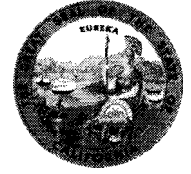




SANDRA SHEWRY  
Director

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



ARNOLD SCHWARZENEGGER  
Governor

DATE: September 25, 2007

MMCD All Plan Letter 07013

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM  
REQUIREMENTS FOR 2008

**Purpose:**

This All Plan Letter clarifies the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans for 2008. As contractually required, all Medi-Cal managed care health plans must comply with the 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, Family Mosaic Project, Kaiser PHP Marin/Sonoma and SCAN Health Plan). Specialty plans should review their contracts in conjunction with this letter to see which requirements apply.

**Requirements:**

1. 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 Healthcare Effectiveness Information and Data Set (HEDIS®; formerly referred to as the Health Plan Employer Information and Data Set) 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 Department of Health Care Services (DHCS) 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 one or more firms licensed by the National Committee for Quality Assurance (NCQA) to conduct the HEDIS compliance audits, which are paid for by the State.
- c) The required EAS measures for 2008 will be changed as follows:
- The Chlamydia Screening for Women measure will no longer be required.
  - The Ambulatory Care measure will be added as a new requirement. This measure includes the following four categories: outpatient visits; emergency department (ED) visits; ambulatory surgery/procedures performed in hospital, outpatient facilities or freestanding surgical centers; and observation room stays that result in discharge.
  - For the Comprehensive Diabetes Care measure, in addition to the four currently required indicators for retinal eye exam, LDL-C screening, HbA1c testing, and medical attention to nephropathy, three additional indicators will be required – HbA1c poor control (>9.0%), HbA1c good control (<7.0%), and LDL-C control (<100 mg/dL).
  - For the Childhood Immunization Status measure, the Combo 3 indicator will now be required along with the currently required Combo 2 indicator. (NCQA will discontinue Combo 2 in 2009.)
- d) Attachment 1 lists all 12 HEDIS measures required for 2008 (i.e., measurement year 2007), as well as those required for the two previous years.
- e) 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 DHCS specified timelines.
- f) All health plans must calculate and report HEDIS rates at the county level unless otherwise approved by DHCS. Current exceptions to this requirement have been approved for plans operating in Riverside and San Bernardino counties and the

COHS plans operating in Monterey and Santa Cruz counties and in Napa, Solano and Yolo counties.

- g) The calculation of the required EAS measures will be performed by the health plan. The DHCS contracted EQRO or its subcontractor will audit each health plan's results and will report the results to DHCS.
- h) Health plans must meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. The 2008 MPL for each required measure is the 25<sup>th</sup> percentile of the national Medicaid average as reported in the 2007 version of the *Quality Compass* published by the NCQA. More information about *Quality Compass 2007* is available on NCQA's website at <http://web.ncqa.org/tabid/177/Default.aspx>.
- i) Currently DHCS adjusts the MPLs 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 DHCS by its EQRO.
- j) 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) within 60 days of being notified by DHCS of the measures for which IPs are required. (For example, a plan with HEDIS scores falling below the MPL for two of the 12 required measures must submit two IPs – one for each measure.)
- 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.
  - Plans serving multiple counties under a single contract may submit an IP that addresses more than one county if the plan's scores fell below the MPL for the same measure in more than one county covered by that contract. However, in the IP the plan must address how it will address the targeted population in each county. This may include, but is not limited to, enrollee demographics, health risks, prevalence of the condition, utilization patterns, etc. for each county.

- k) Each IP must be submitted to DHCS using the NCQA Quality Improvement Activity (QIA) form, available through NCQA's website at <http://web.ncqa.org/tabid/125/Default.aspx>. 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.
- l) Each IP must be submitted on a QIA form to DHCS to Doreen Wong, RN, PHN, CPHQ, in the Performance Measurement Unit of the Medi-Cal Managed Care Division (MMCD) at [Doreen.Wong@dhcs.ca.gov](mailto:Doreen.Wong@dhcs.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
- m) DHCS will publicly report the audited HEDIS/EAS results for each contracted health plan, as well as the Medi-Cal managed care average (also known as the "aggregate rate") and the national Medicaid and commercial plan averages for each required performance measure.
- n) Newly established measures (i.e., a new measure introduced by NCQA, some other recognized measurement development organization, or DHCS) and/or measures newly required by DHCS will be reported only in the aggregate for the first year the measure is used, although results will be audited by the EQRO.
- o) DHCS 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 2008 HPL for each required measure is currently the 90<sup>th</sup> percentile of the national Medicaid average as reported in the 2007 version of the NCQA's *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 2008, the selected Use of Services measures will be the same as for previous years with the exception that the Ambulatory Care measure will now be part of the EAS and be audited by the EQRO. (See Attachments 1 and 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 is 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 begin public reporting.

