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MMCD All Plan Letter 06010

ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM
REQUIREMENTS FOR 2007**

Purpose:

This All Plan Letter is to clarify the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans for 2007. As contractually required, all Medi-Cal managed care health plans must comply with requirements for reporting of performance measurement results, including the results of a consumer satisfaction survey. Health plans are also required to conduct quality improvement projects (QIPs) both internally and in collaboration with other contracted Medi-Cal managed care health plans.

Not all of the requirements presented below are applicable to specialty plans (AIDS Healthcare Centers, Kaiser Marin/Sonoma and SCAN Health Plan). Specialty plans should review their contracts in conjunction with this letter.

Requirements:

. External Accountability Set (EAS) Requirements

- a) On an annual basis, all health plans must submit to an on-site EAS Compliance Audit, also referred to as the "HEDIS Compliance Audit™". This audit ensures that the Health Plan Employer Information and Data Set (HEDIS®) performance measure results for each health plan are accurate, reliable, and publicly reportable data that can be used by purchasers and consumers to compare health plans.
- b) All health plans must use the California Department of Health Services (CDHS) selected contractor for performance of the HEDIS Compliance Audit. The External Quality Review Organization (EQRO) or its subcontractor will perform

these audits. Delmarva Foundation for Medical Care, Inc. (Delmarva) is the current EQRO for the Medi-Cal Managed Care program and may subcontract with several firms licensed by the National Committee for Quality Assurance (NCQA) to conduct HEDIS audits. Delmarva-conducted audits are reimbursed by the State.

- c) The required EAS measures for 2007 will remain the same as those for 2006 and will not include any CDHS-developed performance measures. Attachment 1 provides information regarding the HEDIS measures that are required for 2007 (i.e., measurement year 2006), as well as those required for the two previous years.
- d) All health plans (all models) must report audited results on all of the required measures, and must adhere to the most current HEDIS specifications applicable to the reporting year and to CDHS specified timelines.
- e) Commercial plans operating in multiple counties must calculate and report HEDIS rates at the county level. All other health plans will calculate and report HEDIS rates at the contract level.
- f) The calculation of the required EAS measures will be performed by the health plan. The CDHS-contracted EQRO or its subcontractor will audit each health plan's results and will report the results to CDHS.
- g) Health plans must meet or exceed the CDHS established Minimum Performance Level (MPL) for each required HEDIS measure. The 2007 MPL for each required measure is the 25th percentile of the national Medicaid average as reported in the 2006 version of the *Quality Compass* published by the NCQA. More information about *Quality Compass 2006* is available on NCQA's website at <http://www.ncqa.org/Info/QualityCompass/index.htm>.
- h) The MPLs will be adjusted each year to reflect the national Medicaid averages available in the most current version of NCQA's *Quality Compass* at the time the HEDIS rates are provided to CDHS by its EQRO.
- i) For each measure that does not meet the established MPL or is reported as a "No Report" (NR) due to an audit failure, the health plan must submit an Improvement Plan (IP), formerly referred to as a Corrective Action Plan (CAP), within 60 days of being notified by CDHS of the measures for which IPs are required.

