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# CMS Medicare Manual System

## Pub. 100-16 Managed Care

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Department of Health &  
Human Services (DHHS)  
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Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
	Exhibit I - III		
5	Appendix A		
5	Appendix B		

*Red italicized font identifies new material.*

**NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004**  
**IMPLEMENTATION DATE: January 1, 2004**

**Appendix A**, added 2004 National QAPI Project following 2003 National QAPI Project.

**CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.**

**Exhibits I – III and Appendices A and B**, are modified to include the revision number and date which were previously omitted.

**Appendix A, National QAPI Project for 2000**, clarifies that eighth alternative M+C organization indicator must affect the enrollee and be measurable.

**Appendix A, National QAPI Project for 2001**, clarifies the description of alternative congestive heart failure indicators.

**Appendix A, 2003 QAPI Project**, adds instructions on how to access CMS race and ethnicity data., and clarifies Clinical Health Care Disparities.

**Appendix B**, adds a definition for MCO.

## **Exhibit I - Required HEDIS Measures For Medicare Reporting For Summary Data - (Rev. 13, 09-11-02)**

### **Effectiveness of Care**

Anti-depressant Medication Management

Cholesterol Management After Acute Cardiovascular Events

Breast Cancer Screening

Beta Blocker Treatment After A Heart Attack

Comprehensive Diabetes Care

Follow-up After Hospitalization for Mental Illness

Controlling High Blood Pressure

Medicare Health Outcomes Survey

### **Access to/Availability of Care**

Adults' Access to Preventive/Ambulatory Health Services

Availability of Language Interpretation Services, Parts I & II

### **Health Plan Stability**

Years in Business/Total Membership

Practitioner Turnover

### **Use of Services**

Frequency of Selected Procedures

Inpatient Utilization - General Hospital/Acute Care

Ambulatory Care

Inpatient Utilization - Non-Acute Care

Mental Health Utilization - Inpatient Discharges and Average Length of Stay

Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay

Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Outpatient Drug Utilization (for those with a drug benefit)

### **Health Plan Descriptive Information**

Board Certification/Residency Completion

Total Enrollment by Percentage

Enrollment by Product Line (Member Years/Months)

### **Reporting Clarifications**

The following HEDIS measures will not be required to be submitted:

Health Plan Descriptive Information:

Practitioner Compensation

Arrangements with Public Health, etc.

### **Exhibit IA - Continuing Cost Contracts: Required HEDIS Measures For Medicare Reporting For Summary Data - (Rev. 13, 09-11-02)**

#### **Effectiveness of Care**

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**Health Plan Descriptive Information**

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Total Enrollment by Percentage

Enrollment by Product Line (Member Years/Months)

**Exhibit II - Submitting Patient-Level Data - (Rev. 13, 09-11-02)**

**Required Measures**

MCOs must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. MCOs must submit patient-level data by reporting unit. The HIC number is assigned by CMS to the beneficiary when s/he signs up for Medicare, and MCOs use this number for accretions and deletions. In addition to the patient identifier, MCOs also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

**NOTE:** Section 1876 cost contracts (whether or not they convert to become an M+C MCO in the reporting year) should only report patient-level data for the summary measures that are listed in Attachment I.A for the following three domains.

### **1 - Effectiveness of Care**

Breast Cancer Screening

Beta Blocker Treatment After A Heart Attack

Comprehensive Diabetes Care

Follow-up After Hospitalization for Mental Illness

Anti-depressant Medication Management

Cholesterol Management After Acute Cardiovascular Events

Controlling High Blood Pressure

### **2 - Access/Availability of Care**

Adults' Access to Preventive/Ambulatory Health Services

### **3 - Use of Services**

Frequency of Selected Procedures

Inpatient Utilization - General Hospital/Acute Care

Ambulatory Care

Inpatient Utilization - Nonacute Care

Mental Health Utilization- Inpatient Discharges and Average Length of Stay

Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay

Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

To be useful, patient-level data must match the summary data for the measures discussed here, i.e., the patient file should contain all beneficiaries enrolled in the contract at the time that the summary measures are calculated. To ensure an exact match, the MCO

should make a copy, or “freeze” its database when the summary measures are calculated. If the measure was calculated using the hybrid methodology, the patient-level data should be reported on the minimum required sample size (411) or the total denominator population if less than 411. The National Committee for Quality Assurance (NCQA) will provide MCOs with exact file specifications and explicit instructions by the spring of the reporting year, which is sufficient time to allow MCOs to identify the best way to fulfill this requirement. These instructions and file specifications will be posted on NCQA’s web site at [www.ncqa.org](http://www.ncqa.org). MCOs are advised to frequently review the NCQA web site for updates on the data submission process.

## **Exhibit III - Additional Information On The Medicare Health Outcomes Survey - (Rev. 13, 09-11-02)**

### **Data Feedback**

Please remember that individual member level data will not be provided to plans after baseline data collection. However, you will receive the following from CMS:

### **HOS Plan Performance Profile**

This profile will be mailed to all plans participating in the last year’s baseline cohort. This quality improvement tool, which presents an aggregate overview of the baseline health status of your MCO’s Medicare enrollees, was developed and extensively tested to ensure that MCOs would find the data useful and actionable. Your state Peer Review Organization/Quality Improvement Organization will also receive copies of the performance profiles and stands ready to collaborate with you on interpreting the data, identifying opportunities to improve care, assisting you in planning effective, measurable interventions, and evaluating and monitoring the results of your interventions. Using data from the Health Outcomes Survey to plan and conduct a quality improvement project may fulfill one of the Quality Assessment and Performance Improvement requirements (QAPI) under QISMC. If you do not receive your performance profile by June 30 of each year, please contact Health Services Advisory Group (HSAG) at 1-(888) 880-0077 or e-mail to [azpro.hos@sdps.org](mailto:azpro.hos@sdps.org). Each MCO receives one performance profile free of charge. Additional and replacement copies are available at cost from HSAG.

### **Vendor Reports**

The vendors administering the survey may provide you with reports on the progress of mail and telephone survey administration. Each report may consist of data on the number of surveys issued during the first and second survey mailings, the number of surveys returned completed or partially completed, the number of sampled members for whom a survey could not be obtained (e.g., due to death, disenrollment, language barrier), and mail and telephone response rate calculations.

Please DO NOT ask your vendor for additional analyses or member specific data. They are prohibited from providing this type of information.

Requests for interpretation of the data or more detailed analyses of the data should be directed to your State PRO/QI.

## **Appendix A - National QAPI Projects - (Rev. 13, 09-11-02)**

### **1999 - Diabetes**

Diabetes is a major health problem which is becoming more prevalent in all age groups. The increasing prevalence is attributed both to higher detection and to poorer health habits.

Adult onset diabetes is highly prevalent in the Medicare population and over 150,000 Americans die each year from diabetes and its complications. Complications of the disease include blindness, kidney failure, nerve damage, and cardiovascular disease. For most persons with diabetes, many of these complications can be prevented or delayed with appropriate monitoring and treatment. However, studies in both fee-for-service and managed care settings indicate that care is suboptimal. The Diabetes National Project focuses on improving monitoring in the outpatient setting.