3. Consumer Satisfaction Survey

In 2008, DHCS will not administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. DHCS currently plans to have the CAHPS survey conducted again in 2009. The All Plan Letter addressing the quality and performance measurement requirements for 2009, scheduled to be issued in August 2008, will include the requirements related to the next CAHPS survey.

4. Quality Improvement Projects (QIPs)

***Number of QIPs Required***

Health plans are currently required to conduct and/or participate in two QIPs – the Department-led statewide collaborative and *either* an internal QIP (IQIP) or a planned small group collaborative (SGC). Health plans holding multiple Medi-Cal managed care contracts are required to conduct two QIPs for each contracted entity.

Both IQIPs and SGCs must be approved by DHCS. Health plans that contract with DHCS after the initiation of the current 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 DHCS.

***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 DHCS) 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 0.05 as the threshold for statistical significance.
  - Prospective identification of indicator goals. Where benchmarks exist, these should be considered when indicator goals are established. Preferred sources for establishment of indicator goal(s) include benchmark or “best in class” performance, a goal or goals specified by DHCS, or a goal defined in advance by the health plan. If a benchmark or DHCS specific goal is not used, the health plan must provide the rationale or justification for the chosen indicator goal(s).
- b) Although not required, QIPs may be based on HEDIS measures. Under such circumstances, health plans must adhere to the HEDIS specifications in place 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, DHCS 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 DHCS.
- c) QIPs typically last 12 to 36 months. Use of the Rapid Cycle Improvement approach is expected as part of the quality improvement work when feasible.
- d) If desired, plans serving multiple counties under a single contract may submit a QIP that addresses the same improvement topic in more than one county – if the targeted improvement is relevant in more than one county covered by that contract. However, the QIP proposal and subsequent status reports must specifically address the needs of the targeted population in each county included in the QIP, such as enrollee demographics, health risks, prevalence of the condition, utilization patterns, etc.

### ***Approval and Validation Process for QIP Proposals and Status Reports***

All QIP proposals and status 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 DHCS.

- a) QIP proposals, both for IQIPs and SGCs, should be sent to Doreen Wong, RN, PHN, CPHQ in MMCD's Performance Measurement Unit at [Doreen.Wong@dhcs.ca.gov](mailto:Doreen.Wong@dhcs.ca.gov).
- b) DHCS will send the health plan an approval of a QIP proposal or a request for further development within approximately one month of receipt. Once a proposal is approved, DHCS will forward it to the EQRO for validation and notify the plan that the validation process has begun.
- c) 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](mailto:CAQIP@dfmc.org) with a "cc" to Doreen Wong at [Doreen.Wong@dhcs.ca.gov](mailto:Doreen.Wong@dhcs.ca.gov) for **IQIPs** and **SGCs** and with a "cc" to [ERcollab@dhcs.ca.gov](mailto:ERcollab@dhcs.ca.gov) for the **statewide collaborative** on avoidable ER visits.
- d) Each completed QIA form must 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) Upon notification by the EQRO that a final QIP report (a report closing out the QIP) has been validated and meets QIP requirements, plans must submit a new QIP proposal to DHCS as described above within 90 days of the validation notification.

Attachment 3 presents an overview of QIP requirements in table form.


