



TOBY DOUGLAS
Director

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



EDMUND G. BROWN JR.
Governor

DATE: JANUARY 14, 2014

ALL PLAN LETTER (APL) 14-003
(SUPERSEDES APL 13-005)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM
REQUIREMENTS FOR 2014

PURPOSE:

This APL clarifies the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans (MCPs) for Reporting Year (RY) 2014 (measurement year 2013). The Department of Health Care Services (DHCS) requires MCPs to annually report performance measurement results, produce improvement plans for poor performance, participate in the administration of a consumer satisfaction survey, and conduct ongoing Quality Improvement Projects (QIPs).

Some MCPs that participate in the Medi-Cal managed care program serve a specialized population or provide a specialized set of services. These are known as specialty health plans. Not all of the requirements presented below apply to specialty health plans (e.g., AIDS Healthcare Foundation Healthcare Centers, Family Mosaic Project, Senior Care Action Network). For specialty health plans, requirements are noted when applicable. Specialty health plans should refer to their contracts for further information.

POLICY:

A. External Accountability Set (EAS) Performance Measures.

1. General Requirements.

- a. **Designated Contacts.** MCPs must provide DHCS with one contact for primary performance measurements (HEDIS^{®1} lead) and at least one designated backup contact. In the absence of the HEDIS[®] lead, the backup contact shall be familiar enough with the performance measures to assume the duties of the HEDIS[®] lead. Only under certain circumstances will DHCS approve an MCP's request for an extension of time to submit performance measurement related submissions (e.g. HEDIS Improvement Plans [IPs] or Corrective Actions Plans [CAPs]) due to staff absence.

¹ Healthcare Effectiveness Data Information Set (HEDIS[®]). HEDIS[®] is a registered trademark of the National Committee for Quality Assurance.

4. **EAS Measure Development for RY 2015.** There is no change in EAS measures in RY 2015 from EAS measures required for RY 2014.
5. **Special Considerations.**
 - a. **SPDs.** MCPs, regardless of model type, must stratify selected RY 2014 HEDIS[®] measures (noted in Attachment 1) for the SPD population using the stratification methodology in Attachment 2.

MCPs must stratify reported data by SPD and non-SPD populations using a DHCS-developed template that will be made available to the MCPs in February 2014.
 - b. **HFP.** Pursuant to Assembly Bill 1494, Section 11(e), participants in the HFP began to transition into Medi-Cal managed care in January 2013. DHCS will not require the MCPs to report on additional performance measures for this new population; however, MCP's should include former HFP members that meet the eligibility criteria in its 2014 rates. The performance measures for the HFP and Medi-Cal managed care were compared, and the current integrated list of measures was developed (see Attachment 1).
6. **Audits.**
 - a. **Annual Onsite EAS Compliance Audit.** MCPs must submit to an annual onsite performance measure validation audit. This audit consists of an assessment of an MCP's (or an MCP's vendor's) information systems capabilities, followed by an evaluation of an MCP's ability to comply with specifications outlined by the State for HEDIS[®] and non-HEDIS[®] measures. The EQRO follows the National Committee for Quality Assurance (NCQA) HEDIS[®] Compliance Audit[™] methodology for HEDIS[®] measures to assure standardized reporting of quality performance measures throughout the health care industry. **Exception:** Family Mosaic Project must undergo a performance measure audit of its two internally-developed measures (see Attachment 1) that follows the Centers for Medicare and Medicaid Services' (CMS's) protocol for conducting performance measure validation.
 - b. **Contracted EAS Auditor.** MCPs must use DHCS's selected contractor for conducting performance measure validation. Health Services Advisory Group, Inc., (HSAG) is DHCS's current EQRO contractor for the Medi-Cal managed care program and will perform the 2014 EAS audits at DHCS's expense. HSAG may subcontract with one-or-more independent auditors licensed by NCQA to conduct some of the EAS audits.

7. EAS Reporting Requirements.

- a. **Calculating and Reporting Rates.** Each MCP will calculate its rates for the required performance measures, and these rates will be confirmed by the EQRO or its subcontractor and reported to DHCS. Each MCP must report to the EQRO the results for each of the performance measures required of that MCP while adhering to HEDIS[®] or other specifications for the RY. MCPs must follow NCQA's timeline for collecting, calculating, and reporting rates.
- b. **County-Level Reporting.** MCPs must calculate and report HEDIS[®] rates at the county level, unless otherwise approved by DHCS. MCPs that operate under the Two-Plan Model in Riverside and San Bernardino Counties and MCPs that operate under the County-Organized Health System model in Monterey, Santa Cruz, Napa, Solano, and Yolo counties were approved for combined county reporting many years ago.
- c. **Expansion into New Counties.** Existing MCPs expanding into new counties must report separate performance measure rates for each new county, unless otherwise approved by DHCS.
- d. **Public Reporting of Performance Measurement Results.** DHCS will publicly report the audited results of HEDIS[®] and other performance measurements for each MCP, along with the Medi-Cal managed care program average and comparisons to national data for each DHCS-required performance measure.

