



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



ARNOLD SCHWARZENEGGER
Governor

DATE: October 27, 2008

MMCD All Plan Letter 08-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM
REQUIREMENTS FOR 2009

Purpose:

This All Plan Letter clarifies the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans for 2009. As contractually required, all Medi-Cal managed care health plans must report their performance measurement results, to include 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, and SCAN Health Plan) or prepaid health plans (Kaiser PHP Marin/Sonoma). For these plans, requirements are noted where applicable, but plans should review their contracts in conjunction with this letter for further information.

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 is a two-part process consisting of an information systems capabilities assessment followed by an evaluation of an organization's ability to comply with Healthcare Effectiveness Data and Information Set (HEDIS®) specifications. The NCQA audit methodology was developed to assess the standardization of quality performance reporting throughout the health care industry.
- b) All health plans must use the Department of Health Care Services (DHCS) selected contractor for the HEDIS Compliance Audit. The External Quality

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Review Organization (EQRO) or its subcontractor will perform these audits. As the result of a competitive procurement process, Health Services Advisory Group was selected In July 2008 as the EQRO for the Medi-Cal Managed Care (MCMC) program. The EQRO may conduct the 2009 audits or may subcontract with one or more firms licensed by the NCQA to conduct HEDIS audits. These audits are paid for by the State.

- c) For 2009, the only change in required EAS measures pertains to the Childhood Immunization Status measure, for which only the Combination 3 indicator will be required. (NCQA is discontinuing Combination 2 as of the 2009 reporting year.)
- d) Attachment 1 lists all 12 HEDIS measures required for 2009 (i.e., measurement year 2008) for full-scope plans, as well as those required for the two previous years. Note that some measures have multiple indicators. Specialty and prepaid plans are required to report on two HEDIS or other performance measures, agreed upon between DHCS and the plan and appropriate for each plan's population.
- e) Each health plan (any model type) must report the results on all of the performance measures required of that plan, while adhering to the HEDIS or other specifications for 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) Calculation of the rate for each required EAS measure will be performed by the health plan. The DHCS contracted EQRO or its subcontractor will audit each health plan's HEDIS processes and will report the plans' HEDIS results to DHCS.
- h) Health plans must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required HEDIS measure. The 2009 MPL for each required measure is the 25th percentile of the national Medicaid results for that measure as reported in the 2008 edition of the *Quality Compass*,[®] published by NCQA. (More information about *Quality Compass 2008* is available on NCQA's website at <http://web.ncqa.org/tabid/177/Default.aspx>.)

- 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 *Quality Compass* at the time the EQRO provides HEDIS rates to DHCS.
- j) 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 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 in 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 discuss how it will address the targeted population in each county, including, but not limited to 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>. Each completed QIA form must be submitted with a cover page including the following information: name of the health plan, counties included in the IP, name of the IP, and submission date, along with the name, phone number, and e-mail address of the health plan's IP contact person.
 - All pertinent data requested on 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.

- Each IP must be on a QIA form and submitted via e-mail to DHCS at gipsmail@dhs.ca.gov, the address established by the Medi-Cal Managed Care Division's (MMCD) Performance Measurement Unit for this purpose.
- l) DHCS will publicly report the audited HEDIS/EAS results for each contracted health plan, along with the Medi-Cal Managed Care program average (also known as the "aggregate rate"), 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 publicly reported only in the aggregate for the first reporting year. Plans will still provide the EQRO with first year results of any measures DHCS newly requires.
- m) DHCS establishes a High Performance Level (HPL) for each required EAS measure and publicly acknowledges health plans that meet or exceed the HPLs. The 2009 HPL for each required measure is the 90th percentile of the national Medicaid results for that measure as reported in the 2008 edition of 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 2009, the selected Use of Services measures will be the same as for previous years. (See Attachment 3.)
- b) 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 MMCD'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 will be administered in 2010. This means that contracted plans will not be required to provide member information to the survey vendor in 2009.