- Each IP must specify the steps that will be taken to improve the subsequent year's performance relative to the specific HEDIS measure.
 - Each IP must include, at a minimum, a root cause analysis, identification of interventions that will be implemented, identification of the team that will address the problem, and a proposed timeline.
- j) Each IP must be submitted to CDHS using the NCQA Quality Improvement Activity (QIA) form, available through NCQA's website at <http://www.ncqa.org/Programs/Accreditation/QIAInstructions.doc> . All pertinent data, as requested by the QIA form, must be incorporated. Special attention should be paid to addressing the barrier analysis (also known as the "root cause analysis") conducted by the health plan and the interventions planned and/or implemented to address the identified barriers. The health plan may submit additional supporting documentation with the completed QIA form.
- k) The QIA forms must be submitted to CDHS to Doreen Wong, RN, PHN, CPHQ, in MMCD's Performance Measurement Unit at dwong@dhs.ca.gov. Each completed QIA form should be submitted with a cover page including the following information: name of health plan, counties included in the IP, name of the IP, submission date, and name, phone number and e-mail address of the plan's contact person for the IP
- l) CDHS will publicly report the audited HEDIS/EAS results for each contracted health plan, as well as the Medi-Cal managed care average (or aggregate rate) and the national Medicaid average for each performance measure. Pilot measures, defined as measures that have not been previously tested and/or validated by CDHS or a recognized measurement development organization (e.g., NCQA), will be reported in the aggregate only for the first year the measure is used. In subsequent years, health plan results for these measures will be audited by the EQRO and publicly reported.
- m) CDHS will establish a High Performance Level (HPL) for each required EAS measure and will publicly acknowledge health plans that meet or exceed the HPLs. The 2007 HPL for each required measure is the 90th percentile of the national Medicaid average as reported in the 2006 version of the NCQAs *Quality Compass*.

2 Under/Over-Utilization Monitoring

- a) Health plans are required to report rates for selected HEDIS Use of Services measures for the monitoring of under and over-utilization. For 2007, the selected Use of Services measures will be the same as for previous years as specified in Attachment 2.
- b) The Use of Services rates are reported to the certified subcontractor performing the HEDIS audits under the direction of MMCD's EQRO, but are not audited. Currently these rates are not publicly reported but are used internally. In future years, MMCD may decide to audit these measures, modify the selected measures, establish benchmarks, and/or to begin public reporting.

3 Consumer Satisfaction Survey

In 2007, all health plans except for the specialty plans are required to provide the data required for administration of the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS), formerly known as the Consumer Assessment of Health Plans Survey. This survey will be conducted by the NCQA-certified survey vendor contracted with the Department's EQRO. Health plans must adhere to the specifications for the CAHPS survey as set forth by NCQA.

- a) For reporting year 2007, the EQRO's certified survey vendor will administer the 4.0H Adult Version and the 3.0H Child Version of CAHPS (including children with chronic conditions modules) in both English and Spanish.
- b) The CDHS will assume responsibility for the costs associated with the administration of this survey, but is not financially responsible for any supplemental questions added by individual health plans or for any additional analyses initiated by plans.
- c) The summary report will be publicly available on the CDHS website. Health plans will be notified when this report becomes available.

4 Quality Improvement Projects (QIPs)

Number of QIPs Required

All health plans are currently required to conduct and/or participate in four QIPs. Health plans holding multiple Medi-Cal managed care contracts are required to conduct four QIPs for each contracted entity. Health plans should continue to

conduct their four QIPs as previously stated in MMCD Policy Letter 03-01, available on the CDHS website at <http://www.dhs.ca.gov/mcs/mcmcd/default.htm> .

MMCD is in the process of amending all contracts to require only two QIPs. One QIP will be the statewide collaborative, and the other QIP will be either an internal QIP (IQIP) or a small group collaborative (SGC). Both IQIPs and SGCs must be approved by CDHS. Health plans that contract with CDHS after the initiation of the statewide collaborative will be required to participate in a SGC or develop an IQIP in place of their participation in the statewide collaborative, subject to approval by CDHS.

The reduction in required QIPs from four to two is projected to be effective as of January 1, 2007; however, it could be later as this change is contingent upon full execution of all health plan contracts. CDHS staff is in the process of further defining the specific details for this change in QIP requirements, including the transition of existing QIPs.

- Health plans that currently have fewer than four QIPs underway have the option of participating in the pre-planning workgroup to develop the new Emergency Room (ER) Statewide Collaborative in lieu of one QIP. Activities within the ER Statewide Collaborative pre-planning workgroup may include, but will not be limited to, development of measurable objectives; researching Medicaid best practices related to decreasing ER utilization; surveying beneficiary beliefs, values and practices regarding ER use; and researching provider challenges related to member use of ERs. Health plans that would like to participate in this workgroup should contact Ms. Rose Recostodio, RN at RRecosto@dhs.ca.gov in MMCD's Medical Policy Section.

