POLICY AND PROCEDURE	
Policy # and TITLE: External Quality Review Requirements	
Primary Policy owner: Quality Management	**POLICY #:** QM17
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☒Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☐ Care Management (CM) 5) ☐ Claims (CLMS) 6) ☐ Community Marketplace & Member Engagement (MAR) 7) ☒ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☒ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☐ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☒ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** N/A

I. PURPOSE

The process for Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") compliance with Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) requirements to annually submit the results of an audit conducted by an external quality review organization (EQRO) to review performance within a select set of performance measures called the Managed Care Accountability Set (MCAS) to meet DHCS requirements and Health Equity and Quality Measure Set (HEQMS) to meet DMHC requirements. In addition, this policy

covers Performance Measurement requirements for the National Committee for Quality Assurance (NCQA) Health Plan Accreditation, Health Care Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience survey audits. These activities are aligned with internal quality and health equity efforts and aligns with DHCS's Comprehensive Quality Strategy and DMHC APL 23-029- Health Equity and Quality Measure Set Benchmark, Accreditation and Stratification Process. Health Plan aligns health equity goals with DHCS' HealthEquity Framework within the Comprehensive Quality Strategy (CQS) Report, and stratifies DHCS-selected MCAS measures by various demographics.

II. POLICY

A. Annually or more frequently as directed by DHCS, Health Plan shall cooperate with and assist the EQRO designated by the State to conduct an audit of required Quality Performance Measures and Health Equity Measures in accordance with 42 USC section 1396u-2(c)(2), and 42 CFR sections 438.310 et seq and 42 CFR sections 438.310 et seq., APL 19-017, and the CMS EQR protocols, which provide detailed instructions on how to complete the EQR activities. Health Plan cooperates with DMHC HEQMS in alignment with Health and Safety Code section 1399.871 (d)(1). Health Plan contracts with an NCQA approved auditor to complete an audit of the performance measurement set used to calculate Health Plan's Accreditation measure set used for star ratings. Health Plan works with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures. Health Plan calculates, and reports all required Quality Performance Measures and Health Equity measures at the reporting unit level as directed by DHCS.

B. The audit consists of an assessment of Health Plan and, when applicable, its vendor's information system capabilities, followed by an evaluation of Health Plan's ability to adhere to specifications outlined by DHCS for HEDIS® and non-HEDIS® measures. The EQRO follows the NCQA HEDIS® Compliance Audit™ methodology for HEDIS® measures

to assure standardized reporting of quality performance measures throughout the health care industry.

C. Health Plan must use DHCS's selected EQRO contractor for conducting the performance measure validation of the DHCS prescribed measure set. The EQRO contractor performs the Managed Care Accountability Set (MCAS) audits at DHCS's expense. The EQRO contractor may subcontract with one-or-more independent auditors licensed by the NCQA to conduct any portion of the MCAS audits.

D. Health Plan must designate at least one primary contact as the HEDIS lead and one alternate who is familiar enough with the performance measures to assume the duties of the HEDIS lead. This information is submitted to DHCS's EQRO and NCQA.

III. PROCEDURE

A. **Calculating and Reporting Rates**: Health Plan calculates its rates for the required performance measures by means established before the end of the measurement year. These rates are audited by the EQRO or its subcontractor and reported to DHCS. Health Plan must report to the EQRO the results for each of the performance measures required, while adhering to HEDIS® or other specifications for the period under review. Health Plan must follow NCQA's timeline for collecting, calculating, and reporting rates. Health Plan reports audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS.

