



# DHCS Updates: Medi-Cal 2020 Waiver, Final Rule, and Managed Care Plan Quality

DMHC Financial Solvency Standards (FSSB) Meeting  
September 14, 2016

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# Presentation Outline

1. Managed Care Final Rule

1. Medi-Cal 2020 Waiver:  
Access Assessment and Whole Person Care Initiatives

3. Aggregated Quality Factor Score

4. Plan Rating System

5. Questions/Open Discussion



# Managed Care Final Rule



# Final Rule Overview

## CMS Goals

- Modernize and align the Medicaid managed care program with the Affordable Care Act (ACA) Marketplaces and Medicare Advantage
- Add consumer protections to improve the quality of care and beneficiary experience
- Improve accountability and transparency

## Implementation Dates

- Effective July 5, 2016
- Some provisions effective July 5, 2016 (IMD and in-lieu-of services)
- Phased implementation over three years, starting with contracts on or after July 1, 2017



# Major Provisions By Implementation Year

## July 1, 2017 contract rating year

- Information Requirements
- Grievances and Appeals
- Cultural Competency
- Care Coordination
- Quality Improvement Program
- Prescription Drugs Utilization Review
- Program Integrity
- Annual MCP Report

## No later than July 1, 2018

- Managed Care Quality Strategy

## July 1, 2018 contract rating year

- Network Adequacy
- Provider Screening and Enrollment
- Annual Network Certification
- Beneficiary Support System

## 2019 and beyond

- EQRO Validation of Network Adequacy
- Quality Rating System



# DHCS Approach to Implementation

## Stakeholder Input

- DHCS will work collaboratively with its Medi-Cal managed care health plans and stakeholder groups including the DHCS Stakeholder Advisory Committee, Managed Care Advisory Group, topic-specific workgroups, and external partners such as DMHC.
- DHCS will develop materials, deliverables, and/or processes with input from the above entities prior to implementation.

## Plan Guidance

- DHCS will provide forthcoming guidance to assist MCPs with implementation on each of the activities via All Plan Letters and contract amendments.
- DHCS will provide deliverables requirements to the MCPs on a flow basis throughout the implementation phases.



# Access Assessment



# Access Assessment Overview

## Objectives

- Evaluate primary, core specialty, and facility access to care for Medi-Cal managed care beneficiaries based upon network adequacy requirements set forth in the Knox Keene Act and MCP contracts with DHCS
- Consider State Fair Hearing, Independent Medical Review (IMR) decisions, provider, encounter, and grievances and appeals/complaints data

## Advisory Committee

- The Advisory Committee will provide recommendations into the Assessment design and the structure of the Access Assessment Report.
- The Advisory Committee is comprised of MCPs, plan and provider associations, advocates, and beneficiaries.<sup>2</sup>
- The first Advisory Committee meeting will be held in November 2016.

## Assessment Process

- Post the Governor signing SB 815, DHCS has 90 days to amend its External Quality Review Organization (EQRO) contract to direct the EQRO to conduct the assessment.
- Following amendment of the contract, DHCS has 6 months to submit the Access Assessment design to CMS for approval.
- The EQRO has 10 months post CMS approval to conduct the assessment and produce an initial draft report.
- DHCS will post the draft report for a 30-day public comment period after it has incorporated feedback from the Advisory Committee.
- The EQRO will complete a final report that includes a comparison of health plan network adequacy compliance across different lines of business, as well as recommendations in response to any systemic network adequacy issues identified.
- DHCS will submit the final Access Assessment Report to CMS.

<sup>2</sup> Please visit [the DHCS Final Access Assessment Committee Document](#) for the listing of the Access Assessment Advisory Committee.





# Whole Person Care



# Whole Person Care (WPC) Overview

## Program Goal

- To test the coordination of physical health, behavioral health, and social services for high utilizers users of multiple health care systems who continue to have poor outcomes

## Program Overview

- WPC Pilots will collaborate between two or more public entities (e.g. county mental health plans and local housing authorities), at least one managed care health plan (MCP), and other community entities.
- WPC Pilots are to identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population health progress.
- Up to \$1.5 billion in federal funds is available over five years to match local public funds for the WPC pilots



# WPC Overview

## Target Populations include, but are not limited to, individuals:

- with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness; and/or
- individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g. hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.)