#### **Overview of Diabetes Project**

The CMS-sponsored national project for 1999 focused on diabetes mellitus, using a standardized measurement set for diabetic processes of care and suggested interventions. M+C organizations with existing diabetes mellitus projects were allowed to substitute their own studies in place of CMS's project. However, those who participated in CMS's study had the benefit of participation in a national standardized measurement system. CMS did not require pre-approval of such projects.

One of the main objectives of this project is to reduce rates of blindness, amputations, kidney failure and the rate of diabetes-associated cardiovascular disease that is the major cause of death for the elderly population with diabetes. Diabetes and the complications of the disease can be prevented or delayed by management of blood glucose through diet, exercise and medication, by management of other risk factors such as lipids, blood pressure, smoking and by appropriate and timely examinations and treatment (e.g., eyes and feet).

The performance measures that were used for this project were the Diabetes Quality Improvement Project (DQIP) Measures. The finalized set of DQIP measures were released in August, 1998. Adoption of the DQIP measures was the result of a collaborative effort among several organizations, including CMS, the American Diabetes Association (ADA) and the National Committee for Quality Assurance (NCQA) Council

on Performance Measures, which adopted six of the eight DQIP measures for its Health Employer Data Information Set (HEDIS) for the year 2000.

## **2000 - Pneumonia**

According to the Centers for Disease Control and Prevention, pneumonia and influenza are the sixth leading causes of death in the United States. The incidence of pneumonia increases with age and approximately 90 percent of deaths attributed to this condition are in the population age 65 and older. Medicare patients with pneumonia are being hospitalized at the rate of approximately 600,000 per year, utilize over 4.2 million inpatient days, and account for more than 500,000 emergency department visits each year.

### **Overview of Pneumonia Project**

The main objective of this project is to decrease the morbidity and mortality associated with community-acquired pneumonia in Medicare beneficiaries enrolled in M+C Organizations. In order to accomplish this goal, a series of process objectives have been developed which include:

- Increase immunization rates for pneumococcal and influenza vaccines;
- Increase the number of inpatients receiving timely antibiotic administration;
- Increase the use of initial antibiotic therapy consistent with current guidelines;
- For inpatients, increase the collection of blood cultures prior to the initial antibiotic dose; and
- Increase the number of hospitalized patients screened for or given pneumococcal or influenza vaccines.

### **National Pneumonia Project Quality Indicators**

The Centers for Medicare & Medicaid Services (CMS) worked with a pneumonia technical expert panel whose members included representatives from the American Thoracic Society, the Infectious Disease Society of America, the Pneumonia Patient Outcomes Research Team, the American Pharmacy Association, the Institute of HealthCare Improvement, and other influenza/pneumococcal experts. This panel guided the writing of the final pneumonia indicators based upon a combination of both ambulatory and hospital-based data.

Medicare+Choice organizations could choose one or more of the national pneumonia indicator(s) from the list below. In addition to the seven defined quality indicators, CMS was also interested in exploring alternative options with M+C Organizations (as described below). The seven national pneumonia indicators were:



- Influenza vaccination rates;
- Pneumococcal vaccination rates;
- Proportion of patients given an initial antibiotic consistent with current recommendations;
- Proportion of inpatients who have blood cultures collected before antibiotics administered;
- Proportion of inpatients with pneumonia screened for or given influenza vaccination;
- Proportion of inpatients with pneumonia screened for or given pneumococcal vaccination; and
- Proportion of patients who receive the initial antibiotic dose within eight hours of hospital arrival.

### **Alternative M+C Organization 8th Indicator**

CMS was aware of M+C Organization expertise and creativity in the development of ambulatory quality indicators, as well as their participation in collaborative, community-based projects working to reduce the development of antibiotic resistant bacteria. If a QAPI project based on these activities required a quality indicator different from the above seven, M+C Organizations were allowed to submit those indicators for CMS comment. This alternative quality indicator had to meet the following requirements:

- Indicator *must* affect the M+C Organization's Medicare enrollees;
- Indicator *must* be measurable; and
- Indicator *must* reflect the national pneumonia project goal of reducing morbidity and mortality associated with pneumonia.

Organizations interested in pursuing this eighth option were required to work through their CMS RO representative.

### **Support/Communication for Projects**

CMS encourages M+C Organizations to work in collaboration with their local Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO), as they proceed with the conduct of the pneumonia project. Under the PRO Sixth Scope of Work, PROs were required to conduct a pneumonia project using the indicators described above. It is to the mutual advantage of the QIO/PRO and the M+C Organization to work collaboratively on their respective projects to promote efficiency, administrative simplification and reduction of resource burden. The Oklahoma Foundation for Medical Quality has been identified as the Pneumonia Clinical Area

Support QIO/PRO, or “CASPRO”, and will serve as a resource to other QIO/PROs in maintaining project staff lists, pneumonia literature and pneumonia intervention data on their web page ([www.nationalpneumonia.org](http://www.nationalpneumonia.org)). Pneumonia data entry and analysis provider software were available on the web site in March of 2000. In addition to PRO support, CMS and the Centers for Disease Control and Prevention (CDC) have collaborated on an immunization intervention project using standing orders programs to increase adult immunization rates. An evidence-based standing orders program and intervention materials have been developed and CMS and CDC are available to representatives from M+C Organizations to discuss implementing this program in M+C Organization settings. If an M+C Organization chooses not to utilize QIO/PRO support, questions regarding design and implementation should be directed to their CMS RO representative.

## **2001 - Congestive Heart Failure**

Year 2001 National Project on Congestive Heart Failure (CHF) for Medicare + Choice Organizations (M+C Organization).

Note that a related activity, Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care in 2002 and 2003 is included in Chapter 7 of this manual.

For the year 2001, the national project must address congestive heart failure (CHF). According to the American Heart Association, approximately 3,000,000 Americans are currently diagnosed with CHF. Of these, over 80 percent (2,400,000) are over the age of 65, most being Medicare enrollees. The one-year mortality rate for CHF is between 20 - 30 percent in the elderly. CHF patients also experience significant functional limitations. Recent studies suggest effective clinical treatments and disease management strategies which may be effective in improving patient function, reducing mortality rates, decreasing hospital admissions and improving overall patient quality of life.

The National CHF QAPI project is similar in many ways to the previous diabetes and pneumonia national efforts. M+C Organizations will identify the relevant patient population, perform baseline data collection and calculate the baseline values for the selected quality indicators. They will then design and implement improvement strategies, and perform follow-up indicator data collection and measurement.

However, there are aspects to this National CHF QAPI project which differ from previous projects. This project requires M+C Organizations to measure and report performance on two specified quality indicators instead of one, and CMS will review the outcome on each indicator. M+C Organizations will be expected to achieve significant and sustained improvement on the second indicator (QAPI #2).

As with the 1999 and 2000 national quality projects, some organizations may have existing projects that could be modified to meet the requirements of the national CHF project. Those organizations wishing to utilize projects currently underway may do so if:

- They follow the requirements of this Manual chapter;
- Utilize the CHF quality indicators as described herein, and
- Conduct a re-measurement in 2001 to establish a new baseline against which to assess their improvement.

