State of California—Health and Human Services Agency
Department of Health Care Services

WHOLE PERSON CARE
UNIVERSAL AND VARIANT METRICS
TECHNICAL SPECIFICATIONS

Revised September 1, 2017

Measure Modification Disclaimer:

Non-Healthcare Effectiveness Data and Information Set (HEDIS®) Whole Person Care defined measures were based on HEDIS® measures and modified by DHCS for purposes of the Whole Person Care Pilot program.

The measure specification methodology used by the Department of Health Care Services (DHCS) is different than the National Committee for Quality Assurance's (NCQA) methodology. NCQA has not validated the altered measure specifications, but has granted DHCS permission to modify as needed.

This page is left intentionally blank.

TABLE OF CONTENTS

1. OVERVIEW 5

2. UNIVERSAL METRICS 9

2.1 Ambulatory Care (AMB) 10

2.2 Inpatient Utilization – General Hospital/Acute Care (IPU) 12

2.3 Follow-up After Hospitalization for Mental illness (FUH) 13

2.4 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) 15

2.5 Comprehensive Care Plan 18

3. VARIANT METRICS 19

3.1 Variant Metrics: Non-Housing Metrics 20
3.1.1 All-Cause Readmissions (ACR) 20
3.1.2 Decrease Jail Incarcerations 23
3.1.3 Overall Beneficiary Health 24
3.1.4 Controlling High Blood Pressure (CBP) 26
3.1.5 Comprehensive Diabetes Care (CDC –H8). 28
3.1.6 PHQ-9/Depression Remission at Twelve Months (NQF 0719) 30
3.1.7 Adult Major Depressive Disorder: Suicide Risk Assessment (MDD)(NQF 0104) 32

3.2 Variant Metrics: Housing Metrics 33
3.2.1 Permanent Housing 33
3.2.2 Housing Services 34
3.2.3 Supportive Housing 35

4. APPENDICES 36

4.1 Glossary of Terms (Attachment A) 36

4.2 Attachment GG (Attachment B) 36

4.3 Attachment MM (Attachment C) 36

This page is left intentionally blank.

1. OVERVIEW

Program Overview

Whole Person Care (WPC) is a 5-year program authorized under California's Medi-Cal 2020 waiver[1] to test locally-based initiatives that will coordinate physical health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple health care systems and continue to have poor outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC pilots will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population health progress.

Document Purpose

The purpose of this Whole Person Care (WPC) Technical Specifications Guide is to provide Lead Entities (LEs) with information and resources to be able to report accurately on universal and variant metrics to the Department of Health Care Services (DHCS).

Source of Measure Specifications

The universal and variant metrics selected for WPC and included in this document are based on Healthcare Effective Data and Information Set (HEDIS®)[2] and National Quality Forum (NQF) measures, as well as DHCS-developed measures pertaining to housing and jail recidivism.

This document is a summary compilation of these aforementioned resources. For detailed descriptions of the specific measures and data elements, please refer to 2017 HEDIS® specifications and value sets which can be obtained at the *NCQA Store* [3] and the specific sources referenced for each metric in the document. This guide does not address other reporting requirements, such as baseline data reporting and payment for deliverables reporting. DHCS will issue separate guidance on these requirements at a later time.

Nomenclature for the Measured Population

Under the heading "Eligible Population", each metric in this document references an "Initial Population: Medi-Cal Beneficiaries Enrolled in WPC". Enrollment status is reported by the LE to DHCS monthly on the enrollment template. WPC LEs will apply the WPC reporting definitions to "enrolled", "enrollment" or "enrollment gap" in the metrics' other Eligible Population criteria. These definitions should be applied consistently across all reported WPC metrics. Likewise, references to "enrollment" and "member(s)" in the full HEDIS® specs should be taken to mean "Medi-Cal Beneficiaries (including Fee-For Service FFS) enrolled in WPC" and "Medi-Cal Beneficiary WPC enrollee(s)" respectively.

---

[1] Medi-Cal 2020 Waiver Special Terms and Conditions (STCs), 110-126: http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs12-8-16.pdf

[2] HEDIS® is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS® consists of 81 measures across five domains of care. HEDIS® is a registered trademark of the National Committee for Quality Assurance.

[3] HEDIS® Publications: http://store.ncqa.org/index.php/performance-measurement/hedis-publications-outline.html#qrs On the NCQA Store, WPC Lead Entities should be using the 2017 HEDIS® Specifications for Health Plans and the 2017 Quality Rating System (QRS) HEDIS® Value Set Directory

The "Eligible Population" in each metric is not to be confused with a WPC Lead Entity's "WPC Eligible Population. The former is a set of inclusion criteria specific to each metric, whereas the latter is a theoretical population based on the WPC enrollment criteria set by each Lead Entity.

WPC Reporting

LEs will be required to report universal and variant metrics in order to assess their success in achieving the goals and strategies specified in STCs 110 and 112. All LEs are required to report on the same set of universal metrics as described in Attachment MM of the STCs and as specified in the variant metrics menu. Even though DHCS will calculate the measures indicated on page seven for purposes of the mid-year and annual reports, the pilots are responsible for tracking these metrics at the local level and making the appropriate changes to improve performance based on the DHCS results and local data.

As a condition of participation in the WPC Pilot program, each Lead Entity is required to submit mid-year and annual reports to DHCS on universal and variant. The LEs are required to identify partners to provide needed data and engage in bi-directional data sharing. The mid-year reports will be used to determine progress toward the WPC Pilot requirements. The annual report demonstrates that the WPC Pilot is conducted in compliance with the requirements set forth in the STCs and attachments, the approved application, and any agreement between DHCS and the Lead Entity, and/or policy letters and guidance from DHCS. Please refer to the Appendix for more detailed information on the mid-year and annual reporting requirements (Attachment GG) and the performance metrics and reporting requirements (Attachment MM).

