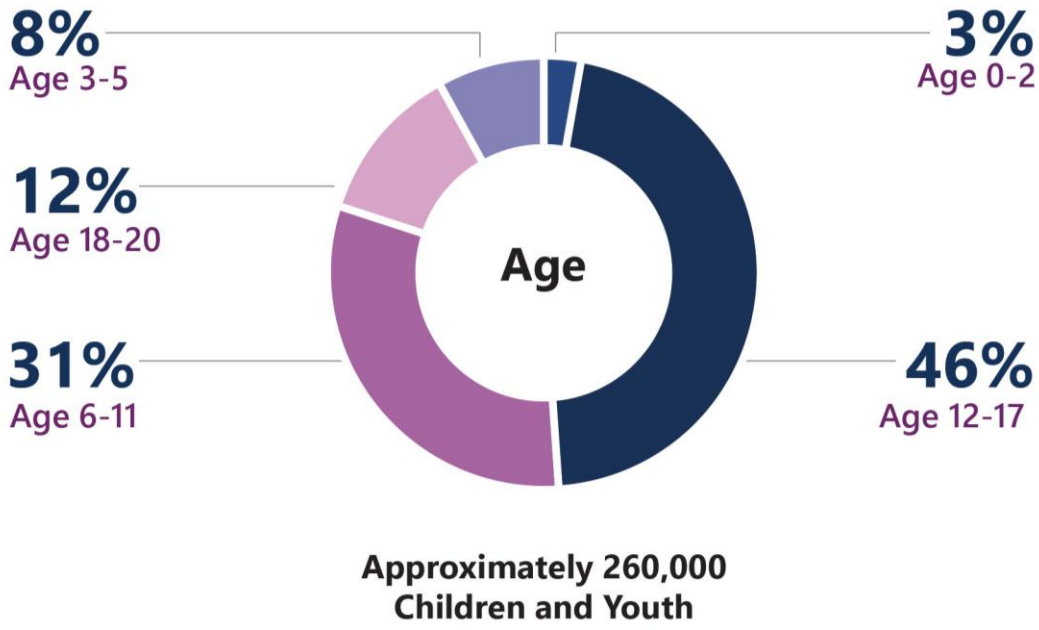
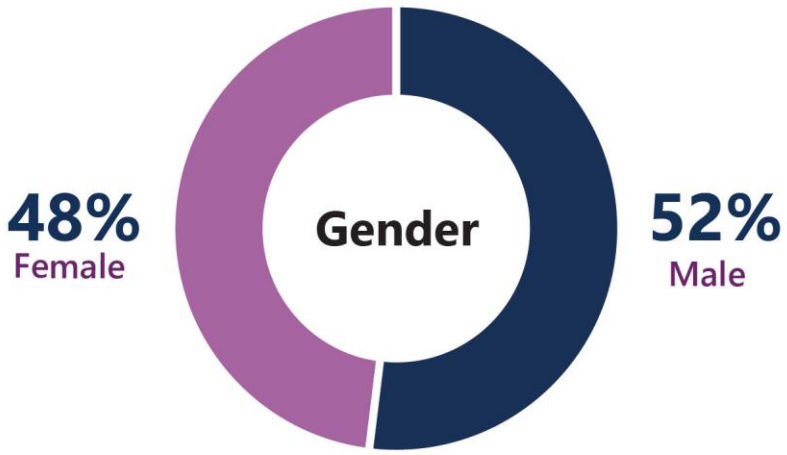
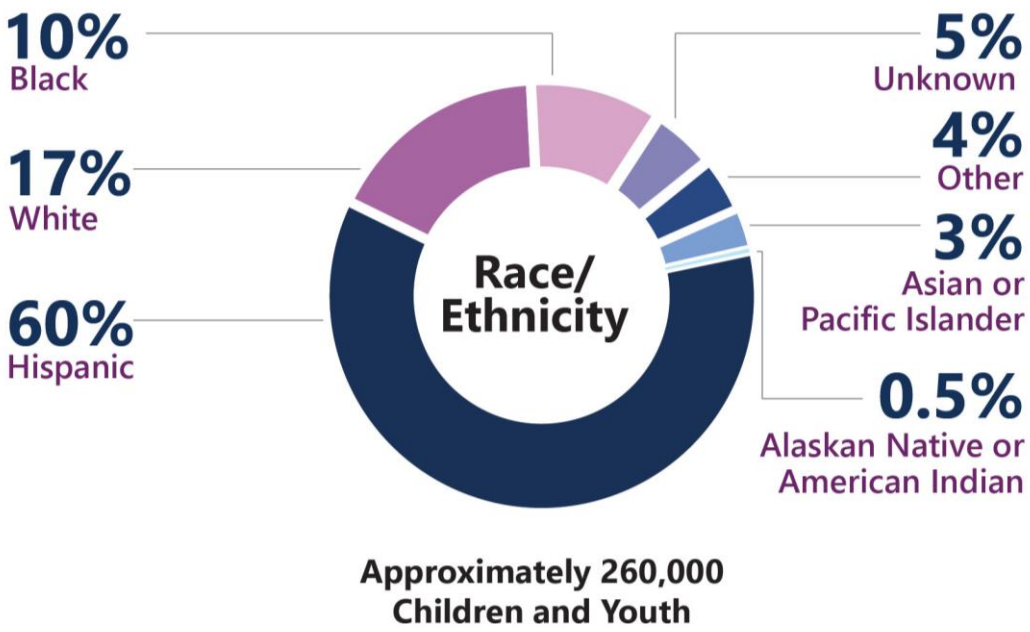


Figure 8: Medi-Cal SMHS—Children by Gender



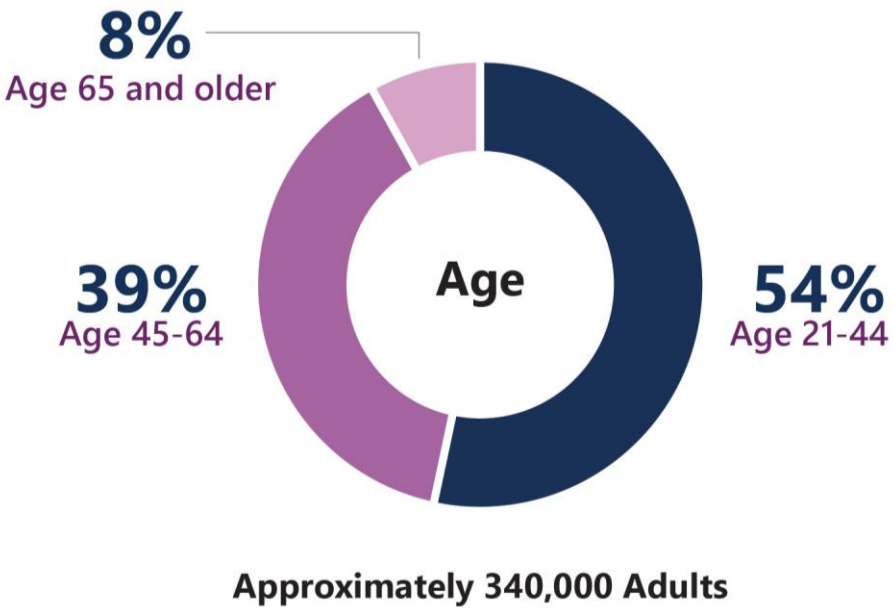
Data on other genders not available

Figure 9: Medi-Cal SMHS—Children by Race/Ethnicity



Nearly 340,000 adults received SMHS between July 2019 and June 2020. The demographics of these adults are summarized below in Figures 10, 11, and 12:

Figure 10: Medi-Cal SMHS—Adults by Age*



*The total percentage adds up to 101% due to rounding; actual numbers for each age category are as follows: Ages 21-44: 53.8%; Ages 45-64: 38.7%; Ages 65+: 7.5%.

Figure 11: Medi-Cal SMHS—Adults by Gender

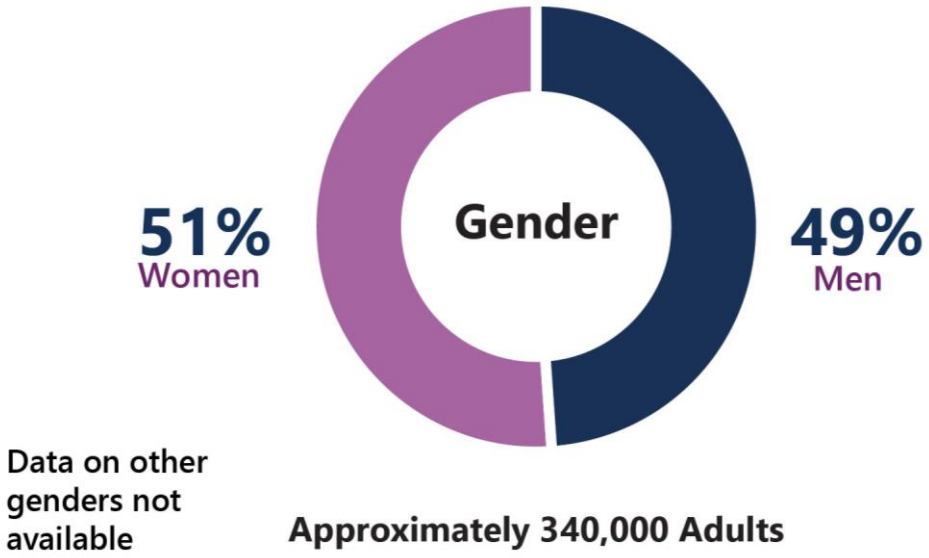
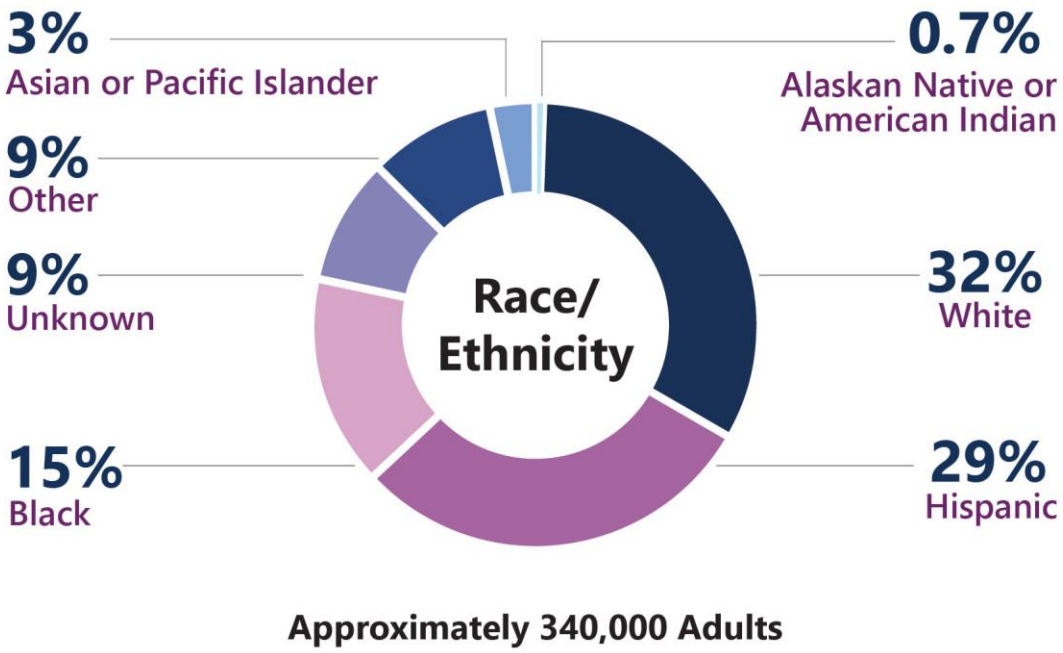


Figure 12: Medi-Cal SMHS—Adults by Race/Ethnicity



DHCS has proposed in its current 1915(b) renewal to add peer support specialist services as a new SMHS in order to promote client recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer support specialists will support California's effort to promote health equity by providing culturally competent services to promote recovery and enhanced access to care across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and geographic regions.

DHCS is also making programmatic changes to improve access to care and support a "no wrong door" approach so beneficiaries receive needed services wherever they enter the delivery system. DHCS is clarifying that treatment services are reimbursable prior to formal diagnosis and in the presence of an SUD; streamlining screening, assessment, and transitions between delivery systems and documentation processes; and implementing payment reform, moving from a cost-based to a rate-based reimbursement approach to support improved quality reporting and future alternative payment models.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

Since 2015, California counties have had the option to participate in the DMC-ODS (under the Section 1115 demonstration) to provide Medi-Cal beneficiaries who reside in their county with a range of evidence-based SUD treatment services, in addition to services available at the time under the Medi-Cal State Plan. To date, 37 of California's 58 counties have implemented DMC-ODS, covering 96 percent of the total Medi-Cal population statewide. DHCS is engaging with prospective new counties to participate in DMC-ODS, with the goal of eventually expanding DMC-ODS services to Medi-Cal beneficiaries in all counties, and has included transitioning most elements of this program to the 1915(b) waiver in its most recent waiver renewal submission. The DMC-ODS boilerplate contract and other information on the program is available on the DHCS website.

The goal of DMC-ODS is to demonstrate how organized SUD care can lead to higher value (improving health outcomes while decreasing costs) by providing a continuum of care modeled after the American Society of Addition Medicine (ASAM) criteria for SUD treatment services. Providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse

Prevention, Trauma-Informed Treatment, and Psycho Education. Medication for addiction treatment, also known as medication-assisted treatment (MAT), is available at all levels of care as a component of all services below.

DMC-ODS services include:

- Early Intervention
- Outpatient Treatment
- Intensive Outpatient Treatment
- Residential Treatment
- Partial Hospitalization (optional)
- Opioid Treatment
- Case Management
- Physician Consultation Services
- Telehealth
- Recovery Support Services
- Peer Support Specialist Services (as of July 2022)

As part of CalAIM, DHCS is proposing several policy improvements to DMC-ODS, including:

- Integrating participating DMC-ODS and MHPs to have a unified behavioral health administrative structure by 2027. This would better facilitate the delivery of integrated treatment for beneficiaries with mental health and SUD diagnoses, and streamline administrative burdens for counties and the state.
- Adding contingency management services (use of motivational incentives along with behavioral health treatment) – part of the HCBS Spending Plan – as another evidence-based practice and a critically needed treatment option for beneficiaries with stimulant use disorder, for which there is no available pharmacotherapy treatment.
- Providing access to traditional healers and natural helpers as culturally specific evidence-based practices for Tribal 638 and urban clinics to provide culturally appropriate SUD services and supports.

Indian Health Services

California is home to more people of Native American/Alaska Native heritage than any other state in the country, with 109 federally recognized Indian tribes.[11] The health status of California Native American/Alaska Natives is recognized as among the lowest of any ethnic group in the state, with higher prevalence rates of infant mortality, asthma, poor perinatal outcomes, substance use disorders, diabetes, and other chronic diseases, compared to that of the general population, as well as having a disproportionate impact from COVID-19.

DHCS regularly seeks advice from designees of Indian Health Programs (IHP) and Urban Indian Organizations on matters having a direct effect on Indians, IHPs, or Urban Indian Organizations as required by the American Recovery and Reinvestment Act of 2009 (ARRA). DHCS also recently established the Office of Tribal Affairs to serve as the principal entity in the Department to facilitate early engagement on policy initiatives and to collaborate in addressing the significant health disparities in this population.

DHCS administers the MCMC program in accordance with federal and state laws and regulations,[12] which includes special protections for American Indians in managed care. DHCS issued All Plan Letter (APL) 17-020 to provide guidance to plans regarding the requirement to attempt to contract with Indian Health Centers (IHC).

FFS and Other Programs

There are a number of Medi-Cal delivery systems that operate outside of managed care and instead operate on a FFS basis, governed by Section 1902(a)(30)(A) of the Social Security Act.[13] These programs are critical to DHCS' overall approach to quality and health equity for our beneficiaries, and are described briefly below.

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[11] Tribal FAQs

[12] Code of Federal Regulations (CFR) at 42 CFR 438
State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval

[13] Medi-Cal FFS and other programs are not required to be included in the CQS by Code of Federal Regulations (CFR) 42 CFR 438.340, as amended, under the Managed Care Final Rule, but are incorporated given their vital role in the Medi-Cal program and impact on quality and health equity.

These FFS programs include:

- Full or restricted scope FFS Medi-Cal: As of January 2022, the remaining populations in FFS will be the restricted scope population, individuals in the state or county inmate programs, share-of-cost individuals, and individuals enrolled in presumptive eligibility programs. Once dual eligible members transition to managed care enrollment in 2023, approximately 9 percent of Medi-Cal beneficiaries will remain in FFS.
- Dental FFS: Statewide (except two counties) dental delivery supported by a contracted Administrative Services Organization and a Fiscal Intermediary that support the provision of dental benefits and provider enrollment and payments.
- DMC State Plan: For counties not participating in DMC-ODS, this program provides a more limited set of SUD treatment services.
- Services currently carved out of MCMC to FFS[14] (note, LTC will be carved in as part of CalAIM in 2023):
    - California Children's Services (CCS) (unless Whole Child Model counties; details below)
    - LTC in certain counties

DHCS also supports a number of other programs that provide high-quality, equitable care, especially to specific populations. These include:

- **In-Home Supportive Services (IHSS):** A personal care services program with 520,000 IHSS providers serving 600,500 eligible aged, blind, and disabled individuals as an alternative to out-of-home care, enabling recipients to remain safely in their own homes.
- **California Children's Services (CCS):** A program for children and youth under 21 years of age with specific CCS-eligible medical conditions (e.g., cancer, diabetes, cerebral palsy, congenital heart defect, sickle cell disease, hearing loss,

[14]Of note, SMHS and DMC-ODS services are carved out of MCMC, but delivered through their respective county-based managed care plans, as described in the MCMC section above. Organ transplants and outpatient pharmacy benefits used to be carved out, but are carved in to MCMC, effective January 1, 2022.

and cystic fibrosis) that provides coverage for medical diagnosis and treatment services, medical case management, and physical and occupational therapy.

» **Program of All-Inclusive Care for the Elderly (PACE):** A comprehensive medical and social service delivery system using an interdisciplinary team approach that provides and coordinates all needed preventive, primary, acute, and LTC services.

» **California Community Transitions (CCT)** is California's Money Follows the Person (MFP) Rebalancing Demonstration program. CCT provides residents of LTC institutions, who want to return to live and receive LTSS at home or in a community-based setting, with transition and care planning services from experienced transition coordination staff employed by CCT lead organizations. Under CCT, beneficiaries who are transitioned to the community receive 365 days of post-transition follow-up care to ensure the HCBS care plan meets their nursing facility level of care needs in the community.

» **1915(c) HCBS Waivers:** Provide long-term, community-based services and supports to Medi-Cal-eligible beneficiaries in the home or community setting of their choice. Medically necessary services are identified within a person-centered plan of care to maintain the health and safety of an individual with at least nursing level of care needs, in a community setting instead of an institution. California currently administers six 1915(c) waiver programs serving different populations.

  - **Assisted Living Waiver (ALW)** provides 24-hour care, 7 days a week, to adults (21+ years of age) with disabilities, living in community care settings or public subsidized housing within 15 counties.
  - **HIV/AIDS Medi-Cal Waiver Program (MCWP)** provides long-term services and supports to individuals diagnosed with HIV or AIDS (all ages) who require at least nursing facility level of care.
  - **Home and Community-Based Alternatives (HCBA)** waiver provides long-term services and supports to individuals (all ages) who require at least nursing facility level of care, in their own home or community setting of choice.
  - **HCBS Waiver for Individuals with Developmental Disabilities (HCBS-DD)** provides long-term services and supports to individuals (all ages) with

intellectual or developmental disabilities, who require at least nursing facility level of care.

- **Multipurpose Senior Services Program (MSSP) Waiver** provides long-term services and supports to individuals who are at least 65 years of age, who require at least nursing facility level of care, within 46 counties.
- **Self-Determination Program (SDP) Waiver for Californians with Developmental Disabilities** provides long-term services and supports to individuals (all ages with intellectual or developmental disabilities), who require at least nursing facility level of care.

» **Additional programs for specific populations:**

- Newborn Hearing Screening Program
- Genetically Handicapped Persons Program
- Health Care Program for Children in Foster Care
- Every Woman Counts
- Prostate Cancer Treatment Program
- Family Planning, Access, Care, and Treatment Program (Family PACT)
- Breast and Cervical Cancer Treatment Program

DHCS also administers several federal behavioral health grants awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the full behavioral health continuum of care, from prevention and early intervention through treatment and recovery services, including the coverage of services that are not Medi-Cal benefits. Federal opioid funding has been used to expand access to MAT and to build capacity to integrate MAT into the entire delivery system, including primary care, mental health care, emergency departments, hospitals, jails, prisons, diversion courts, tribal health care, and the full spectrum of SUD treatment services, including harm reduction programs (e.g., syringe services). Funding is also deployed to support administration initiatives, such as building out mobile crisis response services.

1.3 Quality Management Structure at DHCS

The CalAIM initiative aims to transform DHCS' Medi-Cal program to achieve health equity, population health, and quality outcomes. In order to achieve these goals, DHCS

has significantly changed its quality management structure, as well as invested in leveraging data-drive improvement; workforce diversity, equity, and inclusion efforts; and more robust member engagement as key pillars in its quality improvement efforts. Each of these is described in more detail in this section.

Centralization and Reorganization of Quality and Health Equity Management

Recognizing the centrality of quality and health equity to this agenda, DHCS created a new executive position, Chief Quality Officer (CQO) and Deputy Director for Quality and Population Health Management (QPHM), and is centralizing and standardizing all health equity, quality, and PHM functions across DHCS. The QPHM program will serve as a hub of technical expertise in quality assurance and monitoring, performance improvement, health equity, and program evaluation. To further develop this expertise, QPHM will undergo training specifically in LEAN and Results Based Accountability (RBA), which are improvement frameworks that QPHM will leverage in all of its activities.

QPHM, in partnership with health care programs and other support services, will help elevate and address quality and health equity across all DHCS delivery systems. This partnership is summarized in the functional organizational structure in Figure 13 below. Detailed functions that describe the ongoing work of QPHM and programs to review, revise, and improve all aspects of DHCS' quality and health equity work in this new centralized model are provided in Table 1.

Figure 13: Quality and Health Equity Functions

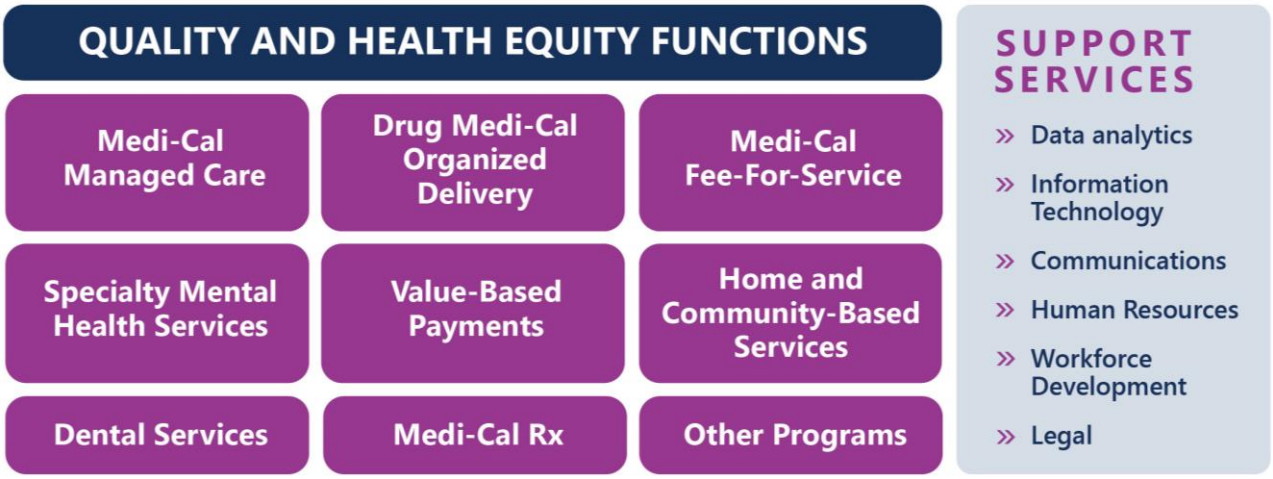


Table 1: QPHM and Operational Program Responsibilities and Activities

Activity	Centralized QPHM	MCMC/FFS/Program
Strategic Planning	» Quality Strategy and Health Equity Roadmap » PHM Strategy and PHM service	» Stakeholder engagement
Policy Development	» Leverage lessons learned from continuous quality improvement to create/revise policy » Ensure alignment across DHCS for quality, health equity, and PHM policy	» Ensure alignment with program-specific federal and state regulations » Issue new and modified policy guidance (via All Plan Letters, contracts, etc.) » Issue guidance and provide technical assistance for policy implementation
Data and Metric Selection	» Centralized metric selection working group to ensure alignment with strategy and key objectives » Lead dashboard development for key performance indicators and training for leveraging dashboards for continuous quality improvement	» Support development of program-specific metrics and key performance indicators

Activity	Centralized QPHM	MCMC/FFS/Program
Reporting	» With the data analytics team, lead alignment efforts on reporting race, ethnicity, language, sexual orientation and gender identity (SOGI), and other data for health equity efforts » Define reporting standards and oversee clinical quality-related report submission	» Implement data collection standards (especially for race, ethnicity, language, and SOGI) for all delivery systems » Proactive state level reporting of CMS Adult and Child Core Measure set and other federal/state reporting requirements » Reporting of all operational metrics, including eligibility statistics, network adequacy, timeliness standards, and complaints and grievances
Health Equity/Disparity Reduction	» Define best practices for disparity reduction; design and implement disparity reduction efforts in collaboration with each program » Ensure all efforts include an anti-racism framework, and leverage community partnerships » Provide executive-level leadership for DHCS on health equity	» In partnership with QPHM, stakeholders support health disparity reduction efforts » Public reporting of program-specific health disparity metrics

