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

California Department of Health Services
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MMCD Policy Letter No. 03-01

TO: County Organized Health Systems (COHS)
Geographic Managed Care Plan (GMC)
Local Initiative Plans
Prepaid Health Plans (PHP)
Two-Plan Model Plans

FROM: Luis R. Rico, Acting Chief
Medi-Cal Managed Care Division

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM

Purpose:

The purpose of this policy letter is to provide clarification as to the requirements of the Medi-Cal Managed Care Quality and Performance Improvement Program as set forth by the California Department of Health Services (DHS). This letter replaces the former draft policy letter dated December 29, 1999.

Background:

Section 1932(c)(1) and Section 1903(m) of the Social Security Act, and Section 4705(a) of the 1997 Balanced Budget Act require states entering into contracts with health plans to develop and implement a quality assessment and improvement strategy. At a minimum, these strategies must include: 1) access standards; 2) measures that examine aspects of care and services directly related to improving the quality of care; 3) procedures for monitoring and evaluating the quality and appropriateness of care and services received by Medicaid enrollees; and 4) requirements for the provision of data.

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Policy:

All Medi-Cal managed care plans must comply with the requirements for external reporting of performance measurement results, including results of a consumer satisfaction survey. Additionally, all plans are required to conduct quality improvement projects, independently and in collaboration with other contracted managed care plans. Specifically, each health plan must perform and/or report the activities listed below.

1. External Accountability Set (EAS)

   a) Beginning January 2004, on an annual basis, all health plans must submit to an on-site EAS Compliance Audit (also referred to as the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to assess the plans' information and reporting systems, as well as the plans' methodologies for calculating performance measure rates. All health plans must use the DHS-selected contractor for performance of the EAS/HEDIS Compliance Audit and calculation of DHS-developed performance measures that constitute the EAS. Compliance Audits will be performed by an External Quality Review Organization (EQRO) as contracted and paid for by the State.

   b) By August 1 of each year, DHS will notify all contracted plans as to the performance measures selected for inclusion in the following year's EAS. Should DHS elect to rotate or alternate performance measures, the number of total calculated EAS measures that require medical record review (i.e., hybrid measures) would remain the same. Moreover, the Department will select a rotation schedule consistent with the applicable National Committee for Quality Assurance (NCQA) rotation schedule. (Please see Enclosure A for a listing of EAS measures for calendar years 2004 and 2005.)

   c) All health plans must report audited results on the measures selected by the Department for inclusion in the EAS. Health plans must adhere to the latest version of HEDIS specifications that are applicable to the reporting period and to DHS timelines.

   d) All health plans will calculate and report HEDIS rates at the contract level. Commercial plans operating in multiple counties will be required to calculate and report HEDIS rates at the county level. Proportional sampling may no longer be used in the calculation of the rates. If, however, a commercial plan's counties of operation are identical to those of another contracted Medi-Cal managed care plan in that area, the commercial plan may report HEDIS by contract.

Local Initiative health plans, Geographic Managed Care plans, and County Organized Health System plans will continue to report HEDIS rates by contract, (i.e., county specific). Health plans that provide services through subcontracting plans are encouraged to calculate HEDIS rates using proportional sampling to ensure sample representation from each subcontracting plan.

e) All health plans must provide the necessary data for calculation and reporting of DHS-developed performance measures selected for inclusion in the EAS. Health plans must adhere to the DHS-developed specifications and timelines. The calculation and reporting of rates for these measures will be performed by the DHS-contracted EQRO.

f) Health plans must meet or exceed the DHS-established Minimum Performance Level (MPL) for each HEDIS measure. For each measure that does not meet the MPL set for that year, or is reported as a "Not Report" (NR) due to an audit failure, the plan must submit an improvement plan outlining the steps that will be taken to improve the subsequent year's performance. The improvement plan must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline. Improvement plans are due to the Department within 60 calendar days of the Department's notification that the plan has performed at or below the MPL for the period under review. Additional reporting may be required of the plan until such time that improvement is demonstrated.

g) On an annual basis, DHS will publicly report the audited rates for each contracted plan, as well as the Medi-Cal Managed Care average, or aggregate rate, for each performance measure. Pilot measures, defined as those measures that have not been previously tested and/or validated either by DHS or a recognized measurement-development organization (e.g. NCQA), will be reported in the aggregate only.

2. Under/Over-Utilization Monitoring

In addition to the EAS performance measures, all plans must submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon select HEDIS Use of Service measures. These measures will be audited as part of the EAS/HEDIS Compliance Audit and rates are to be submitted with the EAS audited rates. The measures selected for inclusion in the set will be chosen by DHS, in consultation with the plans, on an annual basis. By August 1 of each year, DHS will notify all contracted plans as to the HEDIS measures selected for inclusion in the following year's Utilization Monitoring Measure Set.