8. EAS Performance Standards Established by DHCS.

- a. **Minimum Performance Level (MPLs).** MCPs must meet or exceed the DHCS-established MPL for each required HEDIS[®] measure (excluding the utilization/"use of services" measures). DHCS's MPL for RY 2014 for each required measure is the 25th percentile of the national Medicaid results for that measure as reported in the 2013 edition of NCQA's Audit Means, Percentiles, and Ratios. For measures where a lower rate is better, the MPL is the 75th percentile.
- b. **High Performance Level (HPLs).** DHCS establishes an HPL for each required performance measure and publicly acknowledges MCPs that meet or exceed the HPLs. DHCS's HPL for RY 2014 for each required measure is the 90th percentile of the national Medicaid results for that measure as reported in the 2013 edition of NCQA's Audit Means, Percentiles, and Ratios. For measures where a lower rate is better, the HPL is the 10th percentile.
- c. **First-Year Measure Requirements.** MCPs are not subject to the MPL in the first year that rates are reported for a newly required measure, as this is

considered the baseline rate. Therefore, MCPs need not submit a HEDIS[®] IP if a rate for a new measure is below the MPL.

9. Plan Performance Results and Compliance.

- a. **HEDIS[®] IPs.** MCPs must submit an IP for each measure that does not meet the DHCS-established MPL or is given an audit result of “Not Reportable” (NR), with two exceptions stated in paragraphs i and ii below.
 - i. **First-Year for New Plans or New Counties.** A new MCP or MCP expanding into a new county need not submit a HEDIS[®] IP if the MCP’s first-year reported rate is below the MPL.
 - ii. **Significant Changes to Technical Specifications.** DHCS does not require MCPs to submit IPs for measures with significant changes to the technical specifications or for other reasons as determined by DHCS.
 - iii. **Submission Format.** MCPs must submit the required IPs to DHCS using the current version of the HEDIS[®] IP Submission Form (Attachment 3), or other format provided by DHCS.
 - iv. **Technical Assistance Calls.** An MCP may be required to participate in technical assistance conference calls with DHCS’s EQRO prior to or after submitting its IP.
 - v. **Multiple Counties.** An MCP that serves multiple counties under a single contract may submit an IP that addresses more than one county if the MCP’s scores fall below the MPL for the same measure in more than one county covered by that contract. However, the IP must separately discuss how it will address the targeted population in each county.
 - vi. **Analysis of Plan Rate.** IPs must include an analysis of barriers, targeted interventions, and relevant data to support its analysis.
 - vii. **Interventions.** IPs must include new targeted interventions, justify including interventions from the prior year if applicable, include prioritization of barriers and interventions, and include a mechanism for evaluating interventions.
 - viii. **Rapid Cycle/Continuous Improvement.** DHCS expects MCPs to incorporate a rapid cycle/continuous quality improvement process to guide “course corrections” and achieve desired IP outcomes. As part of this approach, MCPs should perform real-time tracking of their interventions and conduct, at a minimum, quarterly evaluations of their interventions. The documentation should include:
 - ◆ Most recent data-driven barrier analyses.
 - ◆ Prioritization of the barriers.

- ◆ Selected interventions to address the high priority barriers.
- ◆ Tracking results of the implemented interventions.
- ◆ Interpretation of the intervention's implementation and effectiveness.
- ◆ Resulting changes to the improvement strategy.

ix. **Reporting Requirements.**

- **Medical Director Signature.** IPs must contain the signature of the MCP's Medical Director who approved the IP prior to submission to DHCS.
 - **Timeline.** MCPs must submit the required IPs within 60 days of being notified by DHCS of each measure for which an IP is required.
 - **Submission.** MCPs must submit IPs to DHCS's mailbox at: qipsmail@dhcs.ca.gov.
- b. **CAPs.** DHCS may require a CAP from MCPs that have numerous or sustained rates of performance below the MPL or rates that have fallen precipitously from the previous year, including, but not limited to:
- ◆ Quarterly reporting of HEDIS® IPs with corresponding continuous rapid-cycle improvement activities.
 - ◆ Additional QIPs.
 - ◆ Additional technical assistance calls.