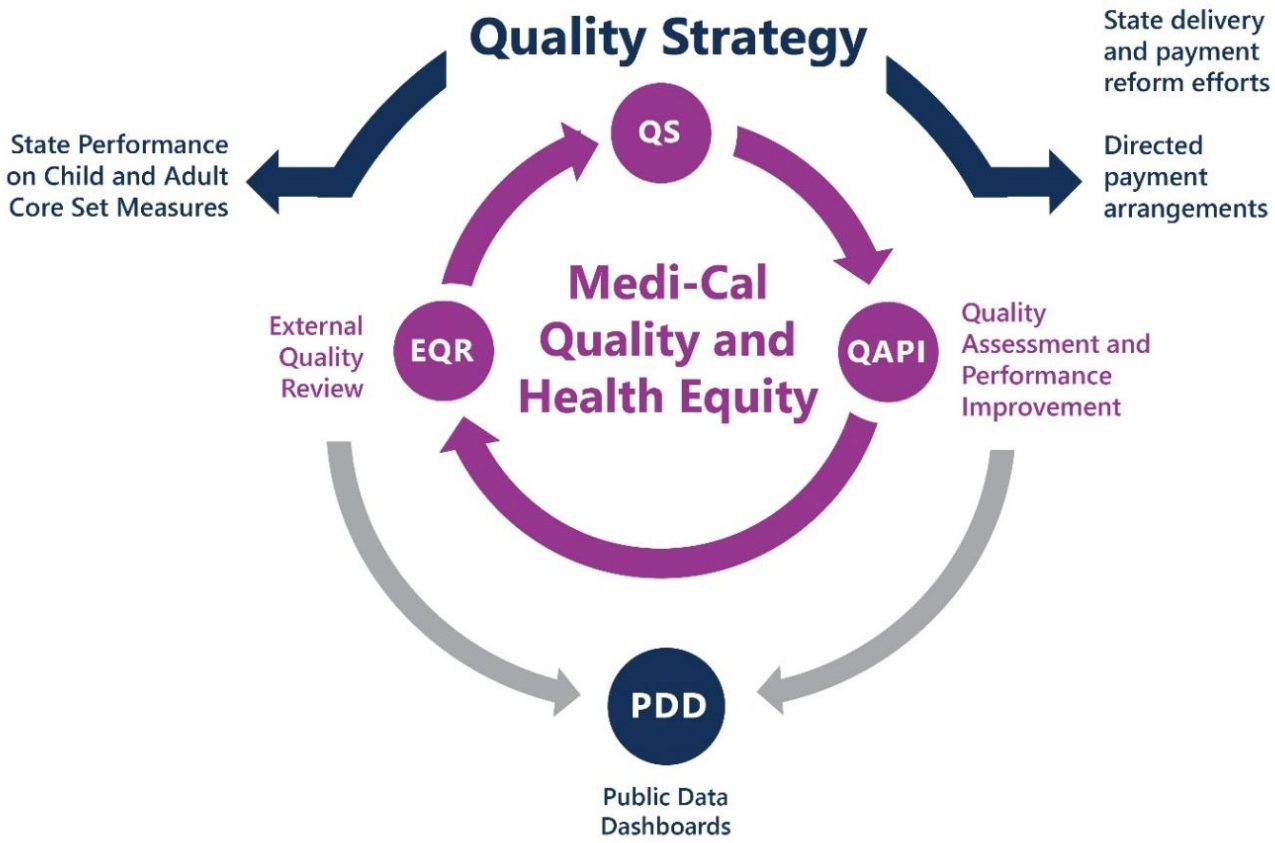
Activity	Centralized QPHM	MCMC/FFS/Program
VBP/Performance Incentives	» Ensure alignment of VBP/performance incentives with overall quality and health equity priority areas » Provide technical expertise on design and implementation of VBP to drive quality and equity outcomes » Implement and oversee all quality components of incentive and VBP programs (e.g., Quality Improvement Program)	» Implement and oversee all operational incentive programs (e.g., Behavioral Health Quality Improvement Program, CalAIM dental initiatives)
PHM	» Support alignment of DHCS programs with overarching PHM strategy to drive high-value care and improve health equity and clinical outcomes » Oversee design and implementation of PHM service and PHM standards across all programs	» Identify program-specific PHM needs and elements

Activity	Centralized QPHM	MCMC/FFS/Program
Quality Improvement (QI)/ Performance Improvement	» Standardize QI processes using LEAN and RBA, and lead training for internal capacity-development » Work directly with health plans, counties, providers, and programs on QI and health equity efforts for clinical quality outcomes » In conjunction with DHCS' External Quality Review Organization (EQRO), review Performance Improvement Projects (PIP) to assess program improvements	» Work directly with stakeholders and programs on QI and health equity efforts for non-clinical/operational improvements (e.g., access, network adequacy) » In conjunction with DHCS EQRO, review PIPs to assess operational program improvements
Accountability and Monitoring	» Set clinical standards for monitoring across programs » Monitor clinical and health equity outcomes across programs, including proactive monitoring of key performance indicators » Work directly with MCMC/FFS/programs on corrective action plans (CAP)/sanctions for quality related topics » Implement recommendations from program evaluations for continuous improvement of clinical findings	» Conduct site reviews/audits, and monitor program compliance » Provide technical assistance training for all program requirements » Monitor adherence to contractual, state, and federal requirements » Follow up and address all findings from internal and external monitoring activities related to non-clinical findings

Activity	Centralized QPHM	MCMC/FFS/Program
External Quality Review (EQR)	» Provide centralized EQRO oversight and contracting and ensure alignment of EQRO activities across all programs and with quality and health equity strategy, with federal requirements » Use EQRO findings to support continuous quality improvement	» Review EQRO reports to identify program areas needing improvement, and work to implement recommendations

Within this new structure, the QPHM team will lead quality and health equity policy for all DHCS programs (managed care, FFS, and other programs, as described previously). DHCS' CQS serves as the Department's strategic plan for quality and health equity. DHCS will leverage this strategy to inform all health care transformation efforts, directed payment and VBP programs and managed care contracts. The strategy will also directly inform DHCS' approach to quality assessment and performance improvement focus areas as well as improvements to public dashboards. Centralizing the External Quality Review (EQR) process and standardizing across delivery systems will help improve the assessment of these activities through EQR. This feedback loop of continuous improvement based on the quality strategy, improvement activities, public data and EQR assessment is outlined in Figure 14 below.

Figure 14: DHCS Continuous Quality Improvement Cycle



Critical parts of this continuous improvement loop are the transparency and accountability provided by public data dashboards. DHCS, its managed care plans, and stakeholders currently use a variety of dashboards to drive continuous quality improvement. The new QPHM program will evaluate the efficacy of current public dashboards and work with stakeholders and programs to modify them so they are closely tied to the CQS and key improvement activities as outlined in this strategy. Currently available dashboards, by program, include:

Medi-Cal Managed Care (MCMC)

- The Managed Care Performance Dashboard: Published quarterly with comprehensive data on a variety of metrics, including MCMC plan enrollment, health care utilization, member grievances, network adequacy, and quality of care.
- CMC Performance Dashboard: Published quarterly in collaboration with CMS to provide data on the key aspects of coordinated care through the CMC program.

» Managed Care Whole Child Model (WCM) Dashboard: Published quarterly with comprehensive WCM program data on select metrics for children and youth eligible for CCS and enrolled in a qualifying plan.

Specialty Mental Health Services (SMHS)

» All dashboards published annually at the county and statewide level that include outcomes for children and adults.

» Children and Youth Under the Age of 21 Performance Dashboard - All children and youth under age 21 receiving SMHS.

» Reports specific to child welfare:

- Children and Youth in Foster Care.
- Children and Youth with an Open Child Welfare Case.
- Katie A. Specialty Mental Health Datasets.

» Adult population - All adults ages 21 and older receiving SHMS.

» Children and Youth Demographic Datasets and Report Tool.[15]

» Adult Demographic Datasets and Report Tool.[16]

Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

» DMC-ODS performance dashboards are currently under development (to demonstrate SUD treatment measures; completion date TBD).

Dental Managed Care (Dental MC)

» Dental Data Reports: Published quarterly to monitor utilization through 13 performance measures for both Dental MC and FFS and annual complaints and grievances reports.

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[15]Children and youth under age 21 beneficiary population. These datasets consist of aggregate mental health services data derived from Medi-Cal claims, encounters, and eligibility systems and were developed in accordance with California Welfare and Institutions Code (WIC) § 14707.5, added as part of Assembly Bill 470 (Arambula, Chapter 550, Statutes of 2017).
16 Adults ages 21 and older beneficiary population. Data include aggregate MHS data from claims, encounters, and eligibility systems, developed in accordance with California WIC § 14707.5 added as part of Assembly Bill 470.

Medi-Cal Program Overall

» Eligibility data published monthly to provide Medi-Cal Enrollment Trends.

In addition to these changes within the quality management structure, DHCS is strengthening efforts in several other programs that are critical for improving quality and health equity.

Data-Driven Improvement

Using actionable data to identify gaps in quality and health equity and informing improvement efforts are at the foundation of DHCS' CQS. Recognizing this need, and similar to the new QPHM, DHCS is centralizing all data analytic functions under the Chief Data Officer (CDO) and Deputy Director for Enterprise Data and Information Management (EDIM.) EDIM is leading a number of department-wide initiatives to improve data quality and reporting. These initiatives include:

» Transformed Medicaid Statistical Information System (TMSIS), which transmits Medi-Cal data to CMS.

» Implementation of the Interoperability and Patient Access Rule, which will allow Medi-Cal beneficiaries greater access to their health care data.

» Partnering with the California Health & Human Services Agency's (CalHHS) Center for Data Insights and Innovation to implement the CalHHS Data Exchange Framework.

» Improving public access to data by sharing DHCS data on the CalHHS Open Data Portal.

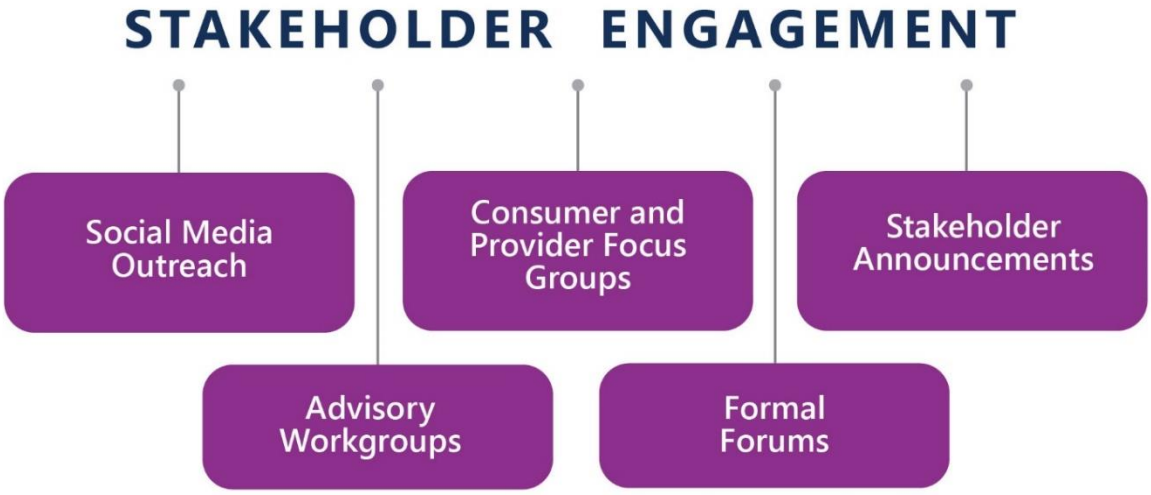
» Partnering with other state agencies to share data for improvement. For example, sharing data with the California Department of Public Health (CDPH) to leverage registries, such as the Vital Records Registry, California Immunization Registry (CAIR), Childhood Blood Lead Registry, the Infectious Disease Reporting Registry, and the HIV/AIDS registry, to improve quality reporting. Similar efforts are underway with the California Department of Social Services (CDSS) to assess children in foster care and child welfare.

External Stakeholder Engagement

Stakeholder participation and feedback is vital to the success of the Medi-Cal program and our quality and health equity efforts. Stakeholders are engaged in a number of

formal forums, advisory groups, and other types of outreach as described in Figure 15, below. Overviews of committee meetings, including agendas and presentations, are publicly available. Recent topics of discussion have included structural racism and health outcomes, CalAIM implementation, strengthened oversight of managed care plans amid the Medi-Cal procurement, Medi-Cal Rx, and COVID-19 vaccination efforts.

Figure 15: DHCS and Stakeholder Engagement



As a part of its Health Equity Roadmap, DHCS recognizes that to truly address structural racism, communities and individuals that have been historically marginalized need an active voice in informing and designing DHCS' programs. Many advocates, including those representing CBOs, participate in the DHCS stakeholder process, and the Medi-Cal Children's Health Advisory Panel (MCHAP) includes dedicated membership for beneficiaries or their parents. However, the member voice is not currently well represented overall in DHCS' stakeholder engagement efforts. Over the next three years, DHCS and its partners will engage Medi-Cal members and CBOs to inform DHCS' work. This engagement will occur at all levels and will include the launch of a DHCS' consumer advisory committee comprised of people from across the state who will advise and inform DHCS' policy and programs. DHCS will also leverage other venues, such as informal focus groups and town halls, site visits and engagement with managed care plans and health care delivery systems, and stakeholder meetings, to ensure broad involvement and member feedback. This engagement is also represented as a key goal of the CQS.

DHCS Workforce Development

DHCS recognizes that supporting and developing its internal workforce is extremely important to help improve the effectiveness and efficiency of its programs, and to achieve its goals on equity and quality. The renewed focus on diversity, equity, and inclusion (DEI) has underscored DHCS' need to embed DEI into all of its programs, at all levels, and to be a leader in this field. DHCS is committed to ensuring that as an organization it can reflect the diversity of California and the Medi-Cal population served. In order to achieve this goal, DHCS has launched a number of initiatives.

- **DEI:** DHCS launched specific workgroups to elevate employee voices in fostering an equitable work culture and improving diversity within the Department. The four workgroups (Workplace Outreach and Awareness, Recruitment/Hiring, Staff Development and Advancement, and Data Utilization and Analysis) are employee-led and are working on recommendations for DHCS to implement.
- **Multi-modal training opportunities for employees:** Provides modules for core competencies, performance improvement, Medicaid policy, analytical skills, and leadership (including the DHCS Academy and Academy+ Programs, comprehensive training and development programs designed specifically for DHCS).
- **Future workforce development:** To further deepen DHCS' quality and health equity improvement skills, the centralized QPHM will receive structured LEAN and RBA training, with a health equity focus, over the next three years.

1.4 Development and Review of the Comprehensive Quality Strategy (CQS)

With this CQS, DHCS meets the requirements for the development, evaluation, revision, and availability of the CQS as described in 42 CFR 438.340(b), (c) and (d). Full details are available in **Appendix C.** The steps that DHCS undertook to review and update the CQS are outlined in Figure 16.

Figure 16: DHCS Quality Strategy Review and Updates Process

1.5 Impact of COVID-19 on Quality and Health Equity

The COVID-19 pandemic has devastated our state, nation, and world, reducing nationwide life expectancy by 1 ½ years in 2020, the largest single drop since World War II[17]. More importantly, it has laid bare the deep racism and economic inequalities that underpin our society, with Black and Latino communities losing almost three years of life expectancy due to COVID-19. The pandemic's impact has fundamentally altered how DHCS envisions our quality and equity work. This updated CQS moves the Department to acknowledge and directly address the structural racism and health inequity present in our communities and within health care, using numerous historic investments made in Medi-Cal through the Budget Act of 2021, CalAIM, the Governor's Master Plan for Aging, and the HCBS Spending Plan.

In March 2020, as COVID-19 community spread accelerated, the State of California enacted one of the nation's earliest stay-at-home orders to curb transmission which has saved countless Californian lives. Despite this swift and effective response, surges of COVID-19 taxed clinics, hospitals and providers. The rapid transition to telehealth altered how members accessed and received care. Many Californians, including Medi-Cal members, avoided accessing medical care out of fear of COVID-19 exposure, resulting in decreased utilization and worsening quality outcomes, especially for preventive services. With the help of several federal COVID-19 PHE regulatory waivers, DHCS worked with plans, providers and key partners to implement COVID-19 specific services, provide flexibilities to reduce in-person requirements, and reduce administrative burdens so providers could focus on clinical care, while also maintaining other health care services. Especially as the emotional toll of the pandemic became clear, DHCS focused on strengthening behavioral health services by improving access to crisis counseling supports using the CalHOPE program, including text and chat supports, 24/7 warm line telephone crisis counseling, and media campaigns to normalize stress and promote help-seeking, providing staffing and telehealth flexibilities to behavioral health providers, and allowing flexibility for SUD providers to ensure patients did not go

[17] Centers for Disease Control and Prevention Provisional Life Expectancy Estimates for 2020, Centers for Disease Control and Prevention Press Release on 2020 Life Expectancy

without medication treatment, including more flexibility for take-home medications at narcotic treatment programs.

As of November 4, 2021, California had nearly 4.7 million confirmed cases of COVID-19 and 71,759 deaths.[18] Medi-Cal disproportionately serves communities of color and essential workers, and played a critical role in supporting these communities during COVID-19. Medi-Cal also served as a key safety net for individuals suffering from the economic consequences of the pandemic and California's shelter in place order. DHCS held regular COVID-19 related calls with all Medi-Cal managed care plans, county behavioral health plans, behavioral health treatment providers, and HCBS waiver programs to help address specific needs and barriers to health care access, including the need to rapidly pivot to providing robust telehealth and telephone services. Despite these efforts, the PHE, including the loss of life, school closures, disruption to health care services, and sheer mental health toll, has had an incalculable impact on clinical quality, health disparities, and overall health. Significant quality and health equity investments improvements are required to transform, rebuild, and strengthen our systems. The subsequent goals have been informed by this lived experience.

[18] COVID-19 State Dashboard

QUALITY AND HEALTH EQUITY IMPROVEMENT STRATEGY

2.1 DHCS' Vision for Medi-Cal

DHCS' ten-year vision for Medi-Cal is that people served by our programs should have longer, healthier, and happier lives. In this whole-system, person-centered, and population health approach to health and social care, health care services are only one element of supporting people to have better health. Partnerships with communities, members, CBOs, and public health, in addition to the health care system, will help support and anticipate health needs, prevent illness, and reduce the impact of poor health. The whole-system, person-centered approach will be equitable, reducing health inequities within the Medi-Cal program as well as between Medi-Cal and other insurance programs. It will improve health (physical, behavioral, developmental, oral, and LTSS) throughout lives, from birth to a dignified end of life, allowing people to access a range of seamless services as close to home as possible, whenever needed. Services will be tailored to the individual and around groups of people, based on their unique needs and what matters to them, as well as quality, equity, and safety outcomes.

Clinical Focus Areas: The long view of health and wellness in California

The COVID-19 pandemic, with its resultant school closures, changes in health care access, and stretched delivery systems, has had a significant impact on Medi-Cal members. The physical and mental health impacts of COVID-19 have been especially marked for children and parents, with declining rates of preventive and prenatal care, higher rates of depression, anxiety, and substance use, and poor maternal and infant outcomes[19].

Even before the pandemic, rates of preventive care for children in Medi-Cal were below national benchmarks, with marked disparities for Black/African American and American Indian/Alaska Native children. While California has made progress in improving maternal mortality and decreasing cesarean (C)-section rates, maternal mortality for Black mothers remains three times as high as white mothers. Black mothers also have the highest C-section rates in the state[20]. While significant progress had been made to

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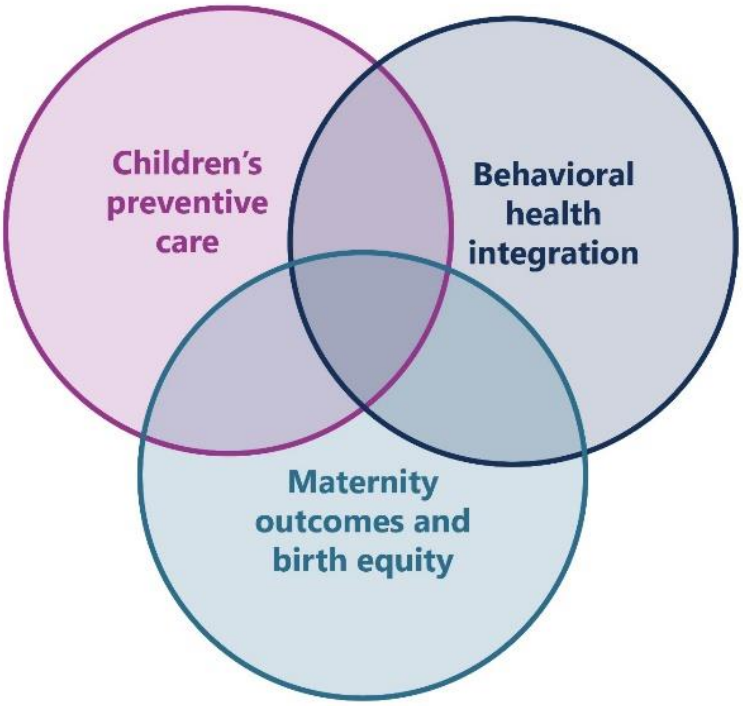
[19] Morbidity and Mortality Weekly report on Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic
The Lancet article on association of COVID-19 infection in pregnancy with preterm birth

[20] CHCF Report on Health Disparities by Race and Ethnicity

improve behavioral health screening and referral to treatment, behavioral health networks struggled to meet demand even before the pandemic.

Figure 17: DHCS Clinical Focus Areas

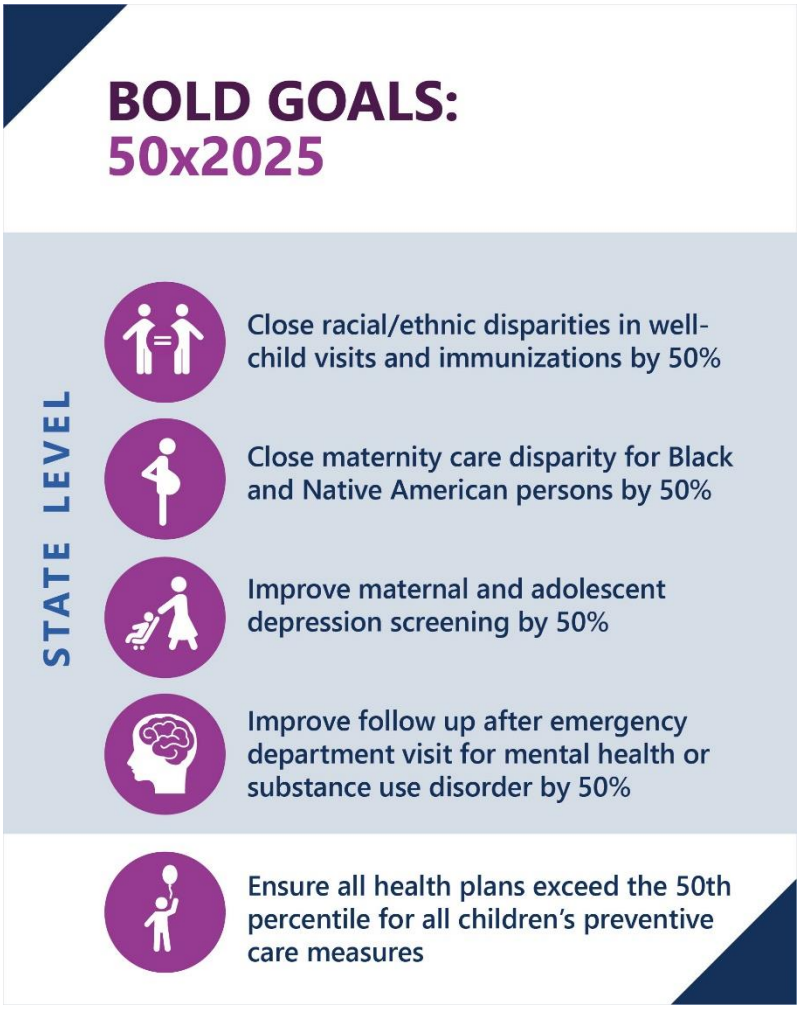


If future Californians are going to have longer, healthier, and happier lives, our quality and health equity efforts must address the foundations of health: preventive efforts that have long-lasting impact from infants to seniors. Addressing child and maternal health and behavioral health for all populations today will reduce chronic diseases and serious illnesses in the decades to come.

Bold Goals: 50x2025

As we recover from the PHE, DHCS will launch its ambitious Bold Goals **50x2025** initiative (summarized in Figure 18 below). **50x2025** will include focused initiatives around children's preventive care, behavioral health integration, and maternity care (see Figure 18), focusing particularly on health equity within these domains. These priority areas will be embedded into the detailed quality objectives and metrics, health equity roadmap, and VBP reform strategy.

Figure 18: Bold Goals 50x2025 Initiative



2.2 CalAIM and Population Health Management (PHM)

CalAIM will help achieve DHCS' vision for Medi-Cal as it encompasses broader delivery system, program, and payment reform across the Medi-Cal program. CalAIM drives fundamental changes in expectations for managed care and behavioral health systems, expanding services and supports, and improving transitions for high-risk patients whose health outcomes are driven, in part, by unmet social needs and systemic racism. The CalAIM goals and guiding principles are outlined in Figure 19, below, and serve as the foundation of DHCS' CQS. While conceived of with extensive stakeholder engagement prior to the COVID-19 PHE, CalAIM's goals are even more relevant as we prepare to

emerge from the pandemic. They have been strengthened with additional historic investments in the FY 2021-22 state budget and the HCBS Spending Plan. DHCS is also procuring contracts for all of its commercial MCMC plans and leveraging this opportunity to not only implement elements of CalAIM via managed care, but to also ensure quality and health equity are at the center of all managed care activities.

Figure 19: CalAIM Goals and Guiding Principles

A cornerstone to CalAIM, and the CQS, is the implementation of PHM, a plan of action for addressing member needs across the continuum of care based on data-driven risk stratification, predictive analytics, identifying gaps in care, and standardized assessment processes. PHM aims to effectively manage *all* beneficiaries by keeping members healthy via preventive and wellness services, assessing and identifying member risks to guide care management and care coordination needs, and identifying and mitigating social drivers of health to reduce disparities. The CQS incorporates and builds upon these fundamental system changes. The PHM Guiding Principles outlined below are designed to be synergistic with the goals of the CQS and leverage data to improve quality outcomes, health equity and member experience.

PHM Guiding Principles:

Drive towards the quadruple aim: enhance the patient experience, improve population health, reduce costs, and improve the work life of health care providers, including clinicians and staff.

Use program and outcomes data to inform policymaking and drive continuous quality improvement (CQI) efforts across Medi-Cal delivery systems that align with DHCS' CQS.