### **National CHF QAPI Quality Indicators**

CMS has developed the quality indicators based on evaluation and treatment recommendations contained in the Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guideline Number 11, Heart Failure: Evaluation and Care of Patients with Left-Ventricular Systolic Dysfunction (AHCPR Publication No. 94-0612, June 1994), the American College of Cardiology/American Heart Association Task Force Report Guidelines for the Evaluation and Management of Heart Failure ("JACC" 1995;26:1376-98), and the Heart Failure Society of America Guidelines for Management of Patients with Heart Failure Caused by Left Ventricular Systolic Dysfunction-Pharmacological Approaches ("J Cardiac Failure" 1999;5:357-82).

The indicators are also based on experience gained from the design and implementation of quality indicators for CMS's Inpatient National Heart Failure Project and the pilot outpatient Heart Failure Performance Improvement Effort, which utilized expert input from an American Heart Association Work Group. Additionally, CMS utilized the principles and recommendations contained in the report of an American Heart Association/American College of Cardiology work group "Evaluating quality of care for patients with heart failure. A summary from the First Scientific Forum on Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke." "Circulation" 2000;101: e122-e140. The indicators have been previously tested by CMS for feasibility of data collection in the outpatient setting, reliability, and acceptability of the measure to providers. M+C Organizations, physicians and trade associations provided input throughout this process to help refine the design and selection of the quality indicators.

The two National project CHF QAPI quality indicators are:

- QAPI #1 = Proportion of CHF patients with assessment of left ventricular function;
- QAPI #2 = Proportion of CHF patients with left ventricular systolic dysfunction (LVSD) who:
  - Have been prescribed an angiotensin-converting enzyme inhibitor (ACEI); or
  - Have documentation of a reason why ACEI was not prescribed.

Appendix I contains more detailed measurement specifications for the CHF indicators.

## Use of Alternative CHF Indicators

At their option, if a M+C Organization has a baseline level above 75 percent for QAPI indicator #1 and 80 percent for QAPI indicator #2, it may design and use an alternative quality indicator. Prior to proceeding to use an alternative indicator, the M+C Organization *should notify their RO representative that it has attained a baseline level greater than 75 percent and intends to use an alternative indicator. If the M+CO desires assistance with the development of its alternative indicator, the M+CO should work with their state QIO.* M+C Organizations are encouraged, although not required, to also work with their state QIO.

Regardless of the choice of alternative indicator, the selected measure must meet the following requirements:

- Indicator *affects* the M+C Organizations Medicare enrollees;
- Indicator *is* measurable; and
- Indicator *reflects* the National CHF QAPI goal of reducing morbidity and mortality associated with congestive heart failure.

## Technical Support for the National CHF QAPI Project

CMS encourages M+C organizations to work in collaboration with their state QIO in the design and implementation of their QAPI CHF projects. In the event that the M+C Organization chooses not to utilize the QIO, questions regarding design and implementation should be directed to the CMS RO managed care staff.

If the M+C organization works cooperatively with the QIO on quality improvement projects, CMS will pay the QIO and/or Clinical Data Abstraction Centers (CDACs) the costs of abstracting information from the M+C Organization medical records, as in prior years. In addition, if the medical records need to be photocopied prior to abstraction by the PRO/CDAC, the M+C organization's cost of such photocopying will be reimbursed by CMS through the QIO.

CMS *has developed* an optional data collection instrument for use in data abstraction. This includes data specifications, e.g., words and phrases that indicate LVEF assessment and LV systolic dysfunction. It also includes lists of ICD-9-CM and CPT codes likely to indicate that LVEF was assessed. These optional tools *are* available to all M+C Organizations regardless of who performs data abstraction. They are posted to our web page at [www.cms.hhs.gov](http://www.cms.hhs.gov).

## QAPI Quality Indicators for Heart Failure

NB: Both quality indicators must be measured and reported to CMS.

### Quality Indicator QAPI 1:

Proportion of heart failure patients with assessment of left ventricular function:

**Population** - M+C Organization enrollees with a continuous enrollment of at least 180 days prior to the date of data collection, who have encounter/billing diagnoses of heart failure in the inpatient or outpatient settings, including: (a) Those enrollees discharged alive from an acute care hospital with a principal discharge diagnosis of heart failure<sup>[1]</sup>; in the one year prior to the date of data collection; as well as: (b) Those enrollees without a hospital principal discharge diagnosis of CHF, but with three or more physician encounters with a diagnosis of CHF<sup>[2]</sup>, in the one year prior to the date of data collection.

**Denominator** - A census or random sample of M+C Organization enrollees from the 'Population' as (LVF) have been evaluated. Documentation of LVF evaluation consists of a billing record indicating that LVF evaluation has been performed, defined above.

**Numerator** - Those in denominator with documentation that left ventricular function quantitative or qualitative lab report of LVF evaluation results, clinician notation that LVF evaluation has been performed, clinician notation of LVF results, or any other chart or administrative evidence that LVF evaluation has been performed.

**Data Sources** - Enrollees with heart failure: Enrollment data, billing data, encounter data, hospital discharge data, any other reviewable source.

**LVF evaluation** - Billing data, radiology or laboratory data, medical records, physician summary, any other reviewable source.

### Quality Indicator QAPI 2:

Proportion of heart failure patients with left ventricular systolic dysfunction (LVSD) who:

- Are prescribed angiotensin converting enzyme inhibitors (ACEI); OR
- Have documented reason for not being on ACEI

**Population:** Those in numerator of QAPI Quality Indicator 1 with left ventricular systolic dysfunction (LVSD). LVSD is defined as an ejection fraction less than 40 percent or equivalent narrative description<sup>[3]</sup>

**Denominator:** A census or random sample of M+C Organization members from the 'Population' defined above.

**Numerator:** Those in denominator who have: 1. Been prescribed ACEI; or 2. Chart documentation of one or more of the following contraindications to ACEI use: Moderate or severe aortic stenosis, or History of angioedema, hives, or severe rash with ACEI

use;or Bilateral renal artery stenosis;or 3. Chart documentation of any specific reason why ACEI is not used (e.g., cough, hyperkalemia, hypotension, renal insufficiency/failure, other physician-noted reason);or 4. Chart documentation of participation in a clinical trial testing alternatives to ACEIs as first-line heart failure therapy.

**Data Sources:** LVF evaluation results (quantitative or qualitative): Radiology or laboratory test results, medical record, physician summary, any other reviewable source. Prescription of ACEI: Pharmacy data, medical records, physician summary, any other reviewable source. Reason for not prescribing ACEI: Inpatient or outpatient diagnosis codes, medical record, any other reviewable source. Participation in a clinical trial testing ACEI alternatives: any reviewable source

## **2002 - Breast Cancer Screening**

### **Overview of the Breast Cancer Screening (BCS) Project**

The main objective of this project is to decrease the morbidity and mortality associated with breast cancer in female Medicare beneficiaries enrolled in M+C Organizations. In order to accomplish this goal, it is important to increase the level of early detection of the disease by encouraging optimal use of mammography.