The schedule for the next CAHPS survey does not affect the requirement for specialty plans to conduct a member satisfaction survey at least every other year and to provide DHCS with results specific to the plan's Medi-Cal managed care members. Each specialty 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.

4. Quality Improvement Projects (QIPs)

Number of QIPs Required

Full-scope health plans are 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 QIP (SGC). Health plans holding multiple MCMC contracts are required to conduct two QIPs for each contracted entity.

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

Both IQIPs and SGCs must be DHCS approved. 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 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) 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 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. 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 – 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, including, but not limited to, the target population's 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 MMCD.

- a) 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.
- b) Within approximately one month of receiving a QIP proposal, DHCS will send the health plan either an approval of the QIP or a request for further development. Once a proposal is approved, DHCS will forward it to the EQRO for validation and will notify the plan that the QIP's validation process has begun. The EQRO will send validation results to both the plan and to MMCD and may request modifications to the plan's proposal before final validation that the plan's QIP proposal is in compliance with both DHCS and federal requirements.
- c) 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 at an e-mail address yet to be established with a "cc" to gipsmail@dhs.ca.gov.
- 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, and QIP phase (proposal, baseline, annual, or final report), along with the name, phone number, and e-mail address of the health plan's QIP contact person.
- e) 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 DHCS as described above.
- f) 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 in this letter. MMCD will notify plan Medical Directors and QI/HEDIS Managers by e-mail of 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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- DHCS' contracted EQRO and general questions about quality and performance improvement program requirements: Rita Marowitz, Chief of MMCD's Performance Measurement Unit, at Rita.Marowitz@dhcs.ca.gov .
- Current or future changes to the HEDIS/EAS measures: Michael Farber, M.D., Chief of MMCD's Medical Policy Section, at Michael.Farber@dhcs.ca.gov .
- HEDIS MPLs and HPLs and the 2009 CAHPS: Lauren Oehler in MMCD's Performance Measurement Unit at Lauren.Oehler@dhcs.ca.gov .
- The current statewide collaborative QIP on avoidable ER visits: Rose Recostodio in MMCD's Medical Policy Section at Rose.Recostodio@dhcs.ca.gov .
- Required QIPs, submission of QIP proposals and status reports, and submission of HEDIS Improvement Plans: Sharon Moody in MMCD's Performance Measurement Unit at Sharon.Moody@dhcs.ca.gov .

Performance measurement and quality improvement are important aspects of the Medi-Cal Managed Care program. We know that MMCD's partnership with our contracted health plans results in ongoing improvement of the quality of care and services provided to Medi-Cal beneficiaries. We look forward to continuing this positive relationship.

If you have questions about the information in this letter, please contact Rita Marowitz, Chief of the Performance Measurement Unit, at (916) 449-5146 or via email at Rita.Marowitz@dhcs.ca.gov.

Sincerely,



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

Attachments (3)

EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: 2007-2009¹

<i>Calendar Year 2007</i>	<i>Calendar Year 2008</i>	<i>Calendar Year 2009</i>
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 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*	Well-Child Visits in the 3 rd , 4 th 5 th & 6 th Years of Life*
Adolescent Well-Care Visits*	Adolescent Well-Care Visits*	Adolescent Well-Care Visits*
Childhood Immunization Status – Combo 2*	Childhood Immunization Status – Combo 2* ² & Combo 3	Childhood Immunization Status – Combo 3*
Appropriate Treatment for Children with Upper Respiratory Infection	Appropriate Treatment for Children with Upper Respiratory Infection	Appropriate Treatment for Children with Upper Respiratory Infection
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 	Prenatal & Postpartum Care (2 indicators): <ul style="list-style-type: none"> • Timeliness of Prenatal Care* • Postpartum Care
Chlamydia Screening in Women	Ambulatory Care (4 indicators): <ul style="list-style-type: none"> • Ambulatory Surgery/Procedures • ED Visits • Observation Room Stays • Outpatient Visits 	Ambulatory Care (4 indicators): <ul style="list-style-type: none"> • Ambulatory Surgery/Procedures • ED Visits • Observation Room Stays • Outpatient Visits
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"> • Eye Exam (Retinal) Performed • LDL-C Screening • HbA1c Testing • Medical Attn. for Nephropathy 	Comprehensive Diabetes Care (7 indicators): <ul style="list-style-type: none"> • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/dL) • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Good Control (<7.0%) • Medical Attn. for Nephropathy 	Comprehensive Diabetes Care (7 indicators): <ul style="list-style-type: none"> • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/dL) • Hemoglobin A1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Good Control (<7.0%) • Medical Attn. for Nephropathy
Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ³	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