1. Health Plan reports hybrid measures using the hybrid methodology and administrative measures using administrative methodology.
2. DHCS may report administrative measures on behalf of Health Plan.
3. Stratification may be required based on the population or measure steward (CMS or NCQA).
4. DHCS may report on other measures and apply appropriate benchmarks when applicable. Health Plan is not held accountable for these measures.
5. MCPs are required to participate in an annual performance measure validation audit performed by DHCS' EQRO, and is

required to submit patient-level data as specified by the EQRO as part of the annual performance measurement validation audit process

6. Health Plan adopts NCQA methodology for as of the publication date of Health plan reports to DMHC via the NCQA summary measure results file except for the Quality Health Plan (QHP) measure, regardless of whether the results file includes both aggregate and stratified results or aggregate only.
7. Health Plan follows NCQA technical specifications and follows NCQA timeline for calculating, auditing and submission reporting processes.
8. Health plan submits additional DHCS and DMHC measure reports as prescribed in policy and letter publications.

B. **Reporting Units:** Health Plan must calculate and report Quality and Health Equity performance measure rates at the reporting unit level, as directed by DHCS unless otherwise approved by DHCS for combined county-level reporting or regional-level reporting. Rates are calculated at the organization level for NCQA Health Plan Accreditation purposes. NCQA publicly reports combined rates as well as Health Plan Rankings and Accreditation award for each participating plan in the United States Health Plan must separately report to DHCS all required performance measure results at the reporting unit level for its Fully Delegated Subcontractors and Downstream Subcontractors.

C. **Public Reporting of Performance Measurement Results**: DHCS publicly reports the audited results of HEDIS® and other performance measure rates for each MCP, along with the Medi-Cal managed care average and comparisons to national data, as applicable, for each DHCS-required performance measure. Health Plan must exceed the DHCS established Minimum Performance Level (MPL) for each required quality performance measure and Health Equity measure selected by DHCS. Health Plan must comply with DHCS for remediation and/or corrective action when rates to not meet the threshold. The minimum performance threshold is Medicaid Managed Care 50th percentile. New Contract Language:

1. Health Plan must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors whose rates Health Plan separately reports to DHCS also exceed the DHCS established MPL for each required Quality Performance Measure and Health Equity Measure selected by DHCS.
2. Health Plan must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS

D. **Quality Monitoring Process:** If Health Plan does not meet the minimum required performance on any measure DHCS may impose financial sanctions, administrative sanctions and/or Corrective Actions on Health Plan for failure to meet required Minimum Performance Levels (MPLs). DHSC may require Health Plan to make changes to its executive personnel if the organization has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below MPL over multiple years. DHCS may also limit Health Plan service area expansion or suspend Member Enrollment based on persistent and pervasive poor performance on Quality Performance Measures. DHCS may also limit Contractor's service area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures as evidenced by multiple performance measures consistently below MPL over multiple years. DHCS may also limit Health Plan service area expansion or suspend Member Enrollment based on persistent and pervasive poor performance on Quality Performance Measure

1. In addition to sanctions and corrective actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Health Plan's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to MCPs in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.
2. Health Plan is responsible for ensuring that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also exceed the DHCS-established MPL. If its Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails

to exceed the DHCS-established MPL, Health Plan follows delegation oversight policies and procedures.

E. **Under/Over Utilization:** As a part of the annual HEDIS compliance audit and program evaluation, Health Plan evaluates trends in HEDIS measures that show member over/underutilization. These measures are a part of the MCAS/HEDIS performance measurement set.

F. **Consumer Assessment of HealthCare Providers and Systems (CAHPS):** Annually and at intervals determined by DHCS and DMHC, Health Plan conducts a CAHPS survey. Health Plan provides all appropriate data to the EQRO to facilitate the survey. Annually, Health Plan bears the cost of completing the survey. When the survey is mandated by DHCS, DHCS bears the cost.

G. **Encounter Data Validation:** As directed by DHCS, Health Plan participates in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d) and 438.818.

H. **Focused Studies and Technical Assistance:** As directed by DHCS, Health Plan must participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of and access to, services provided by Health Plan.

   1. In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, Health Plan must implement EQRO's technical guidance provided to Health Plan in conducting mandatory and optional activities described in 42 CRF section 438.358.

