



Department of
Health Care Services



CDSS & DHCS Data Sharing Meeting

April 2, 2013

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Coordinated Care Initiative

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CCI: One person, one plan, all benefits

- Cal MediConnect granted federal approval and the State announced publicly on March 27, 2013.
- Builds on years of work and effort by committed stakeholders and take a major leap forward to better integrate fragmented service delivery systems.
- New opportunity for coordination of care:
 - Medical care
 - Integrated long-term services and supports (LTSS):
 - In-Home Supportive Services (IHSS)
 - Community Based Adult Services (CBAS)
 - Multipurpose Senior Services Program (MSSP)
 - Nursing home care
 - Coordination of county mental health and substance use programs

8 CCI Counties

- **Los Angeles**
 - Health Net and LA Care
- **Orange**
 - CalOptima
- **San Diego**
 - Molina, Care 1st, Community Health Group, Health Net
- **San Mateo**
 - Health Plan of San Mateo
- **Alameda**
 - Alameda Alliance & Anthem Blue Cross
- **Santa Clara**
 - Santa Clara Family Health Plan & Anthem Blue Cross
- **San Bernardino**
 - Inland Empire Health Plan & Molina
- **Riverside**
 - Inland Empire Health Plan & Molina



CCI Consumer Protections

- Member notices will be sent at least 90, 60, and 30 days prior to enrollment (coordinated with CMS).
- Continuity of Care
 - People can continue to see their Medi-Cal providers for 12 months and Medicare doctors for six months.
- Self-Directed Care
 - People will have the choice to self-direct their care, including being able to hire, fire, and manage their IHSS workers.
- Appeals & Grievances
 - For Year 1, the Appeals and Grievances process will not change.
 - DHCS is working with CMS on a coordinated appeals process by 2015.
- Strong Oversight & Monitoring
- Evaluation Coordinated with CDSS, DHCS, and CMS

Health Plan Data and Reporting

Sarah Brooks

Chief, Program Monitoring & Medical Policy Branch
Medi-Cal Managed Care Division (MMCD)

Program Monitoring and Medical Policy Branch

Program Monitoring and Medical Policy Branch (PMMPB) is comprised of three sections:

- Plan Monitoring and Program Integrity
- Medical Policy
- Program Data and Performance Measurement

PMMPB is responsible for:

- Monitoring health plan compliance with federal, state and contractual requirements in multiple areas, including:
 - Quality of care provided to members
 - Member rights
 - Prevention and detection of fraud and abuse
 - Plan and provider performance measurement
 - Quality improvement activities
- Developing policy and addressing critical issues in the aforementioned areas; and
- Providing data support for the entire Medi-Cal Managed Care Program.

Plan Monitoring and Program Integrity Section:

- **Medical Monitoring Unit** is responsible for:
 - Reviewing health plan deliverables (for example, policies and procedures) prior to implementation of a new health plan or addition of an additional line of business (for example, Seniors and Persons with Disabilities);
 - Conducting Facility Site Reviews (FSRs) at plan providers to determine compliance with certain contractual requirements; and
 - Medical Exemption Requests (MERs) – forms completed by members requesting to stay in Fee-for-Service Medi-Cal.
- **Member Rights/Program Integrity Unit** is responsible for:
 - Monitoring health plan compliance with contract requirements and all applicable State and federal statutes and regulations related to member rights; and
 - Reviews plan compliance with requirements in such areas as member grievances, prior authorization request notifications, marketing and enrollment programs, cultural and linguistics services, and fraud and abuse.

Medical Policy Section is responsible for:

- Working collaboratively with program staff and contracted managed care plans to develop and clarify medical policies and contract requirements related to the quality of care provided to plan members;
- Overseeing individual health plan Quality Improvement Projects (QIPs) – plans are required to participate in one annually;
- Running the statewide collaborative QIP in which all health plans are required to participate; and
- Meeting with health plan medical directors quarterly to address clinical and policy issues.

Program Data and Performance Measurement Section is responsible for:

- **Program Data:**
 - Analyzes enrollment trends, utilization of medical and non-medical services, and the overall quality of care provided to members.
- **Performance Measurement:**
 - Administers the federally required External Quality Review Organization (EQRO) contract and monitor the health plan encounter data. HEDIS (performance measures) and CAHPS (member satisfaction survey) are audited and validated by the EQRO contractor and made publicly available.
- **Encounter Data Quality (new in 2013):**
 - Will evaluate the completeness, accuracy, timeliness and reasonableness of encounter data;
 - Will measure health plan compliance with encounter data reporting; and
 - Will provide technical assistance to plans specific to encounter data issues.

DHCS Strategic Initiatives in 2013

Encounter Data Project

- **Importance of Reliable Encounter Data**
 - Allows DHCS and health plans to structure care in a way that is best for members; and
 - Will no longer be able to use Fee-for-Service data.
- **Department-wide workgroup**
 - Focused on improving the accuracy, timeliness, reasonability and completeness of encounter data.
 - Identifying ways to measure compliance with data reporting requirements and improve the encounter data.
 - Decreases issues with data lag.
- **Work Is Ongoing**
 - Working directly with the plans now and expect to see improvements to the encounter data in early spring.