The reporting frequency and due dates for the reports are outlined below:

Report Type	Frequency	Due Date
Baseline	One-time submission of calendar year 2016 data using PY 2 enrollment.	3/1/18
Mid-Year	60 calendar days after 6/30 of each year. Note: For second round LEs, no report due for calendar year 2017.	Report due 8/31
Annual	90 calendar days after the end of each program year excluding 1st program year	Report due 4/2

Measure	Rates for Required Calculations	Data Needed for Baseline Rate Calculation	Reporting Frequency	Calculation Responsibility
Ambulatory Care – Emergency Department (AMB-ED)	Number of Visits per 1,000 Member Months	Pre-WPC Medi-Cal data for calendar year 2016	Semi-annual	DHCS
Inpatient Utilization – General Hospital/Acute Care (IPU)	Total Inpatient	Pre-WPC Medi-Cal data for calendar year 2016.	Semi-annual	DHCS
Follow-up After Hospitalization for Mental Illness (FUH)	• FUH-30 • FUH-7	Pre-WPC Medi-Cal data for calendar year 2016	Annual	DHCS
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET)	• Initial of AOD Treatment • Engagement of AOD Treatment	Pre-WPC Medi-Cal data for calendar year 2016	Annual	DHCS
Comprehensive Care Plan	• The percentage of new enrolled members in the measurement year who had a Comprehensive Care Plan within 30 days of enrollment • The percentage of members with an anniversary date in the measurement year who had a Comprehensive Care Plan within 30 days of anniversary date of enrollment	For the purposes of this measure, Program Year 2 data will be considered Baseline data.	Annual	LE
All Cause Readmissions (ACR)	Total (21 years and Older)	Pre-WPC Medi-Cal data for calendar year 2016	Annual	DHCS
Decrease Jail Incarceration	Incarcerations per 1,000 Member Months	Available pre-WPC Medi-Cal data and incarceration data (from county) for in county data	Semi-annual	LE
Overall Beneficiary Health	• Rating Overall Health • Rating Mental or Emotional Health	For the purposes of this measure, Program Year 2 data will be considered Baseline data.	Annual	LE
Controlled Blood Pressure (CBP)	• Rate of 18-59 years BP<140/90 • Rate of 60-85 years with diabetes BP<140/90 • Rate of 60-85 years without diabetes BP<150/90	Pre-WPC Medi-Cal data for calendar years 2015 and 2016. Medical record review is needed (hybrid measure)	Annual	LE
Comprehensive Diabetes Care (CDC-H8)	HbA1c control (<8.0%)	Pre-WPC Medi-Cal data for calendar years 2015 and 2016. Medical record review is needed	Annual	LE
Depression Remission at Twelve months	Depression remission rates at 12 months	Two years pre-WPC Medi-Cal data for calendar years 2015 and 2016	Annual	LE
Suicide Risk Assessment	Rates of suicide assessments	Pre-WPC Medi-Cal data for calendar year 2016	Annual	LE
Permanent Housing	Total Rates	For the purposes of this measure, Program Year 2 data will be considered Baseline data	Annual	LE
Housing Services	Total Rates	For the purposes of this measure, Program Year 2 data will be considered Baseline data	Annual or	LE

Measure	Rates for Required Calculations	Data Needed for Baseline Rate Calculation	Reporting Frequency	Calculation Responsibility
			Semi-annual	
Supportive Housing	Total Rates	For the purposes of this measure, Program Year 2 data will be considered Baseline data	Annually or Semi-annually	LE

2. UNIVERSAL METRICS

All LEs must report on the same set of universal metrics required of all WPC Pilots. Universal metrics are comprised of four (4) health outcomes measures and three (3) administrative measures:

- Health Outcomes: Ambulatory Care (AMB) – Emergency Department Visits.
- Health Outcomes: Inpatient Utilization-General Hospital/Acute Care (IPU).
- Health Outcomes: Follow-up After Hospitalization for Mental Illness (FUH).
- Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Administrative: Beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment and annually.
- Administrative: Care coordination, case management, and referral infrastructure.
- Administrative: Data and information sharing infrastructure.

The four health outcomes measures selected are standard HEDIS® measures across differing domains of care. Descriptions and calculations of the health outcomes measures are explained in further detail in the sections below.

2.1 AMBULATORY CARE (AMB) MEASURE SPECIFICATION

(Non- HEDIS® WPC-defined measure; Modified from HEDIS® Ambulatory Care Specification. WPC pilots must follow HEDIS® instructions and calculations except as stipulated by DHCS.)

Description
This measure summarizes utilization of ambulatory care in the following category: • ED visits.
WPC Modifications
• Mental health and chemical dependency will not be excluded for WPC. • Eligible population: The eligible population is the subset of WPC enrollees (individuals must be Medi-Cal beneficiary to be enrolled in WPC) including fee-for-service, that meet the HEDIS® AMB specifications for the eligible population, exclusions, etc. • Administrative Specification: Denominator is member months from the eligible population of enrolled WPC members.
Source
HEDIS®
Calculation Responsibility
DHCS
Eligible Population
Initial Population: Medi-Cal Beneficiaries enrolled in WPC.
Calculation
Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: • An ED visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.
Exclusions
Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. • Electroconvulsive therapy (Electroconvulsive Therapy Value Set).

Notes
This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.

2.2 INPATIENT UTILIZATION – GENERAL HOSPITAL/ACUTE CARE (IPU) MEASURE SPECIFICATION

(Non- HEDIS® WPC-defined measure; Modified from HEDIS® Inpatient Utilization – General Hospital/Acute Care Specification. WPC pilots must follow HEDIS® instructions and calculations except as stipulated by DHCS.)

Description
This measure summarizes utilization of acute inpatient care and services in the following category: • Total inpatient
WPC Modifications
• Eligible population: The eligible population is the subset of WPC enrollees (individuals must be Medi-Cal beneficiary to be enrolled in WPC) including fee-for-service, that meet the HEDIS® IPU specifications for the eligible population, exclusions, etc. • Mental health and chemical dependency will not be excluded for WPC.
Source
HEDIS®
Calculation Responsibility
DHCS
Eligible Population
Initial Population: Medi-Cal Beneficiaries enrolled in WPC.
Calculations
See details in *Ref.* HEDIS® – *IPU.*
Exclusions
• Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. • Discharges with a principal diagnosis of live-born infant or an MS-DRG for newborn care will be excluded.

2.3 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH) MEASURE SPECIFICATION

(Non-HEDIS® WPC-defined measure; Modified from HEDIS® Follow-Up After Hospitalization for Mental Illness Specification. WPC pilots must follow HEDIS® instructions and calculations except as stipulated by DHCS.)

Description
The percentage of discharges for beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the beneficiary received follow-up within 30 days of discharge. • The percentage of discharges for which the beneficiary received follow-up within 7 days of discharge.
WPC Modifications
• Eligible population: The eligible population is the subset of WPC enrollees (individuals must be Medi-Cal beneficiary to be enrolled in WPC) including fee-for-service, that meet the HEDIS® FUH specifications for the eligible population, exclusions, etc. • Administrative Specification: Denominator is the number of members discharged within the eligible population of enrolled WPC members according to the specifications.
Source
HEDIS®
Calculation Responsibility
DHCS
Eligible Population
Initial Population: Medi-Cal Beneficiaries Enrolled in WPC. **Ages:** 6 years and older as of the date of discharge. **Continuous enrollment:** Date of discharge through 30 days after discharge. **Allowable gap:** No gaps in enrollment. **Anchor date:** None

Event/ diagnosis: An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

To identify readmissions and direct transfers to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Administrative Specification

Denominator: Number of discharges with a principal diagnosis of mental illness experienced by the eligible population between January 1 and December 1 of the measurement year.