B. Under/Over-Utilization Monitoring. DHCS requires MCPs to submit rates for HEDIS® utilization measures for the monitoring of under- and over-utilization of services.

1. **General.** MCP processes for arriving at rates for selected HEDIS® utilization measures may be audited or un-audited; however, the rates for these measures must be reported to the NCQA-certified auditor who performs the HEDIS® audits under the direction of DHCS's EQRO for Medi-Cal managed care. Un-audited utilization rates are for internal use and are not publicly reported. DHCS may use audited rates to establish benchmarks and/or publicly report the results.
2. **Rates that MCPs Must Report.** Utilization measures for RY 2014 fall under three main categories (see Attachment 4 for a complete list):
 - a. *Frequency of Selected Procedures:* Back Surgery, Bariatric Weight Loss Surgery, Lumpectomy, and Mastectomy.
 - b. *Inpatient Utilization: General Hospital/Acute Care* – includes utilization of acute inpatient services in various categories.

- c. *Ambulatory Care: Includes Outpatient Visits and Emergency Department Visits* submeasures. This measure is audited by the EQRO.

C. Consumer Satisfaction Surveys.

1. **Survey Instrument.** DHCS uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®])² surveys to assess member satisfaction with MCPs. DHCS may develop additional customized survey questions, in compliance with NCQA standards, to assess specific problems and/or special populations.
2. **CAHPS[®] Survey Administration.** The EQRO administered DHCS's last CAHPS[®] survey in early 2013. DHCS will provide each MCP with its MCP-specific report in early 2014. The EQRO will administer the next CAHPS[®] survey for both adults and children in 2015, reflecting members' perceptions of care for a six-month period of time during the prior year.
3. **County-Level Reporting of Survey Results.** In years when DHCS's EQRO for Medi-Cal managed care administers the CAHPS[®] surveys, the EQRO will provide a county-level analysis, when applicable, in its report of the survey results for each MCP. County-level analysis allows DHCS, MCPs, and other stakeholders to better understand how member satisfaction and MCP services vary among counties.
4. **Member Surveys for Specialty Health Plans.** Although specialty health plans are not required to participate in the CAHPS[®] survey, each specialty health plan must conduct a member satisfaction survey annually and provide DHCS with results specific to the specialty health plan's Medi-Cal members. Each specialty health plan must provide DHCS a copy of its survey instrument and survey calculation/administration methodology, so that the EQRO can evaluate them for compliance with state and federal requirements.

D. QIPs.

1. **Number of QIPs Required.** MCPs must conduct and/or participate in a minimum of two QIPs.
 - a. **Full-Scope MCPs.** MCPs must participate in the DHCS-led SWC QIP and conduct an MCP-specific (internal) QIP **or** an MCP-led Small-Group Collaborative (SGC) QIP. To form an SGC, at least four MCPs must participate. If fewer than four MCPs intend to form an SGC, they must provide a justification for the SGC and obtain DHCS's approval. MCPs that hold multiple Medi-Cal managed care contracts or that have a contract that covers multiple counties, must conduct two QIPs for each county.

² CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- b. **Specialty Health Plans.** Specialty health plans must conduct two QIPs; however, they are not required to participate in the SWC QIP. Instead, specialty health plans typically conduct two MCP-specific QIPs. However, a specialty health plan may request DHCS's approval to participate in a SGC or SWC if the specialty health plan believes it is appropriate for its members.
 - c. **New Contract.** MCPs that establish a new contract with DHCS or expand into a new county after the current SWC has begun are not eligible to participate in the SWC. DHCS will require such MCPs to participate in a SGC or develop an MCP-specific QIP instead of participating in the SWC. DHCS and its EQRO for Medi-Cal managed care may adjust reporting requirements to accommodate the particular circumstances of the MCP's start-up date in relation to the reporting cycle. For the initial reports to DHCS, MCPs must seek pre-approval from DHCS and its EQRO to adopt non-SWC QIP topics and timelines.
2. **New QIPs – Proposals and Timelines.** QIP proposals have two phases – topic selection and study design.
- a. **QIP Topic Approval.** MCPs must seek pre-approval from DHCS of topics for all MCP-specific QIPs and SGCs. DHCS strongly recommends that each MCP's QIP topic align with demonstrated areas of poor performance, such as low HEDIS[®] or CAHPS[®] scores, and/or EQRO recommendations.
 - i. **Topic Proposal Timelines.** Approximately 10 months before the end of an existing QIP, DHCS will instruct the MCP to identify its next QIP topic. The MCP will have up to 90 days prior to the established due date for the existing QIP's final QIP summary form to submit a proposed topic for its new QIP.
 - ii. **Topic Proposal Format.** Each MCP must use DHCS's QIP Topic Proposal Form (Attachment 5), which requires MCPs to provide a rationale for the selection of the topic.
 - iii. **Topic Proposal Submission.** Each MCP must submit its completed QIP Topic Proposal Form to DHCS's QIPs mailbox at:
gipsmail@dhcs.ca.gov.
 - iv. **DHCS's Approval of QIP Topic.** Within approximately one month of receiving an MCP's proposed QIP topic, DHCS will send the MCP a notice of approval, a request for additional information, or suggest that the MCP participate in a technical assistance call with the EQRO. Once the topic is approved, DHCS will require no further action from the MCP until the MCP's QIP Study Design Proposal is due.