Medi-Cal Managed Care Dashboard

- **Medi-Cal Managed Care Dashboard – will include CCI measures**
 - Duals pilot at a statewide aggregate and individual plan level, includes quality, enrollment, financial, access, and enrollee satisfaction measures.
 - An initial version of the Dashboard will be ready prior to implementation of the CCI.
- **Monitoring Tool**
 - Establishes a mechanism for ongoing monitoring of the pilot program including plan performance.
 - Allows MMCD to more easily identify program trends, risk areas and successes.

Health Plan Monitoring

Health Plan Monitoring

MMCD evaluates plan reported data including:

- **Continuity of Care Reporting** addresses the standards for access to care including availability of services and ensures that persons who are transitioning into managed care continue to receive all medically necessary services until they are able to see a health plan provider and establish a care plan.
- **Types of Member Grievances (Complaints)** considers issues relating to health plan providers (physicians, hospitals, specialists, pharmacy, medical equipment suppliers), other factors relating to medical care including timely access to medical services, denials of services, and quality of medical services.
- **Health Plan Call Center Operations** ensures that phones are answered in a timely manner, members receive understandable informing materials, and call volumes are assessed to identify trends in managed care issues.

Note: Please refer to the handout for a full listing of the Audits and Reports

Health Plan Monitoring

MMCD evaluates plan reported data including:

HEDIS – The **Healthcare Effectiveness Data and Information Set (HEDIS)**, developed and maintained by the National Committee for Quality Assurance (NCQA), is a set of performance measures used to assess the quality of care provided by managed health care organizations. California managed care is measured on 14 primary HEDIS measures.

Quality Improvement Projects (QIPs) – managed care plans are required to conduct quality improvement projects (QIPs) to assess and improve the quality of a targeted area of clinical or nonclinical care or service provided to Medi-Cal managed care members. Health plans also participate in a statewide QIP – the current QIP focuses on avoidable hospital readmissions.

Note: Please refer to the handout for a full listing of the HEDIS Measures.

Health Plan Monitoring

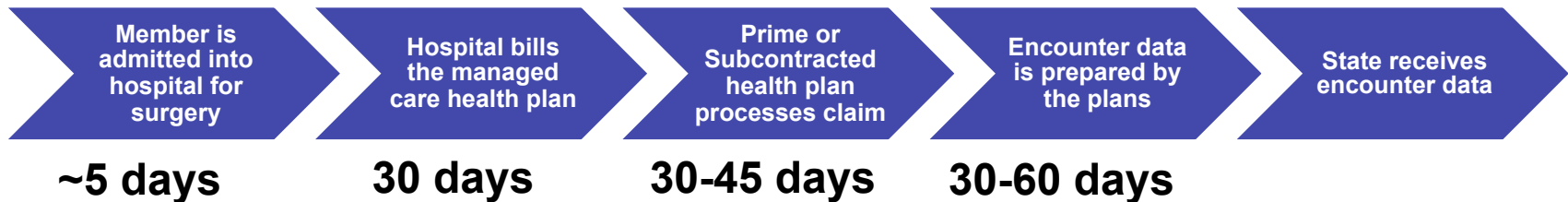
MMCD evaluates plan reported data including:

- **Utilization Management Reporting** ensures that health plans consistently use appropriate processes to review and approve the provision of medically necessary covered services.
- **Medications and Drug Formularies** includes review of formulary changes and exceptions made by the health plans, authorization processes, pharmacy networks, and the health plan's informing materials for the members.
- **Encounter data** includes data which can be used to report the average number of emergency visits, hospital re-admissions, outpatient visits each year, admissions and discharges to hospitals, lengths of inpatient stay, medications, and X-Rays.

Note: Please refer to the handout for a full listing of Audits and Reports.

Encounter Data Reporting

- Encounter data starts with the member's date of service and other types of medical services being delivered
- The State receives the encounter data several months after the member is treated
- Example of the timeline for an inpatient stay:



Average of 3-6 months between the date of service and reporting of encounter data to the State

CDSS and DHCS Coordination of Quality Assurance Data

- **Identify trends in utilization management**
 - Long-Term Care and Hospital Facility Bed Days
 - Average bed days in Hospitals (Inpatient), Skilled Nursing Facilities, and Psychiatric Hospitals and Outpatient Settings
 - IHSS awareness of member transitions from mental institutions, nursing facilities, and analysis of other utilization patterns including readmission rates, short/long-term stays, and intermediate care facilities
- **Detect fraud and abuse, and assist with assessments**
 - Encounter data would be used for IHSS assessments and re-assessments, annually or when there is a change in the member's condition
 - Ability to reference utilization data with work hours (e.g. fraud detection)

Questions?