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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: SEP 21 2011

MMCD All Plan Letter 11-021
(Supersedes APL 11-002)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM REQUIREMENTS FOR 2012

PURPOSE

The purpose of this All Plan Letter (APL) is to clarify the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans for 2012. 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). 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 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®) measures in order to comply with the EAS reporting requirement. DHCS requires the Family Mosaic Project to report on two performance measures developed specifically for that health plan. (See Attachment 1.)

b) 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. The Family Mosaic Project must undergo a performance measure audit of its two (2) internally-developed measures.

c) All health plans must use DHCS's 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 2012 HEDIS audits. HSAG may subcontract with one or more independent auditors licensed by the NCQA to conduct some of the HEDIS audits. These audits are paid for by the State.

d) DHCS has introduced five new measures for the 2012 reporting year and deleted two measures. Several of the new measures may be utilized to support performance measurement related to the implementation of mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities, as required by Welfare and Institutions Code Section 14182 (as added by Stats.2010, c. 714 (SB 208) § 20). Final measure selection was made after consultation with contracted plans and input from the EQRO and other stakeholders during 2011.

   Attachment 1 lists all 14 HEDIS and DHCS developed measures required for reporting year 2012 (i.e., measurement year 2011) for full-scope health plans. Note that some measures have multiple indicators. Attachment 1 also includes the two HEDIS or other performance measures to be reported by each specialty plan. These measures have been agreed upon between DHCS and each health plan as appropriate for each health plan's membership.

e) 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. Each health plan must populate NCQA's Interactive Data Submission System (IDSS) with the final measure rates for all reporting units/counties by June 1, 2012 for final auditor review.

f) All health plans must calculate and report HEDIS rates at the county level unless otherwise approved by DHCS. Current exceptions to this requirement were approved many years ago for health plans operating in Riverside and San Bernardino counties and the County Organized Health System (COHS) plans operating in Monterey, Santa Cruz, 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 any new county.

g) 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.

h) Health plans must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required HEDIS measure. The 2012 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 2011 *Audit Means, Percentiles*, and Ratios at the time the EQRO provides the annual HEDIS rates to DHCS.

i) 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.

j) For <u>each</u> measure that does not meet the established MPL or is reported as a "Not 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 of the required measures must submit two IPs -one for each measure.

- Health plans must submit the required IPs to DHCS using the *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 gipsmail@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 county if the health 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 health plan must discuss how it will address the targeted population in each county.

- Plans are not subject to the MPL in the first year scores are reported for a newly required measure as this score is considered the baseline score. Therefore plans do not have to submit an IP if a score for a new measure is below the MPL. These first-year scores will be reported in the annual aggregate report with an acknowledgement that these are baseline scores that are not subject to the MPL.

k) 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.

l) DHCS establishes a High Performance Level (HPL) for each required performance measure and publicly acknowledges health plans that meet or exceed the HPLs. The 2012 HPL for each required measure is the 90th percentile of the national Medicaid results for that measure as reported in the 2011 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 2012, the selected Use of Services measures are listed in Attachment 3 and include:

- *Frequency of Selected Procedures* -Procedures selected for reporting year 2012 are: back surgery, bariatric weight loss surgery, lumpectomy, and mastectomy.
- *Inpatient Utilization: General Hospital/Acute Care* – Includes utilization of acute inpatient services in various categories
- *Ambulatory Care* – Includes outpatient visits and emergency department visits.

b) Health plan processes for arriving at rates for selected HEDIS Use of Services measures used for the monitoring of under and over-utilization 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 modify the selected measures, may establish benchmarks, and/or may begin publicly reporting the results.

3. Consumer Satisfaction Surveys

a) The next Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for both adults and children will be administered by the EQRO in 2013.

b) In years when the CAHPS surveys are administered, results will be reported by the EQRO for each health plan at the county level. County-level reporting allows the DHCS, contracted health plans, and other stakeholders to better understand how member satisfaction and health plan services varies in individual counties.

c) Although specialty 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 survey calculation/ administration methodology, so that the EQRO may evaluate them for compliance with both federal and contract requirements.

4. Quality Improvement Projects

Number of QIPs Required

Full-scope health plans are required to conduct and/or participate in two QIPs- the Department-led statewide collaborative (SWC) QIP 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 QIPs for each contracted entity.

Specialty health plans also are required to conduct two QIPs, but are not required to participate in the Department-led statewide collaborative QIP. For these health plans, the two QIPs usually will be IQIPs, although health plans may request approval to participate 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 establish new contracts 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 after the plan has been operational for one year, 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 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 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.