Requirements for QIPs

Title 42, CFR, Section 438.240 (b)(1) requires that QIPs be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

- a) In order for health plans to demonstrate significant and sustained improvement, plans are required to provide the following information to document improvement in the annual (or more frequent if required by CDHS) and final QIP reports:
 - Baseline and repeat measures of quality indicators after implementation of improvement interventions and over comparable time periods. Note that

sustained improvement is demonstrated when two consecutive re-measures result in statistically significant improvement.

- Tests of statistical significance calculated on baseline and repeat indicator measurements. For example, a health plan might use a P value of less than or equal to 0.10 as the threshold for statistical significance.
 - Prospective identification of indicator benchmark(s), as either specified by CDHS, found in industry standards, or defined in advance by the health plan, and comparison of the plan's quality indicator results with the benchmark(s). For example, a benchmark might be reducing the performance gap (the percent of cases in which the measure failed) by at least 10 percent.
- b) 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 the QIP proposal is approved by MMCD and validated by the EQRO. If, during the course of the QIP, HEDIS specifications change for any measure selected to evaluate QIP results, CDHS and the EQRO, in collaboration with the health plan, will evaluate the impact of the changes. Any change in methodology for trending QIP performance must be approved by CDHS.
- c) QIPs typically last 12 to 36 months. Use of the Rapid Cycle Improvement Process is expected as part of the quality improvement work when feasible.
- d) All QIP proposals and reports must be submitted using the NCQA QIA form. Initial proposals are first submitted to MMCD for approval and then submitted to the EQRO for validation. Once a QIP proposal is approved, status reports must be submitted at least annually or according to the timeline agreed upon by the health plan and CDHS.
- QIP proposals, both for internal QIPs and SGCs, should be sent to Ms. Doreen Wong, RN, PHN, CPHQ in MMCD's Performance Measurement Unit at dwong@dhs.ca.gov. Once approved, CDHS will forward the proposal to the EQRO for validation and notify the health plan that the validation process has begun.
 - Health plans must send baseline reports (if not included in the proposal), annual status reports and final reports directly to the EQRO at CAQIP@dfmc.org with a "cc" to Ms. Doreen Wong at dwong@dhs.ca.gov.
 - Each completed QIA form should be submitted with a cover page including the following information: name of health plan, counties included in the QIP,

name of the QIP, QIA submission date, QIP phase (proposal, baseline, annual, or final report), and name, phone number and e-mail address of the plan's contact person for the QIP.

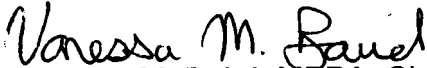
- e) Attachment 3 provides further detail regarding the requirements for small group collaborative QIPs.

MMCD will schedule a Quality Improvement Workgroup conference call after the health plans receive this letter. The agenda for this conference call will include ample time for health plans to ask questions and express concerns about the information included in this letter. Email notices will be sent to Medical Directors and QI Managers concerning the date and time of the call. If you have an *urgent* question or concern that cannot wait until this conference call, please contact the following individuals via e-mail according to your area of concern:

- EAS measures, required QIPs, the CAHPS survey, and submission of QIP proposals and status reports: Doreen Wong at DWong@dhs.ca.gov
- The current statewide collaborative on adolescent health: Penny Horper at PHorper@dhs.ca.gov
- The future statewide collaborative on ER utilization, including the pre-planning workgroup: Rose Recostodio at RRecosto@dhs.ca.gov

Performance measurement and quality improvement are important aspects of the Medi-Cal Managed Care program. We look forward to continuing to work in partnership with our contracted health plans to continuously improve the quality of care provided to Medi-Cal beneficiaries.