### **National BCS QAPI Project Specifications**

This project will involve the use of the HEDIS<sup>®</sup> breast cancer screening measure as described by the NCQA in Volume 2 of its HEDIS 2002 Technical Specifications. This measure considers the percentage of women age 52 through 69 years who were continuously enrolled during the measurement year and the preceding year, and who had a mammogram during the measurement year or the preceding year.

Baseline data for the project will use the Medicare HEDIS 2002 (measurement year 2001) reported rate filed through NCQA by June 28, 2002. M+C Organizations that do not report HEDIS 2002 because they do not meet minimum enrollment or contract effective date requirements will not have to participate in the 2002 BCS project since it is not likely they will have sufficient incidence to develop a baseline due to low enrollment.

Re-measurement, after interventions, will use the HEDIS specifications in effect at that time. If the BCS measure has been rotated or if HEDIS is no longer being used at the point of re-measurement then HEDIS 2002 specifications will be used.

### **Rewarding High Performance**

We recognize that some organizations have already achieved a high rate on screening by mammography and that opportunity for additional improvement would be difficult and costly to achieve. Therefore, CMS has decided that MCOs that have a reported rate at or

above 80 percent for HEDIS 2001 (measurement year 2000) will be excused from performing the national BCS project and will have to perform only the M+C Organization selected project for this year. For HEDIS 2000 there were 61 HEDIS submissions which met or exceeded the 80 percent rate. Additionally, organizations that report a rate below 80 percent for HEDIS 2001, but report a rate at or above 80 percent for HEDIS 2002 (measurement year 2001) will be exempt from the 2002 national project. Organizations that did not report HEDIS 2001, but report a rate at or above 80 percent for HEDIS 2002, will also be exempt from the 2002 national project.

Although CMS does not receive the annual HEDIS report from NCQA until approximately August 1, organizations are aware of their own rates several months earlier. Additionally, most M+C organizations are aware of their previous BCS rates and are in a position to judge the effectiveness of previous interventions so they can determine the level of effort that will be required to achieve demonstrable improvement in the future. Therefore, using HEDIS 2002 for the baseline should not cause a problem for initiating the 2002 national project. Also, it will permit the use of data from the previous year, consistent with QAPI project provisions.

*A list of organizations that do not have to perform the national project will be posted as an addendum to OPL 2001.133 at the CMS Website about October 1st of 2002. This posting will inform the exempt M+C Organizations that they are exempt based on data from HEDIS 2002 (measurement year 2001). A similar posting was made in 2001 for M+COs exempt based on data from HEDIS 2001 (measurement year 2000). CMS will input the exemption into the M+C Quality Review Organization QAPI database.*

### **Project Initiation and Implementation**

CMS requires that the organization achieve demonstrable and sustained improvement in clinical care as a result of performing this project. Therefore, interventions must achieve improvement that is significant and sustained over time.

Organizations that are currently engaged in a similar BCS project as their internally selected project will need to follow guidance in section 1.3.3.3 of the QISMC document. This requires drawing a new baseline based on HEDIS 2002 (measurement year 2001) from which a re-measurement will be made while completing the previously initiated M+C Organization selected project. The national QAPI project will not affect the cycle of internal optional projects.

### **Support/Communication for Projects**

We encourage M+C Organizations to work in collaboration with their local QIO as they seek appropriate interventions to improve mammography rates and reduce burden on providers of services. In addition to QIO support, we would like to alert MCOs about the Centers for Disease Control and Prevention's information resources on the web at <http://www.cdc.gov/cancer/nbccedp/>. Another helpful site is located at <http://cis.nci.nih.gov>.

Please send any questions regarding this OPL/BCS project to your RO managed care staff, or to: Richard Malsbary, (410) 786-1132 in the Center for Beneficiary Choices.

\*Kerlikowske, et al. JAMA 1993; 270(20): 2444-2450

\*\*[http://www.cancer.org/NBCAM\\_fastfacts.html](http://www.cancer.org/NBCAM_fastfacts.html) (cited 2001 January 4)

## **2003 - Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services**

Reducing clinical health care disparities (CHCD) is one of the major challenges facing the entire health care industry. Compelling evidence exists that race and ethnicity correlate with persistent, and often increasing, health disparities. Since 1993, key indicators have shown that our nation's health has greatly improved. However, this good news does not apply to all Americans, a fact that has been recognized by leading organizations and health care researchers across the United States.<sup>[4], [5], [6], [7], [8], [9]</sup> Achieving new health care goals will require a national commitment to identify and address the causes underlying higher levels of disease and disability in certain racial and ethnic groups. The urgent need for this commitment is further emphasized by the fact that the overall population is expected to grow dramatically, especially in the number of Hispanics, Asians and the minority elderly over age 85.

An increasing body of health services research also indicates that the provision of culturally and linguistically appropriate services (CLAS) leads to improved health outcomes, increased patient or beneficiary satisfaction, and organizational efficiencies that result in decreased expenditures. Many of the critical interventions that support the provision of culturally and linguistically appropriate services occur at the clinical encounter between health care providers and patients, but it is not the only focus of concern. A health care organization must also think about how it provides support for its customers in terms of customer service relations and communications, compliance with plan operating procedures, addressing grievances and appeals, etc.

### **Overview of 2003 National QAPI Projects**

For the year 2003 national QAPI project, an M+C organization will have a choice between initiating a project that addresses clinical health care disparities (CHCD) or culturally and linguistically appropriate services (CLAS). M+C organizations that select a project that addresses CHCD must focus on one of four clinical areas - diabetes, pneumonia, congestive heart failure, or mammography. They must also use previous guidelines issued by CMS in the form of *Operational Policy Letters* (OPLs) to determine appropriate quality indicators and implementation strategies. <sup>[10] [11] [12]</sup> M+C Organizations that select a project that addresses CLAS must focus on language access or organizational support for CLAS. M+C Organizations that wish to initiate a CHCD or



CLAS project in 2002 (begin baseline data collection in 2001), may do so and receive credit for the year 2003 national QAPI project.

### **Clinical Health Care Disparities**

CHCD projects must measure and improve care for individuals enrolled in the M+C Organization from any, all, or a subset of the following populations:

- American Indian/Alaskan Native;
- Asian;
- Black/African American;
- Native Hawaiian/Pacific Islander, and
- Hispanic/Latino.

CHCD projects should demonstrate improvement for the selected population(s) in the quality indicators set forth in the OPL for the chosen clinical area. M+C Organizations may measure the disparity between the rate for the selected population(s) and the overall enrolled population, but a reduction in the amount of disparity is not required.