Numerators: A follow-up visit with a mental health practitioner within a number of days after discharge. See details in *Ref.* HEDIS® – *FUH*.

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. Include visits that occur on the date of discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

Exclusions

Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

2.4 INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT (IET) MEASURE SPECIFICATION

(Non- HEDIS® WPC-defined measure; Modified from HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Specification. WPC pilots must follow HEDIS® instructions and calculations except as stipulated by DHCS.)

Description

The percentage of adolescent and adult beneficiaries with a new episode of alcohol or other drug (AOD) dependence who received the following:

- *Initiation of AOD Treatment.* The percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of beneficiaries who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

WPC Modifications

- Age stratification is not required. Report total of those 13 years and older.
- Eligible population: The eligible population is the subset of WPC enrollees (individuals must be Medi-Cal beneficiary to be enrolled in WPC) including fee-for-service, that meet the HEDIS® IET specifications for the eligible population, exclusions, etc.

Definitions

Intake Period: January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.

Index Episode: The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED visit during the Intake Period with a diagnosis of AOD.

For ED visits that result in an inpatient stay, the inpatient discharge is the Index Episode.

IESD: Index Episode Start Date. The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.

For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service.

For an inpatient stay, the IESD is the date of discharge.

For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge. An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.

For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer).

Negative Diagnosis History: A period of 60 days (2 months) before the IESD when the beneficiary had no claims/ encounters with a diagnosis of AOD dependence.

For an inpatient stay, use the admission date to determine the Negative Diagnosis History.

For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.
For direct transfers, use the first admission to determine the Negative Diagnosis History.

Direct transfer: A **direct transfer** is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:

An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.

An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.

An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1) Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2) Identify the admission and discharge dates for the stay.

Source
HEDIS®
Calculation Responsibility
DHCS
Eligible Population

Initial Population: Medi-Cal Beneficiaries Enrolled in WPC.

Ages: 13 years and older as of December 31 of the measurement year.

Continuous enrollment: 60 days (2 months) prior to the IESD through 44 days after the IESD (105 total days).

Allowable gap: None

Anchor date: None

Benefits: Medical and chemical dependency (inpatient and outpatient).

Note: *Beneficiaries with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/ diagnosis: New episode of AOD during the Intake Period. See details in *Ref.* HEDIS® – *IET*.

Administrative Specification
Denominator: The number of individuals in the eligible population with a new episode of alcohol or other drug (AOD) dependence during the Intake Period. **Numerator**: The number of eligible population who initiated treatment or who initiated treatment and who had two or more additional services with a diagnosis of AOD.
Exclusions
Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

2.5 COMPREHENSIVE CARE PLAN MEASURE SPECIFICATION

Description
Percent of beneficiaries who received a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment and the beneficiary's anniversary date of enrollment in WPC. Report two rates for the following categories: • New enrollee in the measurement year • Enrollee with an anniversary date in the measurement year
Definition
Anniversary date: Twelve months from the exact date of enrollment, not the effective date of enrollment.
Source
DHCS measure
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population**:** Medi-Cal beneficiaries enrolled in WPC. Allowable gap: no limitation of gaps in continuous enrollment for enrollee who had an anniversary date in the measurement year. **Anchor date:** Date of enrollment.
Exclusions
Exclude members who are not enrolled at the anniversary date of enrollment in WPC during the measurement year.
Administrative Specifications
Numerator 1: The number of beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of exact enrollment date. **Denominator 1:** The number of new enrollees. **Numerator 2:** The number of beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of anniversary date of exact enrollment date. **Denominator 2:** The number of beneficiaries with an annual anniversary date during the measurement year.

3. VARIANT METRICS

Variant metrics vary by specific target population(s), strategies, and interventions as selected by the WPC Pilots. Lead Entities must select their variant metrics from the WPC Variant Metrics menu. LEs are required to report on four variant metrics; for WPC Pilots that selected a housing component, a fifth metric must be selected specific to this intervention.

Variant Metrics include:

- Metric #1: Administrative.
- Metric #2 Health Outcomes: 30 day All Cause Readmissions.
- Metric #2 Health Outcomes: Decrease Jail Incarcerations.
- Metric #2 Health Outcomes: Overall Beneficiary Health.
- Metric #2 Health Outcomes: Controlling Blood Pressure.
- Metric #2 Health Outcomes: Comprehensive Diabetes Care – CDC-H8.
- Metric #3 Health Outcomes: PHQ-9/Depression Remission at Twelve months (NQF 0104) required for all Pilots utilizing PHQ-9. All other LEs report an alternative health outcome metric from variant metric 2 options not already reported as metric #2.
- Metric #4 Health Outcomes: Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) required for all Pilots with a severely mentally ill target population. All other LEs report an alternative health outcome metric from variant metric 2 options not already reported as metric #2 or #3.
- Metric #5 Housing: Permanent Housing. All Pilots implementing a housing component shall report one of the housing metrics from the variant metric 5 options.
- Metric #5 Housing: Housing Services. All Pilots implementing a housing component shall report one of the housing metrics from the variant metric 5 options.
- Metric #5 Housing: Supportive Housing. All Pilots implementing a housing component shall report one of the housing metrics from the variant metric 5 options.

Descriptions and calculations of each of the above variant measures are explained in further detail in the sections below. The metrics selected are based on standard HEDIS® measures and NQF measures, as well as DHCS developed metrics to target the homeless/at risk for homelessness and incarcerated population.

3.1 VARIANT METRICS: NON-HOUSING METRICS

3.1.1 ALL-CAUSE READMISSIONS (ACR) MEASURE SPECIFICATION

(Non- HEDIS® WPC-defined measure; Modified from HEDIS® Plan All-Cause Readmissions Specification. WPC pilots must follow HEDIS® instructions and calculations except as stipulated by DHCS.)

Description
For beneficiaries 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following categories: 1) Count of Index Hospital Stays (IHS) (denominator). 2) Count of 30-Day Readmissions (numerator).
WPC Modifications
• Classification Period: Only 120 days prior to and including an index discharge date is used. 365 days is not used. • For beneficiaries 18 years of age and older. • Eligible population: The eligible population is the subset of WPC enrollees (individuals must be Medi-Cal beneficiary to be enrolled in WPC) including fee-for-service, that meet the HEDIS® PCR specifications for the eligible population, exclusions, etc.
Source
HEDIS®
Calculation Responsibility
DHCS
Definitions
IHS: Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section. **Index Admission Date:** The IHS admission date. **Index Discharge Date:** The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.

Index Readmission Stay: An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.