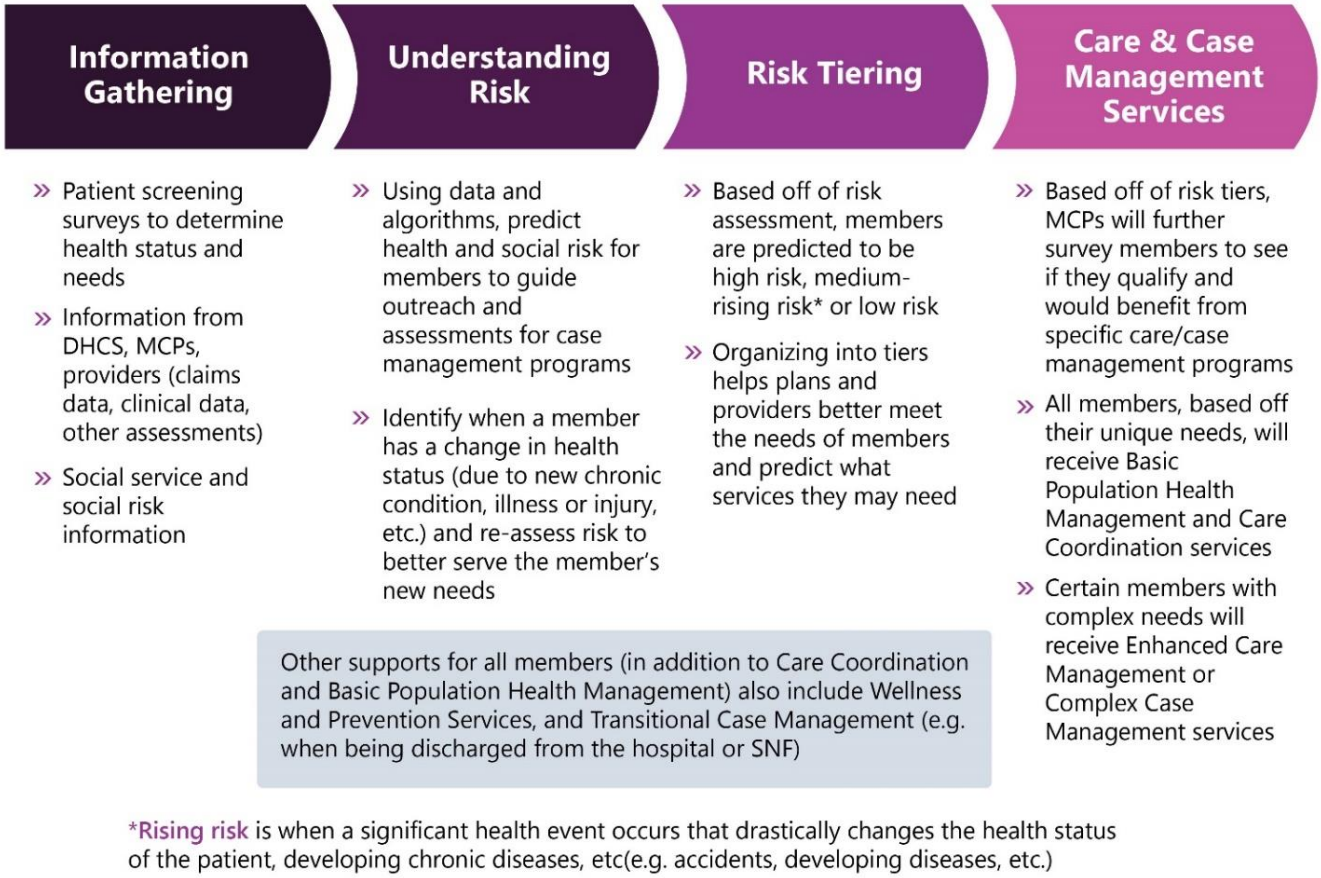
Identify, measure, and develop solutions that address outcome differences by race, ethnicity, language, and other factors to advance health equity.

Develop a unified approach for PHM across DHCS and delivery systems to promote accountability and transparency, integrating national standards and evidence-based practices.

PHM Design Framework

As a part of CalAIM, DHCS will launch the PHM program for all MCMC plans in January 2023. In addition to requirements to meet NCQA accreditation standards for PHM, plans will be required to create systems of care that proactively address member need at each level, including comprehensive wellness and prevention programs, as outlined in Figure 20 below.

Figure 20: Population Health Management Program Framework



*Rising risk is when a significant health event occurs that drastically changes the health status of the patient, developing chronic diseases, etc(e.g. accidents, developing diseases, etc.)

2.3 Goals, Guiding Principles, and Objectives for the Quality Strategy

The goals of and guiding principles for DHCS' CQS (summarized in Figure 21 below and described in this section), are designed to build upon the overarching CalAIM and PHM goals and principles to achieve population health. The subsequent specific objectives for each program and DHCS' **50x2025** Bold Goals initiative are in service of these overarching goals.

Figure 21: DHCS Quality Strategy Goals and Guiding Principles:

Goal 1: Engaging Members in their Own Care

Improving Member Experience

Medi-Cal members currently experience a fragmented health care system where they may have to access six or more separate delivery systems (for example, spanning across managed care, FFS, mental health, SUD, dental, developmental, IHSS, depending on needs) in order to get their needs addressed. Services also vary from county to county, which can lead to significant disruptions in care for beneficiaries if they move. This administrative complexity and variation can significantly impact care coordination needs and clinical outcomes, especially for beneficiaries who may be already experiencing barriers due to socioeconomic factors, limited English proficiency, or greater clinical complexity. These barriers are also reflected in patient experience survey scores, with many California health plans scoring below the 25th percentile nationally. Available results from behavioral health surveys, such as the Treatment Perception Survey, suggest similar barriers. Members also experience disparities in how they can access care, with communities of color significantly more likely to face barriers to broadband and video visits while experiencing higher utilization of audio-only visits during the pandemic, and rural regions facing numerous gaps in provider network and access. This narrative and video report from the California Health Care Foundation provides vivid examples of the challenges people face when trying to access care when they struggle

with mental illness, SUD, and/or homelessness.

The 2022 DHCS CQS aims to actively improve member experience and empower members to own their care and to inform Medi-Cal programs and policy. A number of CalAIM and budget initiatives are focused on this effort, including:

- Standardizing managed care enrollment and benefits across counties to provide a more seamless experience for beneficiaries.
- Moving almost all members to managed care (as described previously) to improve care coordination and experience.
- Carving in services, such as LTC, and eventually moving toward piloting fully integrated plans (with physical, dental, behavioral health, and LTSS provided by one plan) so that seamless, locally-driven care can be provided to the whole person.
- Integrating behavioral health administration and supporting regional contracting to provide a more seamless experience for beneficiaries accessing mental health and SUD services.
- Updating behavioral health policies to streamline administration and improve access to services.
- Transitioning CMC and expanding enrollment in integrated care for dually eligible beneficiaries in D-SNP Exclusively Aligned Enrollment plans.
- Expanding access to HCBS and improving quality of services and care through the HCBS Spending Plan.
- Implementing a new foster care model of care designed to improve the care experience and outcomes for children and youth in child welfare.

DHCS will also incorporate beneficiary experience metrics more consistently into its program assessment and improvement activities, including in VBP programs and managed care accountability sets. It has also increased the frequency of adult Consumer Assessment of Healthcare Provider and Systems (CAHPs) surveys to every two years (previously every three years), and will convert to annual surveys for adults as of 2024 with the new managed care contracts. DHCS will continue to conduct annual experience surveys for its children and youth population (CAHPs), DMC-ODS program (Treatment Perception Survey), SMHS program (Consumer Perception Survey), and dental programs

(both FFS and dental MC) and will explore eventual alignment under CAHPs surveys for all programs, where appropriate.

Engaging members in their care and Medi-Cal

A critical part of the Health Equity Roadmap (described in section 3.2) also includes increasing diversity within the Medi-Cal program, at all levels. Medi-Cal members represent a diversity of demographic and lived experiences that are not currently matched at the provider, plan or state government level. Actively incorporating their perspectives into Medi-Cal program development is essential to furthering health equity. In addition to efforts to solicit beneficiary feedback on Medi-Cal policy efforts described in Section 1.3, , DHCS is also leveraging its 2024 Medi-Cal managed care procurement RFP to include language requiring beneficiary representation in Community Advisory Committees for MCMC plans.

Goal 2: Keeping Families and Communities Healthy

The critical necessity of effective primary care, preventive services and close collaboration with public health has been seen throughout the PHE and also highlighted in a report by the National Academies of Sciences Engineering and Medicine. The foundation of DHCS' CQS, as mentioned previously, is a shift to population health and a renewed emphasis on prevention, especially in collaboration with public health authorities to address prevention at the member, population and community levels. A number of CalAIM and FY 2021-2022 state budget initiatives are focused on this goal, including:

Investments in PHM Infrastructure

- DHCS will launch a statewide PHM service in January 2023, to integrate data, provide PHM analytics support, and allow end-users access to information they need to effectively care for members. The service, which will be procured via a public RFP process in 2022, will integrate multiple sources of data from DHCS, other state departments, health plans, providers, and clinical data feeds to provide a comprehensive medical and social assessment of Medi-Cal populations. It will support PHM analytics (including risk assessment, risk stratification, linkage to health education and population-specific quality and operational outcomes) to inform Medi-Cal policy, drive healthcare value and improve healthcare outcomes while eliminating disparities and identifying areas

for delivery system reform. In addition, the system will provide beneficiaries a service to access their data, and, based on screening, to be connected to health education and community-based services. It will also provide networks and health plans with seamless, integrated information about their assigned lives, including for dual-eligible beneficiaries as a part of the transition to D-SNP models of care.

- A dedicated CalAIM project on improving beneficiary contact and demographic information will enable improved outreach and engagement, especially for beneficiaries who have coverage but are not receiving services.
- Planned updates to the Medi-Cal application will support consent to enable health plans to text and call beneficiaries for health care coordination and outreach efforts.

Added Benefits and Initiatives That Support Prevention and Primary Care

- Effective May 1, 2022, expansion of full scope Medi-Cal coverage to undocumented California residents age 50 or older (who are not eligible to receive federally-funded coverage), which will provide much needed coverage and access to primary care and preventive services for an estimated 235,000 California residents
- Addition of doulas as a Medi-Cal benefit
- Addition of community health workers as a Medi-Cal benefit
- Addition of dyadic services (integrated behavioral health services for the whole family, not just the patient in primary care) as a Medi-Cal benefit
- Addition of dental benefits for early oral health (Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children and certain high-risk and institutionalized populations)
- Expansion of Medi-Cal postpartum coverage from 60 days to 365 days to address post-partum healthcare needs and improve outcomes for mothers and children
- Creation of a virtual services platform for children and youth up to age 25, as a component of the Children and Youth Behavioral Health Initiative, to provide

access to services and support for managing everyday stress and anxiety before problems develop.

» Continue and expand Pay for Performance Initiatives previously initiated under the Dental Transformation Initiative (DTI) that reward the use of preventive services and maintaining continuity of care through a dental home

» Expanding access to the Medi-Cal program for seniors and persons with disabilities by increasing the asset limit in July 2022 and eliminating the asset limit in January 2024

In addition, DHCS will leverage the MCMC plan procurement RFP to strengthen requirements for population health, preventive care, primary care engagement and care coordination, especially for carve-out services such as dental, SUD and mental health, to more effectively address whole person care. Plans will also be required to establish memorandums of understanding and strong partnerships with local entities including HCBS programs, local public health jurisdictions, schools, and school districts to ensure a full continuum of preventive care from community through healthcare settings. MCMC plans will also be required to be NCQA-accredited to improve standardization, quality and health equity across the state.

To support Goal 2, DHCS will launch its **50x2025** initiative focused on preventive children's health, maternity care outcomes and behavioral health integration. DHCS will be reinforcing related metrics and prevention through increased primary care access and utilization throughout its various programs. Preventive care metrics for children's preventive health, oral health, and colon cancer screening will be added to the Managed Care Accountability Set (MCAS) and will also be incorporated into directed payment and VBP programs, where possible. Several of these measures will be included in the health equity metric set to inform and address health disparities in preventive care. Specific goals and targets are listed below.

Goal 3: Providing Early Interventions for Rising Risk

To help preserve health and quality of life for Medi-Cal members, it is critical that Medi-Cal programs effectively manage chronic conditions and identify changes in health status as early as possible. In addition, communities have different levels of access to support structures that help them lead healthier lives (e.g., safe neighborhood parks, fresh fruits and vegetables, and clean air and water), leading to significant health

disparities in rates of chronic diseases such as hypertension, asthma and diabetes. In addition to the population health efforts described above, there are a number of new DHCS initiatives that aim to target rising risk for specific populations. These include:

- Improving early access to behavioral health for children and youth to prevent the development of serious mental illness (SMI) and SUDs. The Children and Youth Behavioral Health Initiative will support strengthening behavioral health partnerships and capacity within California schools, provide student support through the CalHOPE program, scale evidence-based practices across the state, and launch a services and supports platform for behavioral health to allow all youth in California to access early behavioral health interventions
- Improving early diagnosis and treatment of dementia in at-risk populations. The Dementia Aware and Geriatric/Dementia Continuing Education project, part of the HCBS Spending Plan, will aim to train providers and offer incentives to improve earlier diagnosis of dementia, which can lead to improved quality of life.[21]
- Leveraging formularies and pharmacy benefits with the carve-out of pharmacy benefits (Medi-Cal Rx) to improve chronic disease management and improve health outcomes that are sensitive to medical management.
- Adding benefits to support the management of chronic diseases including continuous glucose monitoring for adults with Type 1 diabetes and certain benefits in Community Supports (see details below), such as Medically Tailored Meals and Asthma Remediation are essential for improving chronic disease outcomes through community intervention.
- Continuing efforts to support the treatment of hypertension, diabetes and asthma, and address disparities within these populations; and focusing on new initiatives to address disparities in chronic disease management through the Health Equity Roadmap.

[21] Degenerative Neurological and Neuromuscular Disease journal article on importance of early diagnosis in Alzheimer's disease

Goal 4: Providing Whole Person Care for High-Risk Populations

High-risk populations in Medi-Cal, including those with significant diseases, mental illness, SUD, housing instability, foster children, or justice system-involvement, often suffer from fragmented care that worsens their health and their ability to lead long, healthy, and happy lives. These are often the same populations that have suffered from systemic racism or stigmatization, or both. CalAIM and several HCBS Spending Plan proposals aim to actively support these populations and address known healthcare gaps through targeted interventions that will support non-medical services that drive clinical outcomes, care management and transition services, workforce initiatives, and enhancing HCBS capacity. Select interventions that will be key for addressing high-risk populations include:

Enhanced Care Management (ECM) and Community Supports (formerly In Lieu of Services)

As a part of CalAIM, DHCS will establish a new, statewide, ECM benefit to provide a whole person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. This benefit builds upon current Health Homes Programs and Whole Person Care pilots. Target populations include children or youth with complex physical, behavioral, developmental or oral health needs, individuals experiencing homelessness or at risk of becoming homeless, individuals at risk for institutionalization with SMI or SUD, nursing home residents transitioning to the community, and individuals transitioning from incarceration with significant physical or behavioral health needs.

To better address the needs of these high-risk populations, and recognizing that social drivers of health contribute to avoidable health outcomes and health inequities in these populations, DHCS will also implement Community Supports which are optional wrap-around services that are provided as a substitute for, or to avoid, other services, such as hospitalization. The current list of Community Supports include:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)

- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/Medically Supportive Food
- Sobering Centers
- Asthma Remediation

This set of services is essential for achieving DHCS' vision of whole person care, as well as addressing clear needs of Medi-Cal beneficiaries. Specific performance incentives to implement this program also include measurement of quality metrics in the target populations and assessing workforce diversity as a part of DHCS' Health Equity Framework.

LTC Carve In and D-SNP Transition

Creating a strong foundation of integrated care and HCBS will be essential to meet the needs of older adults and individuals with disabilities. Carving in LTC statewide, combined with Community Supports, exclusively aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans and mandatory MCMC enrollment for dual eligible members will help DHCS build this infrastructure.

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, a lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. As part of the CalAIM initiative DHCS is leveraging the lessons and success of the CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California, including transitioning CMC to D-SNP exclusively aligned enrollment in 2023. This will allow dual eligible members to voluntarily enroll for their Medicare benefits in the D-SNP that is aligned with their MCMC plan. DHCS will require Medi-Cal managed care plans to offer aligned D-SNPs to their members and limit the availability

of D-SNP plans that are not affiliated with an MCMC plan, in order to promote integrated care.

Individuals who require institutionalized care represent some of the most vulnerable members of our communities. Effective January 1, 2023, all MCMC plans will be required to authorize and cover institutional LTC services as required by state and federal law in an appropriate LTC facility.[22] Carving in LTC will help improve care coordination and quality outcomes across the continuum of care for Medi-Cal members. MCMC plans will be required to implement quality monitoring, assurance, and improvement efforts for LTC services at institutional settings. In addition, as a part of the HCBS Spending Plan, DHCS is leading a multi-department initiative to improve LTSS data transparency, including utilization, quality, and cost data. This dashboard will provide the necessary transparency and information to drive quality and health equity efforts within LTSS and close a current a gap in DHCS' reporting capabilities.

Strengthened Behavioral Health Interventions

As a part of CalAIM, DHCS will be encouraging counties to participate in the SMI/SED Demonstration Opportunity, to improve care coordination and transitions to community-based care and to increase access to a full continuum of care, including crisis stabilization.

Through the Behavioral Health Continuum Infrastructure Program (BHCIP), California is making a significant investment in community-based behavioral health infrastructure by providing competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets. DHCS will award $2.1 billion in grants through six rounds of funding. BHCIP will address historic gaps in the behavioral health continuum to meet the growing demand for treatment and service resources in settings that serve Medi-Cal members.

DHCS also included contingency management as part of the HCBS Spending Plan to treat individuals with stimulant use disorder, as an optional pilot in DMC-ODS counties.

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[22] LTC means care that is provided in a skilled nursing facility (SNF), intermediate care facility (ICF), or subacute facility. Those facilities include: SNF, ICF, Intermediate Care Facility for Developmentally Disabled (ICF/DD), Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DDH), Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DDN), Subacute Facilities and Pediatric Subacute Facilities

Contingency management is the only evidence-based treatment available for stimulant use disorder at this time (unlike opioid and alcohol use disorders, there are currently no proven medication treatments). DHCS also included funding for the California Bridge Behavioral Health Navigators program, which supports staffing and training for navigators in emergency departments to connect with people struggling with addiction and/or mental illness, and help connect them to services, as part of a broader effort to ensure MAT is available in all California emergency departments and hospitals.

Justice-Involved Population

Prisons, county jails, and juvenile justice systems have had a disproportionate impact on communities of color as a result of systemic racism. DHCS has proposed a number of interventions to improve the care of justice-involved individuals, including offering Medi-Cal services prior to release ("pre-release services") and ensuring facilitated referral and linkage to community-based services on release ("reentry services"). These services will improve chronic disease management and access to medications, especially for SUD, as well as provide much needed case management and wrap-around services, including housing.

Children and Youth in Foster Care

Children and youth in foster care have complex medical, behavioral, oral, and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences. DHCS convened a Foster Care Model of Care Workgroup to design a comprehensive strategy to address the fragmented child welfare delivery system and drive improvements in the health and well-being of children and youth in foster care and their families. Consistent with the guiding principles established by the workgroup, DHCS and the California Department of Social Services (CDSS) will propose a foster care model of care based on a whole person/whole family approach designed to improve the experience and outcomes for children and families navigating complex systems, ensure children and youth receive needed behavioral health care and wraparound services, and hold the system accountable for ensuring consistent service delivery and improving outcomes.

Providing Access and Transforming Health (PATH)

PATH funds will support a multi-year effort to shift delivery systems upstream to community-based interventions, and advance the coordination and delivery of quality care and services authorized under DHCS' Section 1115 and 1915(b) waivers by

maintaining, building, and scaling the capacity necessary to ensure successful implementation of CalAIM. These capacity-building efforts are critical for helping to provide whole person care and enhancing community-based interventions. They include support for maintaining and building justice-involved services ahead of the implementation of the full suite of statewide CalAIM justice-involved initiatives in 2023, as well as maintaining and building community-level infrastructure and capacity for ECM and Community Supports that will enable the transition of services from Whole Person Care pilot and Health Homes program demonstrations to statewide availability under CalAIM.

Addressing Homelessness

DHCS has proposed a suite of initiatives– in collaboration with other sister departments or on its own – that target homelessness and associated health care consequences. This effort focuses on California's steady increase in individuals experiencing homelessness who are disproportionately impacted by systemic racism and discrimination throughout the state.

These initiatives to address homelessness and housing instability will: expand statewide access to housing services; provide funding for CBOs to expand services and programs; improve access to coordinated health and social services, including housing; reduce avoidable use of costly health care services; and, most importantly, improve whole person health for Medi-Cal enrollees. This suite notably includes a $1.3 billion incentive program through the HCBS Spending Plan to support managed care plans and their local partners to make investments and progress in addressing homelessness and keeping people housed.

Additionally, ECM and Community Supports are ambitious reforms to address Medi-Cal enrollees' needs through coordinated and community-based whole person care. Housing-related Community Supports will include:

- **Housing Transition/Navigation Services:** Assistance with finding and securing safe and stable housing.
- **Housing Tenancy and Sustaining Services:** Support in maintaining safe and stable tenancy once housing is secured.
- **Recuperative Care (Medical Respite):** Short-term residential care for individuals without stable housing who no longer require hospitalization, but still need to heal from an injury or illness.

- **Housing Deposits:** Assistance with identifying, coordinating, securing, or funding one-time services, including first and last rent payments, and making necessary modifications to enable a person to establish a basic household.
- **Short-Term Post-Hospitalization Housing:** A recovery setting after institutional care for people who do not have a secure place to stay and who have high medical or behavioral health needs.
- **Day Habilitation:** Support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully at home.

Community-Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations

As part of California's HCBS Spending Plan, DHCS has proposed implementation of Community Based Residential Continuum Pilots. These pilots, aimed at improving the Medi-Cal beneficiary experience and reducing unnecessary costs, will provide holistic, culturally appropriate, person-centered medical and supportive services in home and community care settings (including residential care facilities and permanent supportive housing). Aligned with the Master Plan for Aging goals, this program will ensure individuals are able to live in the least restrictive setting possible by expanding access to home-based health and other personal care services for vulnerable populations, including seniors and persons with disabilities.

Increase Language Access and Enhance Cultural Competency

In order to promote equity among families being served through California's HCBS programs, DHCS has proposed additional investments for vital document translation, coordination, and streamlining of interpretation and translation services, and implementation of quality control measure to ensure the availability, accuracy, readability, and cultural appropriateness of translations.

2.4 Quality Performance Measures and Specific Objectives

DHCS selects performance measures to drive continuous quality improvement.[23] In order to reduce unnecessary reporting burden and to align priorities and incentives, QPHM leads a cross-division Quality Metric Workgroup that evaluates metrics for all program areas and makes recommendations about which metrics to include for monitoring and accountability.[24] DHCS is also coordinating metric selection efforts with its public purchaser partners, Covered California and the California Public Employees Retirement System (CalPERS), to help increase alignment, especially for health plans and provider networks that serve multiple populations.

Since the 2018 Managed Care Quality Strategy, DHCS has focused almost exclusively on adult, child and behavioral health CMS core measures. While this has helped focus efforts, it has led to some gaps in quality improvement activities, notably in the areas of member experience, maternity care, and some pediatric metrics. As a result, while most of DHCS' metrics moving forward still align with CMS core measure sets, additional national metrics have been included that align with the strategic clinical priority areas around children's preventive care, maternity care, and behavioral health integration. More detailed reports and specific program measures are available on the DHCS Quality Measures and Reporting webpage.

As described in Section 2.1, DHCS' new Bold Goals **50x2025** initiative aims to set ambitious statewide goals to improve clinical outcomes in key clinical focus areas. In addition, DHCS has identified key high priority metrics for each managed care delivery system, with measurable targets for performance. DHCS will partner with plans to help meet these targets, as well as foster cross-plan communication and partnership across delivery systems. A comprehensive list of program-level specific objectives for all programs (those with specific targets and others used for monitoring only) can be found in **Appendix D**.

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[23] 42 CFR 438.340(b)(3)(i)

[24] Metrics are evaluated based on guiding principles. The metrics must: be clinically meaningful; have a high population impact; align with other national and state priority areas and initiatives and other public purchasers; have an availability of standardized measures and data; be evidence based; and promote health equity.

MCMC Specific Objectives

For MCMC plans, DHCS would release a Managed Care Accountability Set (MCAS) of clinical quality measures annually. For Measurement Year (MY) 2022, DHCS has modified this measure set (see Table 2 below) to include key metrics for the clinical focus areas, as well as identified a subset of metrics that will be stratified by race and ethnicity to inform future health disparity reduction targets.

Table 2: MCAS Rate Year (RY) 2023/MY 2022

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
1	Breast Cancer Screening	NCQA	53.93	Yes
2	Cervical Cancer Screening	NCQA	59.12	Yes
3	Child and Adolescent Well-Care Visits	NCQA	45.31	NA
4	Childhood Immunization Status: Combination 10	NCQA	38.2	No
5	Chlamydia Screening in Women	NCQA	54.91	Yes
6	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NCQA	43.19	Yes
7	Controlling High Blood Pressure	NCQA	55.35	Yes
8	Immunization for Adolescents: Combination 2	NCQA	36.74	Yes
9	Prenatal and Postpartum Care: Postpartum Care	NCQA	76.4	Yes
10	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA	85.59	Yes

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
11	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months	NCQA	54.92	NA
12	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	NCQA	70.67	NA
13	Lead Screening in Children	NCQA	71.53	NA
14	Developmental Screening in the First Three Years of Life	OHSU	MPL (to be developed)	NA
15	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	NCQA	MPL (to be developed)	NA
16	Follow-Up After ED Visit for Mental Illness	NCQA	MPL (to be developed)	NA
17	Colorectal Cancer Screening	NCQA	Reporting only*	NA
18	Prenatal Depression Screening and Follow Up	NCQA (ECDS)	Reporting only	NA
19	Postpartum Depression Screening and Follow Up	NCQA (ECDS)	Reporting only	NA
20	Prenatal Immunization Status	NCQA (ECDS)	Reporting only	NA
21	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	TJC	Reporting only	NA
22	Dental Fluoride Varnish	DQA	Reporting only	NA
23	Depression Remission and Response	NCQA (ECDS)	Reporting only	NA

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
24	Pharmacotherapy of Opioid Use Disorder	NCQA	Reporting only	NA
25	Adults' Access to Preventive/Ambulatory Health Services	NCQA	Reporting only	NA
26	Ambulatory Care: Emergency Department (ED) Visits	NCQA	Reporting only	NA
27	Antidepressant Medication Management: Acute Phase Treatment	NCQA	Reporting only	NA
28	Antidepressant Medication Management: Continuation Phase Treatment	NCQA	Reporting only	NA
29	Asthma Medication Ratio	NCQA	Reporting only	NA
30	Contraceptive Care – All Women: Most or Moderately Effective Contraception	OPA	Reporting only	NA
31	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	OPA	Reporting only	NA
32	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications	NCQA	Reporting only	NA

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
33	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	Reporting only	NA
34	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	Reporting only	NA
35	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Reporting only	NA
36	Plan All-Cause Readmissions	NCQA	Reporting only	NA

MPL = Minimum Performance Level (MPL), based on NCQA's 2021 Quality Compass 50th percentile

*Measures are reporting only if no benchmarks exist, or if there are factors affecting reporting (e.g. pharmacy-related measures which may be impacted by MediCal Rx transition or ECDS measures which are more complicated to report). As benchmarks become available or baseline data is available, measures will be moved to being accountability measures in subsequent years.

Dental MC Specific Objectives

For Dental MC, DHCS has set ambitious 10 percent yearly improvement targets on key utilization and quality measures (summarized in Table 3 below) recognizing gaps in this year's measures based on previous data.