The *Quality Improvement Assessment (QIA) Guide for Medi-Cal Managed Care Plans* explains the CMS requirements for QIPs and how the EQRO validates plan QIPs for compliance with the federal requirements. The Q/A Guide is available on the DHCS website at:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/QIA_Assessment_Guide_November_2010.pdf

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* or *QIP Summary Form for Multi-Counties*. The forms are 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 qipsmail@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 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, staff will forward it to the EQRO for validation and 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 qipsmail@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 Performance Measurement Unit, at Helen.MacDonald@dhcs.ca.gov

- HEDIS MPLs and HPLs and the submission of HEDIS Improvement Plans: Helen MacDonald at Helen.MacDonald@dhcs.ca.gov

- HEDIS 2012 audit requirements and QIPs validation process: Jennifer Lenz, Associate Director of EQRO Services, HSAG, at jlenz@hsag.com

- The current statewide collaborative QIP on reducing avoidable ER visits: Rose Recostodio, Nurse Consultant, MMCD Medical Policy Section, at Rose.Recostodio@dhcs.ca.gov.

- The upcoming statewide collaborative QIP on hospital readmissions: Desire Kindarara, Nurse Consultant, MMCD Medical Policy Section, at Desire.Kindarara@dhcs.ca.gov.

- Required QIPs, the submission of QIP proposals and status reports, and QIP due dates: Sarah Reed, Associate Governmental Program Analyst, MMCD Performance Measurement Unit, at Sarah.Reed@dhcs.ca.gov.

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,

Original Signed by Jane Ogle

Jane Ogle, Deputy Director
Health Care Delivery Systems

Attachments (4)

2012 HEDIS PERFORMANCE MEASURES FOR FULL-SCOPE PLANS
August 3, 2011

	HEDIS Reporting Year 2012[1]	***Measure Type***
1.	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	Hybrid measure (Medicaid) *Used for Auto Assignment*
2.	Adolescent Well-Care Visits	Hybrid measure (Medicaid) *Used for Auto Assignment*
3.	Childhood Immunization Status- Combo 3	Hybrid measure (Medicaid) *Used for Auto Assignment*
4.	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Hybrid measure (Medicaid) *Timeliness of Prenatal Care indicator used for Auto Assignment*
5.	Use of Imaging Studies for Low Back Pain	Admin measure (Medicaid)
6.	Cervical Cancer Screening	Hybrid measure (Medicaid) *Used for Auto Assignment*
7.	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	Hybrid measure (Medicaid)
8.	Comprehensive Diabetes Care (8 indicators): • 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)	Hybrid measure (Medicaid) *HbA1c Testing indicator used for Auto Assignment*
9.	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Admin measure (Medicaid)
10.	***NEW FOR 2012*** Children & Adolescents' Access to Primary Care Practitioners	Admin measure (Medicaid)
11.	***NEW FOR 2012*** Immunizations for Adolescents	Hybrid measure (Medicaid)
12.	***NEW FOR 2012*** Annual Monitoring for Patients on Persistent Medications (w/out anticonvulsant indicator)	Admin measure (Medicaid) - addresses members 18 yrs & older
13.	***NEW FOR 2012*** Ambulatory care: • Outpatient visits • Emergency Department visits	Admin measure (Medicaid) - addresses members <1 yr through 85+ yrs
14.	***NEW FOR 2012*** All-Cause Readmissions - Statewide Collaborative QIP measure	Admin measure Statewide Collaborative QIP to define specific measure
		8 Hybrid & 6 Admin measures+

[1] Uses data from 1/1/11 through 12/31/11, "measurement year."

2011 HEDIS PERFORMANCE MEASURES ELIMINATED FROM THE 2012 MEASUREMENT SET

	2011 HEDIS Measure	Measure Type
1.	Appropriate Treatment for Children with Upper Respiratory Infection	Admin measure (Medicaid)
2.	Breast Cancer Screening	Admin measure (Medicaid)

HEDIS PERFORMANCE MEASURES TO BE CONSIDERED FOR 2013

This is not a complete list, other measures may be considered based upon additional information.

- Controlling High Blood Pressure (Hybrid measure- Medicaid)
- The following measures and/or others may be considered for stratified reporting for SPDs in 2013:
  - Children & Adolescents' Access to Primary Care Practitioners
  - Cervical Cancer Screening
  - Controlling High Blood Pressure
  - Ambulatory Care (outpatient visits and emergency department visits)
  - All-Cause Readmissions- Statewide Collaborative QIP measure

  DHCS will develop the requirements for stratified reporting with technical assistance from the EQRO and in consultation with plans.

2013 HEDIS PERFORMANCE MEASURES DEVELOPMENT PROCESS

This approach provides the plans with the draft HEDIS performance measure set prior to when they start collecting data, but allows DHCS to modify the measures based on additional information such as any HEDIS revisions, plan performance, or other factors to be determined.