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 discuss the information included in this letter. E-mail notices will be sent to plan Medical Directors and QI/HEDIS 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:

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- Current or future changes to the EAS measures: Michael Farber, M.D., Chief of MMCD's Medical Policy Section, at [Michael.Farber@dhcs.ca.gov](mailto:Michael.Farber@dhcs.ca.gov).
- Required QIPs, the CAHPS survey, and submission of QIP proposals and status reports: Doreen Wong in MMCD's Performance Measurement Unit at [Doreen.Wong@dhcs.ca.gov](mailto:Doreen.Wong@dhcs.ca.gov).
- The statewide collaborative on adolescent health that ended on July 31, 2007: Penny Horper in MMCD's Medical Policy Section at [Penny.Horper@dhcs.ca.gov](mailto:Penny.Horper@dhcs.ca.gov).
- The new statewide collaborative on avoidable ER visits that began on August 1, 2007: Rose Recostodio in MMCD's Medical Policy Section at [Rose.Recostodio@dhcs.ca.gov](mailto:Rose.Recostodio@dhcs.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 and service provided to Medi-Cal beneficiaries.

Sincerely,

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

Attachments (3)



EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: 2006-2008<sup>1</sup>

<b>Calendar Year 2006</b>	<b>Calendar Year 2007</b>	<b>Calendar Year 2008<sup>2</sup></b>
Well-child visits in the first 15 months of life	Well-child visits in the first 15 months of life	Well-child visits in the first 15 months of life
Well-child visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> & 6 <sup>th</sup> years of life*	Well-child visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> & 6 <sup>th</sup> years of life*	Well-child visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> & 6 <sup>th</sup> years of life*
Adolescent well-care visit*	Adolescent well-care visits*	Adolescent well-care visits*
Childhood immunization status – Combo 2	Childhood immunization status – Combo 2	Childhood immunization status – Combo 2 <sup>3</sup> & Combo 3 <b>New</b>
Appropriate treatment for children with upper respiratory infection (URI)	Appropriate treatment for children with upper respiratory infection (URI)	Appropriate treatment for children with upper respiratory infection (URI)
Prenatal & Postpartum Care: <ul style="list-style-type: none"> <li>• Timeliness of prenatal care*</li> <li>• Appropriate postpartum care</li> </ul>	Prenatal & Postpartum Care: <ul style="list-style-type: none"> <li>• Timeliness of prenatal care*</li> <li>• Appropriate postpartum care</li> </ul>	Prenatal & Postpartum Care: <ul style="list-style-type: none"> <li>• Timeliness of prenatal care*</li> <li>• Appropriate postpartum care</li> </ul>
Chlamydia screening in women	Chlamydia screening in women	Ambulatory Care <b>New</b>
Breast cancer screening	Breast cancer screening	Breast cancer screening
Cervical cancer screening	Cervical cancer screening	Cervical cancer screening*
Use of appropriate medications for people with asthma*	Use of appropriate medications for people with asthma*	Use of appropriate medications for people with asthma*
Comprehensive diabetes care (4 indicators): <ul style="list-style-type: none"> <li>• Retinal eye exam performed</li> <li>• LDL-C screening</li> <li>• Hemoglobin A1c testing</li> <li>• Nephropathy monitoring</li> </ul>	Comprehensive diabetes care (4 indicators): <ul style="list-style-type: none"> <li>• Retinal eye exam performed</li> <li>• LDL-C screening</li> <li>• Hemoglobin A1c testing</li> <li>• Medical attention to nephropathy<sup>4</sup></li> </ul>	Comprehensive diabetes care (7 indicators): <ul style="list-style-type: none"> <li>• Retinal eye exam performed</li> <li>• LDL-C screening performed</li> <li>• LDL-C control (&lt;100 mg/dL) <b>New</b></li> <li>• Hemoglobin A1c testing</li> <li>• HbA1c poor control (&gt;9.0%) <b>New</b></li> <li>• HbA1c good control (&lt;7.0%) <b>New</b></li> <li>• Medical attention to nephropathy</li> </ul>
Inappropriate antibiotic treatment for adults w/ acute bronchitis <sup>5</sup>	Inappropriate antibiotic treatment for adults w/ acute bronchitis <sup>6</sup>	Avoidance of antibiotic treatment of adults w/ acute bronchitis <sup>7</sup>

\* Measures used for the default algorithm. Cervical Cancer Screening will be added for 2008.