The M+C Organization should identify enrollees in the selected population(s) using an appropriate data source, such as plan data collected at the time of, or subsequent to, enrollment, or the data that will be supplied by CMS *starting in January of 2003 on the Monthly Membership Report. The race and ethnicity data supplied by CMS* is collected by SSA at the time of original enrollment in Medicare. *Prior to January 2003, M+COs that would like to receive an aggregated report of race and ethnicity data for their Medicare-enrolled population must send a request to Trisha Kurtz at [pkurtz@cms.hhs.gov](mailto:pkurtz@cms.hhs.gov).*

Other data sources, such as zip-code/census data, may be used to target interventions to appropriate individuals. For M+C Organizations selecting pneumonia as a clinical topic, CAHPS data, which includes the race/ethnicity of respondents, may be used to determine rates. Plans wishing to use CAHPS for this purpose must notify CMS by July 1st of the year of the CAHPS survey; an additional sample of enrollees from the selected population(s), or a subset of the selected population, will be drawn to increase the sample size used in determining the rate.

Examples of two CHCD projects follow. M+C Organizations may find these examples useful in developing their own project plans.

### **Culturally and Linguistically Appropriate Services (CLSA)**

M+C Organizations that select CLAS must conduct a project that addresses one of two broad categories - language access and organizational support. Projects that address language access should focus on Limited English Proficiency (LEP) managed care

enrollees.<sup>[13]</sup> Projects that focus on organizational support should be built on the understanding of, and in response to specific, cultural and linguistic needs of beneficiaries enrolled in a managed care plan. Examples of CLAS projects that address language access and organizational support are provided in Appendix A, "2003 - Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services" of this chapter. M+C organizations may find these examples useful in developing their own project plans. M+C organizations that decide to use one of the example projects provided in this appendix may decide, however, to implement an intervention that is not addressed by the example. This is acceptable, as long as the intervention can be linked to the topic and outcome of the project.

CLAS projects should use the following framework:

- Identify an opportunity for improvement;
- Develop and/or conduct meaningful intervention(s);
- Determine if the opportunity for improvement or goal has been achieved; and
- Review one year later to ensure improvement has been sustained.

### **Project Support and Evaluation**

We encourage M+C organizations to collaborate on or develop a community-wide approach for conducting QAPI projects that focus on CHCD or CLAS. Interventions, for example, may be implemented on a community-wide or regional basis. Each M+C organization, however, will be assessed individually on the success of their project. M+C organizations may have their QAPI projects evaluated at a level less than the contract (H-number), but may not have their QAPI projects evaluated at a level greater than the contract (H-number). For example, an M+C organization may not request an evaluation of QAPI projects for a multi-state area, unless CMS has a contract (H-number) for the multi-state unit.<sup>[14]</sup>

We also encourage M+C organizations to work with their local Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO) to identify interventions that will decrease health care disparities and/or provide culturally and linguistically appropriate services. In addition, to assist M+C Organizations that focus on CLAS for their project, CMS is working with the Agency for Healthcare Quality and Research (AHRQ) and one of their contractors to develop detailed specifications and interventions for two of the example projects.

M+C organizations that meet the following conditions may receive an automatic pass for the 2003 national project by providing CMS the report (analysis) from the State Medicaid Agency or accrediting organizations that verifies the satisfactory completion of the QAPI project and results.

- M+C organizations that have conducted a CLAS project for a state Medicaid program and have met the state's requirement for demonstrable improvement during the project period (projects must be completed or reviewed between 2001 through 2003).
- M+C organizations that have conducted a CLAS project for private accreditation that meets the accreditation organization's requirement for improvement during the project period (projects must be completed or reviewed between 2001 through 2003).

For M+C organizations that complete a project after 2003 that is determined to meet an accrediting organization's or State Medicaid Agency's requirements, CMS will also accept that determination, as long as the determination is made prior to the measurement reporting year, which is 2005. If the project does not meet the accrediting organizations or state Medicaid agency's requirements, however, it must be reported to and reviewed by CMS.

For QAPI projects, CMS requires demonstrable improvement. For non-clinical CLAS projects, CMS will allow an M+C organization to demonstrate improvement by using structural measures that show what was in place prior to the quality improvement effort and what is operational at the end of the project.

### **Additional Resources**

M+C organizations seeking guidance on developing QAPI projects that address CHCD or CLAS may use the following sources:

- U.S. Department of Health and Human Services Office for Civil Rights. Title VI of the Civil Rights Act of 1964: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency. "Federal Register", August 30, 2000. 2000;65(169):52762-74; and
- U.S. Department of Health and Human Services Office of the Secretary. National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. "Federal Register" , December 22, 2000. 2000;65(247):80865-80879.

Send any questions regarding this OPL or CHCD/CLAS projects to your RO managed care staff, or to: Trisha Kurtz, (410) 786-4670 in the *Center for Beneficiary Choices*.

### **Clinical Health Care Disparities Sample QAPI Projects**

These sample projects are not required. M+C organizations may, however, find these sample projects useful in developing their own QAPI project plans.

### **Example 1 - Mammography**

This project seeks to increase the use of mammography screening with a focus on clinical health care disparities. The M+C organization with a Medicare enrollment of 10,000 decides to aggregate all of the potential categories to create a selected population. The M+C organization uses race and ethnicity that is collected at the time an individual enrolls in the plan to identify the population, and determines that in 2001 about 10 percent of its enrollment were in a population that the M+C organization selected for their QAPI project, about 200 of whom were women of appropriate age. Beginning in 2003, the M+C organization uses claims alone to determine the rate. For the baseline year (2002), the rate for the selected population is 50 percent (performance gap of 50 percent), and for the overall enrolled population the rate is 55 percent (performance gap of 45 percent), so although the existence of a disparity in this example, it is not necessary to conduct the project. For this M+C organization the apparent disparity is 5 percent. The M+C organization uses this same methodology to determine the rates for the years 2003, 2004, and 2005.

In 2003, the M+C organization does a mailing to a sample of the selected and the overall enrolled populations to determine if there are any special barriers to mammographic screening among the selected population. It finds that there are two notable barriers - availability of screening centers on evenings and weekends, and the disbelief among the selected population that screening is of benefit. It does a special mailing to enrollees identifying screening centers with extended hours, and making the case for benefits of screening, and makes this mailing available to its PCPs.

For the 2003 reporting period there is no improvement in rates, but in 2004 the rate for the selected population is 56 percent. Compared to baseline this means that the performance gap has been reduced from 50 percent to 44 percent, which is a 12 percent improvement in gap. In 2005 the rate for the selected population is 55 percent, which demonstrates that improvement has been sustained.

### **Example 2 - Pneumonia**

This project seeks to increase flu/pneumonia vaccine rates for a selected population(s). The M+C organization with Medicare enrollment of 5000 decides to aggregate all of the potential categories to create a selected population. In June of 2002 it informs CMS of its need for CAHPS results for the selected population. During the fall of 2002, CMS augments the usual CAHPS sample with an additional sample of 100 enrollees from the selected population. In the spring of 2003, the M+C organization receives CAHPS results for 2002 by racial/ethnic category. For this year, for the 500 respondents, the rates of flu and pneumococcal vaccination were 30 percent and 20 percent. For the selected population, there were a total of 125 respondents, and the rates were 30 percent and 25 percent.

Although there is no disparity between the selected and the overall enrolled population, the MCO proceeds with the project, focusing on interventions specific to the selected

population. The M+C organization requests similar breakdowns of CAHPS results for the reporting years 2003, 2004, and 2005.