Index Readmission Date: The admission date associated with the Index Readmission Stay.

Planned Hospital Stay: A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the Eligible Population.

Classification Period: 120 days prior to and including an Index Discharge Date.

Eligible Population

Initial Population: Medi-Cal beneficiaries enrolled in WPC.

Ages: 18 years and older as of the Index Discharge Date.

Continuous enrollment: 120 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.

Allowable gap: None

Anchor date: Index Discharge Date.

Event/ diagnosis: An acute inpatient discharge on or between January 1 and December 1 of the measurement year.

The denominator for this measure is based on discharges, not beneficiaries. Include all acute inpatient discharges for beneficiaries who had one or more discharges on or between January 1 and December 1 of the measurement year.

Administrative Specification

Numerator: At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Denominator: The number of acute inpatient stays experienced by the eligible population between January 1 and December 1 of the measurement year.

Exclusions

Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude Index hospital stays for the following reasons:

- Index Admission Date is the same as the Index Discharge Date.
- The beneficiary died during the stay.
- A principal diagnosis of pregnancy.
- A principal diagnosis of a condition originating in the perinatal period.

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).
- A principal diagnosis of rehabilitation (Rehabilitation Value Set).
- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).

3.1.2 DECREASE JAIL INCARCERATIONS MEASURE SPECIFICATION

Description
Incarcerations per 1000 member months of beneficiaries 14 years of age and older.
Source
DHCS
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. **Ages:** 14 years and older as of June 30 (for the mid-year report) or December 31 (for the annual report) of the measurement year.
Administrative Specification
Numerator: The total number of incarcerations in the reporting period (note: one member could have more than one incarceration, count all incarcerations). **Denominator:** Total member months for the reporting period for beneficiaries 14 years of age and older.
Exclusions
Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

3.1.3 OVERALL BENEFICIARY HEALTH MEASURE SPECIFICATION

Description
The measure provides self-reported rating for beneficiaries overall health and mental or emotional health. The following rates are calculated: 1. Rating overall health 2. Rating mental or emotional health
Definition
Self-report questions: 1. In general, how would you rate your overall health? • Excellent • Very Good • Good • Fair • Poor 2. In general, how would you rate your overall mental or emotional health? • Excellent • Very Good • Good • Fair • Poor
Source
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey questions
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. **Ages:** All **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of one month.
Administrative Specifications
Numerator 1: Number of responses with answers of “Excellent” or “Very Good” to the question regarding overall health.

Numerator 2: Number of responses with answers of "Excellent" or "Very Good" to the question regarding mental or emotional health

Denominator 1: Number of all responses to the question regarding overall health by the eligible population during the measurement year.

Denominator 2: Number of all responses to the question regarding mental and emotional health by the eligible population during the measurement year.

Exclusions

Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

3.1.4 CONTROLLING HIGH BLOOD PRESSURE (CBP) MEASURE SPECIFICATION

(Non- HEDIS® WPC-defined measure; Modified from HEDIS® Controlling High Blood Pressure Specification. WPC pilots must follow HEDIS® instructions and calculations except as stipulated by DHCS.)

Description
The percentage of beneficiaries 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Beneficiaries 18–59 years of age whose BP was <140/90 mm Hg. • Beneficiaries 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Beneficiaries 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. ***Note:*** *Reporting entities must use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.*
WPC Modifications
• Eligible population: The eligible population is the subset of WPC enrollees (individuals must be Medi-Cal beneficiary to be enrolled in WPC) including fee-for-service, that meet the HEDIS® CBP specifications for the eligible population, exclusions, etc.
Source
HEDIS®
Calculation Responsibility
Lead Entity
Definitions
Adequate control: Adequate control is defined as meeting any of the following criteria: • Beneficiaries 18–59 years of age whose BP was <140/90 mm Hg. • Beneficiaries 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Beneficiaries 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. **Representative BP:** The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the beneficiary is "not controlled."
Eligible Population

Initial Population: Medi-Cal beneficiaries enrolled in WPC.

Ages: 18–85 years as of December 31 of the measurement year.

Continuous enrollment: The measurement year.

Allowable gap: No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: December 31 of the measurement year.

Event/diagnosis: Beneficiaries are identified as hypertensive if there is at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of the measurement year.

Diabetes Flag: See details in *Ref.* HEDIS® – *CBP*.

Hybrid Specification

Numerator: The number of beneficiaries in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Beneficiaries 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Beneficiaries 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Beneficiaries 60–85 years of age as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.

To determine if the beneficiaries BP is adequately controlled, the representative BP must be identified.

Denominator: Beneficiaries from the eligible population who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year. See details in *Ref.* HEDIS® – *CBP*.

Exclusions

Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

3.1.5 COMPREHENSIVE DIABETES CARE (CDC-H8) – {HbA1c CONTROL (<8.0%)} MEASURE SPECIFICATION

(Non- HEDIS® WPC-defined measure; Modified from HEDIS® Comprehensive Diabetes Care Specification. WPC pilots must follow HEDIS® instructions and calculations except as stipulated by DHCS.)

Description
The percentage of beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).
WPC Modifications
• Eligible population: The eligible population is the subset of WPC enrollees (individuals must be Medi-Cal beneficiary to be enrolled in WPC) including fee-for-service, that meet the HEDIS® CDC specifications for the eligible population, exclusions, etc.
Source
HEDIS®
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. **Ages:** 18–75 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). **Anchor date:** December 31 of the measurement year. **Event/diagnosis:** There are two ways to identify beneficiaries with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a beneficiary only needs to be identified by one method to be included in the measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. Refer to HEDIS® – *CDC-8* for additional details.
Hybrid Specification
Numerator: See details in Ref. HEDIS® CDC-H8.

Denominator: See details in Ref. HEDIS® CDC-H8.

Exclusions

Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

3.1.6 PHQ-9/DEPRESSION REMISSION AT TWELVE MONTHS (NQF 0719) MEASURE SPECIFICATION

Description
The percentage of patients 18 years of age or older with Major Depression or Dysthymia who reached remission 12 months (+/- 30 days) after an index visit.
Source
Minnesota Community Measurement
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. **Ages:** 18 years of age or older at the index visit. **Event (Index Visit):** An index visit occurs when ALL of the following criteria are met during a face-to-face visit or contact with an eligible provider in an eligible specialty: • A PHQ-9 result greater than nine. • An active diagnosis of Major Depression or Dysthymia** (*Major Depression or Dysthymia* Value Set). • The patient is NOT in a prior index period. An index period begins with an index visit and is 13 months in duration. ** **For psychiatry providers and behavioral health providers with a psychiatrist on site:** The diagnosis of Major Depression or Dysthymia must be the primary diagnosis. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of one month.
Exclusions
• Beneficiary had an active diagnosis of Bipolar Disorder (*Bipolar Disorder* Value Set). • Beneficiary had an active diagnosis of Personality Disorder (*Personality Disorder* Value Set). • Beneficiary was a permanent nursing home resident at any time during the measurement period. • Beneficiary was in hospice or receiving palliative care at any time during the measurement period. • Beneficiary died prior to the end of the measurement period.
Administrative Specifications
Numerator: The number of beneficiaries in the denominator who reached remission, with a PHQ-9 result less than five, 12 months (+/- 30 days) after an index visit.