Table 3: Dental MC Priority Measures Rate Year (RY) 2023/MY 2022

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
1	Use of Preventive Services for Children Ages 1-20	NA	6% increase from Baseline Year	NA

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
2	Use of Preventive Services for Adults Ages 21+	NA	3% increase from Baseline Year	NA

SMHS and DMC-ODS Specific Objectives

For county MHPs and DMC-ODS, many CalAIM initiatives are designed to improve capacity for accurate quality data reporting and support process improvement. Recognizing this infrastructure need, DHCS has identified the following high priority metrics to drive annual improvements in quality outcomes. Over the next year, DHCS will work with stakeholders to identify a dedicated roadmap for additional high priority quality meausres and quality improvement in our behavioral health programs, building upon the critical infrastructure developments in CalAIM.

Table 4: County MHP Priority Measures Rate Year (RY) 2023/MY 2022

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
1	Follow-Up After Emergency Department Visit for Mental Illness	NCQA	1st year baseline reporting followed by 5% increase per year or >MPL	NA
2	Follow-Up After Hospitalization for Mental Illness	NCQA	1st year baseline reporting followed by 5% increase per year or >MPL	NA

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
3	Antidepressant Medication Management	NCQA	1st year baseline reporting followed by 5% increase per year or >MPL	NA
4	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	1st year baseline reporting followed by 5% increase per year or >MPL	NA
5	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	1st year baseline reporting followed by 5% increase per year or >MPL	NA

Table 5: DMC-ODS Priority Measures Rate Year (RY) 2023/MY 2022

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	NCQA	1st year baseline reportingfollowed by 5% increase per year or >MPL	NA
2	Pharmacotherapy of Opioid Use Disorder	NCQA	1st year baseline reportingfollowed by 5% increase per year or >MPL	NA

#	MEASURE NAME	Measure Steward	Target (MPL)	Target Met in MY 2020 (Yes, No, NA)
2	Use of Pharmacotherapy for Opioid Use Disorder	CMS	1st year baseline reporting; followed by 5% increase per year or >MPL	NA
3	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	NQF	1st year baseline reporting; followed by 5% increase per year or >MPL	NA

LTSS and D-SNP Performance Measures

As part of the Coordinated Care Initiative, DHCS holds contracts with 13 MLTSS plans to provide certain LTSS and Medicare wraparound benefits to dual-eligible beneficiaries not enrolled in CMC, and tracks four quality measures as outlined in **Appendix D**. For CMC beneficiaries, each MMP reports data for 85 quality metrics selected by CMS and DHCS for ongoing monitoring; DHCS posts the CMC Health Plan Quality and Compliance Report on its Reports to the Legislature website.

With the upcoming D-SNP transitions previously described, DHCS will examine existing CMS D-SNP contract requirements and federal quality-based standards to identify opportunities to align with Medi-Cal quality standards. DHCS will work with stakeholders, plans, and CMS to identify the range of quality and reporting results that D-SNPs will report to DHCS on an annual basis, and to the extent possible, align them with other MCMC reporting requirements.

In addition, CMS recently approved California's proposal for funding to develop a HCBS Gap Analysis and Roadmap, providing a critical pathway to evaluate current capabilities and gaps in California's approach to quality monitoring in HCBS, and to identify opportunities for improvement as DHCS transitions to MLTSS.

2.5 Health Equity Roadmap

Racism and inequity have been systemic in our nation since its inception. For years, the Medi-Cal program has acknowledged and measured health disparities, and embedded efforts in its programs to address them. And yet the COVID-19 pandemic empirically showed how powerfully the disparities continued to influence outcomes: the virus spread through nursing homes, affecting the most vulnerable in our community; black and brown communities here and across the nation suffered twice the loss in life expectancy as that of their white fellow Americans. The work that needs to be done to eliminate health disparities will take years, and must include a fundamental shift in how we structure power, decision-making and community engagement. The Health Equity Roadmap is not intended to be comprehensive or final. It offers a framework for how DHCS intends to approach this work and a catalogue of existing efforts. Over the course of the next year, DHCS will engage Medi-Cal members, CBO, health plans, counties, providers and other stakeholders to collectively identify gaps, needs and the work needed to achieve health equity. This dialogue will inform and update the roadmap, and more importantly, fortify the partnerships that are needed to drive change.

In order to support this discussion, DHCS will organize topics based on the DHCS Health Equity Framework. The following domains represent DHCS' multi-pronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities (summarized in Figure 22):

- Data collection and stratification: Complete, accurate data on REAL (Race, Ethnicity, Ancestry and Language) and SOGI (Sexual Orientation and Gender Identity) information for Medi-Cal beneficiaries will be utilized to illuminate and address healthcare inequities across DHCS programs.
- Workforce diversity and cultural responsiveness: Medi-Cal workforce, at all levels, should reflect the diversity of the Medi-Cal beneficiary population and *always* provide culturally and linguistically appropriate care.
- Eliminating healthcare disparities: Eliminate racial, ethnic and other disparities within the Medi-Cal population and support policy efforts to eliminate disparities, driven by social drivers of health, between Medi-Cal beneficiaries and commercial or other Medicare populations.

Figure 22: DHCS Health Equity Framework

DHCS has had a longstanding commitment to health equity and already has a number of current initiatives underway to measure, identify and address health disparities. These activities alone are a fraction of what is needed, but they are important to include in our Health Equity Roadmap so that additional efforts can focus on identifying gaps and creating synergy with existing efforts. A review of these activities and identification of additional gaps will be addressed in co-design sessions in 2022. Current activities, by Health Equity Framework domain, include:

Improvements in Data Collection and Stratification

- Changes to Medi-Cal application and other program applications to better collect demographic information such as race, ethnicity, sexual orientation and gender identity.
- Creating DHCS-wide standards for measuring race and ethnicity, in alignment with federal standards.
- Participation in the development of the CalHHS Health Equity Dashboard
- Participation in the Department of Managed Health Care Health Equity and Quality to inform state-wide managed care health equity and quality metrics.
- Behavioral Health Quality Improvement Program (BH-QIP) to update BH data systems and infrastructure to measure quality/equity outcomes

- Accurate collection of REAL/SOGI data in public and district hospitals as a part of the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program.
- Annual publication of the Managed Care Health Disparities Report.

Improvements in Workforce Diversity and Cultural Responsiveness

- DHCS DEI initiative aimed at improvements in DHCS workforce diversity, hiring, retention, mentorship, and DEI data.
- Participation in the CalHHS Agency-wide racial/health equity workgroup.
- Recruitment of a Chief Health Equity Officer at DHCS to lead health equity efforts within QPHM.
- Standing Partnership with the Office of Health Equity (OHE) at CDPH to leverage best practices in health equity training.
- Holding monthly DHCS health disparities workgroup meetings and a quarterly DHCS health disparities webinar to share efforts and improve knowledge across DHCS on key health equity topics.
- Annually creating and publishing health disparities fact sheets.
- Programs to increase diversity within the home and community-based workforce.
- Increasing diversity in the ECM/Community Supports network workforce via CalAIM incentive programs.
- Adding doula and community health worker benefits to provide more culturally appropriate and community-based care.
- In partnership with CDPH, launching the Community Mental Health Equity Project (CMHEP) to review and revise cultural competence standards for county MHPs.
- Field testing of Medi-Cal materials.
- Requirements for MCMC plans, via the procurement process, to identify a Chief Health Equity Officer, offer DEI training, and involve member participation in their community advisory councils.

Efforts to Reduce Health Care Disparities

- Expansion of Medi-Cal eligibility to all undocumented residents younger than age 26 and older than age 50 to provide health insurance coverage and improve outcomes.
- Medi-Cal expansion for seniors and persons with disabilities by increasing/eliminating the asset limits.
- Incorporating health equity into VBP programs (rate adjustments based on health disparities, Proposition 56 payments to improve care, other incentives).
- Focused efforts for populations disproportionately impacted by systemic racism and discrimination (e.g., foster care, justice-involved, SMI/SUD, individuals experiencing homelessness).
- ECM/Community Supports benefits to address social drivers of health and incentives for adoption of these key benefits.
- Supporting training and paying for Adverse Childhood Experiences screening to address trauma and grants to support trauma-informed care.
- Addition of traditional healer services for Indian Health Services populations.
- MCMC plans required to complete health-equity PIP.
- MCMC plans annual Population Needs Assessment (PNA) requirement to include at least one health equity focused action plan objective.
- Require MCMC plans, via the procurement process, to establish a Quality Improvement and Health Equity committee, achieve NCQA Health Equity Accreditation, and establish closer collaboration and Memorandum of Understanding (MOU) agreements with community-based entities, especially schools and local health jurisdictions, to better address social drivers of health.
- DTI efforts to address disparities in pediatric oral health.
- QIP Directed Payment program with hospitals requires health equity improvement metrics.
- Launch of Health Equity Measure Set in 2022 which will require MCMC plans to stratify the following measures by race and ethnicity (Note: DHCS will establish targets to reduce disparities for MY 2023. Metrics marked (*) connote measures

also recommended for stratification by NCQA in 2022. Additional metrics for future years will be discussed via the Health Equity Roadmap planning process):

- Colorectal cancer*
- Controlling high blood pressure*
- HgbA1c for persons with diabetes mellitus*
- Prenatal and postpartum care*
- Child and adolescent well-child visits*
- Childhood immunizations
- Adolescent immunizations
- Follow up after emergency department visit for mental illness or SUD
- Perinatal and postpartum depression screening and referral

Health Equity Roadmap Proposed Co-Design Content

As acknowledged, the efforts described above are neither comprehensive, nor do they reflect the full spectrum of voices and partners who need to inform our health equity work. As DHCS launches its health equity co-design process in 2022, there are a number of known and unknown gaps, including ensuring that DHCS policies (current and future) are designed and implemented in a way that support health equity, as well as supporting plan and provider capacity to identify and address disparities and to implement care delivery models that advance high-quality, efficient and equitable care for Medi-Cal members. A starting list of outstanding questions is proposed below that will be revised and added to the co-design process.

Vision and Goals

» What should the vision for health equity be for DHCS? Should the focus be on eliminating disparities within Medi-Cal, or between Medi-Cal populations and other populations? What types of disparities should we focus on measuring and addressing?

» What are guiding principles and best practices for health equity work that should be embedded into all of our work, not only at DHCS, but at plan and provider levels?

- What does an actionable set of goals look like to accomplish over the next three to five-years?

Data Collection and Stratification

- While race/ethnicity and sexual orientation/gender identity data collection and standardization efforts are already underway, what opportunities are there to define best practices in collecting these data, and also leveraging data collected outside of DHCS (by plans, providers, and others)?
- What are the disparities for which we do not currently have good data or ways to measure? How should we begin to define these areas and start to collect data?
- What are key social drivers of health that affect health outcomes and what data elements should be collected for them? How can the PHM service be leveraged as a state–wide tool for collecting, storing and sharing these data?
- How can member experience surveys be leveraged to measure healthcare disparities? What questions may need to be changed or modified to include this perspective?
- As efforts focus on workforce diversity, what workforce data elements are needed to support these efforts?
- What aspects of health disparities are not readily collected by existing measures and what innovative measures might be needed?
- What data governance and integrity efforts need to exist to ensure that data critical for health equity work is accurate, timely and standardized across programs and delivery systems?

Workforce Diversity and Cultural Responsiveness

- What are best practices for incentivizing diversity in leadership and staff at all levels (DHCS, plan, providers, etc.)? What barriers in terms of pipeline, training, mentorship, recruitment and retention exist and how can DHCS and its partners work collectively to address these barriers?
- What are best practices for training on health equity and DEI topics that can be incorporated across programs and delivery systems?

- What are best practices for implementing and enforcing culturally and linguistically appropriate standards across health care programs? What policy efforts may help with this?
- What are the biggest gaps in culturally and linguistically appropriate care and what are the root causes of these gaps? What policy or programmatic changes would help address these?

Reducing Health Care Disparities

- What are best practices in how health care disparity reduction efforts should be structured, including best practices in policy development and review to ensure that all DHCS policies support health equity?
- How can we review current DHCS health care disparity reduction efforts and identify high-priority areas, and, if known, root causes and needed interventions to address health disparities?
- What are opportunities as CalAIM and HCBS Spending plan initiatives are launched, especially PHM, to incorporate specific health disparity reduction activities into these initiatives?
- How can we inform best practices for incorporating health equity into VBP programs at DHCS?

While the list of questions may be longer than the list of answers, DHCS is committed to answering these questions only once we have those voices who are most needed to inform these policy and program decisions—those who are directly affected by them—involved in the process.

2.6 Value-Based Payment (VBP) Roadmap

Covering more than one in three Californians and almost half of all children and annual births, DHCS will leverage its role as the largest public purchaser of health care in California to drive quality and health equity in alignment with its quality priorities. DHCS intends to tie payments and reimbursements to clinical quality measures, health disparity reduction, and member experience through a variety of mechanisms. The roadmap below provides a broad overview of DHCS' five-year plan to strengthen alternative payment models and value-based purchasing (see Figure 23).

DHCS already operates a number of payment programs that are tied to quality outcomes, including the Quality Incentive Pool (QIP) program (which provides directed payments to public and district and municipal hospitals for achieving improvements in quality and health equity outcomes), the COVID-19 Vaccine Incentive Program (incentives for MCMC plans to improve COVID-19 vaccination rates and reduce disparities in rates), numerous CalAIM incentive programs (including incentives to support the rollout of ECM and Community Supports, tied to quality outcomes and workforce diversity), and the BH-QIP program (which administers grants to county MHPs for operational improvements to support quality improvement).

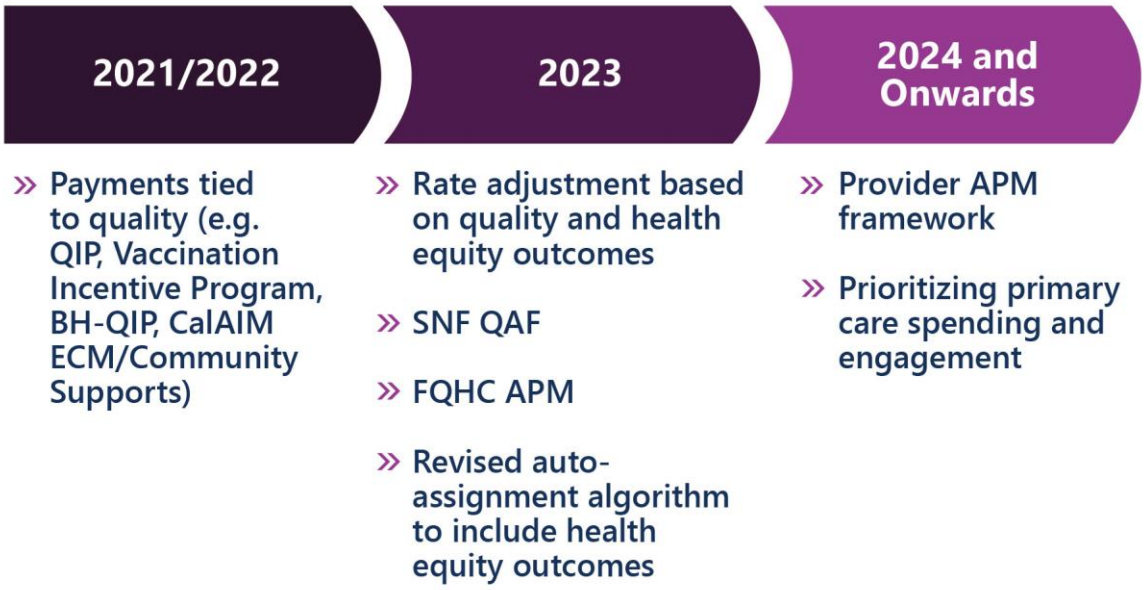
Starting in 2023, DHCS will incorporate MCMC performance on the key measures (including high priority clinical quality measures, health equity measures, and member experience) to adjust payment rates and member assignment. DHCS will engage stakeholders to solicit feedback on the exact methodology and weighting of performance, as well as the anticipated impact on rate setting later this year. In addition, while DHCS already incorporates quality performance scores in its auto-assignment algorithm that determines to which plan members are assigned (if more than one plan in their county of residence), starting in 2023, health disparity rates on the health equity measures will also be incorporated into the auto-assignment algorithm.

DHCS will also launch the Federally Qualified Health Center (FQHC) alternative payment methodology (APM) pilot in 2023 to support primary care transformation efforts in participating health centers. Given the traditional FFS prospective payment system (PPS) reimbursement structure for FQHCs, participation in the APM presents an opportunity for innovation using team-based care that is not always reimbursable through PPS as well as other alternative models of care delivery, such as electronic communication, pharmacist and nurse-led virtual, and in-person care and home visits. The quality incentives in the FQHC APM, while initially paying for reporting, will ultimately be tied to specific quality and equity measures that align with DHCS' CQS and also support the shift to PHM.

In addition, DHCS is working with stakholeders on a proposal for annual rate increases for SNFs to be based on updated cost-based rate increases and a quality per diem rate increase. A quality pool will fund quality per diem rate increases to each SNF based on performance on pre-determined quality metrics that will inform the facility specific annual per diem rate. This payment reform is intended to incentivize facilities to focus on the quality and value of services provided to patients.

Starting in 2024, DHCS will begin exploring models of value-based purchasing to leverage in the future, better understanding APM models that plans use with provider networks and establishing a framework to guide these relationships. DHCS will also explore how to strengthen primary care investment and engagement in its managed care contracts, considering minimum primary care spending targets and advanced primary care metrics.

Figure 23: Value-Based Roadmap



MANAGED CARE ASSESSMENT EVALUATION AND STATE STANDARDS

3.1 Revised Managed Care Monitoring and Oversight Framework

Based on both the review of the efficacy of the DHCS 2018 Managed Care Quality Strategy and significant stakeholder feedback, there are clear opportunities for DHCS to improve transparency, accountability, and monitoring across its programs. This has informed both the CalAIM framework as well as ensuring that "transparency, accountability, and member involvement" is a guiding principle for this CQS. Further, in alignment with the goals of CalAIM, DHCS will centralize all Medi-Cal managed care delivery systems—MCMC, SMHS, DMC-ODS, and Dental MC—under the same federal authority, effective January 1, 2022. Authorizing these managed care delivery systems under the 1915(b) waiver[25] will result in more consistent program policies and monitoring and reporting requirements. DHCS will develop and implement a Managed Care Monitoring and Oversight Framework as a part of the implementation of this CQS. While still in development, key goals of this framework include:

- **Aligning and standardizing DHCS managed care monitoring:** DHCS will review its approach to all aspects of assessment and monitoring to ensure as much consistency across programs as possible. This has been done for network adequacy, but program approaches to member experience, quality performance standards, performance improvement plans, and sanctions vary across different clinical programs. This consistency will reduce administrative complexity and increase the ease of monitoring and compliance, while meeting all state and federal requirements.
- **Creating a proactive monitoring structure to assess managed care performance:** DHCS will enhance its proactive monitoring structure for managed care performance, with standardized data inputs, monitoring domains, and metrics processes and outputs. DHCS will also conduct regular reviews across organizational teams (managed care, behavioral health, HCBS, quality, data analytics, audits and investigations, and compliance) to summarize data at the plan and county/reporting unit level and support early identification of

[25] CalAIM 1915b waiver proposal

patterns and trends; develop targeted interventions; and conduct enforcement activities, followed up by meetings with individual plan leadership to address issues and help plans come into compliance.

- **Establishing an effective monitoring governance structure** DHCS has revised its organizational structure to centralize quality strategy and oversight functions as well as created an Office of Compliance with a new Chief Compliance Officer. DHCS is also centralizing its data and analytic functions under the EDIM team and Chief Data Officer. This reorganization will allow for a standardized approach to measuring, monitoring, and providing oversight for all quality and health equity functions across all programs. It will also allow programs to strengthen their efforts and focus on other elements of monitoring and compliance, especially network adequacy, access, member complaints, and grievances and audit and investigation findings.

DHCS recognizes there are similar opportunities to improve monitoring and accountability outside of the managed care delivery system and has two CalAIM initiatives focused on additional areas:

- **Enhancing oversight and monitoring of Medi-Cal eligibility:** DHCS will utilize a phased-in approach to working with counties to improve Medi-Cal eligibility functions and resolve system mismatches to ensure eligible beneficiaries maintain access to care. This will include reinstating county performance standards, developing an updated process for monitoring and reporting of county performance standards, fostering collaboration and open communication between DHCS and counties, creating a tiered corrective action approach (including financial penalties) and incorporating findings and actions in public facing report cards.
- **Enhancing oversight and monitoring of CCS:** To improve consistency and oversight to support improved quality and health equity outcomes for children in these programs. DHCS will enter into a MOU with all 58 counties to enforce roles and responsibilities along with expectations to ensure program compliance. Enforcement of these expectations will be provided through the MOU, policies, and procedures to assess accountability by counties/cities as they implement their daily operations.

For the subsequent sections on quality assessment, evaluation, and state standards, in addition to the narrative provided, a full description of regulatory requirements, activities by managed care plan type, and links to all reports can be found in **Appendix C**, Managed Care Entity Program Reporting Requirements.

3.2 Quality Assessment and Performance Improvement (QAPI)

Continuous performance improvement in collaboration with managed care plans and provider networks is critical to addressing quality and health disparities, and has informed the entire CQS and the broader CalAIM framework. Each of the managed care and other programs have previously had their own QAPI programs. While all of them meet federal requirements, identifying performance metrics, using quality improvement formats, and meeting regularly with plans, they were not coordinated or standardized efforts. For overlapping delivery networks, these numerous, sometimes uncoordinated programs added administrative burdens without yielding sustainable results. Details of each program's QAPI strategy are available in **Appendix E** (2018 Quality Strategy Review). With the efforts to centralize and coordinate quality efforts, DHCS will standardize the QAPI across all programs to use similar methods and align them with DHCS priorities. DHCS will leverage the considerable infrastructure that is already in place across programs, such as the robust MCMC QI toolkit that was designed to support training and capacity building with managed care plans.

DHCS' Quality and Health Equity Improvement Framework (see Figure 24, below) balances creating a strong, standard foundation of quality across the state with supporting local innovation and improvement efforts. DHCS will leverage required, standardized performance metrics and MPLs to ensure that all delivery systems are providing a necessary level of care to all Medi-Cal members, independent of where the member lives or their individual demographics. A variety of penalties, including CAPs, sanctions, and liquidated damages may be levied if targets are not met, as described in more detail in the state standards section. However, DHCS cannot accept the 50th percentile, or "average", as our goal. This foundation must be coupled with opportunities for incentives that can support local innovation and transformation efforts and achieve our vision of achieving greater than the 90th percentile on key measures, or "excellent care" across programs. DHCS has already started aligning metrics across programs to minimize provider administrative burden and maximize synergy of current measures. Focused initiatives with innovative metrics and incentives will help support

care transformation and new priorities, and help California achieve the quality and equity outcomes its beneficiaries deserve.

Figure 24: Quality and Health Equity Improvement Framework

Impact of COVID-19 on Quality Assessment and Performance Improvement

The COVID-19 pandemic severely disrupted quality assessment, performance improvement, and EQRO evaluation activities for MY 2019 and 2020. The collection of data for CMS quality measures for MY 2019 was severely impacted due to travel restrictions and shelter in place orders in spring 2020 that prevented onsite audits and data gathering. DHCS, in alignment with NCQA, provided MCMC plans with reporting flexibilities on their quality measures, allowing MCMCs to report these measures using a hybrid or administrative methodology, or allowed MCMC plans to use MY 2018 data when reporting hybrid measures. As a result, DHCS decided not to hold MCMC plans accountable to the MPL, and moved forward with alternatively required quality improvement activities, including COVID-19 specific projects. For MY 2020, there was a marked decrease in health care utilization nationally, including among Medi-Cal members, due to shelter in place orders and reluctance to seek non-emergency care due to concerns about COVID-19. As a result, DHCS did not hold the MCMCs accountable to benchmarks on quality measures for MY 2020. However, DHCS did require quality improvement activities based upon performance on those measures, and will hold the MCMCs accountable to quality benchmarks for MY 2021.

Quality reporting on behavioral health services was similarly impacted due to the surge of COVID-19 cases, county staff shortages, and the need for counties and providers to focus on managing the public health crisis. As a result, DHCS placed a temporary moratorium on all behavioral health auditing and oversight activities, including EQRO reviews, through March 1, 2021. EQRO reviews continued thereafter, using a modified process of desk and/or virtual reviews to monitor county performance regarding quality, access, timeliness, and outcomes. EQRO summarized its findings in annual technical reports for both SMHS and DMC-ODS counties.

PIPs and PIP Interventions

DHCS requires all 25 MCMC plans and four MCMC specialty plans to conduct and/or participate in two PIPs annually, in alignment with federal requirements. MCMC plans have been required to have at least one of their PIPs focused on a health equity topic since 2017. SMHS and DMC-ODS plans complete one clinical and one non-clinical PIP. Dental MC plans complete one state-level and one individual PIP. Details by plan type and PIP are provided below (see Table 3). Based on its review of the 2018 Managed Care

Quality Strategy, DHCS will standardize focus areas for PIPs to align with state priorities and areas of low performance.

Table 6: PIPs and Interventions

Managed Care Program	PIP Topic	PIP Aim	PIP Intervention
SMHS: The EQRO validates PIP information on 56 MHPs. Each SMHS submits one clinical and one non-clinical PIP.	See EQRO link for general information about PIPs, and the library link for specific examples.	Each MHP has two unique PIPs specific to their populations, with distinct aims; see library link for a list of PIPs.	Each MHP has two unique PIPs specific to their populations, with distinct interventions; see library link for a list of PIPs.
MCMC: The EQRO validates PIP information on 29 plans (MCMCs + Population Specific Health Plans (PSP)). Each MCMC and PSP submits one health equity and one clinical PIP.	Specific information regarding MCMC plan PIPs can be found within published EQR Technical Reports.	There are a number of aims, as each MCMC plan has a unique PIP supported by DHCS and its EQRO; see EQRO links for details.	There are a number of interventions, as each MCMC plan has a unique PIP supported by DHCS and HSAG. Please see the Plan Specific Evaluation Reports (PSER) link provided for details.

Managed Care Program	PIP Topic	PIP Aim	PIP Intervention
DMC-ODS: The EQRO validates PIP information for 37 counties. Each county is required to submit one clinical and one non-clinical PIP.	See EQRO link for general information about DMC-ODS PIPs, and the library link for specific examples.	Each DMC-ODS plan has two unique PIPs specific to their populations, with distinct aims; see library link for a list of PIPs.	Each DMC-ODS plan has two unique PIPs specific to their populations, with distinct interventions; see library link for a list of PIPs.
Dental MC	Preventive Services Utilization (Statewide Quality Improvement Project)	Increase the annual percentage of children, ages 1-20, enrolled in a Dental MC plan for at least 90 continuous days, who receive any preventive dental service, by 10 percentage points by 2023.	» Develop and deploy the member text message campaign. » Continue the partnership and participation with the Los Angeles and Sacramento DTI projects. » Continue the sponsorship with Early Smiles
Dental MC	Annual Dental Visits (ADV) for Children (Access Dental – Individual Performance Improvement Project)	Increase ADV for children, ages 5–18.	Work with participating provider offices by increasing member outreach and engagement activities to boost ADVs and dental sealant application and support follow-up treatment.