Sincerely,


Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Attachments (3)

EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES – 2005-2007

| EAS Measures | Calendar Year 2005 | Calendar Year 2006 | Calendar Year 2007 |
|-----------------------|--|--|---|
| HEDIS | Well-child visits \leq 15 mos | Well-child visits \leq 15 mos | Well-child visits \leq 15 mos |
| | Well-child visits 3-6 years old ¹ | Well-child visits 3-6 years old | Well-child visits 3-6 years old |
| | Adolescent well-care visits | Adolescent well-care visits | Adolescent well-care visits |
| | Childhood immunizations – Combo 1 | N.A. | N.A. |
| | Childhood immunizations – Combo 2 | Childhood immunizations – Combo 2 | Childhood immunizations – Combo 2 |
| | N.A. | Appropriate testing for children with URI | Appropriate testing for children with URI |
| | Prenatal & Postpartum Care: <ul style="list-style-type: none"> • Timeliness of prenatal care • Appropriate postpartum care | Prenatal & Postpartum Care: <ul style="list-style-type: none"> • Timeliness of prenatal care • Appropriate postpartum care | Prenatal & Postpartum Care: <ul style="list-style-type: none"> • Timeliness of prenatal care • Appropriate postpartum care |
| | Chlamydia screening in women | Chlamydia screening in women | Chlamydia screening in women |
| | Breast cancer screening | Breast cancer screening | Breast cancer screening |
| | Cervical cancer screening | Cervical cancer screening | Cervical cancer screening |
| | Appropriate use of medications for asthmatics | Appropriate use of medications for asthmatics | Appropriate use of medications for asthmatics |
| | Retinal exams for diabetics ² | Comprehensive diabetes care (4 measures only): <ul style="list-style-type: none"> • Retinal eye exam • LDL-C screening • Hemoglobin A1c testing • Nephropathy monitoring | Comprehensive diabetes care (4 measures only): <ul style="list-style-type: none"> • Retinal eye exam • LDLC screening • Hemoglobin A1c testing • Medical attention to nephropathy³ |
| | | Inappropriate treatment for adults w/ acute bronchitis ⁴ | Inappropriate treatment for adults w/ acute bronchitis |
| CDHS-Developed | <ul style="list-style-type: none"> • Blood lead screening • Beta agonist use by asthmatics | N.A. | N.A. |

¹ Not applicable to COHS plans in 2005.

² COHS plans only in 2005

³ Updated wording for consistency with *HEDIS 2007 Technical Specifications*.

⁴ New measure for 2006; first-year results reported at aggregate level only.

REQUIRED USE OF SERVICES MEASURES FOR MEDI-CAL MANAGED CARE PLANS

As indicated in MMCD All Plan Letter 03-015* (dated December 17, 2003), Medi-Cal managed care health plans are required to submit HEDIS rates for the selected Use of Services measures listed below.

1. "Frequency of Selected Procedures" – This measure summarizes the number and rate of various frequently performed procedures. For Medicaid members, plans report the absolute number of procedures and the number of procedures per 1,000 member months by age and sex. The following indicators are reported:
 - a) Myringotomy
 - b) Tonsillectomy
 - c) Non-obstetric dilation and curettage
 - d) Hysterectomy, abdominal
 - e) Hysterectomy, vaginal

2. "Inpatient Utilization: General Hospital/Acute Care" – This measure summarizes utilization of acute inpatient services in the following categories: total services, medicine, surgery, and maternity. The following indicators are reported:
 - 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 measure summarizes utilization of ambulatory services for the following indicators, all expressed per 1,000 member months by ages:
 - a) Outpatient visits
 - b) Emergency Department visits
 - c) Ambulatory surgery/procedures performed in hospital outpatient facilities or freestanding surgical centers

4. "Outpatient Drug Utilization" – This measure summarizes data on outpatient utilization of drug prescriptions during the measurement year, stratified by age.
 - a) Total cost of prescriptions
 - b) Average cost of prescriptions per member per month
 - c) Total number of prescriptions
 - d) Average number of prescriptions per member per year

* MMCD All Plan Letter 03-015 is available on the CDHS website at <http://www.dhs.ca.gov/mcs/mcmcd/default.htm> .