* Measures used for the default algorithm.

¹ Since 2006, the EAS has included only HEDIS measures and no Department-developed measures.

² For 2009, NCQA retired the Child Immunization Status Combo 2 indicator.

³ For 2008, NCQA renamed this measure and removed the inverse nature of the measure's rate, so starting in 2008 a higher rate is better for the AAB measure, as it has been for the other measures.

REQUIRED HEDIS MEASURES FOR SPECIALTY & PHP PLANS: 2009

AIDS Healthcare Centers

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

Family Mosaic

To be determined

Kaiser PHP Marin/Sonoma

- 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

**REQUIRED USE OF SERVICES MEASURES
FOR MEDI-CAL MANAGED CARE PLANS IN 2009**

In 2009, Medi-Cal managed care health plans are required to submit HEDIS rates for measurement year 2008 for the 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

Note: MMCD anticipates changing the Selected Procedures to be reported for 2010.

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. (Note: for 2009, NCQA changed the age bands for member month reporting in Table ORX-1/2/3 to align with ABX-1/2/3.) 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

MMCD QUALITY IMPROVEMENT PROJECT (QIP) REQUIREMENTS: 2009

	<i>Internal QIP (IQIP)</i>	<i>Small Group Collaborative (SGC)</i>	<i>Statewide Collaborative 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 year, 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: Individual plan QIP proposals for the SWC were submitted in Sept & Oct 2007. The first annual status reports are due 11/28/08. Submit to: gipsmail@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 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 QIP) 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 on baseline and repeat indicator measurements. 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."

	<i>Internal QIP (IQIP)</i>	<i>Small Group Collaborative (SGC)</i>	<i>Statewide Collaborative QIP</i>
<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"> 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>Content of QIA cover page</i>	<p>Each completed QIA form must be submitted with a cover page including the following information: name of the health plan(s), counties included in the QIP, name of the QIP, QIA submission date, and the QIP phase (proposal, baseline, annual, or final report), along with the name, phone number and e-mail address of the plan's QIP contact person.</p>		
<i>Submission of QIP proposals</i>	<p>Submit proposals for IQIPs & SGCs on QIA forms to gipsmail@dhs.ca.gov . When a proposal is approved, MMCD will notify plan(s) and forward the approved proposal to the EQRO for validation.</p>		<p>Submit proposals for the SWC on avoidable ER visits on QIA forms to: gipsmail@dhs.ca.gov . When a proposal is approved, MMCD will notify the plan(s) and forward the approved proposal 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, and close-out reports to the EQRO at an e-mil address yet to be established with a "cc" to gipsmail@dhs.ca.gov.</p>		<p>Submit baseline reports (if not included with the proposal), annual status reports, and close-out final reports to the EQRO at an e-mail address yet to be established with a "cc" to gipsmail@dhs.ca.gov .</p>
<i>Submission of new proposal after close-out of QIP.</i>	<p>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 MMCD.</p>		<p>Generally, within 90 days of receiving EQRO notification that a final closing report has been validated, plans are to submit new proposals for the next SWC, but MMCD will determine the specific time frame for plans to submit new SWC proposals.</p>