<sup>1</sup> Since 2006, the EAS has included only HEDIS measures & no Department-developed measures.

<sup>2</sup> First-year results for new measures or new indicators within an existing measure will be reported at the aggregate level only.

<sup>3</sup> Child Immunization Status Combo 2 indicator will be retired by NCQA in 2009.

<sup>4</sup> Updated wording for consistency with *HEDIS 2007 Technical Specifications*.

<sup>5</sup> New measure for 2006; first-year results were reported at aggregate level only in the 2006 report. Plan-specific results will be presented in the 2007 report.

<sup>6</sup> Plan-level results will be reported for the first time in 2007.

<sup>7</sup> Measure renamed by NCQA for 2008; the measure rate will be inverted so a higher rate is better.

**REQUIRED USE OF SERVICES MEASURES  
FOR MEDI-CAL MANAGED CARE PLANS IN 2008**

In 2008, Medi-Cal managed care health plans are required to submit HEDIS rates for measurement year 2007 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. "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

## OVERVIEW OF MMCD QUALITY IMPROVEMENT PROJECT (QIP) REQUIREMENTS: 2008

	<b>Internal QIP (IQIP)</b>	<b>Small Group Collaborative (SGC)</b>	<b>Statewide Collaborative QIP</b>
<i>Required number of plans</i>	One	At least <u>four</u> health plans (Proposals for SGCs with fewer plans require justification & must be approved by DHCS.)	All contracted plans (except specialty plans)
<i>Required meetings</i>	NA	Health plans expected to work collaboratively to review progress, provide insights on overcoming barriers, share specific interventions & tools, adopt process and system changes, & establish best practices. <ul style="list-style-type: none"> <li>• Plans must conduct at least <u>one meeting each quarter each year</u> for this purpose.</li> <li>• At least one staff member from each participating plan must attend each meeting (in person or by telephone).</li> <li>• The designated DHCS contact for the SGC from MMCD's Medical Policy Section should be invited to meetings.</li> </ul>	DHCS will organize meetings at <u>least quarterly</u> each year to work collaboratively with health plans to review progress, provide insights on overcoming barriers, share specific interventions & tools, adopt process and system changes, & establish best practices.
<i>Data Reporting</i>	As specified in the approved & validated IQIP proposal	<ul style="list-style-type: none"> <li>• The SGC must, <u>at a minimum</u>, collect and report baseline data and re-measure annually for two consecutive years.</li> <li>• At the end of the second year, subsequent re-measurements and continuation of the SGC will be evaluated jointly by DHCS and the health plans involved in the SGC.</li> </ul>	Determined by agreement between MMCD and plans & specified in the approved & validated SWC QIP proposals submitted by each plan. <b>Note:</b> Individual plan QIP proposals for the SWC on avoidable ER visits are due NLT 9/14/07. The first annual reports are due 8/31/08. Submit to: <a href="mailto:ERcollab@dhcs.ca.gov">ERcollab@dhcs.ca.gov</a> .
<i>Objectives and indicators</i>	As indicated in the approved/validated QIP proposal	Plans must work on the same measurable objectives and use the same performance measure indicators. These performance measures may be process or outcome measures as applicable to the specific collaborative <sup>1</sup> .	
<i>Methodology for measuring improvement</i>	As indicated in the approved/validated QIP proposal	Plans must measure improvement toward the outcome or process objectives using the same measurement methods <sup>2</sup> to compare post-intervention to baseline and to compare results across plans.	

<sup>1</sup> Acceptable: "All plans in this SGC will increase diabetes screening rates (HbA1C, LDL, eye exams) by 10%." Unacceptable: "Plan A will increase HbA1C screening rates, while Plan B will decrease mean HbA1C levels."