October to December 2011	DHCS begins identifying performance measures for 2013, including gathering input from Dr. Kohatsu, plans, Medical Directors, QI/HEDIS representatives, the MMCD and SPD Advisory Groups, and MMCD staff.
December 2011	DHCS issues a draft of the 2013 Performance Measure set, which is subject to adjustments based on review of 2011 HEDIS data and other key reasons, such as NCQA revising the technical specifications of a HEDIS measure.
May 2012	DHCS issues "final" set of 2013 Performance Measures including identifying measures used to stratify and report the SPDs.
June 2012	DHCS issues APL.
November 2012	• Measures included in auto assignment default algorithm developed and approved. • Assess the new performance measure set development process.

REQUIRED PERFORMANCE MEASURES FOR SPECIALTY PLANS: 2012

AHF Healthcare Centers

- Colorectal Cancer Screening
- Controlling High Blood Pressure

Family Mosaic Project

- *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.

SCAN

- Breast Cancer Screening
- Osteoporosis Management in Women Who Had a Fracture (new for 2012)

MEDI-CAL MANAGED CARE DIVISION

HEDIS IMPROVEMENT PLAN SUBMISSION FORM

Plan Name:_____

HEDIS Measure: _____

MMCD "Minimum Performance Level" (MPL):

County:	Plan's 2011 Score for Measure:

1. Performance Standard and Goal
   Briefly describe your plan's performance goal for this measure, including the target score your plan hopes to achieve in the next two reporting years (2012 and 2013).

2. Plan for Improvement
   Briefly describe the overall plan for improved performance for this measure. Include a description of the strengths and opportunities for improvement This may include improvement suggestions for the following year, such as 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 in the short and/or long term.

3. Barriers and Challenges
   Report the internal and/or external barriers, issues and/or factors that impacted the HEDIS result, identifying the reasons that:
   - Improvement was not made or sustained for reporting year 2011;
   - Goals could not be reached in reporting year 2011; and/or
   - Study, project or intervention could not be completed in time to affect the reporting year 2011 score.

   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.

4. Repeat Improvement Plan
   If your plan has been previously required to submit an Improvement Plan for this measure for more than two consecutive years, please describe how your plan has applied previous lessons learned to the development of this Improvement Plan and how this IP differs from previous IPs or why it does not.

5. Improvement Plan Grid
   List the interventions your plan will use to improve performance for this measure. Indicate whether the intervention is new (N) or continued (C) from a previous IP.

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

_____ ____
Name and title of person completing this HEDIS Improvement Plan Date

_____ ____
Name and title of person in plan approving this HEDIS Improvement Plan Date

REQUIRED USE OF SERVICES MEASURES FOR FULL-SCOPE PLANS: REPORTING YEAR 2012

In the 2011 reporting year, Medi-Cal managed care health plans (with the exception of specialty plans) are required to submit HEDIS rates for measurement year 2011 for the HEDIS Use of Services Medicaid 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) Bariatric Weight Loss Surgery
   c) Lumpectomy
   d) Mastectomy

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. "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

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: 2012

	Internal QIP (IQIP)	***Small Group Collaborative (SGC)***	***Statewide Collaborative (SWC) QIP***
Required number of plans	One	At least four health plans (Proposals for SGCs with fewer plans require justification & must be approved by MMCD.)	All contracted plans (except specialty plans)
Required meetings	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. • Plans must conduct at least one meeting each quarter each year 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 at least quarterly 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.
Data reporting	As specified in the approved/validated IQIP proposal	• The SGC must, at a minimum, 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 10/29/11. Submit to: qigsmail@dhs.ca.gov
Objectives and indicators	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]	
Methodology for measuring improvement	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."

	Internal QIP (IQIP)	***Small Group Collaborative (SGC)***	***Statewide Collaborative (SWC) QIP***
Interventions	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	
Evidence-based interventions	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.		
Intermediate process measures	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.		
Timing of re-measurement	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		
Use of goals	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.		
Use of HEDIS measures	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 OIP, 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.		
Statistical testing	Tests of statistical significance should be calculated between baseline and repeat indicator measurement periods. For example, a health plan might use a P value of less than .05 as the threshold for statistical significance.		
Duration	OIPs 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***
Format for submission of proposals and reports	All QIP proposals and reports must be submitted using HSAG's QIP Summary 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 and in accordance with the timeline agreed upon by the health plan(s) and MMCD.		
Submission of QIP proposals	Submit proposals for IQIPs & SGCs on HSAG's QIP Summary Form 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 QIP Summary Form 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.
Submission of QIP status reports	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 proposal) annual status reports, and close-out reports to the EQRO to HSAG's FTP site with a "cc" to gipsmail@dhs.ca.gov.
Submission of new proposal after close-out of QIP.	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 and meets requirements, 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.