measure, DHCS and the EQRO, in collaboration with the MCP, will evaluate the impact of the changes. Any change in methodology for trending QIP performance must be approved by DHCS.

- c. **QIP Cycle.** QIPs typically last from 24 to 36 months. MCPs that would like to conduct a QIP for more than 36 months must seek DHCS approval unless the EQRO has recommended the extension because the QIP lacked statistically significant or sustained improvement in performance.
- d. **Intermediate Process Measures.** MCPs must incorporate a rapid cycle/continuous quality improvement process to guide “course corrections” and achieve desired QIP outcomes. As part of this approach, MCPs should perform real-time tracking of their interventions and conduct, at a minimum, a quarterly evaluation of their interventions. The documentation should include:
 - ◆ Most recent data-driven barrier analyses.
 - ◆ Prioritization of the barriers.
 - ◆ Selected interventions to address the high priority barriers.
 - ◆ Tracking results of the implemented interventions.
 - ◆ Interpretation of the intervention’s implementation and effectiveness.
 - ◆ Resulting changes to the improvement strategy.
- e. **Documenting QIP Activities.** MCPs must document QIP activities on the QIP Summary Form and have them validated by the EQRO (See 2.b., above).
- f. **Use of Goals.** Existing benchmarks should be strongly considered when establishing indicator goals. DHCS recommends that MCPs base their indicator goals on the following sources in order of precedence: (1) benchmarks of performance; (2) a DHCS-specified goal; or (3) a well-defined goal submitted by the MCP in advance. If an MCP does not use a benchmark or DHCS-specified goal, the MCP must provide justification for its chosen goal(s) to DHCS.
- g. **Assessment of Results.** The EQRO assesses each of the QIP indicators for statistically significant improvement.

h. **Special Considerations.**

- 1) **New MCPs and Existing MCPs Expanding into a New County.** In general, MCPs must submit their QIP proposals after one year plus 90 days of their effective start-up date. DHCS requires new MCPs and existing MCPs with new county start-ups to participate in a technical assistance conference call with DHCS and the EQRO to discuss the appropriateness of QIP topics and the timeline for the MCPs' initial QIP submissions. DHCS and its EQRO may adjust reporting requirements for new MCPs and existing MCPs with new county start-ups to accommodate the particular circumstances of the MCP's date of start-up in relation to the reporting cycle. Please contact the QIP Coordinator listed in the *Key Contacts* section below for step-by-step instructions about the initial QIP process.
- 2) **Multiple Counties.** MCPs that serve multiple counties under a single contract may submit a QIP that addresses the same improvement topic in more than one county, provided the targeted improvement is relevant in more than one county covered by that contract. However, the QIP proposal and subsequent QIP submissions must specifically address the targeted population in each county included in the QIP by submitting county-specific data and results.

i. **Communication and Meetings with DHCS and Among MCPs.**

- 1) **Designated Contacts.** MCPs must provide DHCS with one primary contact (QIP lead) and at least one backup contact for each QIP who is familiar enough with the QIP to step in during the QIP lead's absence. Only under certain circumstances will DHCS approve an MCP's request for an extension of time to submit QIP-related submissions due to staff absence.
- 2) **Technical Assistance.** To ensure that QIPs are sound, valid, and result in real improvements in the care and services provided to MCP members, DHCS periodically holds technical assistance conference calls for all MCPs to: (1) present changes in methodologies or processes and (2) assist MCPs that are having difficulties with a QIP. MCPs are required to participate in these technical assistance calls.