In 2003, the M+C organization does a mailing to a sample of the selected and the enrolled populations to determine if there are any special barriers to flu and pneumococcal vaccination among the selected population. It finds that there are no special barriers. It does a mailing to all enrollees in the fall reminding them of the benefits of screening. Using census data to identify zip codes with higher proportions of residents from the selected population, the M+C organization works with the state health department to publicize the importance of immunization, and available sources of it, in those areas.

Using CAHPS data, in the 2003 reporting year there is improvement in rates for the selected population, to 35 percent (flu) and 30 percent (pneumococcal). Compared to baseline this means that the initial gap of 70 percent has been reduced to 65 percent, which represents a 7 percent improvement in gap. For the 2004 reporting period, the rates for the selected population are 40 percent and 35 percent. This represents a 14 percent improvement in the gap. For the 2005 reporting period the rates for the selected population are unchanged from those of the prior year, which demonstrates that improvement has been sustained.

### **Culturally and Linguistically Appropriate Services Sample QAPI Projects**

These sample projects are not required. M+C Organizations may, however, find these sample projects useful in developing their own QAPI projects plans.

### **Language Access**

Language access is critical for minority individuals who have “Limited English Proficiency” (LEP). Research shows that language barriers have a negative impact on utilization, satisfaction, and possibly adherence to treatment regimens<sup>[15]</sup>. LEP has been linked to fewer physician visits, reduced receipt of preventive services, and higher rates of missed appointments and medication noncompliance among LEP patients <sup>[16]</sup>. Included among the negative effects of language barriers are higher rates of diagnostic testing, omission of vital information, misdiagnoses, inappropriate treatment and misunderstanding<sup>[17]</sup>.

Incentives for M+C Organizations to undertake efforts directed at ensuring access to services for LEP enrollees through the provision of required language access services include:

- More accurate medical histories and clearer descriptions of symptoms leading to fewer diagnostic errors;
- More appropriate testing and screening yielding fewer missed opportunities for early detection and treatment;
- More successful patient education resulting in reduced behaviors constituting risk;

- Factors for disease and exposure to risk;
- Clearer communication between physicians and patients concerning treatment options leading to more appropriate treatment and improved compliance with treatment regimens; and
- Better protection for the M+C Organization against tort liability, malpractice lawsuits, and charges of negligence.

M+C Organizations are also required, as are all recipients of Federal financial assistance, to take steps to ensure LEP persons have meaningful access to the health services they provide.

### **Example 1 - Compile or Enhance and Make Available a Practitioner Directory Identifying Bilingual/Multi-Lingual Practitioners**

#### **Identify an Opportunity for Improvement**

- Identify the languages likely to be encountered by appropriate M+C Organization practitioners; and
- Use these data to assess the need to identify plan practitioners who are bilingual/multi-lingual.

#### **Intervention**

- Survey M+C Organization practitioners to request the voluntary identification of those who are bilingual/multilingual;
- Compile or enhance and publish a directory identifying the bilingual/multi-lingual practitioners and the language(s) in which they are competent;
- Make the directory available to all enrollees through normal channels; and
- Include notice of the availability of the directory in outreach materials to M+C Organization LEP populations.

#### **Benchmark/Goal**

- Make the directory that identifies bilingual/multilingual practitioners, and/or notice of that directory, available to M+C Organization enrollees by completion of the project.

#### **Outcome**

For improvement, M+C Organizations will need to show what was in place prior to the quality improvement effort and what is operational at the end of the project.

## **Example 2 - Establish a System to Identify M+C Organization LEP Beneficiaries and Access and Use This Information**

### **Identify an Opportunity for Improvement**

Assess the adequacy of any existing system(s) for identifying M+C organization LEP enrollees and for accessing and using this information.

### **Intervention**

Identify enrollees written/oral language needs for a medical encounter. (Identification methods include survey, enrollment application, etc.) Incorporate and record this information in the plan data (e.g., plan enrollment database) so that it is accessible to staff and/or providers.

### **Benchmark/Goal**

The M+C organization identifies its LEP enrollees and provides for the access and use of this information by providers and staff. A new or significantly improved system exists to identify M+C organization LEP enrollees and to access and use this information.

### **Outcome**

For improvement, M+C organizations will need to show what was in place prior to the quality improvement effort and what is operational at the end of the project.

## **Example 3 - Acquainting M+C Organization LEP Enrollees of Their Right to Language Services**

### **Identify an Opportunity for Improvement**

Evaluate the plan's current process for acquainting M+C organization LEP enrollees of their right to language access services.

### **Intervention**

Develop or enhance the process for acquainting M+C organization LEP enrollees of their right to language access services.

### **Benchmark/Goal**

New or enhanced procedures exist and are operational to acquaint M+C organization LEP enrollees of their right to receive language assistance services. Procedures include processes for both verbal offers and written notices in the enrollee's preferred language.

### **Outcome**

For improvement M+C organizations *must* show what was in place prior to the quality improvement effort and what is operational at the end of the project.

## **Example 4 - Provide Oral Language Interpretation Assistance to M+C Organization LEP Enrollees**

### **Identify an Opportunity for Improvement**

Identify the languages likely to be encountered in the M+C organization service area and enrollee population by reviewing census data, CMS-provided race and ethnicity data for M+C organization's enrollees and/or data from school systems and community agencies and organizations.

- Select one or more of the most dominant LEP groups in the service area.
- Evaluate the adequacy of any existing process (es) to provide oral language interpretation services to enrollees in the selected LEP groups.
- Identify the points of contact in the M+C organization where language assistance is likely to be needed (e.g., beneficiary services).
- Define the resources that will be needed to provide effective language assistance to M+C organization enrollees in the selected LEP groups, and identify the location and availability of these resources.

### **Intervention**

Expand existing capacity as necessary to address unmet need by hiring bilingual staff or paid interpreters, contracting with interpreters, engaging community volunteers, and/or arranging for telephone interpreter services.

### **Benchmark/Goal**

The M+C organization offers and provides oral language assistance including bilingual staff and interpreter services to M+C organization LEP beneficiaries in the selected groups at points of contact in a timely manner during hours of operation. A new or significantly improved system for providing oral language services to individuals with limited English proficiency in the selected groups who seek services from the M+C organization is implemented and fully operational.

### **Outcome**

For improvement M+C organizations will need to show what was in place prior to the quality improvement effort and what is operational at the end of the project.

## **Example 5 - Provide Written and Oral (Sight) Translations of Vital Documents and Information to M+C Organization LEP Enrollees**



## **Identify an Opportunity for Improvement**

Identify the non-English languages that are likely to be encountered in the M+C Organization's service area by reviewing census data, CMS-provided race and ethnicity data for M+C organization enrollees and/or data from school systems and community agencies and organizations.

Identify one or more of the most dominant LEP language groups in the service area.

Evaluate the adequacy of available translated materials to meet the needs of language group(s).