Denominator: Number of individuals from the eligible population with an index visit for diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine between December 1 of the year prior to the measurement year to November 30 of the measurement year.

Full Specifications: NQF 0710 CMS159v5 (https://ecqi.healthit.gov/system/files/ecqm/2014/EP/measures/CMS159v5_2.html)

3.1.7 ADULT MAJOR DEPRESSIVE DISORDER: SUICIDE RISK ASSESSMENT (MDD) (NQF 0104) MEASURE SPECIFICATION

Description
Percentage of beneficiaries aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.
Source
AMA-convened Physician Consortium for Performance Improvement.
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. **Ages:** All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD). **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of one month.
Administrative Specifications
Numerator: Beneficiaries with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. **Denominator:** The eligible population. **Full specifications:** NQF 0104 CMS161v5 **(**https://ecqi.healthit.gov/ep/ecqms-2017-performance-period/adult-major-depressive-disorder-mdd-suicide-risk-assessment**)**

3.2 VARIANT METRICS: HOUSING METRICS

3.2.1 PERMANENT HOUSING MEASURE SPECIFICATION

Description
Percent of homeless who are permanently housed longer than 6 months' experience of permanently housed.
Source
DHCS measure
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. Homeless who reached the sixth-month time point, between December 1 of the prior year and November 30 of the measurement year, of permanently housed for 6 consecutive months. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of one month.
Exclusions
Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
Administrative Specification
Numerator: Homeless who reached the seventh-month time point, between January 1 and December 31 of the measurement year, of permanently housed for more than 6 consecutive months. **Denominator:** The eligible population.

3.2.2 HOUSING SERVICES MEASURE SPECIFICATION

Description
Percent of homeless who received housing services after being referred for housing services.
Source
DHCS measure
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. Homeless referred for housing services between January 1 and December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of one month.
Exclusions
Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
Administrative Specification
Numerator: Homeless who received housing services after being referred for housing services during the measurement year. **Denominator:** The eligible population.

3.2.3 SUPPORTIVE HOUSING MEASURE SPECIFICATION

Description
Percent of homeless who received supportive housing after being referred for supportive housing.
Source
DHCS measure
Calculation Responsibility
Lead Entity
Eligible Population
Initial Population: Medi-Cal beneficiaries enrolled in WPC. Homeless referred for supportive housing between December 1 of the prior year and November 30 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of one month.
Exclusions
Beneficiaries in hospice: Pursuant to HEDIS® General Guideline 20: Members in Hospice. Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
Administrative Specifications
Numerator: Homeless who received supportive housing after being referred for supportive housing during the measurement year. **Denominator:** The eligible population.

4. APPENDICES

4.1 Glossary of Terms (Attachment A)

4.2 Attachment GG (Attachment B)

4.3 Attachment MM (Attachment C)

ATTACHMENT A
Glossary of Terms

Term	Definition
Homeless	Individuals or families who— (1) lack a fixed, regular, and adequate nighttime residence, (2) have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (3) are living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); (4) resided in a shelter or place not meant for human habitation and is exiting an institution where he or she temporarily resided; or (5) otherwise meets the definition of 42 U.S. Code Sections 11302(a)(5), (6) or (b).
Housing Services	Evidence-based services, such as assertive community treatment, critical time intervention, motivational interviewing, and trauma-informed care, to help people experiencing homelessness to access and maintain housing stability. These services include— (1) In-person services that outreach to and engage people experiencing homelessness to form trusting relationships and to develop goals for improving health outcomes based on the client's stated needs. (2) Individual housing transition services that provide direct support to people experiencing homelessness, such as— a. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers. b. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both

Term	Definition
	reimbursed and not reimbursed by Medicaid, may be required to meet the goal. c. Assisting with the housing application process. Assisting with the housing search process, including identifying and meeting with landlords. d. Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses. e. Ensuring that the living environment is safe and ready for move-in. f. Assisting in arranging for and supporting the details of the move. g. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized. (3) Individual housing and tenancy sustaining services to support individuals to maintain tenancy once housing is secured, such as— a. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations. b. Education and training on the role, rights and responsibilities of the tenant and landlord. c. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy. d. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action. e. Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized. f. Assistance with the housing recertification process. g. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. h. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Term	Definition
Incarceration	Police officers and other law enforcement officers are authorized by federal, state, and local lawmakers to arrest and confine persons suspected of crimes. The judicial system is authorized to confine persons convicted of crimes. This confinement, whether before or after a criminal conviction, is called incarceration. Juveniles and adults alike are subject to incarceration.
Permanently Housed	Residing in independent housing without time limitation, where the tenant may live in his/her home as long as he/she meets the basic obligations of tenancy. While participation in services is encouraged, it is not a condition of living in the housing or of receiving a rental subsidy. Housing affordability is ensured either through a rent subsidy or by setting rents at affordable levels. Tenants hold all rights and responsibilities of tenancy under California law.
Supportive Housing	Supportive housing links decent, safe, affordable, community-based housing with flexible, voluntary support services designed to help the individual or family stay housed and live a more productive life in the community. Like other housing existing in the market, people living in supportive housing have a private and secure home, with the same rights and responsibilities afforded renters under California law. Supportive housing tenants may access, at their option, services designed to build independent living and tenancy skills, assistance with integrating into the community, and connections to community-based health care, treatment, and employment services. Housing is without time limitation, and tenants may live in their homes as long as they meet the basic obligations of tenancy. The housing is affordable to tenants, and tenants do not pay more than one-third of their income in rent. Housing affordability is ensured either through a rent subsidy or by setting rents at affordable levels. While participation in services is encouraged, it is not a condition of living in the housing or receiving a subsidy. Supportive housing follows “Housing First” principles, including the following: (1) Tenant screening and selection practices promote accepting applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services. (2) Applicants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, criminal convictions unrelated to tenancy, or behaviors that indicate a lack of “housing readiness.” (3) Acceptance of referrals directly from shelters, street outreach, drop-in centers, and other parts of crisis response systems frequented by vulnerable people experiencing homelessness, including, where relevant, coordinated entry and access systems.