Managed Care Program	PIP Topic	PIP Aim	PIP Intervention
Dental MC	Coordination of Care for High-Risk Members (Health Net Dental and Liberty Dental – Individual Performance Improvement Project)	Increase the rate of deep cleanings or periodontal maintenance procedures completed among members ages 65 to 85 who are living with diabetes and identified as high risk.	Conduct text message outreach using a series of member engagement messages to inform members living with diabetes about the benefits of having deep cleanings or periodontal maintenance completed.

Intermediate Sanctions

The Managed Care Final Rule requires this CQS to include the state's appropriate use of intermediate sanctions for managed care organizations (MCO). DHCS has sanction policies in place for MCMC and Dental MC plans. DHCS is developing a sanction policy that will apply to MHPs and DMC-ODS Plans. It will be announced to counties by mid-2022, and imposed as part of the 2022 certification package. Counties out of compliance in the 2022 certification process will receive sanctions if they do not achieve sufficient progress on their CAPs.

For MCMC plans, DHCS released APL 18-003 in January 2018 to remind them of existing law and policy that authorizes DHCS to impose administrative and financial sanctions on MCMCs. Sanctions may be imposed on actions that violate applicable California Medi-Cal and federal Medicaid laws, the Knox-Keene Health Care Services Act of 1975 (Knox-Keene Act) standards, or the terms of their MCMC contract with DHCS; this also ensures that MCMC delegates similarly comply with all state and federal laws and regulations and other contract requirements.

DHCS levied financial sanctions against two MCMC plans in 2018 that failed to meet quality CAP requirements, namely, they failed to meet required quality measure benchmarks that were part of the CAP process for MY 2017. DHCS also placed five MCMC plans under quality CAP in 2018, and four in 2019, for failing to meet required

benchmarks on quality measures. The quality CAPs consisted of increased monitoring, including routine meetings with plan leadership, providing increased technical assistance, and establishing annual CAP requirements.

Additionally, DHCS levied financial sanctions against five MCMC plans in 2019 and three MCMC plans in 2020 for failing to meet data quality requirements imposed under CAPs or stipulated in DHCS All-Plan letters. One of the sanctions imposed in 2019 was due to an MCMC plan's failure to correct encounter data completeness for dates of service spanning a portion of FY 2014-15, which was part of a CAP, while the remainder of CAPs were for late submissions of managed care provider data. DHCS also had seven MCMC plans under CAP in 2018 for reporting unreasonable or inaccurate network providers, which were all successfully completed by April 2020. These CAPs resulted in an increase in the quality of target data elements, increased improvement in communications between technical teams, and improved monitoring efforts.

DHCS had 20 MCMC plans under a CAP in 2019 and 22 MCMC plans under a CAP in 2020 for non-compliance with network adequacy standards, namely not meeting provider-to-member ratios and time and distance standards. All 2019 CAPs were successfully closed out in January 2020, and all 2020 CAPs were successfully closed out in May 2021. The CAP mandates included providing out-of-network access, including transportation, to any member that requested it regardless of cost, until the CAP was closed out.

For Dental MC, DHCS released APL 16-011 in September 2016 to mandate compliance with the Managed Care Final Rule regulations effective in July 2016. DHCS incorporated the Final Rule provisions into the Dental MC contracts and strengthened the sanction policy to comply with the Final Rule. The contracts detail DHCS' options for intermediate sanctions, including, but not limited to, termination hearings, appointment of temporary management, civil monetary penalties, and member and contractor rights in the case of temporary suspension orders and contract termination.

DHCS conducted the following onsite audits of the Dental MC plans:

- Access Dental Plan: An audit was conducted from February 24, 2020, through February 28, 2020. The audit covered the review period of January 1, 2019, through December 31, 2019. Access Dental Plan had nine findings in the areas of utilization management, access and availability of care, and quality management

that required CAPs. Audit findings were adequately addressed, and CAPs were closed on December 16, 2020.

» Health Net Dental: An audit was conducted from March 16, 2020, through March 19, 2020. The audit covered the review period of March 1, 2019, through February 29, 2020. Health Net had two findings in the areas of utilization management and quality management that required CAPs. Audit findings were adequately addressed, and CAPs were closed on September 1, 2020.

» Liberty Dental Plan: An audit was not completed in 2020. The last audit was conducted from May 13, 2019, through May 24, 2019, and covered the period of May 1, 2018, through April 30, 2019. Liberty had thirteen findings in the areas of utilization management, access and availability of care, member rights, and quality management that required CAPs. Audit findings were adequately addressed, and CAPs were closed on September 3, 2020.

3.3 External Quality Review (EQR) Arrangements

The following table provides a description of DHCS' EQR arrangements for annual, external, and independent review of quality outcomes and timeliness of access to services covered under each MCO, PIHP, Prepaid Ambulatory Health Plan (PAHP), and Primary Care Case Management (PCCM) plan, in accordance with 42 CFR 438.250. DHCS intends to consolidate and standardize EQR activities across managed care program types by 2024 which may modify some of the strategy outlined below. DHCS has no applicable arrangements to report regarding non-duplication of mandatory EQR activities (according to 42 CFR 438.360 (c)).

Table 7: EQR Arrangements

Program	Name of Organization	Activities To Be Conducted 2022 - 2026	
		Mandatory Activities	Optional Activities
MCMC	HSAG, Inc., (contract through 2025.) Will be re-bid during Section 1915(b) waiver period.	» Assessment of the MCMC quality strategy » Compliance reviews of MCMCs, including follow up on audits and CAPs » Assessment of PIPs » Calculation, validation and trend assessment of performance measures for MCMCs » Follow-up on the EQRO's prior year's recommendations, both to DHCS and MCMCs » The EQRO is also contracted to validate network adequacy as specified under 42 CFR §438.358(b)(1)(iv); pending issuance of protocols from CMS » The state also mandates the following EQR activities: » Alternative Access Standards (Network Adequacy) California Welfare and Institutions Code (WIC)§ 14197.05(a)(b) and (d) » SNF/Intermediate Care Facility (Network Adequacy) CA WIC § 14197.05(c) and (d)	» Validation of encounter data submitted by MCMCs » (conducted at least every three years) » Administration and validation of CAHPS surveys » Administration of focused studies (active studies in 2021 include: Health Disparities; Statewide Network Analysis; Network Hot Spots; and Population Needs Assessment » Technical assistance to MCMCs on quality improvement topics through calls, webinars, email support, and annual quality conference » EQRO contracted to provide assistance with quality rating of MCMCs consistent with 42 CFR § 438.334 pending issuance of protocols from CMS

Program	Name of Organization	Activities To Be Conducted 2022 - 2026	
		Mandatory Activities	Optional Activities
Dental MC	HSAG, Inc., (contract through 2025). Will be re-bid during Section 1915(b) waiver period.	» Validation of PIPs » Calculation and validation of Dental MC plan performance measures » Dental MC plan compliance reviews » Validation of Dental MC plan network adequacy	
MHPs	Behavioral Health Concepts (contract through June 2022).	» Validation of PIPs » Validation of MHP performance measures » MHP compliance reviews » Validation of MHP network adequacy	» Validation of encounter data reported by county MHP » Validation Consumer Perception Surveys » Technical assistance to MHPs through participation in statewide QI coordinator meetings » Conduct additional PIPs or focused studies
DMC-ODS	Behavioral Health Concepts (contractthrough June2022)	» Validation of PIPs » Validation of DMC-ODS plan performance measures » DMC-ODS plan compliance reviews » Validation of DMC-ODS plan network adequacy	» Validation of encounter data reported by DMC-ODS plan » Validation ofTreatment Perception Surveys » Conduct additional PIPs or focused studies » Technical assistance forDMC-ODS plans

3.4 State Standards

Network adequacy and availability of services

DHCS published its network adequacy standards in July 2017 to comply with the network adequacy provisions of the Managed Care Final Rule. The DHCS network adequacy standards document was subsequently amended in March 2018 to reflect changes under Assembly Bill 205 (Wood, Chapter 738, Statutes of 2017), which was codified in WIC §14197 and amended California's network adequacy standards to base the standards on the population density of each county, rather than population size.

DHCS certifies managed care networks on an annual basis and submits an Assurance of Compliance Report to CMS annually. DHCS also requires managed care networks[26] (MCMC, Dental MC, SMHS, DMC-ODS) to report within 60 business days whenever there is a significant change that would affect the adequacy of capacity and services as defined by DHCS. A significant change is a change in the composition of the Medi-Cal managed care plan's network, services, benefits, geographic service area, or enrollment of a new population. The significant change may occur as a result of a termination, suspension, or decertification of a network provider or subcontractor impacting 2,000 or more members, or because the network is out of compliance with network adequacy standards. If DHCS' review of significant changes results in a county and/or managed care plan being out of compliance with any standard, DHCS will issue a CAP. DHCS makes available to CMS, upon request, all documentation collected due to the annual network certification. DHCS has aligned its network adequacy certification process across all delivery systems, including managed care, behavioral health, and dental.

For CMC, during the readiness review process for implementation, each CMC plan was required to sign an attestation that their LTC provider network was sufficient to ensure placement of a beneficiary within 72 hours of notification. This requirement has remained in effect throughout the duration of the program.

As of July 2018, MHPs and DMC-ODS plans were required to comply with the appointment time standards in accordance with section 1300.67.2.2(c)(1-4), (7) of Title 28 of the California Code of Regulations, in addition to complying with provider network

[26] Network Adequacy Certification Materials for MCMC, Dental, SMHS, DMC-ODS

adequacy as a PIHP (network certification analyses also include compliance with timely access standards). MHPs and DMC-ODS plans must also proportionately adjust the number of network providers to support any anticipated changes in enrollment and utilization.[27]

In addition to certifying for network adequacy for Dental MC as described, DHCS has included similar network requirements in its dental FFS delivery system contract with its delegated Administrative Services Organization (ASO). The ASO must submit annual plans, describing strategic approaches to increase the number of providers and access to care, with an emphasis on areas and subpopulations with low utilization. Performance measures must also be tied to the plan contract. The ASO must conduct annual surveys to receive data for participating providers about their satisfaction with the Medi-Cal Dental Program, and for unenrolled providers to gauge their interest in the program. Additionally, an annual Provider Capacity Survey[28] is conducted to gauge how enrolled offices serve Medi-Cal members, and to learn about issues providers encounter in serving the Medi-Cal population.

Evidence-Based Clinical Guidelines

The Managed Care Final Rule requires the CQS to include examples of evidence-based clinical practice guidelines the state requires in accordance with 42 CFR 438.236. It further requires the MCMC, SMHS, DMC-ODS, and Dental MC plans to adopt and disseminate these clinical practice guidelines to plan providers and Medi-Cal beneficiaries.

DHCS requires all contracted managed care entities to develop and implement processes that reflect evidence-based clinical practice guidelines. Clinical practice guidelines are based on medical evidence and allow managed care entities to monitor the safety and effectiveness of provider services. DHCS and its contractors review and update clinical practice guidelines regularly to provide consistency with best practices. For behavioral health programs, DHCS provides guidance through various avenues, such as the annual Evidence-Based Practices Symposium, technical assistance on clinical PIPs

[27] See BHIN 21-023 for details about the SMHS and DMC-ODS capacity and composition requirements and methodology.
[28] Dental FFS

via the EQRO, and through ASAM-based assessment tools for DMC-ODS. Specific clinical guidelines are provided below.

MCMC and MMPs

Through its contracts with MCMC plans, DHCS requires that they develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS-developed cultural awareness and sensitivity instruction for seniors and persons with disabilities or chronic conditions. DHCS also requires, through its contracts, that MCMC plans ensure that their pre-authorization, concurrent review, and retrospective review decisions are based on a set of written criteria or guidelines for utilization review that are based on sound medical evidence and are consistently applied, regularly reviewed, and updated. MCMC plans must utilize evaluation criteria and standards to approve, modify, defer, or deny services, and must document the manner in which providers are involved in the development and or adoption of specific criteria used by the MCMC plan. Additionally, DHCS requires, through its contracts, that MCMC plans ensure that the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adults (age 21 or older). All preventive services identified as USPSTF "A" and "B" recommendations must be provided. Further, DHCS contracts specify that MCMC plans must follow the most recent American Academy of Pediatrics (AAP) Bright Futures guidelines for the provision of preventive services to children, and the most recent American College of Obstetrics and Gynecology (ACOG) guidelines for the care of pregnant members.

MCMC plans must submit policies and procedures for ensuring providers receive training on a continuing basis regarding clinical protocols and evidence-based practice guidelines. MCMC plans are audited on their utilization management practices, including the application of evidence-based guidelines, and provider training protocols as part of the annual medical compliance audits conducted by DHCS on all MCMC plans. Similar provisions apply to MMPs, in conjunction with related federal Medicare requirements.

MHPs

Through its contracts with MHPs, DHCS requires the adoption and dissemination of clinical practices and guidelines as specified in 42 CFR 438.236. DHCS' contract with MHPs specifies criteria for SMHS and program requirements. MHPs must have processes in place to disseminate this information to providers and beneficiaries upon request.

MHPs submit their policies and procedures to DHCS during triennial compliance reviews. DHCS holds MHPs accountable to all contract components; if there are deficiencies, DHCS imposes a CAP and meets with the MHP at least monthly until the deficiencies are resolved.

Furthermore, as with MCMCs, DHCS requires MHPs to ensure that their authorization decisions are based on a set of written criteria or guidelines for utilization review that are based on clinical practice standards, are consistently applied and regularly reviewed, and updated as appropriate. Each MHP is required to implement mechanisms to monitor the safety and effectiveness of medication practices at least annually. As such, a majority of MHPs have adopted clinical practice guidelines pertaining to clinical monitoring practices for psychotropic medications, consistent with the best practices in the California guidelines for the use of Psychotropic Medication with Children and Youth in Foster Care.

In 2018, DHCS and CDSS jointly released the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care. This inter-departmental effort produced a guide to best practices for the treatment of mental health conditions affecting children and youth in out-of-home care, which has resulted in downward trends in psychotropic use. The guidelines cover principles and values, expectations about treatment plan monitoring, and options for non-pharmacologic treatment, safety, and informed consent. They are intended to be used by SMHS providers when prescribing psychotropic medication to children and youth in foster care. DHCS conducts compliance reviews to ensure that MHPs implement the guidelines in accordance with state and federal requirements.

DMC-ODS

Counties that implement the DMC-ODS are required to use the ASAM criteria to ensure that eligible beneficiaries gain access to SUD services that best align with their treatment needs and identified level of appropriate care. The ASAM criteria are the result of a collaboration of experts that began in the 1980s to define a national set of criteria for proving outcome-oriented and results-based care in the treatment of a SUD. The ASAM criteria are a proven model in the SUD field and the most widely used comprehensive set of guidelines for assessing patient needs and optimizing placement into SUD treatment. Counties are responsible for ensuring their network providers are trained and conduct ASAM assessments on beneficiaries seeking SUD services.

DMC-ODS counties must identify and train their network providers to use two of the five evidence-based practices listed below:

- Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
- Motivational Interviewing: A beneficiary-centered, empathic but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on beneficiaries' past successes.
- Relapse Prevention: A behavioral coping-focused process that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a standalone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
- Psycho-education: Psycho-education groups are designed to educate beneficiaries about substance abuse and related behaviors and consequences. Psycho-education groups provide information designed to have a direct application to beneficiaries' lives. These groups instill self-awareness; suggest options for growth and change; identify community resources that can assist beneficiaries in recovery; develop an understanding of the process of recovery; and prompt people using substances to take action on their own behalf.
- Trauma-informed treatment: Services take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.

DHCS is proposing a new evidence-based practice, contingency management for stimulant use disorders, in the new HCBS Spending Plan waiver proposal. In addition, DHCS requires all treatment providers to offer or refer to MAT to ensure this service is available at all levels of care and is accessible to beneficiaries whether they are in residential or outpatient care. MAT is also available in Narcotic Treatment Programs (NTPs), and all DMC-ODS counties are required to cover and ensure access to NTP services.

Dental MC

Through its contracts with Dental MC plans, DHCS requires them to abide by the clinical criteria outlined in the Medi-Cal Dental Program Provider Handbook (Handbook),

inclusive of Section 5 – Manual of Criteria (MOC). The MOC provides dental clinical parameters for providers treating Medi-Cal members, setting forth program benefits and clearly defining limitations, exclusions, and special documentation requirements. The MOC outlines DHCS policy for procedures offered through the program that Dental MC plans are required to adopt and disseminate to providers. The handbook serves as a reference guide for all Medi-Cal dental providers, in addition to being available to members and the general public. The handbook contains: the criteria for dental services; program benefits and policies; and instructions for completing forms used in the dental FFS program. The Dental MC contract also requires plans to maintain their own provider manual that, following DHCS approval, should be disseminated to providers and, upon request, to members and potential members. The plan-specific provider manual must rely on clinical evidence and specific clinical practice guidelines to which providers must adhere.

The Dental MC contract requires plans to provide dental services in accordance with intervals that meet reasonable standards of dental practice, including the American Academy of Pediatric Dentistry periodicity schedule for dental services to children. DHCS has also provided Dental MC plans and dental providers with information regarding intravenous sedation and general anesthesia services, as well as services for pregnant women and postpartum individuals. The contract also states that services must be furnished in an amount, duration, and scope that is no less than the same services furnished to members under the dental FFS program.

Transitions of Care Policy

The Managed Care Final Rule requires the CQS to include the state's managed care transition of care policy. Effective July 1, 2018, Title 42 of the CFR, part 438.62 requires the state to have in effect a transition of care policy to ensure continued access to services during a beneficiary's transition from Medi-Cal FFS to a managed care program, or transition from one managed care entity to another, when the beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. Each managed care program has developed specific transition-of-care policies, detailed in the sections below.

MCMC Plans and MMPs

DHCS released APL 18-008 in March 2018, which established continuity of care requirements for Medi-Cal beneficiaries who transition into MCMC. Medi-Cal members

who are assigned a mandatory aid code and are transitioning from FFS into MCMC have the right to request continuity of care in accordance with state law and the MCMC contracts, with some exceptions. All MCMC beneficiaries with pre-existing provider relationships who make a continuity of care request to an MCMC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible beneficiaries may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCMC plan. Duals Plan Letter (DPL) 16-002 provides continuity of care requirements for CMC plans, known as MMPs.

MHPs

DHCS issued Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 18-059, which established a continuity of care policy for the SMHS delivery system. To ensure compliance with CMS' Parity in Mental Health and SUD Final Rule (Parity Rule) in the Federal Register (81.Fed.Reg. 18390), DHCS' transition-of-care policy for MHPs is consistent with its policy for MCMC, and all eligible Medi-Cal members receiving SMHS have the right to request continuity of care. Members with pre-existing provider relationships making continuity of care requests to the MHP must be given the option to continue treatment with an out-of-network Medi-Cal provider or a terminated network provider, including employees of the MHP or a contracted organizational provider, provider group, or individual practitioner. If a beneficiary requests continuity of care, any SMHS necessary to complete a course of treatment will be provided for a period not to exceed 12 months, and the MHP will arrange for a safe transfer to another provider as determined by the MHP, in consultation with the beneficiary and provider, and consistent with good professional practice.

DMC-ODS

The transition of care policy for DMC-ODS counties (MHSUDS Information Notice No. 18-051) ensures a beneficiary has continued access to the same provider during a county's transition from a State Plan DMC network into a DMC-ODS network, or a beneficiary's move from one DMC-ODS county to another DMC. Counties are required to allow a beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious harm to their health or be at risk of hospitalization or institutionalization. SUD treatment services with the existing provider

will continue for a period of no more than 90 days unless medical necessity requires the services to continue for a longer period, not exceeding 12 months.

Dental MC

In April 2018, DHCS released Dental APL 17-011E, which provided Dental MC plans with updated policy guidance regarding transition of care requirements for individuals who transition to Dental MC plans from Dental FFS or other Dental MC plans. Medi-Cal members mandatorily enrolled in Dental MC and who are transitioning from FFS into a Medi-Cal Dental MC plan have the right to request continuity of care in accordance with state law and the Dental MC contracts, with some exceptions. All Dental MC members with pre-existing provider relationships who make a continuity of care request to a Dental MC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal dental FFS provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal dental FFS or through another Dental MC plan.

Continuity and Coordination of Care:

DHCS requires, in accordance with 42 CFR 438.208, that managed care plans must support coordinated care by ensuring that enrollees have an ongoing source of primary care appropriate to their needs, a person or entity is formally designated as primarily responsible for coordinating the services accessed by the enrollee, and timely and coordinated access to all medically necessary services is provided to all beneficiaries. DHCS also requires that contracted plans provide appropriate continuity of care for members to ensure uninterrupted access to services and to minimize the disruption of care.

To ensure the state's compliance with the Medicaid Mental Health Parity Rule, DHCS adopted continuity of care policies for SMHS and SUD services that are consistent with the requirements in place for MCMCs. DHCS' continuity of care policy for MCMC plans includes non-participating physician providers.

MCMC and MMPs

DHCS has issued several APLs addressing continuity of care requirements specific to populations. In 2017, DHCS released APL 17-12, which addresses care coordination requirements for MLTSS, as well as APL 17-017, which addresses long-term care coordination, disenrollment and continuity of care. In 2018, DHCS released APL 18-008, which addresses continuity of care requirements for Medi-Cal members who transition

from FFS into managed care.

MCMC members with pre-existing provider relationships who make a continuity of care request to a MCMC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. APL 18-008 clarifies the requirements of continuity of care services.

Similar to the MCMC population, members enrolled in CMC are afforded the same continuity of care provisions. DPL 16-002 clarifies these requirements for the CMC program. When the CMC program transitions to D-SNP exclusively aligned enrollment, similar continuity of care requirements will remain in effect through the D-SNP and Medi-Cal contracts.

MCMCs historically have met their contractual requirements for the reporting of Medical Exemption Request (MER) denial reports and other continuity of care request data to DHCS by utilizing proprietary Microsoft Excel templates developed by DHCS. In August 2021, in support of MCMC program data quality improvement initiatives, DHCS transitioned the reporting of MER denial reports and other continuity of care requests to a standardized JSON reporting format. This allows DHCS to capture MER denial reports and other continuity of care request data in much finer detail, allows for automated processing and validation of this data, and provides near real time feedback to submitters regarding data deficiencies.

DHCS' contracts with MCMCs also address coordination of care requirements, including basic and comprehensive care management, person-centered planning for seniors and persons with disabilities, discharge planning, targeted case management, and out-of-network case management and coordination of care. The contracts also outline the requirement for MOUs between the MCMCs and several external partners, including, but not limited to, CCS, local public health departments, county mental health providers, and local education agencies, to coordinate care for members.

MHPs

MHPs are required to coordinate care for all Medi-Cal beneficiaries receiving SMHS, in accordance with Title 42 of the Code of Federal Regulations, § 438.208, and the terms of the SMHS contract. Care coordination requirements include the coordination of services between settings of care, with services the beneficiary receives from other managed care entities or in FFS, services from community and social support providers, and services from other human services agencies. In addition, per the SMHS contract and Title 9 of

the California Code of Regulations, §1810.370, MHPs are required to enter into a MOU with any MCMC serving MHP beneficiaries.

DMC-ODS

DMC-ODS counties are responsible for coordination and continuity of care for their enrolled beneficiaries. The county is required to ensure that each beneficiary has an ongoing source of care appropriate to their needs, and a person or entity is formally designated as primarily responsible for coordinating the services accessed by the beneficiary. Information on how to contact their designated person or entity at enrollment must be provided to beneficiaries. To support an effective care coordination system, counties are required to enter into a MOU with any MCMC that enrolls beneficiaries served by the DMC-ODS. MOUs must include a description of how responsibilities will be divided and the services provided, including comprehensive substance use, physical health, and mental health screenings; the delineation of case management responsibilities; availability of clinical consultations; and collaborative treatment planning. Care coordination includes coordinating changes between levels of care, including discharge planning, connecting beneficiaries to community and recovery supports, and coordinating health care services through MOUs with all MCMCs operating in the county.

Through this coordination process, continuity of care is achieved, reducing fragmentation of services and improving patient safety and quality of care.

Dental MC

Dental MC plans are responsible for coordinating the care of their beneficiaries. DHCS issued Dental APL 18-007 and amended the Dental MC contracts to ensure plans: 1) conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful; and 2) share with DHCS or other managed care plans serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities.

In addition, for members with Special Health Care Needs (SHCN), each Dental MC plan is required to: 1) implement mechanisms to comprehensively assess members identified as having SHCN to identify any ongoing special conditions that require a course of treatment or regular care monitoring; and 2) produce a member-specific treatment or service plan for those members that are determined through assessment to need a course of treatment or regular monitoring. Please note that "a member-specific

treatment or service plan" is statutorily required language that means the same as "a care plan." Dental APL 18-007 establishes a definition for members with SHCN to assist Dental MC plans in identifying members with SHCN for the purpose of conducting assessments and developing treatment plans.

In July 2018, DHCS reviewed and approved all Dental MC plans' submitted policies and procedures and oral health information forms to confirm that Dental MC plans have effective processes in place to demonstrate compliance with these requirements.

Identification of Persons Who Need LTSS or Persons with SHCN

The Managed Care Final Rule requires the CQS to include the mechanisms implemented by the state to comply with § 438.208(c)(1), relating to the identification of persons who need LTSS or persons with SHCN.

In California, some Medicaid LTSS benefits are provided through managed care and others through 1915(c) and other waiver and State Plan programs that are carved out of managed care. Medicaid LTSS in California includes SNF care, a large personal care services program called IHSS, and a number of other HCBS waiver programs authorized under Section 1115, 1915(b), and 1915(c) waivers. The LTSS programs included in MCMC include Community-Based Adult Services (CBAS), SNF care in 27 counties, and, starting in 2022, certain Community Supports. In 2023, SNF care will be provided through MCMC in the remaining 31 counties in California.

Identification of persons who need LTSS is accomplished through several processes:

- For MCMC, including the CMC program and Dental MC, the state provides MCMCs and Dental MC plans with enrollment files that include the aid codes associated with each newly enrolled beneficiary. For beneficiaries enrolling in managed care from FFS, the MCMCs and Dental MC plans also receive the beneficiary's FFS utilization data, including certain HCBS waiver enrollment data. The aid code and FFS utilization data, if provided, are used by plans to identify individuals utilizing LTSS, or persons with other SHCNs. Further details are provided in **Appendix D.**
- MCMC and CMC plans are required to conduct an initial health assessment in which a provider of primary care services can comprehensively assess the member's current acute, chronic, and preventive health needs and identify those

members whose health needs require coordination with appropriate community resources and other agencies, including LTSS.

» Each MCMC (and CMC plans) must apply a state-approved health risk stratification mechanism or algorithm to identify newly enrolled seniors and persons with disabilities with higher risk and more complex health care needs within 44 days (45 days for the CMC program) of enrollment.

» Each MCMC must develop methods to identify enrollees who may benefit from complex case management services, using the risk stratification and health risk assessment results, as well as utilization and clinical data and any other available information across medical, LTSS, and behavioral health domains, as well as self and provider referrals.

» Data on SNF residents is available to MCMC plans in those counties where that benefit is carved-in to managed care. In preparation for the carve-in of this benefit in remaining counties, data on these residents will be provided to the plans.