## **Intervention(s)**

One or more of the following:

- Secure written translations into the selected LEP language(s) of vital documents and information. Translated materials should be responsive to the culture as well as the levels of literacy of M+C organization LEP enrollees in these language groups;
- Provide/post signs in public areas (e.g., waiting rooms) in the selected LEP language(s) notifying LEP enrollees of a variety of patient rights, availability of conflict and grievance resolution, and directions to service locations;
- Provide/post way-finding signs to identify or label the location of specific services (e.g., registration, examining rooms); and
- Make available translated written documents to LEP enrollees in the selected language group(s).

## **Benchmark/Goal**

A new or significantly improved system for improving access for LEP beneficiaries to easily understood patient-related materials and/or posted signage is implemented and fully operational. The M+C organization makes available translations of, at a minimum, vital documents and information for the selected one or more most dominant LEP language groups in the service area. For other language groups, the M+C organization provides written notice in the primary language of the LEP beneficiary of the right to receive oral translation of written materials.

## **Outcome**

For improvement M+C organizations must show what was in place prior to the quality improvement effort and what is operational at the end of the project.

## **Potential Organizational Support Class QAPI Projects**

For purposes of the QAPI project, the premise for the organizational support for CLAS is built on understanding and responding to specific cultural and language needs of Medicare and Medicaid beneficiaries enrolled in the managed care plan. Health journal literature indicates that the provision of culturally and linguistically appropriate services leads to better health outcomes, increased customer satisfaction, and organizational efficiencies that result in decreased expenditures.

Many of the critical interventions that support the provision of culturally and linguistically appropriate services occur at the clinical encounter between health care providers and patients. But that is not the only focus of concern. A health care organization must carefully think about how it provides support for its customers in terms of customer service relations and communications, compliance with plan operating procedures, negotiating complaints and grievance and appeals processes, etc.

### **Example 1 - Establish and Implement a Plan to Recruit and Retain Bi/Multi-Cultural and Bi/Multi-Lingual Minority Employees Who Reflect the Dominant Racial, Ethnic and Linguistic Minorities Served**

#### **Rationale**

There are distinct communication and service advantages to recruiting and retaining employees within the M+C organization who reflect the demographics of the enrolled population. This is especially true at key points of beneficiary encounters, such as customer service, including navigating the complaints and appeals processes. Also, the customer service representative provides a wide array of information across all aspects of plan services and refers beneficiaries to other parts of the organization to obtain information, assistance and services.

#### **Initial Assessment**

Identify dominant cultural and linguistic minority groups enrolled in the M+C organization; assess whether M+C organization employees at key points of beneficiary encounters have the capacity to understand and meet cultural and language needs of enrollees.

#### **Interventions (Steps in Completing the Project)**

- Assess the diversity of populations served with regard to culture and language.
- Review employee recruitment and retention practices; do these practices reflect sensitivity to the linguistic and cultural needs of communities served?
- Develop a written plan with regard to recruiting and retaining employees who reflect sensitivity to the linguistic and cultural needs of communities served.

- Acquire Board *of Directors* sign-off to implement the plan with an effective date within the next year and has a budget to support the plan.

### **Benchmark/Goal**

The M+C organization has a written plan for recruiting and retaining employees who reflect sensitivity to the linguistic and cultural needs of the communities served. The organization is better able to meet the needs of linguistic and cultural minorities by systematically attempting to recruit and retain employees who reflect the cultural and linguistic minority communities served.

**NOTE:** This does not require a particular ratio be met with regard to so many employees per so many beneficiaries.

### **Outcome**

For improvement M+C Organizations *must* show what was in place prior to the quality improvement effort and what is operational at the end of the project.

### **Example 2 - Establish and Implement a Plan to Recruit and Retain Bi/Multi-Cultural and Bi/Multi-Lingual Minority Practitioners Who Reflect the Dominant Racial, Ethnic And Linguistic Minorities Served**

#### **Rationale**

There are distinct communication and service advantages to recruiting and retaining practitioners who reflect the demographics of the enrolled population. This is especially true at key points of beneficiary encounters, such as the clinical setting, where the practitioner provides a wide array of direct services.

#### **Initial Assessment**

Identify dominant cultural and linguistic minority groups enrolled in the M+C Organization; assess whether M+C organization practitioners have the capacity to understand and meet cultural and language needs of enrollees.

#### **Interventions - (Steps in Completing the Project)**

- Assess the diversity of populations served with regard to culture and language.
- Review practitioner recruitment and retention practices to ensure that these practices reflect sensitivity to the linguistic and cultural needs of communities served.
- Develop a written plan with regard to recruiting and retaining practitioners that reflect sensitivity to the linguistic and cultural needs of communities served.

- Acquire Board of Directors sign-off to implement the plan with an effective date within the next year and has a budget to support the plan.

### **Benchmark/Goal**

The M+C organization has a written plan for recruiting and retaining practitioners who reflect sensitivity to the linguistic and cultural needs of the communities served. The organization is better able to meet the needs of linguistic and cultural minorities by systematically attempting to recruit and retain practitioners who reflect the cultural and linguistic minority communities served.

**NOTE:** This does not require a particular ratio be met with regard to so many practitioners per so many beneficiaries.

### **Outcome**

For improvement M+C organizations must show what was in place prior to the quality improvement effort and what is operational at the end of the project.

### **Example 3 - Develop or Provide Access to Culturally Linguistic Appropriate Services (CLAS) Training Programs for Employees and Practitioners**

#### **Rationale**

CLAS training programs increase cultural awareness, knowledge, and skills, leading to changes in clinical and administrative understanding of patients. CLAS training provides a way to introduce staff to interaction issues that have previously gone unnoticed or misinterpreted. Therefore, a critical part of organizational support for CLAS is ensuring that employees and practitioners receive ongoing generalized training and education in delivery of CLAS. Further, at the clinical level in particular, continuing medical education related to specific disease incidence and prevalence and treatment efficacy and outcomes is critical.

#### **Initial Assessment**

Review current capabilities for developing or providing CLAS training either through internal or external sources.

#### **Interventions - (Steps in Completing the Project)**

- Assess the diversity of populations served with regard to culture and language.
- Establish and/or identify CLAS training that addresses the needs of the enrolled population. (CMS will provide technical assistance regarding CLAS training sources for optional use by M+C Organizations.)
- Assist employees and practitioners in attending CLAS training.

- Establish a mechanism to record that employees and practitioners have attended CLAS training.

### **Benchmark/Goal**

Employees and/or practitioners have received CLAS training. If CLAS training is already underway, then the M+C organization shall increase the number attending the training. If the program is new, then the M+C organization shall demonstrate that the program is initiated and that there is participation with significant attendance by employees and practitioners.

### **Outcome**

For improvement M+C organizations *must* show what was in place prior to the quality improvement effort and what is operational at the end of the project.

### **Example 4 - Conduct an Organizational Assessment to Identify Opportunities for Improvement and Develop a Multi-Year Plan for Improving Provision of CLAS**

#### **Rationale**

An organizational assessment to identify opportunities for improvement is essential for creating an incremental, coherent effort in the provision of CLAS. An assessment provides a status check on where the M+C organization is in the provision of CLAS, and a gap analysis between where the organization is now and where it wants to be at a future point in time.