3) **SGC.**

- DHCS expects MCPs to work collaboratively to review their progress, provide insights on how to overcome barriers, share specific interventions and tools, adopt process and system changes, and establish best practices.
- MCPs must conduct at least one SGC meeting with participating MCPs each quarter of each year for the aforementioned purpose.
- At least one staff member from each participating MCP must attend each meeting in person or by telephone.
- MCPs must invite the designated DHCS contact for the SGC from the Medical Policy Section to each meeting.

4) **SWC.** DHCS will organize SWC meetings at least quarterly each year to work collaboratively with participating MCPs to review progress, provide insights on how to overcome barriers, share specific interventions and tools, adopt process and system changes, and establish best practices.

4. **Data Reporting.**

- a. **MCP-Specific QIP.** MCPs must report data as specified in their approved/validated QIP proposals.
- b. **SGC.** The SGC must, at a minimum, collect and report baseline data and annual remeasurement data for two consecutive years. At the end of the second remeasurement, DHCS and the MCPs involved in the SGC will evaluate subsequent remeasurements and continuation of the SGC.
- c. **SWC.** DHCS and participating MCPs determine and agree upon SWC reporting requirements and specify these requirements in the approved and validated SWC QIP proposals submitted by each MCP. The next annual status reports are due September 30, 2014. DHCS will notify MCPs if DHCS determines that the MCP must submit an interim status report.

5. **QIP Submission Instructions.**

- a. **Forms and Form Locations.**
 - i. **QIP Topic Proposals.** DHCS will send each MCP its QIP Topic Proposal Form approximately ten months before the end of each MCP's current QIP (Attachment 5).
 - ii. **QIP Study Design Proposal or QIP Status Reports.** HSAG's QIP Summary Form and QIP Summary Form for Multi-Counties are readily

available to MCPs as part of the QIA Guide for Plans on DHCS's website.

b. Submission Instructions.

- i. **QIP Topic Proposals.** MCPs must submit topic proposals to DHCS's QIPs mailbox at: gipsmail@dhcs.ca.gov.
 - ii. **QIP Study Design Proposal and Annual Status Report Submissions.** MCPs must submit QIP study design proposals, baseline reports (if not included in the study design proposal), annual status reports, and final reports to the EQRO via HSAG's FTP website and a copy must be emailed to DHCS's QIPs mailbox at: gipsmail@dhcs.ca.gov.
6. **Timing of Submission.** Each MCP must submit its status and/or remeasurement reports at least annually, or according to a timeline agreed upon by the MCP, DHCS, and the EQRO.

ADDRESSES FOR ELECTRONIC SUBMISSIONS:

- **HSAG's FTP Website.** HSAG uses an FTP website. All current MCPs have identified FTP users who have been assigned user names and passwords by HSAG to access each MCP's specific folder. To establish additional user profiles or remove previous users, MCP staff should contact Jen Montano at JMontano@hsag.com.
- **DHCS's Submission E-Address.** DHCS's QIPs mailbox: gipsmail@dhcs.ca.gov.

KEY CONTACTS:

If you have questions or concerns about the information in this APL, please contact the following individuals by e-mail according to your area of concern:

- **General questions about the requirements of DHCS's quality and performance improvement program:** Muhammad Nawaz, Chief, MMCD Plan Performance Measurement Section, at Muhammad.Nawaz@dhcs.ca.gov.
- **EAS, HEDIS[®] MPLs and HPLs, and HEDIS[®] IPs:** Susan McClair, MD, Medical Consultant, MMCD Medical Policy Section, at Susan.McClair@dhcs.ca.gov.
- **HEDIS[®] audit requirements and QIPs validation process:** Patricia Ferry, Director of EQRO Services, HSAG, at PFerry@hsag.com.

- **The current SWC QIP on *All-Cause Readmissions*:** Gloria Padre, Nurse Consultant, MMCD Medical Policy Section, at Gloria.Padre@dhcs.ca.gov
- **QIP proposals and status reports, QIP process, and QIP due dates:** Gina Gee-Wong, QIP Coordinator, MMCD Plan Performance Measurement Section, at Gina.Gee-Wong@dhcs.ca.gov.