3. Consumer Satisfaction Survey

On a biennial basis (i.e., every other year), all health plans must provide the necessary data to participate in a consumer satisfaction survey conducted by the Department's EQRO contractor. The survey instrument will be selected by DHS, will include an adult and child version, and will be available in a minimum of two languages. Survey scores will be calculated and reported at the contract level. Should the Department elect to use the Consumer Assessment of Health Plan Survey (CAHPS®), health plans will be required to adhere to the specifications set forth by the NCQA, as well as DHS timelines. DHS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. DHS is not financially responsible for any analyses initiated by the plans.

4. Quality Improvement Projects (QIPs)

a) All health plans are required to conduct and/or participate in four (4) QIPs. For plans holding multiple Medi-Cal managed care contracts, each contracted entity will be required to conduct and/or participate in four QIPs.

b) Among the four QIPs:

i) At least one must be plan-specific ("internal QIP"); and
ii) At least one must be in collaboration with at least one other health plan ("small -group collaborative"); and
iii) One must be the statewide collaborative QIP ("Cal-QIP").

Additionally, among the four:

i) One must be non-clinical (i.e., availability, accessibility or cultural competency of services; appeals, grievances, and complaints); and
ii) One must be clinical (i.e., to improve clinical services or clinical interventions).

c) Although not required, QIPs may be based on HEDIS measures. Under such circumstances, health plans must adhere to the HEDIS specifications selected at the time of the QIP design. If, over time, specifications change for any one HEDIS measure selected to evaluate QIP performance, the Department and the EQRO, in collaboration with the plan, will evaluate the impact of the changes. In the event that comparability is compromised by such changes, the plan must develop and obtain the Department's approval for an alternate methodology to trend QIP performance.

d) Collaboratives must include a minimum of two (2) health plans and must use standardized measures and clinical practice guidelines. Additionally, all plans participating in a collaborative must agree to the same timelines for development, implementation, and measurement. Plans must also agree on the nature of plan commitment of staff and other resources to the collaborative project.

e) Health plans participating in small-group collaboratives may choose varying interventions; the evidence-base or, if no evidence is available, the rationale supporting the selection of each intervention must be documented. In some cases where evidence supports the effectiveness and/or cost-benefit of a specific intervention, DHS may elect to mandate specific interventions. Consideration will be given to individual plan characteristics, performance, and current and past interventions.

f) Plans may include only one county in a collaborative regardless of whether the plan's contract covers multiple counties. However, if multiple counties are to be included, the health plan must demonstrate that the measurement strategies are adequate to assess the impact of the intervention within each county. DHS must approve the plan's proposal before the plan may proceed with their intended approach for multiple county measurement.

g) Plans participating in a QI collaborative must determine the appropriate timeline for each collaborative based on the nature of the problem and interventions selected. QI projects will typically last 12-30 months; rapid cycle improvement projects are permissible and encouraged.

h) Plans wishing to initiate a QI collaborative other than those offered by MMCD must prepare a written proposal outlining the proposed collaborative.

i) All QIP proposals and reports, including those for plan-specific and small-group collaboratives, are to be submitted using the NCQA Quality Improvement Activity (QIA) form. After obtaining DHS proposal approval, an initial QIP report is to be submitted within three months of QIP initiation. Thereafter, QIP reports will be due on a quarterly basis, or according to a timeline agreed upon by the plan(s) and DHS. At a minimum, all plans must submit annual QIP reports.

If there are any questions regarding this letter, please contact your contract manager.

Enclosure

Enclosure A: External Accountability Set Performance Measures

EAS Measures	Calendar Year 2003	Calendar Year 2004	Calendar Year 2005
HEDIS	DHS will not require reporting of HEDIS measures for calendar year 2003. However, submission of calculated HEDIS rates, whether audited or unaudited, is requested. This information will not be made public. Submission of administrative data for the Chlamydia Screening measure is required in fulfillment of participation in the statewide quality improvement collaborative.	• Well-child visits ≤ 15 mos. • Well-child visits 3-6 y.o.* • Adolescent well-care visits • Childhood IZ status combination 1 • Childhood IZ status combination 2 • Timeliness of prenatal care • Postpartum care • Chlamydia screening • Appropriate use of meds for asthmatics • Breast cancer screening • Cervical cancer screening * Substitute Retinal exams for diabetics for COHS	• Well-child visits ≤ 15 mos. • Well-child visits 3-6 y.o.* • Adolescent well-care visits • Childhood IZ status combination 1 • Childhood IZ status combination 2 • Timeliness of prenatal care • Postpartum care • Chlamydia screening • Appropriate use of meds for asthmatics • Breast cancer screening • Cervical cancer screening * Substitute Retinal exams for diabetics for COHS
DHS-Developed	DHS will not require reporting of DHS-developed measures for calendar year 2003	• Blood lead screening • Beta Agonist	• Blood lead screening • Beta Agonist