## Allowable activities/services include:

- Care coordination
- Recuperative care/medical respite
- Sobering centers
- Transportation
- Field-based care, such as case managers, therapists, or nurses delivering services on the street or in the home
- New IT infrastructure



# Housing Supports/Services

## Housing Supports & Services

- **Individual Housing Transition Services:** housing transition services to assist beneficiaries with obtaining housing, such as individual outreach and assessments.
- **Individual Housing & Tenancy Sustaining Services:** services to support individuals in maintaining tenancy once housing is secured, such as tenant and landlord education and tenant coaching.
- **Additional transition services,** such as searching for housing, communicating with landlords, and coordinating moves.

## Additional Transition Services

- Transportation
- Environmental accommodations for accessibility
- Housing transition services beyond case management services that do not constitute room and board, such as:
  - Security deposits
  - Utility set-up fees
  - First month coverage of utilities
  - One-time cleaning prior to occupancy, etc.

## Flexible Housing Pool

- May include funding created from savings generated by reductions in health, behavioral, and acute care costs, which result from WPC pilot housing-related strategies
- Can be used to fund additional supports and services that are not available for (FFP), such as rental subsidies, home setup, deposits, and utilities



# Implementation Progress

## Application Updates

- DHCS is reviewing the 18 applications<sup>1</sup> received and requesting applicants for additional information and modifications to their budgets if needed
- Applications are due to CMS on October 7.
- DHCS will notify WPC applicants of decisions by October 24.
- WPC Lead Entities must provide formal acceptance to DHCS by November 3.

## Program Implementation

- WPC Pilots start implementation in November 2016.

## Reopening of Applications

- DHCS will begin a 2<sup>nd</sup> round of applications for new applicants and/or expansion of previously submitted applications in early 2017.

<sup>1</sup> Please visit [the DHCS WPC Applicants document](#) for the listing of applicants.



# Quality: Aggregated Quality Factor Score



# Aggregated Quality Factor Score

- The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) indicators.
- It is a composite rate calculated as a percent of the National High Performance Level (HPL).
  - The High Performance Level is 100%. The Minimum Performance Level is 40%. The weighted average is 60%.



# Aggregated Quality Factor Score (AQFS) Calculation

## Step 1: Calculate the Assigned Score

- For each HEDIS indicator DHCS monitors, assign a score to each plan at the county level according to its NCQA benchmark (percentile) performance as follows:

<b>NCQA Percentile Performance</b>	<b>Assigned Score</b>
Below 10%	1
<=10% and <17.5%	2
<=17.5% and <25%	3
<=25% and <37.5%	4
<=37.5% and <50%	5
<=50% and <62.5%	6
<=62.5% and <75%	7
<=75% and <82.5%	8
<=82.5% and <90%	9
90% and above	10





# AQFS Calculation

## Step 2: Weighting

- Weight Assigned Scores of first-year HEDIS indicators by 25%.

## Step 3: Total Assigned Scores

- Calculate a total score for each plan at county level by summing the final Assigned score of all HEDIS indicators.

## Step 4: Identify the Aggregate HPL (High Performance Level, 90th percentile of national level) score

- Assign the maximum possible score to each HEDIS indicator (10, or 2.5 for first-year indicators) and sum. The total is the Aggregate HPL score.