Performance measurement and quality improvement are important aspects of the Medi-Cal managed care program. The partnership between DHCS, its contracted MCPs, and the EQRO is meant to improve the quality of care and services provided to Medi-Cal beneficiaries. MMCD looks forward to continuing this positive relationship.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Assistant Deputy Director
Health Care Delivery Systems

Attachments

2014 External Accountability Set

(HEDIS^{®1}) Measures Required for Full-Scope Plans Reporting Year 2014²

#	HEDIS [®] Acronyms	HEDIS [®] Measure	Measure Type (Methodology)	SPD Stratification Required ³	Used in Auto Assignment Algorithm
1.	ACR	All-Cause Readmissions – Statewide Collaborative QIP measure	Admin measure Non-NCQA measure: Defined by Statewide Collaborative QIP	Yes	No
2.	AMB-OP AMB-ED	Ambulatory Care: <ul style="list-style-type: none"> Outpatient visits Emergency Department visits 	Admin measure (Medicaid) - addresses members <1 yr through 85+ yrs	Yes	No
3.	MPM-ACE MPM-Dig MPM-Diu	Annual Monitoring for Patients on Persistent Medications (without anticonvulsant, 3 indicators): <ul style="list-style-type: none"> ACE inhibitors or ARBs Digoxin Diuretics 	Admin measure (Medicaid) - addresses members 18 yrs & older	Yes	No
4.	AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Admin measure (Medicaid)	No	No
5.	CCS	Cervical Cancer Screening	Hybrid measure (Medicaid)	No	Yes
6.	CIS-3	Childhood Immunization Status – Combo 3	Hybrid measure (Medicaid)	No	Yes
7.	CAP-1224 CAP-256 CAP-711 CAP-1219	Children & Adolescents' Access to Primary Care Practitioners: <ul style="list-style-type: none"> 12-24 Months 25 Months – 6 Years 7-11 Years 12-19 Years 	Admin measure (Medicaid)	Yes	No
8.	CDC-E CDC-LS CDC-LC CDC-HT CDC-H9 CDC-H8 CDC-N CDC-BP	Comprehensive Diabetes Care (8 indicators): <ul style="list-style-type: none"> Eye Exam (Retinal) Performed LDL-C Screening Performed LDL-C Control (<100 mg/dl) HbA1c Testing HbA1c Poor Control (>9.0%) HbA1c Control (<8.0%) Medical Attn. for Nephropathy Blood pressure control (<140/90 mm Hg) 	Hybrid measure (Medicaid)	Yes	Yes, for <i>HbA1c Testing and LDL-C Control</i> indicators only

¹ HEDIS[®] (Healthcare Effectiveness Data Information Set) is a registered trademark of the National Committee for Quality Assurance.

² Uses data from 1/1/13 through 12/31/13 for "measurement year."

³ Stratification is required to identify Seniors and Persons with Disabilities (SPD). MMCD will provide the Plans with a reporting template for reporting the SPD population and non-SPD population.

#	HEDIS® Acronyms	HEDIS® Measure	Measure Type (Methodology)	SPD Stratification Required ³	Used in Auto Assignment Algorithm
9.	CBP	Controlling High Blood Pressure	Hybrid measure	No	No
10.	IMA-1	Immunizations for Adolescents	Hybrid measure (Medicaid)	No	No
11.	MMA	Medication Management for People with Asthma	Admin measure	No	No
12.	PPC-Pre PPC-Pst	Prenatal & Postpartum Care (2 indicators): <ul style="list-style-type: none"> • Timeliness of Prenatal Care • Postpartum Care 	Hybrid measure (Medicaid)	No	Yes, for <i>Timeliness of Prenatal Care indicator only</i>
13.	LBP	Use of Imaging Studies for Low Back Pain	Admin measure (Medicaid)	No	No
14.	WCC-BMI WCC-N WCC-PA	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents <ul style="list-style-type: none"> • BMI percentile • Counseling for nutrition • Counseling for physical activity 	Hybrid measure (Medicaid)	No	No
15.	W-34	Well-Child Visits in the 3 rd , 4 th 5 th & 6 th Years of Life	Hybrid measure (Medicaid)	No	Yes
Total Number of Measures			8 Hybrid and 7 Admin measures		
Total Number of Indicators			31		

Performance Measures Required for Specialty Plans Reporting Year 2014

AIDS Healthcare Foundation Healthcare Centers

- Colorectal Cancer Screening
- Controlling High Blood Pressure

Family Mosaic Project

- *Out-of-Home Placements:* The percentage of Medi-Cal managed care members enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.
- *Second Measure – to be determined.*

SCAN

- Breast Cancer Screening (BCS)
- Osteoporosis Management in Women Who Had a Fracture (OMW)

2014 Hybrid Stratification Methodology for Reporting the *Comprehensive Diabetes Care Measure*

The Medi-Cal Managed Care Division (MMCD) established a stratification methodology for the hybrid measure: *Comprehensive Diabetes Care*.