I. **MCAS Performance Measures:** Health Plan must designate a performance measurement and equity lead and backup contact to report performance measures and assume the duties of the performance measurement lead. Health Plan also convenes a regional and health equity team to support the QI and Health Equity lead to support the QI and Health Equity for all counties across DHCS designated reporting units. Health plan develops or leverages existing regional quality and equity teams to support QI and equity work for all designated counties. Health Plan attends, at a minimum, quarterly regional collaborative meetings that may be in-person. Health Plan

lead and designate must partner with DHCS and attend technical assistance calls to resolve technical difficulties and communicate changes to reporting.

J. Health Plan must comply with DHCS's performance improvement activities including PDSA Cycle worksheets for measures below the MPL. Health Plan must follow DHCS's instructions for PDSA cycle improvements, communication requirements between Health Plan and DHCS and implement efficient interventions when more than one reporting unit falls below MPL. MCPs that perform below DHCS' established MPLs are required to conduct additional Quality Improvement and health equity improvement projects as determined in the MCAS: Quality Improvement and Health Equity Framework Policy Guide. Health Plan's Medical Director approves all submissions prior to submission to the DHCS mailbox dhcsquality@dhsc.ca.gov. PDSAs must comply with DHCS guidelines and DHCS Nurse Consultant recommendations.
    1. Exceptions to PDSA Cycle submissions:
        a. New MCPs or Created Regions when the regions are new to reporting.
        b. Significant changes to technical specifications
        c. Other reasons determined by DHCS
    2. When no measures fall below MPL, PDSA Cycle worksheets are not required.
    3. When rates are declining, DHCS recommends PDSA cycles or other QI Tools.

K. **Performance Improvement Projects:** Health Plan must designate one primary and one backup PIP contact. DHCS Requires Health Plan to participate in two PIPs that range between 12-18 months in duration. Health plan is required to participate in DHCS mandated statewide collaborations or additional initiatives that may improve quality and equity of care for Medi-Cal members as directed by DHCS. . Fully delegated subcontractors and downstream fully delegated subcontractors also conduct and participate in PIPs and any collaborative PIP workgroup as directed by DHCS or CMS.
    1. Each PIP must include the following:

a. Measurement of performance using objective quality indicators.
b. Implementation of equity-focused interventions to achieve improvement in the access to and quality of care.
c. Evaluation of the effectiveness of the interventions based on the performance measures; and
d. Planning and initiation of activities for increasing or sustaining improvement

2. PIP topics must be approved by DHCS. PIP implementation must follow DHCS guidelines. MCPs with new counties must collaborate with DHCS and the EQRO for PIP topic approval. PIP results are evaluated by the EQRO. To secure member level data, MCPs are required to submit PHI through EQRO SFTP. Health Plan must report the status of each PIP at least annually to DHCS.

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Managed Care Accountability Set (MCAS)
D. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)
E. New MCAS for Med Dir mtg.
F. NCQA HEDIS Technical Specifications

V. REFERENCES

A. DHCS 2024 Contract
B. DHCS APL 24-004: Quality Improvement and Health Equity Transformation Requirements
C. Title 22, CCR, Section 53860 (d)
D. Title 28, CCR, Section 1300.70(a)(3)

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date

000	06/19, 06/20, 04/22	N/A
001	Moved to new template	5/17/2023
002	Updated to include additional DHCS and DMHC requirements for measure reporting, measure stratification and CAHPS.	7/1/2024
Initial Effective Date: 6/1/2019		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	002	8/22/2024
• Privacy & Security Oversight Committee (PSOC)		
• Risk Management		
• Delegation Oversight		
• Policy Review	002	08/21/2024
Quality Improvement Health Equity Committee (QIHEC)		
• Quality Of Care		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager	002	7/19/2024

Department of Managed Care (DMHC)	DMHC Attorney	001	3/18/2024

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy