



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



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DATE: March 9, 2010

MMCD All Plan Letter 10-001
(Supersedes APL 08-009)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM
REQUIREMENTS FOR 2010

PURPOSE

This Medi-Cal Managed Care Division (MMCD) All Plan Letter clarifies the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans for 2010. All Medi-Cal managed care health plans are contractually required to report annual performance measurement results, participate in a consumer satisfaction survey, and conduct ongoing quality improvement projects (QIPs).

Not all of the requirements presented below are applicable to specialty health plans (AHF Healthcare Centers, Family Mosaic Project, and SCAN Health Plan) or prepaid health plans (Kaiser PHP in Marin County). For these health plans, requirements are noted where applicable, but health plans should refer to their contracts for further information.

REQUIREMENTS

1. External Accountability Set Performance Measurement Requirements

- a) All Medi-Cal managed care health plans must submit annual report scores for the required External Accountability Set (EAS) performance measures. With the exception of the specialty health plan Family Mosaic Project, the Department of Health Care Services (DHCS) currently requires all contracted health plans to report selected Healthcare Effectiveness Data Information Set (HEDIS[®])

- b) measures to comply with the EAS reporting requirement. Beginning in 2010, the Family Mosaic Project will report on two (2) performance measures developed specifically for that health plan (See Attachment 1).
- c) All contracted health plans must submit to an annual on-site EAS compliance audit, currently referred to as the "HEDIS Compliance Audit™," except for the Family Mosaic Project. This audit is a two-part process consisting of an information systems capabilities assessment, followed by an evaluation of an organization's ability to comply with HEDIS audit specifications. The HEDIS audit methodology was developed by the National Committee for Quality Assurance (NCQA) and is used to assure standardized quality performance measure reporting throughout the health care industry. Beginning in 2010, Family Mosaic Project will undergo a performance measure audit of its two (2) internally-developed measures.
- d) All health plans must use DHCS's (the Department) selected contractor for the HEDIS Compliance Audit. The Health Services Advisory Group (HSAG) is DHCS's current External Quality Review Organization (EQRO) contractor, and will perform the 2010 HEDIS audits. HSAG may subcontract with one (1) or more firms licensed by the NCQA to conduct some of the HEDIS audits. These audits are paid for by the State.
- e) For the 2010 reporting year, DHCS made the following changes to the required HEDIS measures from the previous year:
- Discontinued the *Well-Child Visits in the First 15 Months of Life* measure.
 - Added the *Use of Imaging Studies for Low Back Pain* measure.
 - Removed the previously required *Ambulatory Care* measure from the audited EAS measures (This measure now will be included in the separately submitted "Use of Services" measures).
 - Discontinued the *Use of Appropriate Medications for People with Asthma* measure.
 - Added the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measure.
 - Added the *Blood Pressure Control (<140/90 mm HG)* indicator under the *Comprehensive Diabetes Care* measure.
 - Changed the reported HbA1c control measure from <7.0 percent to <8.0 percent under the *Comprehensive Diabetes Care* measure.

The required measures for reporting year 2010 were communicated to all contracted health plans via e-mail from Rita Marowitz, Chief of the Program Data and Performance Measurement Section, MMCD, on September 10, 2009.

- f) Attachment 1 lists all 11 HEDIS measures required for reporting year 2010 (i.e., measurement year 2009) for full-scope health plans, as well as those which were required for the previous year. Note that some measures have multiple indicators. Attachment 1 also includes the two (2) HEDIS or other performance measures to be reported by each specialty and prepaid health plan. These measures have been agreed upon between DHCS and each health plan as appropriate for each health plan's membership.
- g) Each health plan (any model type) must report to the EQRO the results on all the performance measures required of that health plan, while adhering to HEDIS or other specifications for the reporting year and to the timelines specified by DHCS and its EQRO.
- h) All health plans must calculate and report HEDIS rates at the county level unless otherwise approved by DHCS. Exceptions to this requirement were approved many years ago for health plans operating in Riverside and San Bernardino counties and the County Organized Health Systems (COHS) health plans operating in Monterey and Santa Cruz counties and in Napa, Solano, and Yolo counties. When existing health plans expand into new counties, if enrollment exceeds 1,000 members as of July of a given calendar year, health plans are required to report separate HEDIS rates for each county. DHCS does not intend to approve new combined county reporting of HEDIS measures if a health plan has 1,000 or more members in the new county.
- i) Each contracted health plan will calculate its scores for the required performance measures, and these scores will be confirmed by the EQRO or its subcontractor and reported to DHCS.
- j) Health plans must meet or exceed DHCS-established Minimum Performance Levels (MPLs) for each required HEDIS measure. The 2010 MPL for each required measure is the 25th percentile of the national Medicaid results for that measure as reported in the most current edition of NCQA's *2009 Audit Means, Percentiles, and Ratios* at the time the EQRO provides the annual HEDIS rates to DHCS. The percentiles are publicly available in March of each year on NCQA's website at: <http://www.ncqa.org/tabid/334/Default.aspx>
- k) DHCS adjusts the MPLs each year to reflect the 25th percentile of the national Medicaid results for each measure. The percentiles are drawn from the most current edition of NCQA's *Audit Means, Percentiles and Ratios* at the time the EQRO provides HEDIS rates to DHCS.
- l) For each measure that does not meet the established MPL or is reported as a "No Report" (NR), 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 health plan with HEDIS scores falling below the MPL for two (2)

of the 11 required measures must submit two (2) IPs – one (1) for each measure).

- Health plans must submit the required IPs to DHCS using the *2010 HEDIS Improvement Plan Submission Form* (Attachment 2). The most current version of this form is provided to each health plan at the time DHCS notifies the plans of the measures for which IPs must be submitted and the due date.
 - The IPs are submitted to DHCS at qipsmail@dhs.ca.gov, the address established by MMCD's Performance Measurement Unit for this purpose.
 - Health plans serving multiple counties under a single contract may submit an IP that addresses more than one (1) county if the health plan's scores fell below the MPL for the same measure in more than one (1) county covered by that contract. However, in the IP the health plan must discuss how it will address the targeted population in each county.
- m) DHCS will publicly report the audited HEDIS or other performance measurement results for each contracted health plan, along with the Medi-Cal managed care program average, the national Medicaid average, and the national commercial average for each DHCS-required performance measure. However, measures newly established by NCQA, DHCS, or another recognized measurement-development organization will be reported publicly only in the aggregate for the first reporting year. Health plans must still provide the EQRO with all results of any required measures, including first-year measures.
- n) DHCS establishes a High Performance Level (HPL) for each required performance measure and publicly acknowledges health plans that meet or exceed the HPLs. The 2010 HPL for each required measure is the 90th percentile of the national Medicaid results for that measure as reported in the 2009 edition of NCQA's *Audit Means, Percentiles and Ratios*.

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 2010, the selected Use of Services measures are listed in Attachment 3 and include:
- *Frequency of Selected Procedures* – New procedures selected for reporting year 2010 are: back surgery, coronary angioplasty, cardiac catheterization, coronary artery bypass graft, total hip replacement, and total knee replacement.
 - *Inpatient Utilization: General Hospital/Acute Care.*
 - *Outpatient Drug Utilization.*
 - *Ambulatory Care.*

- b) Health plan processes for arriving at Use of Services rates are not audited, but the rates for these measures are reported to the NCQA-certified auditor performing the HEDIS audits under the direction of DHCS's EQRO. These Use of Services rates are for internal use and are not publicly reported. In future years, MMCD may include these measures in the HEDIS audits, may modify the selected measures, may establish benchmarks, and/or may begin publicly reporting the results.

3. Consumer Satisfaction Surveys

The next Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for both adults and children will be administered by the EQRO in 2010. For the first time, DHCS will provide the "sample frame" member information for contracted health plans to the EQRO, so health plans will not be required to do this. However, health plans will be required to participate in a validation process for selected member records in accordance with the NCQA's specified survey methodology.

Although specialty and prepaid health plans are not required to participate in the CAHPS survey, these health plans are required to conduct a member satisfaction survey at least every other year and to provide DHCS with results specific to the health plan's Medi-Cal managed care members. Each specialty health plan must provide DHCS with a copy of the survey instrument and the calculation/administration methodology, so that the EQRO may evaluate them for compliance with both federal and contract requirements.

CAHPS results for the 2010 survey will be reported by the EQRO for each health plan at the county level. In previous years, scores for health plans operating in multiple counties were "rolled up" into an aggregate score. County-level reporting will allow DHCS and contracted health plans to better understand how member satisfaction with provider and health plan services varies in individual counties.

4. Quality Improvement Projects

Number of QIPs Required

Full-scope health plans are required to conduct and/or participate in two (2) QIPs – the Department-led statewide collaborative and *either* an internal QIP (IQIP) or a health plan-led small group collaborative (SGC) QIP. Health plans holding multiple Medi-Cal managed care contracts are required to conduct two (2) QIPs for each contracted entity.

Specialty and prepaid health plans are also required to conduct two (2) QIPs, but are not required to participate in the Department-led statewide collaborative QIP. For these health plans, the two (2) QIPs usually will be IQIPs, although health plans may request approval for participation in a SGC appropriate to their member population.

Both IQIPs and SGCs must be approved by DHCS and validated by the EQRO in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements for performance improvement projects. Full-scope health plans that contract with DHCS after the current statewide collaborative begins will be required to participate in a SGC or to develop an IQIP in place of their participation in the statewide collaborative, subject to DHCS approval.

Requirements for QIPs

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

a) In order to demonstrate significant and sustained improvement, each health plan is required to provide the following information in the QIP status reports and the QIP final report:

- A quality indicator baseline result followed by subsequent measurement results for the same quality indicator during and after implementation of improvement interventions. Note that sustained improvement is demonstrated when two (2) consecutive re-measures result in a 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. Existing benchmarks should be strongly considered when establishing indicator goals. DHCS recommends that indicator goal(s) be based on the following sources in order of precedence: benchmarks of performance, a DHCS-specified goal, or a well-defined goal submitted in advance by the health plan. If a benchmark or DHCS-specified goal is not used, the health plan must provide justification for the chosen goal(s).

b) QIPs may be based on HEDIS measures, although this is not required. Under such circumstances, health plans must adhere to the HEDIS specifications in place at the time the QIP proposal is approved by DHCS and validated by the EQRO. If, during the course of the QIP, HEDIS specifications change for the

QIP's HEDIS measure, 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, and use of the Rapid Cycle Improvement approach is expected when feasible. Health plans wishing to conduct a QIP beyond 36 months must get approval from DHCS.
- d) If desired, health plans serving 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 (1) county covered by that contract. However, the QIP proposal and subsequent status reports must specifically address the targeted population in each county included in the QIP by submitting county-specific data and results for the following QIP activities:
- Sampling methods
 - Data collection procedures
 - Assessment of improvement strategies
 - Data analysis and interpretation of study results
 - Assessment for real improvement
 - Assessment for sustained improvement

The above QIP activities and others are documented by health plans on the *QIP Summary Form* and validated by the EQRO.

Approval and Validation Process for QIP Proposals and Status Reports

All QIP proposals and status reports must be submitted on HSAG's *QIP Summary Form*, which is provided to health plans by the EQRO when health plans are notified that new QIP proposals are due. The form is also available to health plans on HSAG's File Transfer Process (FTP) site. (*Note: All current Medi-Cal managed care health plans already have identified FTP users who have been assigned user names and passwords by HSAG in order to access each health plan's specific folder. To establish additional user profiles or remove previous users, health plan staff should contact Denise Driscoll at DDriscoll@hsag.com.*)

- a) Health plans first submit QIP proposals to MMCD for approval. Once MMCD has approved the topic of the QIP proposal, MMCD forwards the proposal to the EQRO for validation. Once a health plan's QIP proposal is fully approved and validated, the health plan must submit status reports at least annually or according to a timeline agreed upon by the health plan, MMCD, and the EQRO.

- b) QIP proposals, both for IQIPs and SGCs, should be sent to gipsmail@dhs.ca.gov, the e-mail address established by MMCD's Performance Measurement Unit for submission of QIP proposals and status reports.
- c) Within approximately one (1) month of receiving a QIP proposal, MMCD will send the health plan either an approval of the QIP or a request for further development. Once a proposal is approved by MMCD, it will be forwarded to the EQRO for validation who will notify the health plan that the QIP's validation process has begun. The EQRO will send validation results to both the health plan and to MMCD and may request modifications to the health plan's proposal before final validation that the health plan's QIP proposal is in compliance with both DHCS and CMS requirements.
- d) Health plans must send baseline reports (if not included in the proposal), annual status reports, and final reports for all QIPs directly to the EQRO via HSAG's FTP site with a "cc" to gipsmail@dhs.ca.gov.
- e) Within 90 days of receiving EQRO notification that a final closing QIP report has been validated and meets requirements, health plans must submit a new QIP proposal to MMCD as described above.
- f) Attachment 4 presents an overview of QIP requirements in table form.

KEY CONTACTS

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

- General questions about MMCD's quality and performance improvement program requirements: Helen MacDonald, Chief, MMCD's Performance Measurement Unit, at Helen.Macdonald@dhcs.ca.gov.
- HEDIS MPLs and HPLs and the 2010 CAHPS: Lauren Oehler, MMCD's Performance Measurement Unit, at Lauren.Oehler@dhcs.ca.gov.
- HEDIS 2010 audit requirements, 2010 CAHPS survey process, and QIPs validation process: Jennifer Lenz, HSAG, at jlenz@hsag.com.
- The current statewide collaborative QIP on avoidable ER visits: Rose Recostodio, MMCD's Medical Policy Section, at Rose.Recostodio@dhcs.ca.gov.
- Required QIPs, submission of QIP proposals and status reports, and submission of HEDIS IPs: K.A. Corley (Corley), MMCD's Performance Measurement Unit, at K.A.Corley@dhcs.ca.gov.

March 9, 2010

Performance measurement and quality improvement are important aspects of the Medi-Cal managed care program. The partnership between MMCD, its contracted health plans, and the EQRO results in ongoing improvement of the quality of care and services provided to Medi-Cal beneficiaries. We look forward to continuing this positive relationship.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tanya Homman', with a stylized circular flourish at the beginning.

Tanya Homman, Chief
Medi-Cal Managed Care Division

Attachments (4)

REQUIRED HEDIS MEASURES: REPORTING YEARS 2009 & 2010

Reporting Year 2009	Reporting Year 2010	Notes re: 2010 Measures
Well-Child Visits in the First 15 Months of Life		Discontinued Hybrid measure for 2010.
Well-Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life*	Well-Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life*	Hybrid measure; used for Auto Assignment.
Adolescent Well-Care Visits*	Adolescent Well-Care Visits*	Hybrid measure; used for Auto Assignment.
Childhood Immunization Status – Combo 3*	Childhood Immunization Status – Combo 3*	Hybrid measure; used for Auto Assignment.
Appropriate Treatment for Children with Upper Respiratory Infection	Appropriate Treatment for Children with Upper Respiratory Infection	Admin measure
Prenatal & Postpartum Care (2 indicators): <ul style="list-style-type: none"> • Timeliness of Prenatal Care* • Postpartum Care 	Prenatal & Postpartum Care (2 indicators): <ul style="list-style-type: none"> • Timeliness of Prenatal Care* • Postpartum Care 	Hybrid measure Prenatal indicator used for Auto Assignment.
Ambulatory Care (4 indicators): <ul style="list-style-type: none"> • Ambulatory Surgery/Procedures • ED Visits • Observation Room Stays • Outpatient Visits 	Use of Imaging Studies for Low Back Pain <i>Ambulatory Care measure moved back to Use of Services unaudited measures.</i>	* For 2010, added Imaging Studies Measure & removed Ambulatory Care Measure from audited measures (both Admin measures). * Imaging Studies measure relates to DHCS strategic focus on older adults, possible over use, & patient safety issues.
Breast Cancer Screening	Breast Cancer Screening	Admin measure
Cervical Cancer Screening*	Cervical Cancer Screening*	Hybrid measure; used for Auto Assignment.
Use of Appropriate Medications for People with Asthma*	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	*For 2010, discontinued asthma measure (admin). Most plans scoring above, at or near 90 th percentile. * Added Hybrid measure relevant to DHCS strategic goals, statewide provider initiative, & national public health issue.
Comprehensive Diabetes Care (7 indicators): <ul style="list-style-type: none"> • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/DI) • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<7.0%) • Medical Attn. for Nephropathy 	Comprehensive Diabetes Care (8 indicators): <ul style="list-style-type: none"> • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/DI) • HbA1c Testing* • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attn. for Nephropathy • Blood pressure control (<140/90 mm Hg) 	* For 2010, chose <8.0% HbA1c control measure as less burdensome to plans than the <7.0% measure. * HbA1c testing will be new Auto Assignment measure. * Added Hybrid blood pressure control indicator; not excessive burden since medical record review already required for other indicators.
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Admin measure
8 Hybrid & 4 Admin measures+	7 Hybrid & 4 Admin measures+	

* Measures used for the Auto Assignment default algorithm.

+ Hybrid measures require both administrative data & medical record review, while Admin measures require only administrative data.

REQUIRED HEDIS MEASURES FOR SPECIALTY & PHP PLANS: 2010

AHF Healthcare Centers

- Adults' Access to Preventive/Ambulatory Health Services
- Colorectal Cancer Screening

Family Mosaic Project

Beginning in 2010, the Family Mosaic Project will report results for the following customized performance measures, which were developed in collaboration with the DHCS's External Quality Review Organization, Health Services Advisory Group:

- *Inpatient Hospitalizations*: The percentage of Medi-Cal managed care members enrolled in Family Mosaic who have a mental health admission to an inpatient hospital facility during the measurement period.
- *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.

Kaiser PHP in Marin County

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection

SCAN

- Glaucoma Screening in Older Adults
- Persistence of Beta-Blocker Treatment After a Heart Attack

MEDI-CAL MANAGED CARE DIVISION

2010 HEDIS IMPROVEMENT PLAN SUBMISSION FORM

Plan Name: _____

HEDIS Measure: _____

Plan's 2010 Score for Measure: _____

MMCD "Minimum Performance Level" (MPL): _____

1. Performance Standard and Goal

Briefly describe your plan's performance goal for this measure.

2. Plan for Improvement

Briefly describe the overall plan for improved performance for this measure.

3. Improvement Plan Grid

Briefly outline the steps your plan will take to improve performance for this measure.

Item	Interventions	Anticipated Completion Date	Responsible Person(s)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

4. Goals and Timeline for Completing Improvement Plan5. Results of Interventions

Include a description of the results for the most recent measurement cycle, if available. May include graph or table.

6. Analysis of Interventions

If results are included above, report if any change occurred – rate increased or decreased.

7. Barriers and Challenges

Report the internal and/or external barriers, issues and/or factors that impacted the program, initiative or activity and identify the possible reasons that:

- Improvement could not be made or sustained;
- Goals could not be reached; or
- Study, project or intervention could not be completed.

Note: Internal barriers are often associated with lack of a particular resource. Once identified, barriers often become opportunities for improvement for the following year or next remeasurement cycle.

8. Opportunities for Future Improvement

Include a description of the strengths and opportunities for improvement that were identified as part of the overall program evaluation. This may include suggestions for improving the program for the following year, modifications to goals and objectives, newly established goals and objectives, changes in methodology due to an unforeseen nuance, or other changes that will enhance the program for the following year.

Name and title of person completing this HEDIS Improvement Plan

Date

REQUIRED USE OF SERVICES MEASURES REPORTING YEAR 2010

In the 2010 reporting year, Medi-Cal managed care health plans (with the exception of specialty and prepaid health plans) are required to submit HEDIS rates for measurement year 2009 for the HEDIS 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) Back surgery
 - b) Coronary angioplasty (PTCA)
 - c) Cardiac catheterization
 - d) Coronary artery bypass graft (CABG)
 - e) Total hip replacement
 - f) Total knee replacement

2. Inpatient Utilization: General Hospital/Acute Care – This measure summarizes utilization of acute inpatient services in the following categories: total inpatient, medicine, surgery, and maternity. The following data are 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. Outpatient Drug Utilization – This measure summarizes data on outpatient utilization of drug prescriptions during the measurement year, stratified by age. The following data are reported:
 - 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

4. “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
 - d) Observation room stays

Note:

Results for these measures are reported to the EQRO consistent with HEDIS technical specifications and in a format designated by DHCS. However, these measures are not included in the EQRO's audit process.

MMCD QUALITY IMPROVEMENT PROJECT (QIP) REQUIREMENTS: 2010

	<i>Internal QIP (IQIP)</i>	<i>Small Group Collaborative (SGC)</i>	<i>Statewide Collaborative (SWC) QIP</i>
<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 MMCD.)	<u>All</u> 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"> Plans must conduct at least <u>one meeting each quarter each year</u> for this purpose. At least one staff member from each participating plan must attend each meeting (in person or by telephone). The designated MMCD contact for the SGC from MMCD's Medical Policy Section should be invited to meetings. 	MMCD will organize meetings <u>at 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"> The SGC must, <u>at a minimum</u>, collect and report baseline data and then annual re-measurement data for two consecutive years. At the end of the second re-measurement, subsequent re-measurements and continuation of the SGC will be evaluated jointly by MMCD and the health plans involved in the SGC. 	Determined by agreement between MMCD and plans & specified in the approved & validated SWC QIP proposals submitted by each plan. Note: The next annual status reports are due 10/29/10. Submit to: qipsmail@dhs.ca.gov
<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 ¹ .	
<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 ² to compare post-intervention to baseline and to compare results across plans.	

¹ Acceptable: "All plans in this SGC will increase diabetes screening rates for HbA1C, LDL, and eye exams by 10%." Unacceptable: "Plan A will increase HbA1C screening rates, while Plan B will decrease mean HbA1C levels."

	<i>Internal QIP (IQIP)</i>	<i>Small Group Collaborative (SGC)</i>	<i>Statewide Collaborative (SWC) QIP</i>
<i>Interventions</i>	As indicated in the approved/validated QIP proposal	At least some interventions must be the same or similar across plans. ³ Other interventions may differ across plans.	
<i>Evidence-based interventions</i>	If evidence-based interventions exist, it is preferable that they be applied. In addressing topics for which evidence-based interventions do not exist, a plan (for IQIPs) or plans (for SGCs & the SWC QIPs) may try other interventions based on community standards, best practices, etc. to see what works with their plan model and/or their provider and membership populations.		
<i>Intermediate process measures</i>	Plans may use different intermediate process measures ⁴ based on the specific interventions being implemented. These process measures should be collected (but not necessarily reported to MMCD) 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 specified by MMCD and 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, MMCD 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 MMCD.		
<i>Statistical testing</i>	Tests of statistical significance should be calculated between baseline and repeat indicator measurement periods. For <u>example</u> , 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.		

² 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."

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."

	Internal QIP (IQIP)	Small Group Collaborative (SGC)	Statewide Collaborative (SWC) QIP
<i>Format for submission of proposals and reports</i>	All QIP proposals and reports must be submitted using HSAG's <i>QIP Summary Form</i> . <ul style="list-style-type: none"> 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 and in accordance with the timeline agreed upon by the health plan(s) and MMCD. 		
<i>Submission of QIP proposals</i>	Submit proposals for IQIPs & SGCs on HSAG's <i>QIP Summary Form</i> to gipsmail@dhs.ca.gov . When a proposal is approved, MMCD will forward the approved proposal to the EQRO for validation. Proposals are approved only after the EQRO certifies that it has passed validation requirements.		Submit proposals for the SWC on avoidable ER visits on HSAG's <i>QIP Summary Form</i> to: gipsmail@dhs.ca.gov . When a proposal is approved, MMCD will forward the approved proposal to the EQRO for validation. Proposals are approved only after the EQRO certifies that it has passed validation requirements.
<i>Submission of QIP status reports</i>	Submit baseline reports (if not included with proposal), annual status reports, and close-out reports to the EQRO via HSAG's FTP site with a "cc" to gipsmail@dhs.ca.gov .		Submit baseline reports (if not included with the proposal), annual status reports, and close-out final reports to the EQRO to HSAG's FTP site with a "cc" to gipsmail@dhs.ca.gov .
<i>Submission of new proposal after close-out of QIP.</i>	Within 90 days of receiving EQRO notification that a final closing QIP report has been validated and meets requirements, plans must submit a new QIP proposal to the MMCD.		Generally, within 90 days of receiving EQRO notification that a final closing QIP report has been validated, plans are to submit new proposals for the next SWC. However, the MMCD will determine the specific time frame for plans to submit new SWC proposals.