	<b>Internal QIP (IQIP)</b>	<b>Small Group Collaborative (SGC)</b>	<b>Statewide Collaborative QIP</b>
<i>Interventions</i>	As indicated in the approved/validated QIP proposal	At least some interventions must be the same or similar across plans. <sup>3</sup> Other interventions may differ across plans.	
<i>Evidence-based interventions</i>	If evidence-based interventions exist, it is preferable that they be applied. For topics for which evidence-based interventions do not exist, a plan (for IQIPs) or plans (for SGCs & the SWC QIP) may try different interventions based on community standards, best practices, etc. to see what works with their plan model and/or their provider and member populations.		
<i>Intermediate process measures</i>	Plans may use different intermediate process measures <sup>4</sup> based on the specific interventions being implemented. These process measures should be collected (but not necessarily reported to DHCS) more frequently than the outcome measures to guide "course corrections" in the Plan-Do-Study-Act (PDSA) cycles or the rapid cycle improvement process.		
<i>Timing of re-measurement</i>	Re-measurement of quality indicators after baseline should be performed after implementation of improvement interventions and over comparable time periods. Note: sustained improvement is demonstrated when two consecutive re-measures result in statistically significant improvement.		
<i>Use of goals</i>	Goals, as either specified by DHCS, found in industry standards, or defined in advance by the health plan, should be prospectively identified. The plan's quality indicator results should be compared with the stated goals. For example, a goal might be to reduce the performance gap (the percent of cases in which the measure failed) by at least 10 percent.		
<i>Use of HEDIS measures</i>	QIPs may be based on HEDIS measures. When QIPs are HEDIS-based, health plans must adhere to the HEDIS specifications in place at the time the QIP proposal is approved & validated. If the HEDIS specifications change during the course of the QIP, DHCS 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 DHCS.		
<i>Statistical testing</i>	Tests of statistical significance should be calculated on baseline and repeat indicator measurements. For example, a health plan might use a P value of less than .05 as the threshold for statistical significance.		
<i>Duration</i>	QIPs typically last 12 to 36 months. Use of the Rapid Cycle Improvement approach is expected when feasible.		

<sup>2</sup> Acceptable: "All plans in this SGC will measure HbA1C screening rates by chart review." Unacceptable: "Plan A will measure HbA1C screening rates by chart review, while Plan B will measure HbA1C screening rates by a survey of its physicians."

<sup>3</sup> 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."

<sup>4</sup> 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."

	<b>Internal QIP (IQIP)</b>	<b>Small Group Collaborative (SGC)</b>	<b>Statewide Collaborative QIP</b>
<i>Format for submission of proposals and reports</i>	<p>All QIP proposals and reports must be submitted using the NCQA QIA form.</p> <ul style="list-style-type: none"> <li>Initial proposals are first submitted to MMCD for approval and then submitted to the EQRO for validation.</li> <li>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(s) and DHCS.</li> </ul>		
<i>Content of QIA cover page</i>	<p>Each completed QIA form must 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 the name, phone number and e-mail address of the plan's contact person for the QIP.</p>		
<i>Submission of QIP proposals</i>	<p>Submit proposals for IQIPs &amp; SGCs on QIA forms to <a href="mailto:Doreen.Wong@dhcs.ca.gov">Doreen.Wong@dhcs.ca.gov</a>. When approved, DHCS will notify plan &amp; forward to the EQRO for validation.</p>		<p>Submit proposals for the SWC on avoidable ER visits on QIA forms to: <a href="mailto:ERcollab@dhcs.ca.gov">ERcollab@dhcs.ca.gov</a>. When approved, DHCS will notify plan &amp; forward to the EQRO for validation.</p>
<i>Submission of QIP status reports</i>	<p>Submit baseline reports (if not included with proposal), annual status reports, &amp; close-out reports to the EQRO at <a href="mailto:CAQIP@dfmc.org">CAQIP@dfmc.org</a> with "cc" to <a href="mailto:Doreen.Wong@dhcs.ca.gov">Doreen.Wong@dhcs.ca.gov</a>.</p>		<p>Submit baseline reports (if not included with proposal), annual status reports, &amp; close-out reports to the EQRO at <a href="mailto:CAQIP@dfmc.org">CAQIP@dfmc.org</a> with "cc" to <a href="mailto:ERcollab@dhcs.ca.gov">ERcollab@dhcs.ca.gov</a>.</p>
<i>Submission of new proposal after close-out of QIP.</i>	<p>Within 90 days of notification of validation of close-out report.</p>		<p>Generally within 90 days of notification of validation of close-out report, but will be specified by DHCS whenever a new SWC is implemented.</p>