PROCESS AND REQUIREMENTS FOR APPROVAL OF SMALL-GROUP COLLABORATIVE QIPS FOR MEDI-CAL MANAGED CARE PLANS

The purpose of this document is to clarify the process and requirements for approval for small-group collaborative (SGCs) Quality Improvement Projects (QIPs) conducted by plans (i.e., not led by California Department of Health Services (CDHS) staff). These requirements will also apply to any CDHS-facilitated collaboratives. *Note: Footnotes provide examples of acceptable and unacceptable approach to satisfying SGC requirements.*

A. Process

- 1 Two months before the proposed start date of the new small group collaborative, a letter addressing the "Requirements for Approval" below must be submitted to the Medi-Cal Managed Care Division's Performance Measurement Unit, to the attention of Doreen Wong, RN, PHN, CPHQ, at DWong@dhs.ca.gov .
- 2 MMCD will review the request and send an approval or denial letter within one month of receipt.
- 3 If approved, the plan must proceed with submitting a detailed proposal of the project for final approval. The NCQA QIA form must be used for this purpose as explained in All-Plan Letter 06010.

B. Requirements for Approval

- 1 Ideally, the SGC should involve at least four health plans. Requests for SGCs with only two or three plans require additional justification.
- 2 The SGC, at a minimum, must collect and report baseline data and re-measure annually for two consecutive years. At the end of the second year, subsequent re-measurements and continuation of the SGC will be evaluated jointly by CDHS and the health plans involved in the SGC.
- 3 Plans must work on the same measurable objectives and the same performance measure indicators. These performance measures may be process or outcome measures as applicable to the specific collaborative¹

¹ Acceptable: "All plans in this SGC will increase diabetes screening rates (A1C, LDL, eye exams) by 10%." Unacceptable: "Plan A will increase A1C screening rates, while Plan B will decrease mean A1C levels."

4. Plans must measure improvement toward the outcome or process objectives using the same measurement methods² comparing post-intervention to baseline and comparing results across plans.
5. At least some interventions must be the same or similar across plans.³ (Other interventions may differ across plans.)
6. If evidence-based interventions exist, it is preferable that interventions be applied. For topics for which evidence-based interventions do not exist, the collaborative participants may try different interventions based on community standards, best practices, etc. to see what works with their plan model or with their provider and member populations.
7. Plans may use different intermediate process measures⁴ based on the specific interventions they are implementing. These process measures should be collected (but not necessarily reported to the CDHS) more frequently than the outcome measures to guide "course corrections" in the interventions in PDSA (Plan-Do-Study-Act) cycles or the rapid cycle improvement process.
8. Health plans must work collaboratively to review progress, provide insights on overcoming barriers, borrow each other's specific interventions/tools, adopt processes and systems changes, and establish best practices. At a minimum plans must participate in quarterly meetings for this purpose. Furthermore, at least one staff member from each participating plan should attend each collaborative meeting (in person or by telephone). The designated CDHS point of contact for the SGC from the MMCD Medical Policy Section should be invited to SGC meetings.
9. In order for other Medi-Cal managed care plans to benefit from the expertise of a SGC, the SGC must disseminate the lessons learned in verbal and in written formats to other plans.⁵

² Acceptable: "All plans in this SGC will measure A1C screening rates by chart review." Unacceptable: "Plan A will measure A1C screening rates by chart review, while Plan B will measure A1C screening rates by a survey of its physicians."

³ Acceptable: "All plans in this SGC will participate in a joint training and will establish a diabetes registry. Plan A will also use group visits, while Plan B will improve linkages to community resources." Unacceptable: "Plan A and B do not plan to implement similar interventions. Plan A will conduct training and will establish a diabetes registry, while Plan B will conduct group visits and will improve linkages to community resources."

⁴ Acceptable: "Plan A will track number/percent of provider practices using group visits, while Plan B will determine the percent of patients referred to ophthalmologists."

⁵ Acceptable: "We will make a presentation at the February 2008 Medical Directors meeting and will email our final collaborative report in PDF format to MMCD in June 2008."