## Step 5: Normalize

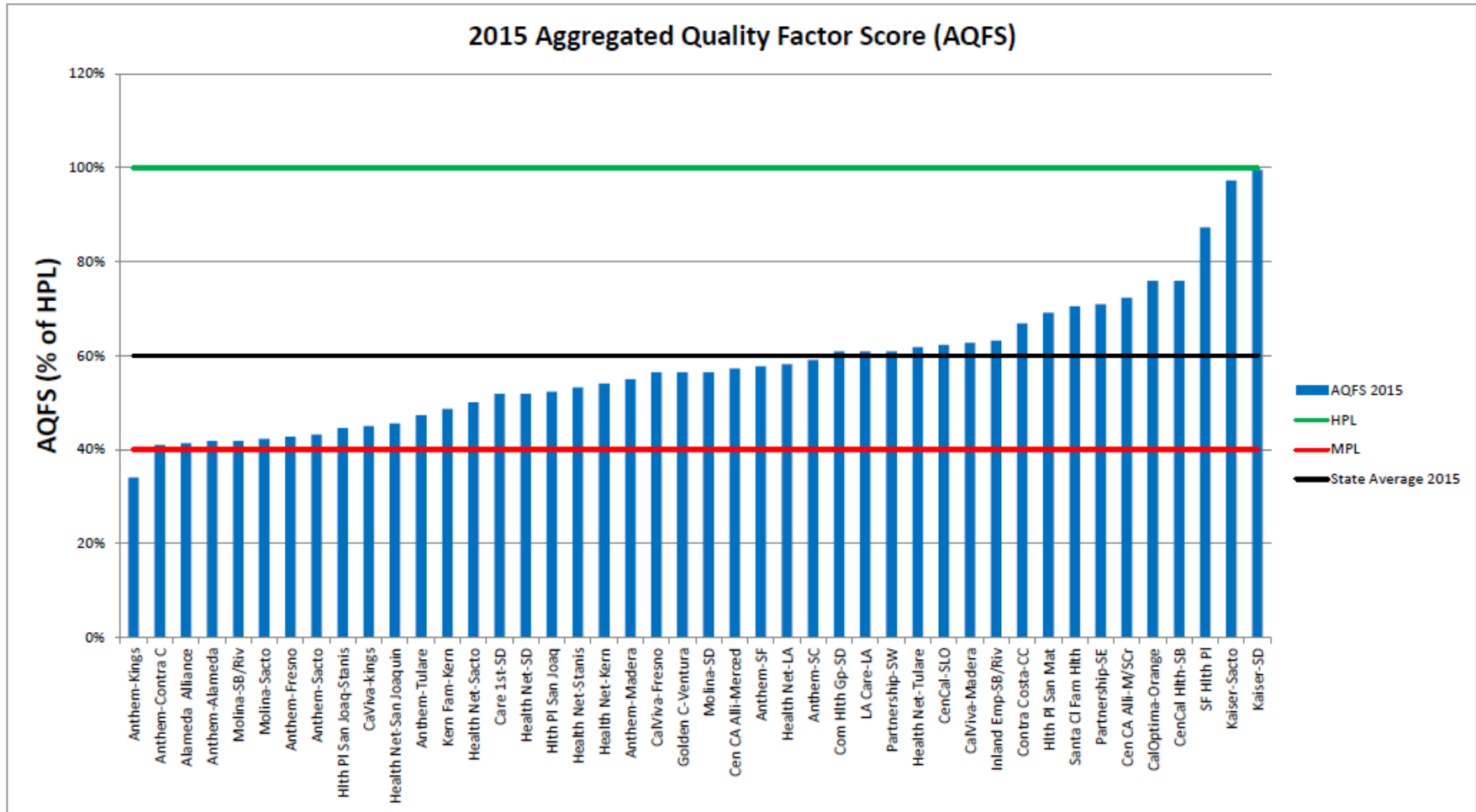
- Normalize (divide) the total score calculated in Step 3 above by the aggregated HPL score calculated in Step 4. The final score is the AQFS for each plan at the county level.

## Step 6: Interpretation

- The AQFS is a single score that accounts for plan performance on all DHCS-selected HEDIS indicators. It is a composite rate calculated as percent of the HPL (National High performance Level, 90th percentile of national level).



# Aggregated Quality Factor





# Plan Rating System



# Plan Rating System (PRS) Overview

- DHCS is currently developing a Plan Rating System that will be used for:
  - Having on-demand data on plan performance
  - Monitoring plans
  - Providing technical assistance where needed
  - Increasing transparency
  - Increasing consumer and stakeholder engagement
  - Enabling Medi-Cal beneficiaries to consider quality when choosing a managed care plan
- The Plan Rating System will allow DHCS to utilize data that the Department is already receiving through various inputs across five (5) domains.



# Plan Rating System Domains

## Health Care Quality

HEDIS, NCQA Quality Certification, health disparities, facility site reviews, performance improvement projects

## Beneficiary Experience

CAHPS, State Fair Hearings data, grievances data, Ombudsman call reports, call center reports

## Data Quality

Encounter data, provider file

## Network Adequacy

Network certification, Timely Access surveys, time and distance Geo-Access reports, PCP ratios, out of network access data

## MCP Compliance

A&I audits, DMHC surveys, grievances and appeals, State Fair Hearings granted, Appeals not in the MCP's favor



# Plan Rating System Overview

## The Plan Rating System allows for:

### **Comparability**

- The methods that are used for the plan rating system are in line with those that are commonly accepted and being used for quality ranking at national, regional, state, and local levels.

### **Innovation**

- Currently, other plan rating systems only include quality elements.
- DHCS' plan rating system will include network, compliance, data, and beneficiary experience in addition to quality elements.



# Plan Rating System Next Steps

DHCS is continuing development and testing of automated use of individual data.

Testing of the Plan Rating System is anticipated to begin by 1<sup>st</sup> Quarter of 2017.

DHCS is targeting to issue the report publically in July 2018.

CMS will be issuing guidance in 2018 related to the Quality Rating System in the Managed Care Final Rule.

- DHCS will need to align to the methodology and quality measures framework that CMS issues.



# Questions/ Open Discussion