Term	Definition
	(4) Supportive services emphasize engagement and problem solving over therapeutic goals and service plans that are highly tenant-driven without predetermined goals. (5) The use of alcohol or drugs in and of itself, without other lease violations, is not a reason for eviction. (6) Case managers and service coordinators are trained in and actively employ evidence-based practices for client engagement, including, but not limited to, motivational interviewing and client-centered counseling. (7) Services are informed by a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of tenants' lives, where tenants are engaged in nonjudgmental communication regarding drug and alcohol use, and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if the tenant so chooses. (8) The project and specific apartment may include special physical features that accommodate disabilities, reduce harm, and promote health and community and independence among tenants.

ATTACHMENT B
Medi-Cal 2020 STC Attachment GG – WPC Reporting and Evaluation

a. **Progress Reports**. Each WPC Pilot Lead Entity ("Lead Entity") shall submit mid-year and annual reports for the duration of the WPC Pilot according to the requirements in this Attachment. The State shall specify the manner and format in which WPC Pilots shall submit data for the mid-year and annual reports.

b. **Mid-Year Reports**. Lead Entities of WPC Pilots shall submit a mid-year report to the State.
   i. Reporting requirements shall be specified in guidance set forth by the State, and shall include:
      1. A minimum standard required data set for all WPC Pilots. The minimum required data shall include data points from the following categories at a minimum:
         a. Participant characteristics
         b. Number of participants
         c. Type and volume of medical and non-medical services utilized
         d. Type and volume of emergency department and inpatient services utilized
         e. Total amount of overall funds spent
      2. Additional data and information as specified in Attachment MM WPC Requirements and Metrics and the approved WPC Pilot application.
      3. Additional data and information to support measurement of the purpose of the WPC evaluation as set forth in STC 123 including:
         a. Improve coordination across participating entities including data and information sharing;
         b. Improve beneficiary health outcomes;
         c. Reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient);
         d. Increase access to social services;
         e. Improve care coordination across participating entities; and
         f. Improve housing stability, if applicable.
      4. A list of participating entity and/or stakeholder meetings, as applicable, held during the period, including agendas, and a narrative description of program activities during the period including identified barriers, challenges, and successes.
      5. Data and other documentation as described in the WPC Pilot application demonstrating progress in the approved activities.
      6. The data described in the approved WPC Pilot application demonstrating the progress toward WPC Pilot goals in relation to the infrastructure, services, and other strategies as described in the approved WPC Pilot application and WPC Pilot Special Terms and Conditions.
   ii. The mid-year report including data and information through June 30 shall be due to the State no later than 60 days after June 30 each year.
   iii. For Program Year 1, no mid-year report shall be submitted.
   iv. Upon submission of a complete (as determined by the State) mid-year report, the State will determine whether progress toward the WPC Pilot requirements approved in the WPC Application has been made. To the extent that progress has been made in a manner approved in the Application, notification of such and an interim payment in an amount proportional to the progress toward achievement of the WPC Pilot goals based on the approved annual total computable funding agreed to in the approved WPC Pilot application shall be paid to the WPC Pilot Lead Entity. If the

state determines that less than 50% of the annual payment is due, the WPC Pilot will be given 14 days to respond and revise reports as appropriate. At the discretion of the State, a proportional amount of interim funding will be adjusted and paid.

v. Within 30 days of the determination of the interim payment due based on the mid-year report, the State will issue requests to the WPC Pilot for the necessary intergovernmental transfer amounts. The WPC Pilot entities will make intergovernmental transfer of funds to the State in the amount specified within 7 days of receiving the State's request. If the intergovernmental transfers are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.

c. **Annual Reports**. On an annual basis, Lead Entities shall submit an annual report to the State for the purpose of demonstrating that the WPC Pilot is conducted in compliance with the requirements of the WPC Pilot as set forth in the STCs and attachments, the WPC Pilot approved application, any agreement between the State and the WPC Pilot Lead Entity, and/or policy letters and guidance set forth by the State. Lead Entities will submit their reports using the structured report template provided for this purpose by the State. The annual report will also be used to determine if the interventions were performed in the manner agreed upon in the WPC Pilot approved application and to report on the impact of the WPC Pilot interventions, as applicable and as described in the approved WPC Pilot application.

i. Annual reporting requirements shall be specified in guidance put forth for WPC Pilot applications by the State and shall include at a minimum:
    1. The same data elements included in the minimum standard required data set from the mid-year report.
    2. The same additional data elements set forth in Attachment MM WPC Reporting and Requirements and as agreed to in the approved WPC Pilot application.
    3. A narrative describing the activities and interventions the WPC Pilot performed during the year for each component as described in the application including barriers, challenges, and successes.
    4. A narrative of how the WPC Pilot is making progress toward accomplishing the objectives described in STC 123 (Mid-Point and Final Evaluations) and STC 112 (WPC Strategies)
    5. Progress achieved in the activities and interventions in the approved WPC Pilot application.
    6. For Program Year 1, the annual report shall consist of baseline data and information as set forth in this Attachment and Attachment MM, WPC Requirements and Metrics.

ii. The annual report shall be due no later than 60 calendar days after the end of the program year unless otherwise specified by the State.

iii. Upon submission of a complete (as determined by the State) annual report, the State will determine whether the WPC Pilot requirements approved in the WPC Application have been met. If the requirements for a deliverable have been fully met, the State will notify the WPC Pilot and provide funding in an amount equal to the amount agreed to in the WPC Pilot Application for that deliverable, less any amount already received from the mid-year report. If the required deliverables have been partially met, notification of such partial completion will be sent to the WPC Pilot entity, and the WPC Pilot entity will be given 14 days to respond and revise reports as appropriate. At the discretion of the State, an adjusted amount of proportional funding will be determined. The amount of such proportional payments shall reflect the activities or progress performed as documented in the annual report, less any amounts already received from the mid-year report.

iv. Within 30 days of the determination of the end of year payment due based on the annual report, the State will issue requests to the WPC Pilot for the necessary intergovernmental transfer amounts. The WPC Pilot entities will make intergovernmental transfer of funds to the State in the amount

specified within 7 days of receiving the State's request. If the intergovernmental transfers are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.

v. The State may impose sanctions, including the recoupment of funds from the WPC Pilot, should it be determined that the WPC Pilot is out of compliance with its requirements as set for in the STCs and attachments, the agreement between the WPC Pilot and the State, and/or policy letters or guidance set forth by the State. In addition to the requirements accompanying recoupment described above, any recoupment imposed as a sanction shall only occur after technical assistance has been provided by the State and failure to comply with corrective action occurs by the WPC site. Prior to initiating any recoupment of WPC Pilot funds, the State shall provide the Lead Entity notice and an opportunity to comment regarding the identified area of non-compliance and the expected amount of recoupment, as appropriate. In the event of such recoupments, the State must return the associated IGT funds to the transferring entities within 14 calendar days of funds being recouped.

vi. The State shall make the annual reports available to the public on its website.