» For LTSS not included in MCMC, identification processes are determined based on federally approved waiver and state plan provisions, which generally indicate that local HCBS waiver agencies or counties contracted with the state will conduct assessments to determine individuals needing LTSS. For example, IHSS assessments are conducted by county staff, and HCBA assessments are conducted by local waiver agencies.

» CalAIM initiatives on PHM will strengthen MCMC health risk assessments and risk stratification, including identification of persons who need LTSS.

» Each MCMC is required to implement and maintain a program for Children with SHCN (CSHCN), who are defined by the state as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond that generally required by children. Each MCMC's CSHCN program is required to include standardized procedures for identifying CSHCN at enrollment and on a periodic basis after enrollment. Members identified as CSHCN must receive comprehensive assessment of health and related needs. The MCMC must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN. Dental MC plans are required to implement

and maintain a program for CSHCN, which includes standardized procedures, such as dental care provider training for the identification of CSHCN at and after enrollment. Members identified as CSHCN receive comprehensive oral assessment and a written dental treatment plan.

CONCLUSION

DHCS envisions a future of Medi-Cal that enables all members to lead longer, healthier, and happier lives via a whole-system, person-centered approach to health and social care. While DHCS has always had an unwavering commitment to quality and health equity in Medi-Cal, as the evaluation of DHCS' 2018 Managed Care Quality Strategy (**Appendix E**) and stakeholder feedback have demonstrated, DHCS will need to address numerous gaps to achieve its future state vision. Also, as the COVID-19 pandemic and national awakening to racial injustice have demonstrated, incremental improvements are insufficient. The transformative investment in Medi-Cal through CalAIM, the FY 2021-22 state budget, and the HCBS Spending Plan, along with the disruption of COVID-19 and a society-wide desire for change, offer us a unique opportunity to transform Medi-Cal and achieve high-quality, equitable health care for all. To truly address health, and not just healthcare, DHCS' approach and programs will need to expand outside of healthcare's four walls and partner with communities, schools, public health jurisdictions and CBOs to collectively transform drivers of heatlh. This is what we envision. This will not be an easy journey. It will require significant transformation and partnership at all levels, and in different ways than have been attempted before, to achieve the ambitious goals we have outlined in this CQS. We invite you to join us on this journey.

APPENDICES

Appendix A: Commonly Used Acronyms

AAP	American Academy of Pediatrics
ACA	Affordable Care Act
ACOG	American College of Obstetrics and Gynecology
ALW	Assisted Living Waiver
APL	All-Plan Letter
ARF	Adult Residential Facilities
APM	Alternative Payment Method
ASAM	American Society of Addiction Medicine
BH	Behavioral Health
BH-QIP	Behavioral Health Quality Improvement Program
BH-SAC	Behavioral Health Stakeholder Advisory Committee
CalAIM	California Advancing and Innovating Medi-Cal
CalHHS	California Health and Human Services Agency
CalOMS	California Outcomes and Measurement System
CANS	Child and Adolescent Needs and Strengths Scale
CAP	Corrective Action Plan
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAIR	California Immunization Registry
CA-WIC	California Welfare Institute Code
CBO	Community-Based Organization
CCI	Coordinated Care Initiative
CCT	California Community Transitions
CCP	Cultural Competency Plan
CCS	California Children's Services
CCPR	Cultural Competency Plan Requirements

CDPH	California Department of Public Health
CDSS	California Department of Social Services
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLAS	Culturally and Linguistically Appropriate Services
CMC	Cal MediConnect
CMHEP	Community Mental Health Equity Project
COHS	County Organized Health System
CMS	Centers for Medicare & Medicaid Services
CQS	Comprehensive Quality Strategy
CSHCN	Children with Special Health Care Needs
DEI	Diversity, Equity, and Inclusion
Dental MC	Dental Managed Care
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMHC	Department of Managed Health Care
D-SNP	Dual Eligible Special Needs Plan
DTI	Dental Transformation Initiative
EAS	External Accountability Set
EBP	Evidence-Based Practice
ECM	Enhanced Care Management
EDIM	Enterprise Data and Information Management
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review

EQRO	External Quality Review Organization
FPACT	Family Planning, Access, Care, and Treatment
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GHPP	Genetically Handicapped Persons Program
GMC	Geographic Managed Care
HCBA	Home and Community-Based Alternatives
HCBS	Home and Community-Based Services
HCBS-DD	Home and Community-Based Services Waiver for Individuals with Developmental Disabilities
HCPCFC	Health Care Program for Children in Foster Care
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIO	Health Insuring Organization
HIPAA	Health Insurance Portability and Accountability Act of 1996
IA	Intergovernmental Agreement
ICF/DD	Intermediate Care Facilities for the Developmentally Disabled
IHSS	In-Home Supportive Services
IHP	Indian Health Program
ILOS	In Lieu of Services/Community Supports
KKA	Knox-Keene Act
LI	Local Initiative
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MAT	Medication Assisted Treatment

MCAS	Managed Care Accountability Set
MCHAP	Medi-Cal Children's Health Advisory Panel
MCMC	Medi-Cal Managed Care
MCO	Managed Care Organization
MCWP	Medi-Cal Waiver Program
MER	Medical Exemption Request
MFP	Money Follows the Person
MHP	Mental Health Plan
MHGB	Mental Health Services Block Grant
MLTSS	Managed Long-Term Supports and Services
MOC	Manual of Criteria
MOU	Memorandum of Understanding
MPL	Minimum Performance Level
MMP	Medicare-Medicaid Plans
MSSP	Multipurpose Senior Services Program
MTM	Medically Tailored Meals
MY	Measurement Year
NTP	Narcotic Treatment Program
PAHP	Prepaid Ambulatory Health Plan
PATH	Providing Access and Transforming Health
PAVE	Provider Application & Validation for Enrollment
PCCM	Primary Care Case Management
PHE	Public Health Emergency
PHM	Population Health Management
PIHP	Prepaid Inpatient Health Plan
PHN	Public Health Nurse

PIP	Performance Improvement Project
PSER	Plan Specific Evaluation Report
PSP	Population Specific Health Plan
QAIP	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIP	Quality Improvement Project
QPHM	Quality and Population Health Management
RBA	Results Based Accountability
RCFE	Residential Care Facilities for Elderly
REAL	Race, Ethnicity, and Language
RFP	Request for Proposal
SABG	Substance Abuse Prevention and Treatment Block Grant
SAG	Stakeholder Advisory Group
SAMHSA	Substance Abuse and Mental Health Services Administration
SCC	Special Care Center
SDP	Self-Determination Program
SMHS	Specialty Mental Health Services
SOGI	Sexual Orientation and Gender Identity
SOR	State Opioid Response
SPAWDD	Strategic Planning and Workforce Development Division
SPD	Seniors and Persons with Disabilities
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TMSIS	Transformed Medicaid Statistical Information System
USPSTF	U.S. Preventive Services Task Force
VBP	Value-Based Payment Program

WCM Whole Child Model

WPC Whole Person Care

WPCS Waiver Personal Care Services

Appendix B: Managed Care Program Structure

Table 1: MCMC Plan Information[1]

County	Managed Care Model	Type of Program	MC Authority[2]	Name of Plan
Alameda	Two-Plan	MCO	1915(b)	Alameda Alliance for Health; Anthem Blue Cross Partnership Plan (ABC)
Alpine	Regional	MCO	1915(b)	ABC; California Health and Wellness (CHW)
Amador	Regional	MCO	1915(b)	ABC; CHW
Butte	Regional	MCO	1915(b)	ABC; CHW
Calaveras	Regional	MCO	1915(b)	ABC; CHW
Colusa	Regional	MCO	1915(b)	ABC; CHW
Contra Costa	Two-Plan	MCO	1915(b)	ABC; Contra Costa Health Plan
Del Norte	COHS	HIO	1915(b)	Partnership HealthPlan of California (PHC)
El Dorado	Regional	MCO	1915(b)	ABC; CHW
Fresno	Two-Plan	MCO	1915(b)	ABC; CalViva Health
Glenn	Regional	MCO	1915(b)	ABC; CHW
Humboldt	COHS	HIO	1915(b)	PHC
Imperial	Imperial	MCO	1915(b)	CHW; Molina Healthcare of California Partner Plan, Inc. (Molina)
Inyo	Regional	MCO	1915(b)	ABC; CHW

[1] All MCMC plans listed serve the same population of patients: low-income children and adults, pregnant women, and families.
[2]Current authority for managed care plans is under the 1115 waiver, but is included in DHCS' 1915(b) submission to CMS that is under review.

County	Managed Care Model	Type of Program	MC Authority[2]	Name of Plan
Kern	Two-Plan	MCO	1915(b)	Health Net Community Solutions, Inc (Health Net); Kern Family Health Care
Kings	Two-Plan	MCO	1915(b)	ABC; CalViva Health
Lake	COHS	HIO	1915(b)	PHC
Lassen	COHS	HIO	1915(b)	PHC
Los Angeles	Two-Plan	MCO	1915(b)	Health Net; L.A. Care Health Plan
Madera	Two-Plan	MCO	1915(b)	ABC; CalViva Health
Marin	COHS	HIO	1915(b)	PHC
Mariposa	Regional	MCO	1915(b)	ABC; CHW
Mendocino	COHS	HIO	1915(b)	PHC
Merced	COHS	HIO	1915(b)	Central California Alliance for Health
Modoc	COHS	HIO	1915(b)	PHC
Mono	Regional	MCO	1915(b)	ABC; CHW
Monterey	COHS	HIO	1915(b)	Central California Alliance for Health
Napa	COHS	HIO	1915(b)	PHC
Nevada	Regional	MCO	1915(b)	ABC; CHW
Orange	COHS	HIO	1915(b)	CalOptima
Placer	Regional	MCO	1915(b)	ABC; CHW
Plumas	Regional	MCO	1915(b)	ABC; CHW
Riverside	Two Plan	MCO	1915(b)	Inland Empire Health Plan (IEHP); Molina

County	Managed Care Model	Type of Program	MC Authority[2]	Name of Plan
Sacramento	GMC	MCO	1915(b)	Aetna Better Health of California (Aetna); ABC; Health Net; Kaiser Permanente; Molina
San Benito	GMC	MCO	1915(b)	ABC
San Bernardino	Two Plan	MCO	1915(b)	IEHP; Molina
San Diego	GMC	MCO	1915(b)	Aetna; Blue Shield of California Promise Health Plan; Community Health Group Partnership Plan; Health Net; Kaiser Permanente; Molina; United Healthcare Community Plan
San Francisco	Two Plan	MCO	1915(b)	ABC; San Francisco Health Plan
San Joaquin	Two Plan	MCO	1915(b)	Health Net; Health Plan of San Joaquin
San Luis Obispo	COHS	HIO	1915(b)	CenCal Health
San Mateo	COHS	HIO/MCO[3]	1915(b)	Health Plan of San Mateo (HPSM)
Santa Barbara	COHS	HIO	1915(b)	CenCal Health
Santa Clara	Two Plan	MCO	1915(b)	ABC; Santa Clara Family Health Plan
Santa Cruz	COHS	HIO	1915(b)	Central California Alliance for Health
Shasta	COHS	HIO	1915(b)	PHC
Sierra	Regional	MCO	1915(b)	ABC; CHW

[3] As previously approved in the Bridge to Reform (2010) and Medi-Cal 2020 Section 1115 demonstrations, HPSM is considered a COHS even if it is not considered an HIO by federal standards because it became operational after January 1, 1986.

County	Managed Care Model	Type of Program	MC Authority[2]	Name of Plan
Siskiyou	COHS	HIO	1915(b)	PHC
Solano	COHS	HIO	1915(b)	PHC
Sonoma	COHS	HIO	1915(b)	PHC
Stanislaus	COHS	HIO	1915(b)	Health Plan of San Joaquin
Sutter	Regional	MCO	1915(b)	ABC; CHW
Yuba	Regional	MCO	1915(b)	ABC; CHW
Tehama	Regional	MCO	1915(b)	ABC; CHW
Trinity	COHS	HIO	1915(b)	PHC
Tulare	Two Plan	MCO	1915(b)	ABC; Health Net
Tuolumne	Regional	MCO	1915(b)	ABC; CHW
Ventura	COHS	HIO	1915(b)	Gold Coast Health Plan
Yolo	COHS	HIO	1915(b)	PHC

Table 2: Dental MC Plans[4]

County	Type of Program	MC Authority[5]	Name of Plan
Sacramento	PAHP	1915(b)	Access Dental Plan; Health Net of California, Inc.; Liberty Dental Plan of California, Inc.
Los Angeles	PAHP	1915(b)	Access Dental Plan; Health Net of California, Inc.; Liberty Dental Plan of California, Inc.

[4] All Dental MC plans listed serve the same population: Medicaid children without disabilities, and parents and expansion adults, ages 20-64.

[5] Current authority for the Sacramento and Los Angeles Dental MC plans is under the Section 1115 waiver, but is included in DHCS' 1915(b) submission to CMS that is under review.

Table 3: Cal MediConnect MMPs[6]

County	Type of Plan	MC Authority[7]	Name of Plan
Los Angeles	MMP	Federal 1115(a)	ABC, Blue Shield of California Promise Health Plan; Health Net; L.A. Care Health Plan; Molina
Orange	MMP	Federal 1115(a)	CalOptima
Riverside	MMP	Federal 1115(a)	IEHP; Molina
San Bernardino	MMP	Federal 1115(a)	IEHP; Molina
San Diego	MMP	Federal 1115(a)	Blue Shield of California Promise Health Plan; Community Health Group; Health Net; Molina;
San Mateo	MMP	Federal 1115(a)	Health Plan of San Mateo
Santa Clara	MMP	Federal 1115(a)	ABC; Santa Clara Family Health Plan

Table 4: County MHPs[8]

County	Type of Program	MC Authority	Name of Plan
Alameda	PIHP	1915(b)	Alameda Behavioral Health Care Services
Alpine	PIHP	1915(b)	Alpine County Behavioral Health Services
Amador	PIHP	1915(b)	Amador County Behavioral Health

[6] All MMPs listed serve the same population: dual eligibles (individuals eligible for Medicare and Medi-Cal) older than age 21, residing in the seven counties under the CCI.
[7] Current authority for MMP plans is under the Section 1115(a) waiver for CMS.
[8] All listed MHPs serve the same population: Medicaid beneficiaries meeting criteria for SMHS.

County	Type of Program	MC Authority	Name of Plan
Butte	PIHP	1915(b)	Butte County Department of Behavioral Health
Calaveras	PIHP	1915(b)	Calaveras County Behavioral Health Services
Colusa	PIHP	1915(b)	Colusa County Department of Behavioral Health
Contra Costa	PIHP	1915(b)	Contra Costa County Mental Health Services
Del Norte	PIHP	1915(b)	Del Norte County Mental Health Branch
El Dorado	PIHP	1915(b)	El Dorado Health and Human Services Agency
Fresno	PIHP	1915(b)	Fresno County Department of Behavioral Health
Glenn	PIHP	1915(b)	Glenn County Department of Mental Health
Humboldt	PIHP	1915(b)	Humboldt County Health and Human Services
Imperial	PIHP	1915(b)	Imperial County Behavioral Health Services
Inyo	PIHP	1915(b)	Inyo County Mental Health
Kern	PIHP	1915(b)	Kern County Mental Health Department
Kings	PIHP	1915(b)	Kings County Behavioral Health
Lake	PIHP	1915(b)	Lake County Behavioral Health Department
Lassen	PIHP	1915(b)	Lassen County Health and Social Services
Los Angeles	PIHP	1915(b)	Los Angeles County Department of Mental Health
Madera	PIHP	1915(b)	Madera County Behavioral Health Services
Marin	PIHP	1915(b)	Marin County Health and Human Services
Mariposa	PIHP	1915(b)	Mariposa County Mental Health
Mendocino	PIHP	1915(b)	Mendocino County Mental Health
Merced	PIHP	1915(b)	Merced County Mental Health

County	Type of Program	MC Authority	Name of Plan
Modoc	PIHP	1915(b)	Modoc County Health Services
Mono	PIHP	1915(b)	Mono County Behavioral Health
Monterey	PIHP	1915(b)	County of Monterey
Napa	PIHP	1915(b)	Napa County Health and Human Services
Nevada	PIHP	1915(b)	Nevada County Behavioral Health
Orange	PIHP	1915(b)	Orange County Healthcare Agency Behavioral Health Services
Placer/Sierra	PIHP	1915(b)	Placer County Adult Systems of Care
Plumas	PIHP	1915(b)	Plumas County Mental Health
Riverside	PIHP	1915(b)	Riverside Department of Mental Health
Sacramento	PIHP	1915(b)	Sacramento County Behavioral Health Services
San Benito	PIHP	1915(b)	Health and Human Services San Benito County Behavioral Health
San Bernardino	PIHP	1915(b)	San Bernardino County Behavioral Health
San Diego	PIHP	1915(b)	San Diego County Behavioral Health
San Francisco	PIHP	1915(b)	San Francisco Community Behavioral Health Services
San Joaquin	PIHP	1915(b)	San Joaquin County Behavioral Health Services
San Luis Obispo	PIHP	1915(b)	San Luis Obispo County Behavioral Health
San Mateo	PIHP	1915(b)	San Mateo County Behavioral Health and Recovery Services
Santa Barbara	PIHP	1915(b)	Santa Barbara County Alcohol, Drug and Mental Health Services
Santa Clara	PIHP	1915(b)	Santa Clara County Valley Health and Hospital Systems Mental Health Department

County	Type of Program	MC Authority	Name of Plan
Santa Cruz	PIHP	1915(b)	Santa Cruz County Mental Health and Substance Abuse Services
Shasta	PIHP	1915(b)	Shasta Mental Health, Alcohol and Drug
Sierra	PIHP	1915(b)	Placer County Adult Systems of Care
Siskiyou	PIHP	1915(b)	Siskiyou County Health and Human Services Agency
Solano	PIHP	1915(b)	Solano County Health and Social Services
Sonoma	PIHP	1915(b)	Sonoma County Department of Health Services
Stanislaus	PIHP	1915(b)	Stanislaus County Behavioral Health and Recovery Services
Sutter/Yuba	PIHP	1915(b)	Sutter/Yuba Mental Health Services
Tehama	PIHP	1915(b)	Tehama County Health Services Agency, Behavioral Health
Trinity	PIHP	1915(b)	Trinity County Behavioral Health Services
Tulare	PIHP	1915(b)	Tulare County Health and Human Services Agency
Tuolumne	PIHP	1915(b)	Tuolumne County Health and Human Services
Ventura	PIHP	1915(b)	Ventura County Behavioral Health Department
Yolo	PIHP	1915(b)	Yolo County Department of Alcohol, Drug, and Mental Health Services

Table 5: DMC-ODS Plans[9]

County	Type of Program	MC Authority[10]	Name of Entity
Alameda	PIHP	1915(b)	County of Alameda
Contra Costa	PIHP	1915(b)	County of Contra Costa
El Dorado	PIHP	1915(b)	County of El Dorado
Fresno	PIHP	1915(b)	County of Fresno
Humboldt	Regional	1915(b)	PHC
Imperial	PIHP	1915(b)	County of Imperial
Kern	PIHP	1915(b)	County of Kern
Lassen	Regional	1915(b)	PHC
Los Angeles	PIHP	1915(b)	County of Los Angeles
Marin	PIHP	1915(b)	County of Marin
Mendocino	Regional	1915(b)	PHC
Merced	PIHP	1915(b)	County of Merced
Modoc	Regional	1915(b)	PHC
Monterey	PIHP	1915(b)	County of Monterey
Napa	PIHP	1915(b)	County of Napa
Nevada	PIHP	1915(b)	County of Nevada
Orange	PIHP	1915(b)	County of Orange
Placer	PIHP	1915(b)	County of Placer
Riverside	PIHP	1915(b)	County of Riverside

[9] All DMC-ODS plans listed serve the same population: Medicaid beneficiaries meeting criteria for SUD treatment.

[10] Current authority for DMC-ODS is under the Section 1115 waiver, but is included in DHCS' 1915(b) submission to CMS that is under review.

County	Type of Program	MC Authority[10]	Name of Entity
Sacramento	PIHP	1915(b)	County of Sacramento
San Bernardino	PIHP	1915(b)	County of San Bernardino
San Benito	PIIHP	1915(b)	County of San Benito
San Diego	PIHP	1915(b)	County of San Diego
San Francisco	PIHP	1915(b)	County of San Francisco
San Joaquin	PIHP	1915(b)	County of San Joaquin
San Luis Obispo	PIHP	1915(b)	County of San Luis Obispo
San Mateo	PIHP	1915(b)	County of San Mateo
Santa Barbara	PIHP	1915(b)	County of Santa Barbara
Santa Clara	PIHP	1915(b)	County of Santa Clara
Santa Cruz	PIHP	1915(b)	County of Santa Cruz
Shasta	Regional	1915(b)	PHC
Siskiyou	Regional	1915(b)	PHC
Solano	Regional	1915(b)	PHC
Stanislaus	PIHP	1915(b)	County of Stanislaus
Tulare	PIHP	1915(b)	County of Tulare
Ventura	PIHP	1915(b)	County of Ventura/Ventura County Behavioral Health Department
Yolo	PIHP	1915(b)	County of Yolo/Yolo County Department of Alcohol, Drug, and Mental Health Services

Appendix C: Managed Care Entity Program Reporting Requirements

DHCS meets the requirements for developing, evaluating, revising, and making available the CQS as described in §438.340(b) (c) and (d). This section includes examples of the reporting requirements for entities covered by the CQS. Reporting requirements are subject to change.

42 CFR	Summary of Requirement	DHCS Strategy Details
438.340 (b)	Requires state to include, at a minimum, the following: 1. Defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPS; 2. Examples of evidence-based clinical practice guidelines; goals and objectives for continuous quality improvement that must be measurable; 3. A description of the quality metrics and performance targets, PIPs, and a description of interventions if required; 4. Arrangements for external independent review; 5. Description of the transition of care policy; 6. Plan to identify health disparities and disability status; 7. Intermediate sanctions (MCOs); 8. Identification /support for those who need LTSS and persons with SHCN; 9. Non-duplication of EQR activities; and 10. Definition of "significant changes."	» Interdisciplinary team led by QPHM met and worked with all relevant DHCS areas to review materials and update the quality strategy (programs, admin, IT/EDIM, CalAIM leads). » Reviewed all available documentation and previous public comment from 2019, as outlined in CMS Quality Strategy Toolkit. » DHCS defines a significant change as: Significant restructuring of the quality management within DHCS o Significant change in the numbers, types or timeframes of quality reporting o A significant change to the managed care population o Changes to quality standards or reporting requirements by state or federal regulations

42 CFR	Summary of Requirement	DHCS Strategy Details
438.340 (c)	The State must: 1. Make the strategy available for public comment before submitting the strategy to CMS for review; 2. Review and update the quality strategy as needed, but no less than once every three years; review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. The state must ensure that updates to the quality strategy consider the recommendations provided by an EQRO and should describe how updates to the quality strategy take those recommendations into consideration. 3. Submit a copy of the initial strategy for CMS comment/feedback prior to adopting it in final and submit a copy of the revised strategy whenever significant changes are made to the document.	» DHCS posted the draft strategy for public review in December 2021, presented it at stakeholder meetings, sought Tribal consultation, and incorporated feedback. » Please see stakeholder engagement and key partnerships section for additional entities that have provided input over time. » DHCS acknowledges that it will update its CQS at least every three years, or sooner due to significant change. » This revision is the three-year update, although it incorporates some significant changes in the quality structure at DHCS. » DHCS has reviewed the effectiveness of the 2018 Managed Care Quality Strategy and has summarized the results in **Appendix E**. » DHCS has reviewed all recent EQRO reports and addressed them; in addition, overarching themes have been incorporated in this revised CQS. EQRO Reports can be found at CalEQR. And Managed Care Quality Performance EQRTR.
438.340 (d)	The State must make the final quality strategy available on the DHCS website	» DHCS posts the final report on the DHCS CQS website.

Network Adequacy and Availability of Services:

(CFR Section: 42 CFR 438.68 – Network Adequacy Standards; 42 CFR 438.206 – Availability of Services)

Program	Report Title	Description
MCMC	Time or Distance Accessibility Analysis	» Annual report, and any time there is a significant change to the MCMC's network, which includes the plan's geographic access assessment for all provider types by service area required by WIC 14197.
	Alternative Access Standard Requests	» Annual report, and any time there is a significant change to the plan's network that details the exception request of the plan for provider-specific network standards.
	Provider Network Report	» Quarterly report in which the plan reports on the plan's provider terminations during the previous quarter.
	Quarterly Monitoring Response Template	» Quarterly report in which the plan reports on their DHCS Timely Access Survey Results
	Provider-to-Member Ratios	» Annual and quarterly report on the plan's compliance with provider-to-member ratios.
	Significant Changes in Provider Network	» Immediate notice of significant changes in the plan's provider network that will affect the adequacy and capacity of services
	Provider Suspensions and Termination Notification	» Immediate notice of any independent action taken by the plan to suspend or terminate network provider
CMC	LTC Placement	» During the readiness review process for the implementation of CMC, each CMC plan was required to sign an attestation that their long-term care provider network was sufficient to ensure placement of a beneficiary within 72 hours of notification. This requirement has remained in effect throughout the duration of the program.

Program	Report Title	Description
	CBAS Provider Network	» During the readiness review process for the implementation of CMC, each CMC plan was required to contract with all of the licensed CBAS providers in the plan's county. This requirement has remained in effect throughout the duration of the program.
	MSSP Provider Network	» During the readiness review process for the implementation of CMC, each CMC plan was required to contract with all of the MSSP providers in the plan's county. This requirement has remained in effect throughout the duration of the program.
	Medicare Provider Network Report	» Annual report for the Medicare provider network is reviewed and approved by CMS.
	Significant Changes in Provider Network	» Immediate notice of significant changes in the plan's provider network that will affect the adequacy and capacity of services.
	Provider Suspensions and Termination Notification	» Immediate notice of any independent action taken by the plan to suspend or terminate a network provider
MHPs	Attestation of Network Certification Compliance	» Cover letter for Annual Network Certification Report
	Annual Network Certification Report	» Annual report of counties' compliance/non-compliance with network adequacy standards
	Approved Alternative Access Standards	» Annual report of county meeting time and distance standards with an Alternative Access Standards request
	Annual Network Certification CAP Report	» Annual report on the status of counties found out-of-compliance with network adequacy standards

Program	Report Title	Description
DMC-ODS	Attestation of Network Certification Compliance	» Cover letter for Annual Network Certification Report
	Annual Network Certification Report	» Annual report of county compliance/non-compliance with network adequacy standards.
	Approved Alternative Access Standards	» Annual report of counties meeting time and distance standards with an Alternative Access Standards request.
	Annual Network Certification CAP Report	» Annual report on the status of counties found out-of-compliance with network adequacy standards.
Dental MC	X12 274 Provider Network Data Report	» Monthly submission of plan provider network data.
	Plan Provider Network Report	» Monthly reporting of all direct subcontracting providers, specialists and provider groups, including FQHCs and Rural Health Clinics (RHC).
	Timely Access and Specialty Referral Report	» Quarterly reporting of the average amount of time for members to obtain initial primary care dentist appointments, routine appointments, specialist appointments/referrals, emergency appointments, percentage of "no show" appointments, and other requirements.
	Annual Attestation of Network Certification	» Annual attestation of network certification letter.
	Annual Network Certification Report	» Annual report of Dental MC plan compliance with network adequacy standards.