Medi-Cal managed care health plans (MCPs) should use the following sampling method in order to determine the three denominators from which to calculate distinct rates for the *Comprehensive Diabetes Care* measure for each county:

- The overall county rate.
- The Seniors and Persons with Disabilities (SPD) population rate.
- The non-SPD population rate.

See illustrative example below assuming a required sample size of 411 for a hybrid measure:

MCP Sampling Method		
Sample	Selection Process	Example
1	Select required number of member medical records from Medi-Cal at large (the National Committee for Quality Assurance-required sample size). This will include members in both the SPD and non-SPD populations. Determine the number of members in each of the populations (SPD and non-SPD) that are Sample #1.	Assume a random sample of 411 cases is selected with the following distribution: 200 SPD members 211 non-SPD members
2A	Supplement the SPD sample population with additional SPD member records to reach the required sample size in #1.	200 SPD members + 211 additional SPD members = 411 SPD members
2B	Supplement the non-SPD sample population with additional non-SPD member records to reach the required sample size in #1.	211 non-SPD members + 200 additional non-SPD members = 411 non-SPD members
		822 Total Member Records

Sample #1 will be the denominator for the MCP's Healthcare Effectiveness Data Information Set[®] (HEDIS[®]) submission.

Sample #2A is the SPD population denominator.

Sample #2B is the non-SPD population denominator.

Sample #2A and #2B will reported on a MMCD-provided reporting template.

HEDIS Improvement Plan (IP) for Reporting Year 2014

Section I – Demographic Information: Complete one HEDIS improvement plan (IP) form for each HEDIS measure below the Minimum Performance Level (MPL) or reported as a “Not Report” (NR). Health plans may submit one improvement plan (IP) for multiple counties as long as the target population for each county is addressed. Please enter the health plan name, applicable HEDIS measure, 2014 MMCD MPL, type of submission, and contact information for the person responsible for implementing the IP and the medical director responsible for approving the IP for the plan.

Health Plan Name:

HEDIS Measure:

2014 MMCD MPL:

Type of Submission

Date:

Initial Submission

Resubmission

Other (please specify)

Person Responsible for Implementing IP

Name: _____ Title: _____

Phone: _____ Email: _____

Medical Director Responsible for Approving IP

Name: _____ Title: _____

Phone: _____ Email: _____

Section II – HEDIS Measure(s) below the MPL: Please enter below the name of each county, the Plan 2014 Rate, and the Plan 2015 Target Goal Rate for improvement. Check the appropriate boxes to indicate if the HEDIS measure was below the MPL for the previous three years.

County	Plan 2014 Rate	Plan 2015 Target Goal Rate	Below MPL 2013?		Below MPL 2012?		Below MPL 2011?	
			Yes	No	Yes	No	Yes	No
			<input type="checkbox"/>					
			<input type="checkbox"/>					
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HEDIS Improvement Plan (IP) for Reporting Year 2014

Section III – Barriers and Challenges: Identify and briefly describe barriers and challenges. Please address the following applicable elements: 1) Why improvement was not made or sustained for the reporting year, 2) Why goals were not reached, 3) Why interventions were not effective, 4) Identification of new barriers since the previous year, 5) Strength of current interventions and whether interventions are still applicable given the barrier analysis, 6) Lessons learned and how they will be applied to the current improvement plan, 7) Applicability of the barrier analysis to multiple counties below the MPL, and 8) Provide relevant data to support the barrier analysis.

Description of barriers and challenges:

Section IV – Improvement Plan: Briefly describe and address the following applicable elements: 1) Improvement Plan based upon the barrier analysis, 2) Timelines, 3) Relative strength of new interventions planned, 4) Relative strength of existing interventions planned, 5) Modifications to existing intervention(s), 6) Method(s) for evaluating interventions, 7) Allocation of resources, and 8) Commitment and accountability to improving the HEDIS rate to a level above the MPL.

Description of improvement plan:

HEDIS Improvement Plan (IP) for Reporting Year 2014

Section V – Improvement Plan Grid: Enter interventions which correlate to the barrier analysis. Interventions should be measurable and include the following description: what, where, when, how, and to whom. If multiple interventions are planned, list interventions in order of relative strength (e.g., strongest correlation to the barrier analysis, best practice, etc.) and include the county/counties where the intervention will be conducted. *Do not include planning activities.* Enter the targeted barrier for each intervention and check the appropriate box to indicate if it is an existing intervention. If it is an existing intervention, indicate the duration of existing intervention prior to the implementation of the new timeline, i.e., number of weeks, months, or years. Enter the new implementation timeline for new and existing interventions, i.e., start and end date. Enter the name of the person(s) and department responsible for the implementation and evaluation of each intervention over time.