II. WPC Evaluation

The state will identify an independent entity to conduct a mid-point and final evaluation. The independent entity shall work with the State to draft an evaluation proposal for approval by CMS. The draft will be shared with WPC Pilot sites and the public for comment. The mid-point and final evaluations will meet standards of leading academic institutions and academic peer review, including standards for the evaluation design, conduct, interpretation, and reporting of findings. The purpose of the evaluations will be to understand the extent to which the WPC Pilot interventions:

i. Improve coordination across participating entities including data and information sharing;
ii. Improve beneficiary health outcomes;
iii. Reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient);
iv. Increase access to social services;
v. Improve care coordination across participating entities; and
vi. Improve housing stability, if applicable.

a. The mid-point evaluation will be due one year prior to the expiration of the demonstration and will include data from program years 1 (as applicable), 2, and (to the extent possible) 3. The final evaluation will be completed no later than six months following the expiration of the demonstration.
    i. Using the data reported in the annual reports pursuant to Section I(b)(i) above, and other data requested from the WPC Pilot sites as specified by the State, the evaluations shall evaluate the extent to which the WPC Pilots individually and collectively accomplished the objectives described in STC 123 (Mid-Point and Final Evaluations) and STC 112 (WPC Strategies).
    ii. Evaluators shall interview state staff, each WPC Pilot and participating entities (as appropriate), and other stakeholders, for purposes of conducting the evaluations.
b. Data collected for purposes of the evaluation shall not be used by the independent entity for purposes other than the evaluation of the objectives described in STC 123 (Mid-Point and Final Evaluations) and STC 112 (WPC Strategies).
c. The mid-point and final evaluations shall be made available to the public on the State's website.

ATTACHMENT C
Medi-Cal 2020 STC Attachment MM – WPC Pilot Requirements and Metrics

I. **WPC Pilot Performance**. All WPC pilots will report universal and variant metrics mid-year and annually, unless otherwise specified below. Universal metrics will be a same set of metrics required of all WPC pilots; Variant metrics will differ between pilots and will be tailored to the unique strategies and target population(s) of each individual WPC Pilot. Data reported during WPC Program Year (PY) 1 shall be for a time period prior to implementation and will establish a baseline. WPC Pilot metric performance may be calculated by the State or WPC Pilot, as specified by the State in a reporting template with instructions.

When utilizing and reporting Plan Do Study Act (PDSA) for purposes of Universal and Variant metrics, WPC pilots shall utilize a template developed by the State, which may be modified as appropriate when reporting on its target population(s) and interventions (as approved by the State). The template shall also demonstrate a change-management plan, including a mechanism for identifying needed adjustments, a process for carrying out the change, a process for observing and learning from the implemented change(s) and their implications, and a process to determine necessary modifications to the change based on the study results and implement them. It shall include requirements pertaining to when new versions of policies and procedures shall be submitted as a result of use of PDSA. The template shall also provide an opportunity for WPC pilots to document when additional changes are not needed based on study results, as approved by the State. The PDSA approach shall be measured within the timelines set forth below for each measure in this Attachment and approved in the application. Reporting including supporting documentation of all measures will be included in and submitted with the mid-year and annual reports as specified in Attachment GG. Health outcomes metrics rates shall be measured annually, however, progress and supporting documentation shall be submitted semi-annually. Administrative Metrics shall include a written description of the structure, barriers and challenges, and activities, if any, relating to the operationalization of them during PY 1; for all other program years PDSA reporting will occur.

II. **Universal Metrics.** Universal metrics will assess the success of all WPC pilots in achieving the WPC goals and strategies as specified in STCs 110 and 112. They will be reported by all WPC Pilots for the duration of the demonstration and shall include:

i. Health Outcomes: Ambulatory Care – Emergency Department Visits (HEDIS®) including utilization of PDSA with measurement and necessary changes a minimum of quarterly.
   1. Children (as applicable)
   2. Adults (as applicable)
   3. Total

ii. Health Outcomes: Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS®) including utilization of PDSA with measurement and necessary changes a minimum of quarterly.
   1. Children (as applicable)
   2. Adults (as applicable)
   3. Total

iii. Health Outcomes: Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS®)
   1. Children (ages 6 – 17) (as applicable)

2. Adults (as applicable)
3. Total

iv. Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS®)
   1. Adolescents (ages 13 – 17) (as applicable)
   2. Adults (as applicable)
   3. Total

v. Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of:
   1. Enrollment into the WPC Pilot
   2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually)

   Utilization of PDSA with measurement and necessary changes a minimum of quarterly to determine any necessary changes to meet the timelines and ensure care plans are comprehensive in nature and accessible by the entire care team.

vi. Administrative: Care coordination, case management, and referral infrastructure.
   1. Measured by:
      a. Submission of documentation demonstrating the establishment of care coordination, case management, and referral policies and procedures across the WPC Pilot lead and all participating entities which provide for streamlined beneficiary case management. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval.
         i. The WPC lead entity may serve as the central communication point across all participating entities. However, all participating entities must have access to and be provided with timely access and updates to beneficiary information for care coordination and case management purposes.
         ii. The policies and procedures shall establish a communication structure for participating beneficiaries. The number of participating entities for purposes of the Pilot as points of contact for beneficiaries shall be minimalized.
      b. Monitoring procedures for oversight of how the policies and procedures set forth in iv.1(a) are being operationalized – including a regular review to determine any needed modifications.
         i. Utilization of PDSA with measurement and necessary changes a minimum of semi-annually.
      c. A method to compile and analyze information and findings from the monitoring procedures set forth in iv.1(b). And a process to modify the policies and procedures set forth in iv.1(a) in a streamlined manner and within a reasonable timeframe.

vii. Administrative: Data and information sharing infrastructure
   1. Measured by:
      a. Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot lead and all participating entities that provide for streamlined beneficiary care coordination, case management, monitoring, and

strategic improvements, to the extent permitted by applicable state and federal law. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval.

i. The WPC lead entity may serve as the central data and information sharing entity across all participating entities. However, all participating entities must have access to and be provided with timely access and updates to necessary beneficiary data and information to the extent permitted by applicable state and federal law for streamlined beneficiary care coordination, case management, monitoring, and strategic improvements.

b. Monitoring procedures for oversight of how the policies and procedures set forth in v.1(a) are being operationalized – including a regular review to determine any needed modifications.
   i. Utilization of PDSA with measurement and necessary changes a minimum of semi-annually.

c. A method to compile and analyze information and findings from the monitoring procedures set forth in v.1(b), and a process to update as appropriate the policies and procedures set forth in v.1(a) in a streamlined manner and within a reasonable timeframe in accordance with PDSA.