Coordination and Continuity of Care:

(CFR Section: 42 CFR 438.208(c)(1) - Additional services for enrollees with SHCNs or who need LTSS)

Program	Report Title	Description
MCMC and CMC	Health Risk Assessment and Individual Care Plan Completion	Enhanced, person-centered care coordination is a key benefit of CMC. The CMC Performance dashboard tracks different measures and aspects of that benefit, including the initial health risk assessment to start the care coordination process, development of an individualized care plan, care coordinators, and post-hospital discharge follow-up care. Health Risk Assessment (HRA): An HRA is a survey tool conducted by CMC plans to assess a member's current health risk(s) and identify further assessment needs, such as behavioral health, substance use, chronic conditions, disabilities, functional impairments, assistance in key activities of daily living, dementia, cognitive and mental status, and the capacity to make informed decisions. Plans must complete assessments for high-risk members within 45 days of enrollment, and for low-risk members within 90 days of enrollment. Individualized Care Plans (ICPs): The care plan is developed by members with their interdisciplinary care team or CMC plan. Engaging members in developing their own care goals and care plans is a central tenant of person-centered care. ICPs must include the member's goals, preferences, choices, and abilities. Documenting discussions of care goals with members is one way to assess how plans are engaging members in their care planning and are monitored through multiple measures. The plans must complete a care plan for each member within 90 days of enrollment. DHCS and CMS continue to work with plans to ensure improved ICP completion rates within 90 days of enrollment.

Program	Report Title	Description
		Follow-up Visits within 30 Days of Hospital Discharge: Supporting members through care transitions, particularly out of an acute hospital stay, is another measure of care coordination activities. In 2016, DHCS released a DPL on discharge planning in CMC, and this continues to be an area of focus for program improvements. Care Coordinators and Interdisciplinary Care Teams (ICT): An ICT works with a member to develop, implement, and maintain an ICP. The ICT is comprised of the primary care provider and care coordinator, as well as other providers at the discretion of the member.
	Continuity of Care (COC)	MCMC members with preexisting provider relationships who make a COC request to an MCMC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. APL 18-008 clarifies the requirements for COC services. Similar COC requirements are also in place for Cal MediConnect, via DPL 16-002. Historically, MCMCs have met their contractual requirements for the reporting of MER denial reports and other COC request data to DHCS by utilizing proprietary Microsoft Excel templates developed by DHCS. In August 2021, in support of MCMC program data quality improvement initiatives, DHCS transitioned the reporting of MER denial reports and other continuity of care requests to a standardized JSON reporting format. This allows DHCS to capture MER denial reports and other COC request data in much finer detail, allows for automated processing and validation of this data, and provides near real time feedback to submitters regarding data deficiencies.
MHP	N/A	

Program	Report Title	Description
DMC-ODS	N/A	
Dental MC	Timely Access and Specialty Referral Report	Quarterly reporting of average amount of time for members to obtain initial PCD appointments, routine appointments, specialist appointments/referrals, emergency appointments, percentage of "no show" appointments, and other requirements.
	Grievance and Appeal Report	Quarterly reporting of grievances and appeals received during the quarter.
	Case Management	Quarterly reporting of case management cases received during the quarter.

Practice Guidelines:

(CFR Section: 42 CFR 438.236 - Practice Guidelines)

Program	Report Title	Description
MCMC	DHCS Provider Manual	Manual of required covered services, including certain applicable clinical parameters, which all managed care and FFS providers must follow, including MCMCs.
	DHCS Boilerplate Managed Care Contracts	Require MCMCs and providers to follow all current recommendations from the AAP Bright Futures, USPSTF and ACOG, as well as develop and implement a process to provide information to providers and to train network providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines.
CMC	CMC Three-Way Contract	DHCS and CMS contract with MMPs to coordinate the delivery of and be accountable for covered Medicare and Medicaid services for participating Medicare-Medicaid enrollees. The MMPs are required to offer quality, accessible care; improve care coordination among medical care, behavioral health, and LTSS; and further the goals of the Olmstead Decision.

Program	Report Title	Description
MHP	Behavioral Health Information Notices	Information notices clarify criteria for SMHS and other program requirements.
	DHCS Boilerplate MHP Contracts	Require MHPs and providers to adopt, follow, and disseminate current practice guidelines, which (1) must be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; (2) consider the needs of the beneficiaries; (3) are adopted in consultation with contracting health care professionals; and (4) are reviewed and updated periodically as appropriate.
DMC-ODS	Behavioral Health Information Notices	Information notices clarify criteria for SUD treatment services and other program requirements
	DHCS DMC-ODS County Contracts	Require DMC-ODS county plans and providers to adopt, follow, and disseminate current practice guidelines, which (1) must be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; (2) consider the needs of the beneficiaries; (3) are adopted in consultation with contracting health care professionals; and (4) are reviewed and updated periodically as appropriate.
Dental MC	DHCS Boilerplate DMC Contracts	Require Dental MC plans and providers to follow and provide all medically necessary dental services as identified in the Medi-Cal Dental MOC, as well as create written criteria or guidelines based on dental standards of care that are regularly reviewed and updated.
	MOC	Manual of required medically necessary dental covered services that all Dental MC and FFS dental providers must follow.

Quality Assessment and Performance Improvement Program:

(CFR Section: 42 CFR 438.330(c) – Performance Measurement; 42 CFE 438.330(d) – Performance Improvement Projects)

Program	Report Title	Description
MCMC	EQR Technical Report, including Performance Measure Validation (PMV) reporting	An annual report that analyzes and evaluates aggregated information on the healthcare services provided by MCMCs, using standard performance measures such as HEDIS and CMS Core Set measures for PMV.
	CAHPS Report	Every two-year report of results from the CAHPS.
	PIP reporting as a part of the PSERs	Annual reporting on the PIPs occurs in the PSERs, which are a part of the annual EQR Technical Report. The PSERs contain information about each MCMC's PIPs, including the validity and reliability of PIP submissions to draw conclusions about the quality and timeliness of and access to care furnished by these plans.
	Health Disparities Report	Annual report that stratifies performance measures by demographic characteristics and conducts disparity analyses to better identify health disparities and create targeted interventions to improve the quality of and access to care.
CMC	PIPs	There were DHCS-led PIPs through 2020. There are no current plans to continue the PIP three-year evaluation cycle, as CMC is transitioning to D-SNP exclusively aligned enrollment in 2023.
MHP	Annual Technical MHP Report for 56 MHPs	DHCS contracts with 56 MHPs and the EQRO reviews annual performance relating to access to services, timely access, quality metrics and outcomes. The reports capture information specific to children and youth in foster care, as well as beneficiary' satisfaction with services using consumer focus groups.
	Annual Statewide Aggregate Technical Report	As a result of annual MHP reviews, the EQRO annually summarizes aggregate key findings, supporting data, examples, and recommendations for all 56 MHPs' performance on access, timeliness, quality, and outcomes.

Program	Report Title	Description
	PIP Reports	Quarterly reports with information regarding MHPs' performance using specific time-limited projects that address clinical and non-clinical areas within the SMHS delivery system. The reports can be found on the CalEQRO website.
DMC-ODS	Annual Technical DMC-ODS county report for 37 counties	DHCS currently contracts with 37 counties operating under the DMC-ODS through the 1115 waiver. The EQRO annually reviews county performance regarding access, timeliness, quality and outcomes. The reports can be found on the CalEQRO website.
	Annual Statewide Aggregate Technical Report	As a result of annual DMC-ODS county reviews, the EQRO annually summarizes aggregate key findings, supporting data, examples, and recommendations for all 37 counties' performance on access, timeliness, quality, and outcomes. The reports are posted on the CalEQRO website.
	PIP Reports	Quarterly reports that contain information regarding DMC-ODS counties' performance using specific time-limited projects that address clinical and non-clinical areas within the DMC-ODS delivery system. The reports can be found on the CalEQRO website.
	UCLA: Annual DMC-ODS Evaluation Report	Annual submission of 1115 waiver DMC-ODS evaluation data, including summaries of client experience surveys. In collaboration with the EQRO, UCLA's Evaluation Report focuses on access to care, quality of care, cost, and the integration and coordination of SUD care, both within the SUD system and with medical and mental health services.
Dental MC	QIP Reports	Quarterly reporting on required QIPs.
	Consumer Satisfaction Survey	Annual reporting of consumer satisfaction survey results.
	EQRO Performance Measure Audit	Annual reporting of audit report conducted by an EQRO.
	Performance Measures	Quarterly self-reported performance measures.

External Quality Review:

(CFR Section: 42 CFR 438.350 – External Quality Review)

Program	Report Title	Description
MCMC	EQR Technical Report with Plan Specific Evaluation Reports	Annual, independent technical report that meets external quality review mandates and summarizes findings on access and quality of care related to the health care services provided by MCMC plans, including opportunities for quality improvement.
CMC	EQR	The external quality review activities for CMC are conducted by the CMS EQRO.
MHP	MHP Report for 56 MHPs	DHCS contracts with an EQRO to conduct annual reviews on 56 MHPs to assess their capability in terms of access, timeliness, quality, and outcomes to maintain an adequate mental health service delivery system for beneficiaries. Findings are obtained using approved methodologies and protocols. These findings are summarized in reports found on the CalEQRO website.
	Annual Statewide Aggregate Technical Report	Annual report that summarizes key findings as well as recommendations for all 56 MHPs' performance on access, timeliness, quality, and outcomes. The report contains specific data and information regarding consumer satisfaction with the provision of services. The reports are posted on the CalEQRO website.
DMC-ODS	Annual Technical DMC-ODS county report for 37 counties	DHCS contracts with an EQRO to conduct annual reviews of 37 counties operating under the DMC-ODS, through the 1115 waiver, to assess their capability in terms of access, timeliness, quality, and outcomes to maintain an adequate SUD service delivery system for beneficiaries. Findings are obtained using approved methodologies and protocols. These findings are summarized in reports found on the CalEQRO website.

Program	Report Title	Description
	Annual Statewide Aggregate Report	Annual report that summarizes key findings as well as recommendations for all 37 counties operating under the DMC-ODS, through the 1115 waiver, on access, timeliness, quality, and outcomes. The reports include beneficiary satisfaction with services and are published on the CalEQRO website.
Dental MC	EQRO Performance Measure Audit (GMC & PHP)	Annual report summarizing EQRO findings and recommendations related to timeliness, quality, and access to dental services for each Dental MC plan.

Nonduplication of Mandatory Activities with Medicare or Accreditation Review:

(CFR Section: 42 CFR 438.360(c) – Nonduplication of Mandatory EQR Activities)

Program	Report Title	Description
MCMC	Not applicable to MCMC	Not applicable to MCMC
CMC	Not applicable to CMC	Not applicable to CMC
MHP	Not applicable to BH	Not applicable to BH
DMC-ODS	Not applicable to BH	Not applicable to BH
Dental MC	Not applicable to Dental MC	Not applicable to Dental MC

External Quality Review Results

(CFR Section: 42 CFR 438.364(a)(4) – Recommendations for improving the quality of health care)

Program	Report Title	Description
MCMC	EQR Technical Report and PSER	Annual, independent, technical report that draws conclusions from findings on the quality and accessibility of healthcare services provided by MCMC plans, which provides recommendations based on those findings to DHCS and MCMCs for improving quality of care. DHCS and MCMCs respond to the recommendations in the following year's Technical Report and PSERs.
CMC	EQR	The external quality review activities for CMC are conducted by the CMS EQRO.
MHP	Annual Statewide Aggregate Technical Report	Annual report that summarizes key findings as well as recommendations for all 56 MHPs' performance on access, timeliness, quality, and outcomes. The fiscal year 2019-20 report showed expanded access through telehealth services and new services for children and youth. The report, as well as previous versions, is posted on the CalEQRO website.
DMC-ODS	Annual Statewide Aggregate Report	Annual report that summarizes key findings as well as recommendations for all 37 counties operating under the DMC-ODS 1115 waiver regarding their performance on access, timeliness, quality, and outcomes. The fiscal year 2019-20 report found that the1115 waiver is improving clients' overall access to treatment and timeliness of service, as well as improving client outcomes in terms of SUD recovery. The report as well as previous reports are posted on the CalEQRO website.
Dental MC	PSERs	Annual oversight report that assesses quality and timeliness of, and access to dental services. This provides DHCS with aggregated results and recommendations for future plan improvement.

Continued Services to Enrollees:

(CFR Section: 42 CFR 438.62(b)(3) – Transition of Care)

Program	APL/Policy Title	Description
MCMC	APL 18-008: COC for Medi-Cal Members who Transition into MCMC	Clarification of COC requirements for Medi-Cal members who transition into MCMC. This APL requires MCMC plans to provide COC for beneficiaries transitioning into managed care, with their FFS provider, if requested.
	APL 17-007: COC for New Enrollees Transitioned to Managed Care after Requesting a Medical Exemption	This APL requires MCMC plans to consider each denied MER to managed care enrollment as an indication for automatic COC with the beneficiary's FFS provider.
	APL 05-002: New Process for Transmitting Enrollment/Disenrollment Data	The process DHCS uses to transmit weekly plan enrollment/disenrollment data to MCMCs operating in the Two-Plan Model, GMC, and PHP plans which assists the health plans with identifying members new to managed care.
	Monthly FFS Data Share with MCMCs	DHCS shares member FFS data with the MCMC plans every month to assist them with better care coordination for their members. This data includes pharmacy data on carved out medications, behavioral health, and dental data.
CMC	DPL 16-002: COC	Clarification of the COC requirements for CMC members who voluntarily or are passively enrolled in CMC.
SMHS	MHSUDS Information Notice 18-059. Federal COC Requirements for MHPs	This information notice informs MHPs that all eligible Medi-Cal beneficiaries receiving SMHS have the right to request COC, with the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider.

Program	APL/Policy Title	Description
DMC-ODS	MHSUDS Information Notice No. 18-051	This information notice addresses county responsibility to ensure that beneficiaries receive continued services during transition from State Plan Drug Medi-Cal to DMC-ODS or transition from one DMC-ODS county to another DMC-ODS county when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
Dental MC	Transition of Care Policy	Annual reporting of the plan's transition of care policy.
	Dental APL 17-011E: Errata to Transition of Care Policy	Medi-Cal beneficiaries assigned a mandatory Dental MC aid code and who are transitioning from Medi-Cal Dental FFS into a Dental MC plan have the right to request COC in accordance with state law and the Dental MC contracts. Dental APL 17-011E provides Dental MC plans with clarification on transition of care requirements.

Sanctions:

(CFR Section: 42 CFR 438.700 - .730 – Sanctions)

Program	Report Title	Description
MCMC	Sanction notices to health plans are posted on the DHCS website	Sanctions levied on MCMCs are made public by posting the sanction notices on the DHCS website.
CMC	Sanction notices to health plans are posted on the DHCS website	Sanctions levied on MCMCs are made public by posting the sanction notices on the DHCS website.
MHP	Sanction policy in development	Sanction policy for compliance with contract requirements and network adequacy in development.

DMC-ODS	Sanction policy in development	Sanction policy for compliance with contract requirements and network adequacy in development.
Dental MC	None	DHCS works with the Department of Managed Health Care (DMHC) to conduct dental surveys. In the event sanctions are levied on a Dental MC plan, information regarding sanctions would be posted on the Dental MC webpage.

Appendix D: Performance Measures

The following table summarizes performance measures collected across programs. Additional measures are also collected for ongoing monitoring and quality assurance purposes.

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Breast Cancer Screening	NCQA	2372	X	SCAN				57.04%	MPL[6]
Cervical Cancer Screening	NCQA	32	X					59.90%	MPL
Child and Adolescent Well-Care Visits	NCQA	1516	X					41.13%	MPL
Childhood Immunization Status: Combination 10	NCQA	38	X					37.95%	MPL
Chlamydia Screening in Women	NCQA	33	X					61.63%	MPL

[1] Medi-Cal Managed Care (MCMC), are MCOs and HIOs;
[2] Population Specific Health Plans (PSPs): AIDS HealthCare Foundation (AHF), Senior Care Action Network (SCAN) and Radys Children's Hospital (Radys). Note Radys contract with DHCS ended December 31, 2021 and was not renewed.
[3] The Specialty Mental Health Services (SMHS) Program and the Drug Medi-Cal Organized Delivery System (DMC-ODS) are PIHPs.
[4] Dental Managed Care (Dental MC) are PAHPs.
[5] Cal MediConnect is a demonstration program that is ending December 31, 2022
[6] The MPL (minimum performance level) for MCMC plans is defined as the 50th percentile using national or state-calculated benchmarks (if national benchmarks not available) and vary from year to year as benchmarks are updated.

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NCQA	59	X	AHF/ SCAN				41.50%	MPL
Controlling High Blood Pressure	NCQA	18	X	AHF/ SCAN				61.80%	MPL
Immunization for Adolescents: Combination 2	NCQA	1407	X					46.05%	MPL
Prenatal and Postpartum Care: Postpartum Care	NCQA	1517	X					78.87%	MPL
Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA	1517	X					87.88%	MPL
Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months	NCQA	1392	X					66.40%	MPL

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Well-Child Visits in the First 30 Months of Life – Well-Child Visits for Age 15 Months – 30 Months	NCQA	1392	X					37.70%	MPL
Colorectal Cancer Screening	NCQA	34	X	AHF/ SCAN				New measure for MY 2022	MPL
Prenatal Immunization Status	NCQA	NA	X					New measure for MY 2022	MPL
Lead Screening in Children	NCQA	NA	X					New measure for MY 2022	MPL
Adults' Access to Preventive/ Ambulatory Health Services	NCQA	NA	X	AHF/ SCAN				New measure for MY 2022	MPL

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Ambulatory Care: Emergency Department (ED) Visits[7]	NCQA	NA	X					31.96%	Reporting only
Antidepressant Medication Management: Acute Phase Treatment[8]	NCQA	105	X					60.05%	MPL
Antidepressant Medication Management: Continuation Phase Treatment[9]	NCQA	105	X					43.09%	MPL
Asthma Medication Ratio[10]	NCQA	1800	X					64.26%	MPL

[7] DHCS does not set a target for this measure because it is a measure of utilization only and difficult to interpret if increased or decreased.
[8] Due to the proposed implementation date of Medi-Cal Rx on January 1, 2021, DHCS had moved this measure to "report only" for measurement year 2021. Medi-Cal Rx was ultimately pushed back to January 1, 2022.
[9] Ibid.
[10] Ibid.

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Contraceptive Care – All Women: Most or Moderately Effective Contraception	OPA	2903 /2904	X	AHF				14.7% (age 15-20), 23.58% (age 21-44)	Reporting only
Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	OPA	2902	X					37.34% (age 15-20), 36.67% (age 21-44)	Reporting only
Developmental Screening in the First Three Years of Life	OHSU	1448	X					23.11%	MPL, per state-calculated national benchmarks

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[11]	NCQA	1932	X					75.74%	MPL
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	NCQA	3488	X	AHF/ SCAN				NA –MY 2021 will be first year of reporting	MPL
Follow-Up After Emergency Department Visit for Mental Illness	NCQA	576	X	AHF/ SCAN				NA –MY 2021 will be first year of reporting	MPL

[11] Due to the proposed implementation date of Medi-Cal Rx on January 1, 2021, DHCS had moved this measure to "report only" for measurement year 2021. Medi-Cal Rx was ultimately pushed back to January 1, 2022.

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	NCQA	108	X					49.28%	Reporting only
Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	NCQA	108	X					43.91%	Reporting only
Metabolic Monitoring for Children and Adolescents on Antipsychotics[12]	NCQA	2800	X					37.60% (total rate)	MPL

[12] Due to the proposed implementation date of Medi-Cal Rx on January 1, 2021, DHCS had moved this measure to "report only" for measurement year 2021. Medi-Cal Rx was ultimately pushed back to January 1, 2022.

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	TJC	NA	X					New measure for MY 2022	Reporting only
Dental Fluoride Varnish	DQA	2528	X					New measure for MY 2022	Reporting only
Depression Remission and Response	NCQA	NA	X	AHF/ SCAN				New measure for MY 2022	Reporting only
Pharmacotherapy of Opioid Use Disorder	NCQA	NA	X	AHF/ SCAN				New measure for MY 2022	MPL
Plan All-Cause Readmissions	NCQA	1768	X				X	0.96	Reporting only
Screening for Depression and Follow-up Plan	CMS	418	X	AHF/ SCAN				18.25% (age 12-17), 11.42% (age 18-64), 13.15% (age 65+)	Reporting only
Prenatal Depression Screening and Follow Up	NCQA	NA	X					New measure for MY 2022	Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Postpartum Depression Screening and Follow Up	NCQA	NA	X					New measure for MY 2022	Reporting only
Number of children and adults that received SMHS[13]					X			Youth: 259,159, Adults: 338.324	No MPL exists; targets in development
Received one or more SMHS visits: proportion of beneficiaries eligible for SMHS who received one or more SMHS visits					X			Youth: 259,159, 4% Adults: 338,324, 4.2%	No MPL exists; targets in development

[13] The behavioral health measures were created through the work of the Performance Outcomes System/Performance Dashboards (POS) as mandated by Welfare and Institutions Code - WIC § 14707.5 and are new, so there is no research with which to compare them.

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Received five or more SMHS visits: proportion of beneficiaries eligible for SMHS who received five or more SMHS visits					X			Youth: 196,130, 2.8% Adults: 216,331, 2.7%	No MPL exists; targets in development
Time between Inpatient Discharge and Step Down Service					X			Youth: 10.3 days Adults: 15.4 days	No MPL exists; targets in development
Median Time Adult Residential Treatment Services Utilized (Adults)					X			103.4 Days	No MPL exists; targets in development
Median Time Case Management/Brokerage Utilized (Adults)					X			431.1 Minutes	No MPL exists; targets in development

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Median Time Crisis Intervention Utilized (Adults)					X			219.6 Minutes	No MPL exists; targets in development
Median Time Crisis Residential Treatment Services Utilized (Adults)					X			21 Days	No MPL exists; targets in development
Median Time Crisis Stabilization Utilized (Adults)					X			24.1 Hours	No MPL exists; targets in development
Median Time FFS Inpatient Utilized (Adults)					X			9.2 Days	No MPL exists; targets in development
Median Time Full-Day Rehabilitation Utilized (Adults)					X			149.9 Hours	No MPL exists; targets in development

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Median Time Full-Day Treatment Intensive Utilized (Adults)					X			126.3 Hours	No MPL exists; targets in development
Median Time Intensive Care Coordination Utilized (Adults)					X			331.8 Minutes	No MPL exists; targets in development
Median Time Intensive Home-Based Services Utilized (Adults)					X			835.2 Minutes	No MPL exists; targets in development
Median Time Inpatient Administrative Utilized (Adults)					X			15.4 Minutes	No MPL exists; targets in development
Median Time Medication Support Services Utilized (Adults)					X			282.9 Minutes	No MPL exists; targets in development

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Median Time Mental Health Services Utilized (Adults)					X			741.6 Minutes	No MPL exists; targets in development
Median Time Psychiatric Health Facility Utilized (Adults)					X			12.9 Days	No MPL exists; targets in development
Median Time Short-Doyle/Medi-Cal Hospital Inpatient Utilized (Adults)					X			5.6 Days	No MPL exists; targets in development
Median Time Therapeutic Behavioral Services Utilized (Adults)					X			2,194.6 Minutes	No MPL exists; targets in development
General Satisfaction (Youth and Adult Surveys)					X			Youth 4.2% Adults 4.4%	Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Perception of Participation in Treatment Planning (Youth and Adult Surveys)					X			Youth 4.1% Adults 4.3%	Reporting only
Perception of Access (Youth and Adult Surveys)					X			Youth 4% Adults 4.3%	Reporting only
Perception of Cultural Sensitivity (Youth and Adult Surveys)					X			Youth 4.2% Adults 4.3%	Reporting only
Perception of Quality and Appropriateness (Adult Surveys)					X			Adults 4.3%	Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Perception of Outcomes of Services (Youth and Adult Surveys)					X			Youth 3.8% Adults 3.9%	Reporting only
Perception of Functioning (Youth and Adult Surveys)					X			Youth 3.9% Adults 3.9%	Reporting only
Perception of Social Connectedness (Youth and Adult Surveys)					X			Youth 4.1% Adults 3.9%	Reporting only
AMB-ED (MLTSSPs)	NCQA	NA						40.36%	Reporting only
PCR (MLTSSPs)	NCQA	1768						0.969	Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Use of Preventive Services for Children Ages 1 – 20						X		Rates by Plan: **Access GMC Plan:** 32.26% **Access PHP:** 40.26% **Health Net GMC:** 30.34% **Health Net PHP:** 34.95% **Liberty GMC:** 33.99% **Liberty PHP:** 35.74%	Targets by Plan: 6% absolute increase per plan per year
Use of Preventive Services for Adults Ages 21+	NA							NA	Targets by Plan: 3% absolute increase per plan per year

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Annual Dental Visit						X			Reporting only
Use of Sealants						X			Reporting only
Count of Sealants						X			Reporting only
Count of Fluoride Varnishes						X			Reporting only
Use of Diagnostic Services						X			Reporting only
Treatment/ Prevention of Caries						X			Reporting only
Exams/Oral Health Evaluations						X			Reporting only
Use of Dental Treatment Services						X			Reporting only
Preventive Services to Fillings						X			Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Overall Utilization of Dental Services (one year, two years, three years)						X			Reporting only
Continuity of Care						X			Reporting only
Usual Source of Care						X			Reporting only
Members with an ICP completed within 90 days of enrollment							X	Performance rate determined by CMS as Met/Not Met	85%
Members with documented discussions of care goals							X	Performance rate determined by CMS as Met/Not Met	65%

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Members receiving Medi-Cal SMHS that received care coordination with the primary mental health provider							X		Performance rate achieved by the highest scoring MMP minus ten percentage points
Members with first follow-up visit within 30 days of hospital discharge							X		Reporting only
Members who have a care coordinator and have at least one care team contact during the reporting period							X	Performance rate determined by CMS as Met/Not Met	88%

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
The number of critical incident and abuse reports for members receiving LTSS							X		Reporting only
Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing							X		Reporting only
Care coordinator training for supporting self-direction under the demonstration							X		Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Reduction in emergency department use for SMI and SUD members							X	Performance rate determined by CMS as Met/Not Met	10% decrease in the performance rate for the measurement year compared to the performance rate for the baseline year.
Readmissions of short- and long-stay nursing facility residents after hospitalization for diabetes, chronic obstructive pulmonary disease (COPD), or any medical diagnosis							X		Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Members with an assessment completed within 90 days of enrollment							X		Reporting only
Members with an assessment completed							X		Reporting only
Members with an annual reassessment							X	Performance rate determined by CMS as Met/Not Met	65%
Members with a care plan completed within 90 days of enrollment							X		Reporting only
Grievances and Appeals							X		Reporting only
Care coordinator to member ratio							X		Reporting only

Measure	Steward	NQF #	MCO/ HIO[1]	PSP[2]	PIHP[3]	PAHP[4]	CMC[5]	Baseline Performance MY 2020	Target
Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements							X	Performance rate determined by CMS as Met/Not Met	100% compliance
Medicare Provider Network							X		Reporting only
LTSS clean claims paid within 30 days, 60 days, and 90 days.							X		Reporting only
Emergency department behavioral health services utilization							X		Reporting only
Nursing Facility Division							X		Reporting only
Minimizing Institutional Length of Stay							X		Reporting only

Appendix E: 2019 DHCS Quality Strategy Evaluation

Evaluation Overview

DHCS conducted a review and evaluation of its 2018 Managed Care Quality Strategy Report in compliance with §438.340(c)(2)(i) and (iii) and §438.364(a)(4) and as outlined in Exhibit 16 of the *Medicaid and Children's Health Insurance Program Managed Care Quality Strategy Toolkit, June 2021*. This appendix summarizes the state's evaluation methodology; 2018 program-specific goals, quality metrics, performance targets, baseline data, and progress toward meeting these targets; PIPs; effectiveness evaluations; and program actions based on evaluation recommendations. The 2018 report represent DHCS' baseline by which to measure the state's progress on its quality goals and objectives.