Intervention	Targeted Barrier	Targeted County/Counties	Existing Intervention		Duration of Existing Intervention	Timeline for Implementation	Responsible Person and Department
			Yes	No			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			

Required Utilization Measures for Full-Scope Medi-Cal Managed Care Plans Reporting Year 2014

For the 2014 reporting year (measurement year 2013), Medi-Cal managed care health plans (MCPs)—with the exception of specialty plans—are required to submit rates for the Healthcare Effectiveness Data Information Set[®] (HEDIS[®]) utilization measures listed below.

Results for these measures are reported to the external quality review organization (EQRO) consistent with HEDIS[®] technical specifications and in a format designated by Medi-Cal Managed Care; however, the *Frequency of Selected Procedures* and *Inpatient Utilization* measures are not included in the EQRO's audit process.

- (1) *Frequency of Selected Procedures* – This un-audited measure summarizes the number and rate of various frequently performed procedures. For Medi-Cal beneficiaries, MCPs report the absolute number of procedures and the number of procedures per 1,000 member months by age and sex. The following indicators are required to be reported:
 - a) Back Surgery
 - b) Bariatric Weight Loss Surgery
 - c) Lumpectomy
 - d) Mastectomy

- (2) *Inpatient Utilization: General Hospital/Acute Care* – This un-audited measure summarizes utilization of acute inpatient services in the following categories: total inpatient, medicine, surgery, and maternity. The following data are required to be reported for each category:
 - a) Discharges
 - b) Discharges/1,000 Member Months
 - c) Days
 - d) Days/1,000 Member Months
 - e) Average Length of Stay

- (3) *Ambulatory Care* – This audited administrative measure addresses members <1 yr. through 85+ yrs.
 - a) Outpatient Visits (AMB-OP)
 - b) Emergency Department Visits (AMB-ED)

Department of Health Care Services, Medi-Cal Managed Care Division

Quality Improvement Project (QIP) Topic Proposal Form
for Internal and Small Group Collaboratives

Requirement: Our records indicate that [PLAN NAME]'s (Plan) final status report for its [TITLE OF QIP] QIP is due [DATE]. Once the External Quality Review Organization (EQRO) validates the Plan's final QIP status report and notifies the Plan that the QIP is closed, the Plan will have 90 days to submit its new QIP proposal. The QIP topic must be preapproved by Medi-Cal Managed Care Division (MMCD). **Note:** The EQRO may determine during validation of the final status report that this QIP must be extended to allow for sustainable improvement.

Instructions to Plan: The Plan should complete this Topic Proposal Form and submit it to MMCD's QIP mailbox at gipsmail@dhcs.ca.gov no later than: [date 90 days prior to current QIP's final submission due date].

Technical Assistance: If the Plan is interested in receiving technical assistance from the EQRO regarding topic selection prior to submission of this form, please contact MMCD's QIPs Coordinator, Gina Gee-Wong at Gina.Gee-Wong@dhcs.ca.gov.

Plan: _____

County/Counties: _____

Date Topic Submitted: _____

Proposed QIP Topic: _____

Study Type: [select one] Clinical Non-Clinical [select one] HEDIS Non-HEDIS

QIP Type: Internal Small Group Collaborative

Plan's Study Leader for New QIP (if known): _____

QIP Topic Rationale

Below are a series of questions regarding the plan's QIP topic selection process. The questions are intended to guide the plan in selecting a topic identified as an area that needs improvement.

1. Does the proposed topic relate to one of the plan's HEDIS scores? If no, why was this topic selected?
2. If the proposed topic relates to a HEDIS score:
 - a. Does the topic address poor performance of an MMCD HEDIS measure?
 - b. Indicate whether an Improvement Plan (IP) is/was required (provide dates).
3. Does the plan have any measure(s), other than the measure(s) included in this proposal, with rates that fell below the MPL(s)? If yes, why was this measure(s) not selected?
4. Is the proposed topic an area of study recommended by the EQRO based on plan-specific report recommendations or technical assistance? If no, please explain why the topics recommended by the EQRO were not selected?
5. Approximately how many Medi-Cal Managed Care members will receive improved quality, access and/or timely care as a result of the proposed topic?
6. Provide any additional documentation or data necessary to justify the topic selection.
7. Is the plan interested in receiving technical assistance from the EQRO for further development of the topic selection?