III. **Variant Metrics.** Variant metrics will assess the success of individual WPC pilots in achieving the WPC goals and strategies as specified in STCs 110 and 112. These metrics shall be specific to the WPC Pilot target population(s), strategies, and interventions. Variant metrics may vary by PY, though some metrics shall be consistent across all PYs of the Pilot. The metrics may include process and/or outcome measures and will utilize PDSA. Variant metrics shall be approved by the State in the WPC Pilot application. The State may request modifications or changes be made to proposed application metrics. Additional documentation may be requested and reviewed for approval by the State for Variant Administrative metrics.

1. Each WPC Pilot shall report on a minimum of:
   1. Four Variant metrics for each PY, including at a minimum items 1, 2, 3, and 4 below (or for pilots implementing a housing component, five Variant metrics for each PY, including at a minimum items 1, 2, 3, 4, and 5): One administrative metrics in addition to the Universal care coordination and data sharing metrics.
   2. One standard health outcomes metrics (e.g., HEDIS®) applicable to the WPC Pilot population across all five program years for each target population.
   3. WPC Pilots utilizing the PHQ-9 shall report the Depression Remission at Twelve Months (NQF 0710) metric; all other Pilots shall report one alternative health outcomes metric.
   4. WPC Pilots including a severely mentally ill (SMI) target population shall report the Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) WPC Pilots; all other Pilots shall report one alternative health outcomes metric.
   5. WPC Pilots implementing a housing component shall report a fifth metric specific to this intervention.

2. Variant metrics must be created through the following standardized process:
    i. Conduct an assessment of:
        1. The target population(s) characteristics and needs (utilizing available data resources); and
        2. Gaps in the WPC Pilot service area infrastructure to meet the identified needs of the target population(s).
    ii. Define specific objectives/strategies that provide for process improvement pertaining to the identified needs and gaps.
    iii. Conduct the following steps based on the identified objectives/strategies:
        1. A literature review including identification of any existing metrics used on a national level to measure outcomes pertaining to the WPC Pilot target population(s)
        2. Consider metrics that are already being captured by one or more participating entities for local programs
    iv. Select metrics that measure progress towards the objectives/strategies, using the following guidelines:
        1. Select metrics that measure changes in infrastructure, processes, and/or outcomes

IV. Annual performance accountability. Universal and Variant metric performance may be assessed according to directional change relative to the initial baseline data and assessment. Performance of individual metrics may also be measured and calculated based on established thresholds as compared to other WPC Pilot performance (adjustments for target population(s), structure, geographic area, and other factors, may be made as needed). For health outcomes metrics, the following measurement process shall be used:

1. PY 1: Approved WPC Pilots shall gather and report baseline data on their target population(s) against which changes in future years will be assessed. Data should only include time periods prior to the beginning of the WPC Pilot interventions. Partial data for PY 1 shall be reported for time periods after the WPC Pilot is implemented, as applicable.
2. PYs 2-3: WPC Pilots will report on all Universal and Variant metrics, and describe in their mid-year and annual reports early trends, potential explanations, and plans to incorporate lessons into a continual cycle of performance improvement (using a PDSA methodology).
3. PYs 4-5: WPC Pilots will report on all Universal and Variant metrics, including discussing the direction of the changes shown in the data. If changes are in the predicted direction, WPC Pilots shall comment on what they believe contributed to the improvement. If changes are not in the predicted direction, WPC Pilots shall comment on what may be hindering improvement, and how interventions will be adapted to improve performance.

For administrative metrics, the following measurement process shall be used:

a. PY 1: Approved WPC Pilots shall report on Universal and Variant administrative metrics including activities relating to establishing the infrastructure to implement them. A description of the infrastructure and/or processes for the time prior to the beginning of the WPC Pilot interventions shall be included.
b. PYs 2-5: WPC Pilots will report on all Universal and Variant administrative metrics and describe in their mid-year and annual reports early trends, potential explanations, and plans to incorporate lessons into modifications to the supporting infrastructures for the administrative

metrics. If the State determines a WPC Pilot does not demonstrate appropriate performance pertaining to administrative metrics as set forth, DHCS may impose corrective action or discontinue operation of the Pilot.

Whole Person Care Variant Metrics Menu

Metric ID:	Variant Metric 1	Variant Metric 2 Options				
Target Population:	All	All target populations across all program years	All target populations across all program years	All target populations across all program years	All target populations across all program years	All target populations across all program years
Measure Type:	Administrative	Health Outcomes: 30 day All Cause Readmissions	Health Outcomes: Decrease Jail Recidivism	Health Outcomes: Overall Beneficiary Health	Health Outcomes: Controlling Blood Pressure	Health Outcomes: HbA1c Poor Control <8%
Description:	To be developed and submitted by each WPC Pilot Applicant and approved by DHCS	30 day All Cause Readmissions	Decrease Jail Recidivism	Improve self-reported health status and reported quality of life at prior assessment	Controlling High Blood Pressure	Comprehensive diabetes care: HbA1c Poor Control <8%
Numerator:	--	Count of 30-day readmission	Total number of incarcerations of WPC participants during the reporting period	Total score of the Likert scale response of WPC participants who responded to a health status survey during the reporting period	Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg	Within the denominator, who had HbA1c control (<8.0%)
Denominator:	--	Count of index hospital stay (HIS)	Total number of WPC participants who were incarcerated during the reporting period	Total number of WPC participants who responded to a health status survey during the reporting period	Members 18–85 years of age who had a diagnosis of hypertension (HTN)	Members 18–75 years of age with diabetes (type 1 and type 2)

Whole Person Care Variant Metrics Menu

Metric ID:	Variant Metric 3	Variant Metric 4	Variant Metric 5 Options		
Target Population:	PHQ-9/depression	SMI population	Homeless/ at-risk for homelessness	Homeless/at-risk for homelessness	Homeless/at-risk for homelessness
Measure Type:	Health Outcomes: Required for Pilots using PHQ-9	Health Outcomes: Required for Pilots w/SMI Target Population	Housing : Permanent Housing	Housing: Housing Services	Housing: Supportive Housing
Description:	NQF 0710: Depression Remission at 12 Months	NQF: 0104 Suicide Risk Assessment	Percent of homeless who are permanently housed for greater than 6 months	Percent of homeless receiving housing services in PY that were referred for housing services	Percent of homeless referred for supportive housing who receive supportive housing
Numerator:	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five	Patients who had suicide risk assessment completed at each visit	Number of participants in housing over 6 months	Number of participants referred for housing services that receive services	Number of participants referred for supportive housing who receive supportive housing
Denominator:	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	Number of participants in housing for at least 6 months	Number of participants referred for housing services	Number of participants referred for supportive housing