DHCS' evaluation concludes that a lack of specific target setting, alignment, and standardization in DHCS' performance improvement activities created difficulty for the state to achieve more meaningful progress on its quality goals and objectives. In many areas, DHCS did not define specific targets for the performance measures outlined in the 2018 report. Moreover, the measures that were chosen did not align with the measures in the CMS Adult and Child Core Set. Additionally, each Medi-Cal delivery system approached PIPs with different requirements and structures leading to variation in the output and quality of these projects. In some focus areas, the state did not meet its goals and objectives. Examples of areas where the state fell short of its specified targets include pediatric immunizations, diabetes control, hypertension control, and utilization of Dental MC preventive services for the pediatric population. Lastly, DHCS did not include CMC or FFS programs in its 2018 Managed Care Quality Strategy report. Without specific FFS measures in the 2018 report, evaluation of these services was not conducted.

Evaluation Methodology:

This evaluation is based on a review of the following:

- 2018 Managed Care Quality Strategy Report.
- Program-specific goals, quality metrics, PIPs and/or QIPs.
- Alignment of 2018 metrics with CMS Core Set measures.
- EQRO technical reports for: MCMC July 1, 2016-June 30, 2017 and July 1, 2017-June 30, 2018; Medi-Cal Specialty Mental Health FY 2017-18; Medi-Cal Specialty

Mental Health EQR – FY2018-19 Statewide Report; DMC-ODS EQR Report FY 2018-2019.

» Dental reports for calendar years (CY) 2017, 2018, and 2019 located on the DHCS website.

» Dashboards: Managed Care Performance Dashboard; SMHS; California Outcome Measurement System (SUD Performance Dashboards are under development).

» University of California at Los Angeles (UCLA) evaluations for the DMC-ODS services located on the UCLA website.

Results of 2018 Performance Measures MCMC Plans:

Listed below are performance measures outlined in the 2018 Managed Care Quality Strategy for five focus areas for MCMCs. Performance targets were set in comparison to the baseline year of CY 2015. This built upon the targets set in the Managed Care Quality Strategy Report for 2013, some of which were achieved in 2014 and sustained in 2015, and some of which DHCS and its MCMCs are still working to achieve. The data reported below were collected from January to December 2018 and reported in July 2019.

Table 1: MCMC 2018 Performance Measures

Focus Area	Performance Measures	Baseline (MY 2015)	Target for MY 2018	MY 2018 Results	Target Reached ?
Postpartum Care	Increase the Medi-Cal weighted average for timely postpartum care	59%	64%	67%	Yes
	Increase the percentage of MCMC reporting units meeting MPL for timely postpartum care	75%	80%	95%	Yes

Focus Area	Performance Measures	Baseline (MY 2015)	Target for MY 2018	MY 2018 Results	Target Reached ?
Immunizations for 2-Year-Olds	Increase the proportion of MCMC beneficiaries with up-to-date immunizations by their second birthday	71%	80%	71%	No
Hypertension	Increase the proportion of MCMC beneficiaries with hypertension whose blood pressure is controlled	61%	66%	65%	No
Diabetes	Decrease the proportion of MCMC beneficiaries with diabetes who had HbA1c testing greater than 9%	40%	35%	34%	Yes
	Increase the proportion of MCMC beneficiaries with diabetes who had up-to-date HbA1c testing	86%	91%	88%	No
Tobacco Cessation	Increase the median proportion of smokers who report being counseled to quit in the prior six months (as measured by 2019 CAHPS survey)	65%	76%	67%	No

Focus Area	Performance Measures	Baseline (MY 2015)	Target for MY 2018	MY 2018 Results	Target Reached ?
	Increase the median proportion of smokers who report a provider discussed tobacco cessation medications in the prior six months (as measured by the 2019 CAHPS survey)	38%	45%	44%	No

Additional MCMC performance information:

For MYs 2017 and 2018, MCMCs reported performance on 17 measures consisting of 30 individual indicators.

- For MYs 2017 and 2018, DHCS held MCMCs accountable for performing at least as well as the national Medicaid 25th percentile, or the MPL, on 21 of 30 indicators.
- For health care services provided in 2017, the MCMCs exceeded the MPLs for 87 percent of the indicators. This left 13 percent of indicators falling below the MPLs. For the same year, MCMCs exceeded the high performance levels (HPL) for 16 percent of the indicators.
- For health care services provided in 2018, for indicators that DHCS held MCMCs accountable to meet the MPLs, 88 percent of the rates were above the MPLs, demonstrating a 1 percentage point increase from the prior year. For the same year, MCMCs exceeded the HPLs on 14 percent of the indicators.

On COVID Impacts: For MY 2019, due to travel restrictions, provider office closures and shelter in place orders in spring of 2020 due to the COVID-19 PHE, the collection of data for reporting of quality measures was severely impacted. DHCS, in alignment with NCQA, provided MCMCs with reporting flexibilities on its quality measures. Many of the quality measures that MCMCs reported on were hybrid measures that require the collection (often, in person) of medical records. DHCS allowed MCMCs to report these measures using hybrid methodology, or administrative methodology, or, in alignment

with NCQA, allowed MCMCs to use last year's (MY 2018) rate when reporting hybrid measures. While hybrid measure data collection was most impacted by COVID, the collection of administrative data was also impacted due to delays in provider submission of data as well as delays in the submission of other supplemental data such as from labs and pharmacies. As a result of these data collection and reporting issues, DHCS elected not to hold MCMCs accountable to the MPL for quality measure results impacted by the above. However DHCS did move forward with alternative required quality improvement activities.

SMHS/County MHPs:

Listed below are performance measures set in the 2018 Managed Care Quality Strategy for two focus areas for MHPs. Performance targets were not set in the 2018 Managed Care Quality Strategy. The data summarized below can be found in the reports posted on the DHCS website.

Table 2: County MHP 2018 Performance Measures

Focus Area	Performance Measures	Baseline (FY 15-16)	Target for FY 17-18	FY17-18 Results	Target Reached ?
Specialty Mental Health Penetration Rate	Received one or more SMHS visits (children and youth ages 0-20)	4.10%	None	4.40%	N/A
	Received one or more SMHS visits (adults ages 21 and over)	4.40%	None	4.20%	N/A
	Received five or more SMHS visits (children and youth ages 0-20)	3.00%	None	3.20%	N/A
	Received five or more SMHS visits (adults ages 21 and over)	2.70%	None	2.50%	N/A

Focus Area	Performance Measures	Baseline (FY 15-16)	Target for FY 17-18	FY17-18 Results	Target Reached ?
Time to Step Down	Percentage of inpatient discharges with step-down within seven days of discharge (children and youth ages 0-20)	63.60%	None	63.30%	N/A
	Percentage of inpatient discharges with step-down within seven days of discharge (adults ages 21 and over)	49.50%	None	52.00%	N/A
	Percentage of inpatient discharges with step-down between eight and 30 days (children and youth ages 0-20)	13.90%	None	13.70%	N/A
	Percentage of inpatient discharges with step-down between eight and 30 days (adults ages 21 and older)	13.10%	None	12.30%	N/A
	Percentage of inpatient discharge with step-down greater than 30 days (children and youth ages 0-20)	11.70%	None	9.30%	N/A

Focus Area	Performance Measures	Baseline (FY 15-16)	Target for FY 17-18	FY17-18 Results	Target Reached ?
	Percentage of inpatient discharge with step-down greater than 30 days (adults ages 21 and over)	22.20%	None	15.00%	N/A

DMC-ODS

Listed below are performance measures set in the 2018 Managed Care Quality Strategy for three focus areas for DMC-ODS. The performance measures in the table below are based on some of the required performance measures the EQRO is monitoring and reporting on, and link to the three overall focus areas for improvement in DMC-ODS health care. Performance targets were not specified in the 2018 Managed Care Quality Strategy. Counties did not begin to implement the service delivery system until February 2017. As the DMC-ODS matures and the volume of data increases from additional counties implementing DMC-ODS services, performance targets will be identified. The data summarized below can be found in the reports posted on the CalEQRO website.

Table 3: DMC-ODS 2018 Performance Measures

Focus Area	Performance Measures	Baseline (FY 16-17) (3 counties)	Target for FY 18-19	FY 18-19 Results (26 counties)	Target Reached ?
Access	Total beneficiaries served	6,620	None	91,175	N/A
	Number of days to first face-to-face DMC-ODS service after referral	13.3	None	11.8	N/A

Focus Area	Performance Measures	Baseline (FY 16-17) (3 counties)	Target for FY 18-19	FY 18-19 Results (26 counties)	Target Reached ?
	Cultural competency of DMC-ODS services to beneficiaries	Qualitative	None	Qualitative	N/A
	Penetration rates for clients	0.75%	None	1.06%	N/A
	Numbers of beneficiaries accessing non-methadone MAT	50	None	3,411	N/A
	Days to medication for NTP services	<1	None	<1	N/A
	Percentage of counties with a 24-hour access call center line available to link clients to ASAM assessments and treatment	100%	None	100%	N/A
Cost-effectiveness	Total costs of approved claims per beneficiary served by each county DMC-ODS	$2,662	None	$3,940	N/A

Focus Area	Performance Measures	Baseline (FY 16-17) (3 counties)	Target for FY 18-19	FY 18-19 Results (26 counties)	Target Reached ?
Quality	COC with physical health and mental health	MOUs required between counties and MCMCs 76-86%, as measured by TPS* and depending on county	None	MOUs required between counties and MCMCs 82-84%, as measured by TPS* and depending on type of coordination (physical or mental health)	N/A
	Timely transitions in levels of care after residential treatment				
	Within 7 days	8%	None	8%	N/A
	Within 14 days	10%	None	11%	N/A
	Within 30 days	13%	None	14%	N/A
	Within any days	16%	None	19%	N/A
	Special needs of high-cost beneficiaries are identified and coordinated	Qualitative	None	Qualitative	N/A

Focus Area	Performance Measures	Baseline (FY 16-17) (3 counties	Target for FY 18-19	FY 18-19 Results (26 counties)	Target Reached ?
	Percentage of clients with three or more withdrawal management episodes and no other treatment to improve engagement	0.62%	None	2.38%	N/A

*TPS = mandated, annual Treatment Perception Survey

Dental MC

Listed below are performance measures set in the 2018 Managed Care Quality Strategy for three focus areas in Dental MC. DHCS monitors Dental MC health plan performance across these 13 performance measures. They also reflect oral health measures identified by CMS. Specific performance targets were set in the 2018 Medi-Cal Managed Care Quality Strategy for three of the performance measures. The program has a fundamental objective to increase utilization of dental visits, particularly preventive services for children. The data summarized below can be found in the reports posted on the DHCS website.

Table 4: Dental MC 2018 Performance Measures

Focus Area	Performance Measures	Baseline (FY 16-17)	Target for FY 19-20	FY 19-20 Results	Target Reached ?
Pediatric Prevention	Utilization rate of pediatric and youth ADVs (ages 0-20)	40.1%	60.0%	38.7%	No

Focus Area	Performance Measures	Baseline (FY 16-17)	Target for FY 19-20	FY 19-20 Results	Target Reached ?
	Annual percent of children who receive any preventive dental service	34.2%	40.2%	33.3%	No
	Percentage of children ages 6-9 who receive a dental sealant on a permanent molar tooth.	14.9%	18.9%	11.6%	No
	Count of sealants	107,838	None	65,781	N/A
	Count of fluoride varnishes	210,426	None	198,593	N/A
Utilization	Diagnostic services utilization rate				
	Ages 0-20	37.7%	None	31.5%	N/A
	Ages 21 and older	16.9%	None	14.6%	N/A
	Treatment/prevention of caries utilization rate				
	Ages 0-20	34.2%	None	29.3%	N/A
	Ages 21 and older	7.7%	None	7.7%	N/A
	Exams/oral health evaluations utilization rate				
	Ages 0-20	34.3%	None	27.9%	N/A
	Ages 21 and older	14.1%	None	12.0%	N/A

Focus Area	Performance Measures	Baseline (FY 16-17)	Target for FY 19-20	FY 19-20 Results	Target Reached ?
	Dental treatment services utilization rate				
	Ages 0-20	19.6%	None	19.5%	N/A
	Ages 21 and older	11.3%	None	11.8%	N/A
	Preventive services to fillings ratio				
	Ages 0-20	0.83	None	0.80	N/A
	Ages 21 and older	0.33	None	0.37	N/A
	Overall utilization rate of dental services (three years*)				
	Ages 0-20	69.9%	None	69.0%	N/A
	Ages 21 and older	43.7%	None	37.5%	N/A
COC	COC				
	Ages 0-20	64.4%	None	53.0%	N/A
	Ages 21 and older	28.1%	None	27.1%	N/A
	Usual source of care				
	Ages 0-20	31.2%	None	29.1%	N/A
	Ages 21 and over	8.4%	None	9.2%	N/A

*3 years = Members continuously enrolled in the same plan for three years

DHCS' Actions in Response to Results of Performance Measures and EQRO Recommendations:

MCMCs

As noted in Table 1 above, DHCS did not meet targets related to immunizations for 2 year olds, hypertension, diabetes, and tobacco cessation. In addition to these

performance rates, DHCS also reviewed the EQRO recommendations in the Medi-Cal Managed Care External Quality Review Technical Report, which assesses the quality and timeliness of, and access to, health care services provided to MCMC members. Recommendations from the EQRO are both at a state level as well as at the individual MCMC level. The EQRO makes MCMC-level recommendations for each individual plan in the PSERs that are found at the end of the technical report on the DHCS website.

In response to the aforementioned performance rates and EQRO recommendations, DHCS continues to work to improve the quality of care in these and other focus areas by:

- Increasing the MPL for applicable measures from the national Medicaid 25th percentile to the 50th percentile for future reporting years, although for MY 2019, DHCS elected not to hold MCMC plans accountable to the MPL due to the COVID-19 PHE.
- Requiring MCMCs to report annually on a subset of the CMS Adult and Child Core Set measures, which now constitute the MCAS.
- Mandating that one of the two MCMCs' PIP topics align to pre-selected priority focus areas:
    - For 2017-2019, pre-selected priority focus areas include timeliness of postpartum care, diabetes, hypertension, and childhood immunizations.
    - For 2019-2021, pre-selected priority focus area involves needed improvement in child and adolescent health.
- Working to reduce health disparities through:
    - Policy initiatives requiring MCMCs to use data from DHCS' annual Health Disparities Report, along with other available data sources, to identify health disparities and develop an action plan to address health disparities as part of the revised group needs or population needs assessment.
    - Requiring MCMCs to conduct one PIP on a statistically significant health disparity identified within the MCMC's member population.
    - Developing quality improvement postcards focused on the challenges of addressing quality and disparities throughout the COVID-19 PHE and maintaining a QI Toolkit available to all MCMC staff with numerous quality and health equity related resources.

- Addressing social drivers of health through:
  - Revising the current member assessment and re-assessment process and working toward requiring a MCMC plans to have a PHM strategy that includes the collection of social determinants of health data
  - Including in the PHM strategy a data-driven risk stratification process, a new standardized member assessment, collection of social drivers of health data, and the provision of Community Supports to help address identified social needs
- Improving data quality and reporting through:
  - Using the annual Encounter Data Validation Study to measure data completeness and the accuracy of encounter data via a review of medical records and Encounter Data Stoplight reports that compare the amount of utilization reported through each MCMC's rate development template and the amount of encounter data reported to DHCS.
  - Using the annual Preventive Services Utilization Report which determines the rates of provision of appropriate preventive services through encounter data, in accordance with AAP Bright Futures for children and USPSTF Grade A and B recommendations for adults. This report will allow DHCS to be able to identify patterns of underutilization and implement targeted improvement strategies.
- Continuing to host the biennial quality conference, which DHCS hosted virtually in October 2021.
- Instructing the EQRO to evaluate and report on each MCMC's actions in response to the prior year's recommendations in order to monitor MCMC response remediation efforts.

SMHS/MHPs

As noted in Table 2 above, DHCS did not set targets in the 2018 Managed Care Strategy for performance measures related to SMHS penetration rates or time to step-down. Benchmarks and performance targets for SMHS are evolving areas, and DHCS will work with counties and stakeholders to determine appropriate benchmarks and performance targets.

DHCS reviewed the EQRO recommendations from its annual aggregate report, which provided information from consumer and family focus groups; network adequacy;

timeliness of services; beneficiary satisfaction; safety and effectiveness of medication practices; and continuity and coordination of care with medical providers and other human services agencies. EQRO mandatory performance measures are assessed as a part of each annual review. Details of these EQRO results and recommendations can be found on the CalEQRO website.

In response to the aforementioned performance rates and the EQRO recommendations, DHCS took the following actions:

- Increasing oversight and monitoring of network adequacy and timely access:
  - Monitoring MHP compliance with time and distance standards, provider-to-beneficiary ratio standards, and timely access standards, and providing intensive technical assistance to all counties with deficiencies. DHCS meets with counties every two to four weeks to work through challenges and resolve deficiencies. This intensive technical assistance has resulted in accelerated resolution of deficiencies and completion of CAPs.
  - DHCS plans to develop a new sanctions policy within the next year for counties that are not improving deficiencies despite CAPs and technical assistance.
  - Expanding automated collection of 274 transactions (provider directory data collection system) to include MHPs to enable streamlined and accurate data collection.
  - Implementing automated collection of timely access to SMHS data.
- Incorporating additional timely access data points to better measure the beneficiary experience of accessing care.
- Improving the delivery of behavioral health care by launching the BH-QIP, which will provide county behavioral health departments with financial incentives, metrics, and milestones to ensure the building blocks of quality improvement are in place, including compliance with new CalAIM behavioral health policies, implementing payment reform with an updated, more detailed code set (which will dramatically improve the quality of behavioral health data), and data exchange.
- Working to reduce health disparities through:
  - Analysis of MHPs' Cultural Competence Plans (CCP) to identify disparities and how MHPs are planning to reduce disparities.

- Implementing the Community Mental Health Equity Project (CMHEP), a collaborative effort between DHCS and CDPH's Office of Health Equity (OHE). DHCS is providing technical assistance through a contractor to help counties identify disparities and create robust action plans to improve service, using evidence-based and community-defined practices.

» Incorporating the Core Set of Behavioral Health Measures for Medicaid (child and adult measures) into the SMHS Performance Dashboard:

- Follow-Up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up After Emergency Department Visit for Mental Illness
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

» Selecting two functional assessment tools to capture pediatric treatment outcomes data – the Child and Adolescent Needs and Strengths Scale: 50-item version (CANS Core 50) and the Pediatric Symptom Checklist: 35-item parent version (PSC-35).

- CANS Core 50 will allow DHCS to evaluate treatment outcomes data in relation to beneficiary diagnosis, type(s) and frequency of SMHS received, types of psychopharmacological agents prescribed (if applicable), and other factors potentially relevant to outcomes.
- PSC-35 is designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions may be initiated as early as possible.
- In July 2018, DHCS began implementing requirements for CANS Core 50 and PSC-35 data collection. Currently, public reporting is not feasible due to incomplete and inaccurate data, as well as the need to implement technical fixes in data collection and aggregation. DHCS will begin reporting on the data after improvement efforts are complete (anticipated no sooner than mid-2023)

» Requiring counties to begin collecting data elements related to the timeliness of requested SMHS assessment appointments and treatment for Medi-Cal beneficiaries.
    - DHCS phased in requirements on MHPs with the final phase deployed in November 2020.
    - Using this data, DHCS measures whether the MHP provides assessment appointments and treatment appointments in accordance with timely access standards.
» Establishing baseline information to assess access to SMHS for children and youth in foster care in order to determine the responsiveness, and efficiency in the delivery of mental health services to children and youth in foster care in a given county.
    - Data trends in coming years will assist DHCS in identifying deficiencies and taking corrective actions.
    - The long-term goal is to reduce the trauma associated with changing foster care placements. DHCS will report on this effort as data and information become available.
» Requiring each county MHP to complete and submit an annual QI Work Plan (QIWP), as well as an annual QIWP evaluation to DHCS for review. The QIWP must include the following:
    - Evidence of the monitoring activities, including review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records reviews.
    - Evidence that QI activities, including PIPs, have contributed to meaningful improvement in clinical care and beneficiary service.
    - A description of completed and in-process QI activities including:
        - Monitoring efforts for previously identified issues, such as tracking issues over time.
        - Objectives, scope, and planned QI activities for each year.
        - Targeted areas of improvement or change in service delivery or program design.
    - A description of mechanisms the MHP has implemented to assess the accessibility of services within its service delivery area. These include goals for responsiveness for the MHP's 24-hour toll-free telephone number,

timeliness for scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.
    - Evidence of compliance with the requirements for cultural competence and linguistic competence specified in the MHP's contract with DHCS.
    - Each MHP's QIWP is available on the DHCS website.

» Requiring each MHP to conduct two PIPs, one clinical and one non-clinical, during the 12 months preceding the annual EQRO review. Each PIP is expected to produce consumer-focused outcomes. The EQRO summarizes its findings in individual MHP reports, quarterly PIP reports, and in the annual aggregate summary reports. The EQRO posts the reports on its website on the CalEQRO website.

DMC-ODS

As noted in Table 3 above, DHCS did not set targets in the 2018 Managed Care Strategy for performance measures related to DMC-ODS. DHCS plans to work with counties and stakeholders to develop minimum performance standards. In addition to these performance rates, DHCS also reviewed the EQRO recommendations from its annual aggregate report across 26 counties. Both the county-specific reports and the statewide annual report for FY 2018-19 present the results of the EQRO's validation of the performance metrics. Details of these EQRO results and recommendations can be found on the CalEQRO website.

In response to the performance rates and the EQRO recommendations, DHCS continues to work to improve the quality of care in these and other focus areas by:

» Providing DMC-ODS training and technical assistance for counties and providers, based on new CalAIM policies and EQRO findings.
    - Understanding new treatment criteria (including allowing treatment during assessment period, and treatment of co-occurring conditions).
    - Understanding new documentation standards.
    - Understanding how to conduct and bill for case management.
    - Teachings on the models and elements of client-centered care and the role of family therapy.

» Providing guidance to counties to assist in the development of recovery service plans.

    - Counties and providers have focused on basic treatment requirements, and need technical assistance on offering the full range of recovery services (since addiction is a chronic disease).
    - Understanding the role of recovery residences (not a Medi-Cal benefit, but part of the continuum of care).
- » Continuing to provide technical assistance to counties on how to implement various aspects of the ASAM criteria (e.g., brief screening, initial assessment, follow-up assessment, treatment planning), including optional DHCS-approved ASAM criteria-based screening/assessment tools, and guidance for assessing fidelity to the criteria.
- » Continuing expansion of MAT access in residential treatment programs and detention centers. These efforts will enhance client outcomes in treatment and for detention releases and also could prevent potential deaths from overdose and recidivism.
- » Reorganizing the division:
    - In an effort to increase overall QI and efficiencies Department-wide, the MHSUDS divisions reorganized on July 1, 2019.
    - The objectives of the new Behavioral Health division are to increase program administration accountability, improve service delivery, decrease processing times, and increase communication and engagement with stakeholders and employees.
    - The reorganization created four separate divisions. The Local Governmental Financing Division reports to the Deputy Director of Health Care Financing. The other three divisions (Licensing and Certification, Community Services, and Medi-Cal Behavioral Health) report to the Deputy Director of Behavioral Health.

Dental MC

As noted in Table 4 above, DHCS did meet targets for increasing utilization of pediatric and youth ADVs, annual percentage of children who receive any preventive dental service, and percentage of children ages 6-9 who receive a dental sealant on a permanent molar. The program did not set specific targets for its other performance measures. However, in its overarching objective of increasing utilization of dental visits, comparisons of fiscal year 2019-20 to the baseline fiscal year 2016-17 show that across the various measures, utilization rates are not increasing. In addition to these

performance rates, DHCS also reviewed the EQRO recommendations from the technical reports summarizing access and quality of care findings for Dental MC plans, last released in April 2021, summarizing FY 2019-20 data. Details of these EQRO results and recommendations can be found on the DHCS website.

In response to the aforementioned performance rates and the EQRO recommendations, DHCS continues to work to improve the quality of care in these and other focus areas by:

- Monitoring Dental MC plans' progress in meeting the 10 percent increase in preventive services utilization for children ages 1-20 over a five-year period, with an annual target increase of 2 percent each state FY.
- Continuing to mandate PIPs for plans. For its statewide collaborative improvement project, DHCS selects a key area for all DMC plans to focus on. Additionally, DHCS mandates individual improvement projects in which Dental MC plans have the discretion to focus on any area self-identified as in need of improvement.
- Leveraging the EQRO to closely monitor and assess the Dental MC plans' adherence to the rapid-cycle quality improvement process and to ensure the use of measurable goals and prompt revision of interventions when favorable results are not achieved.
- Monitoring the 13 performance measures, producing quarterly reports to identify trends and conducting gap analyses
- Assessing for health disparities
- Collaborating with CDPH in achieving shared strategic goals

Summary

DHCS continues to make progress toward reaching some of its 2018 Managed Care Quality Strategy goals and objectives. As a result of the evaluation of the 2018 report, DHCS is making significant structural, procedural, and technical changes to its approach to quality and health equity. These changes outlined in detail in the main CQS, focus on centralizing and elevating the quality management structure; aligning quality assurance, performance improvement, and compliance and monitoring policies and processes across delivery systems; and including specific and measurable targets for its quality goals and objectives in the 2022 CQS. Additionally, performance measures are being

selected to more closely align with the CMS Adult and Child Core Set. DHCS is also now including FFS programs in its 2022 CQS and aims to evaluate these services in future reports. Finally, DHCS will continue to leverage EQRO evaluations to determine additional interventions.