#### **Initial Assessment**

Review current activities relating to conducting an organizational assessment of the provision of CLAS.

#### **Interventions**

- Assess the diversity of populations served with regard to culture and language.
- Assess organizational capacity for providing CLAS.
- Use the organizational assessment to build a multi-year plan for providing CLAS.
- Put into place the necessary organizational structure needed to execute the multi-year plan.

### **Benchmark/Goal**

M+C Organization conducts an organizational assessment to identify opportunities for improvement in the provision of CLAS. Based on the assessment, M+C Organization

puts into place the necessary organizational structure needed to execute the multi-year plan.

## **Outcome**

For improvement M+C Organizations *must* show what was in place prior to the quality improvement effort and what is operational at the end of the project.

## **2004 – Diabetes**

### *Background*

*Diabetes is a major health problem which is becoming more prevalent in all age groups. The increasing prevalence is attributed both to higher detection and to poorer health habits. Adult onset diabetes is highly prevalent in the Medicare population and over 150,000 Americans die each year from diabetes and its complications. Complications of the disease include blindness, kidney failure, nerve damage, and cardiovascular disease. For most persons with diabetes, many of these complications can be prevented or delayed with appropriate monitoring and treatment. However, studies in both fee-for-service and managed care settings indicate that care is suboptimal. The Diabetes National Project focuses on improving monitoring in the outpatient setting.*

### *Goal*

*Improve the health status of Medicare enrollees with diabetes within the Medicare+Choice population through improved monitoring and treatment.*

### *Objectives*

- 1. Maximize CMS's opportunity to improve the health status of Medicare managed care enrollees.*
- 2. Seek consistency with the Quality Improvement Organization's (QIO) quality improvement efforts in diabetes for the Medicare fee-for-service population.*
- 3. Reduce the level of burden in terms of cost and effort on M+C organizations and their health care providers.*
- 4. Coordinate the project with existing initiatives and programs of public and private organizations.*
- 5. Recognize and reward performance of M+COs.*

### *Overview of Diabetes Project*

*The CMS-sponsored national project for 1999 focused on diabetes mellitus, using the Diabetes Quality Improvement Project (DQIP) Measures. The CMS-sponsored national*

*project for 2004 will also focus on diabetes mellitus and use the DQIP Measures because further review of the data indicates additional opportunity for improvement. One of the objectives of this project is to reduce rates of blindness, amputations, kidney failure and the rate of diabetes-associated cardiovascular disease that is the major cause of death for the elderly population with diabetes. Diabetes and the complications of the disease can be prevented or delayed by management of blood glucose through diet, exercise and medication, by management of other risk factors such as lipids, blood pressure, smoking and by appropriate and timely examinations and treatment (e.g., eyes and feet).*

*Selection of diabetes as a topic was based on:*

- 1. Aligning managed care quality efforts with fee-for-service quality activities in order to improve health care outcomes for beneficiaries;*
- 2. Reducing provider burden as it is a “performance expectation” for the National Business Coalition on Health/V-8 for 2002;*
- 3. Existence of HEDIS measures;*
- 4. Relevance to both Medicare and Medicaid populations; and*
- 5. Maximizing Quality Improvement Organization (QIO)/Peer Review Organization (PRO) resources by selecting a M+CO project consistent with current QIO clinical priority areas.*

*Performance Indicators for 2004 Diabetes National QAPI Project*

*The performance measures for the 2004 Diabetes National QAPI Project are based on the Diabetes Quality Improvement Project (DQIP) Measures. The data for the project can be easily obtained and should not place additional burden on health care providers in the accumulation of the information. M+COs will have multiple indicators to choose from for the project while being obligated to report on only one indicator. M+COs may perform the 2004 national QAPI project using HEDIS 2004 (measurement year 2003) for the baseline and by selecting and reporting on one of the DQIP indicators. This gives organizations the opportunity to select from screening measures permitting data collection by the administrative method or from outcome measures requiring medical record review.*

*M+COs that submitted one, two or three indicators for their 1999 Diabetes National Project may not repeat any of the same indicators for their 2004 Diabetes National Project. However, an exception will be permitted for those M+COs that reported four or more indicators for their 1999 Diabetes National Project. CMS is permitting this exception because M+COs had the option to submit multiple indicators through HPMS and accreditation organizations may require M+COs to submit multiple indicators for their 1999 Diabetes National QAPI Project. M+COs who submitted four, five or all six HEDIS DQIP indicators for their 1999 Diabetes National QAPI Project will have the flexibility to repeat any/or all of the six indicators for their 2004 Diabetes National QAPI Project. CMS will not restrict a M+CO from repeating indicators when that M+CO's*

*1999 National QAPI Project resulted in the M+CO reporting on four, five or all six DQIP indicators.*

*The Comprehensive Diabetes Care Measures in HEDIS consists of six indicators for which rates must be filed annually by Medicare managed care organizations. Based on HEDIS 2001 (measurement year 2000) mean rates for two of the six indicators exceeded 80 percent. Hemoglobin tested was 83.4 and LDL-C screening was 80.9. With mean rates this high it may be difficult for M+COs to achieve much further improvement and projects pertaining to the other indicators might be more productive. In fact, the National Business Coalition on Health (V8) has eliminated these two indicators from its performance expectation criteria .*

*For M+COs that prefer to collect data administratively through claims systems rather than through medical record review in order to reduce the need to have contact with provider offices, it is possible to collect information administratively for the process or screening indicators, Eye Exams and Kidney Disease Monitored. The outcome indicators, HbA1C Poorly Controlled and LDL-C Controlled, require medical record review to obtain accurate rates. However, most M+COs use the hybrid methodology, a combination of administrative and medical record review, to collect the data since this generally improves the rate. By selecting a QAPI project that uses HEDIS reported information, an M+CO would not necessarily have to do additional medical record review. It will be up to the M+CO to determine whether to use the administrative or hybrid method, however, the methodology used for the baseline must be the same methodology used to measure initial and sustained improvement.*

#### *Alternative Option*

*M+COs have the option to complete the National Diabetes QAPI Project for 2004 or a local/collaborative marketplace initiative. Parameters for an acceptable collaborative effort require that:*

- 1. It must be a community-wide initiative in which most or all MCOs participate and be initiated, facilitated, approved or required by a private purchaser group, QIO, State Medicaid Agency or other state government agency;*
- 2. The topic must be relevant to the Medicare population;*
- 3. Medicare enrollees must be in the population sample for the project;*
- 4. The M+CO must report out M+CO specific data, although, Medicare data does not need to be separated from the other purchasers (Medicaid/commercial) unless separation of data is necessary for other reporting purposes such as Medicare HEDIS requirements, and*
- 5. M+COs must follow QAPI requirements as established earlier in Chapter 5 of the M+C manual (use of baseline, measurement, re-measurement and interventions).*



### *Rewarding Performance*

*Similar to the approach used for the National M+CO Breast Cancer Screening QAPI in 2002, high performing M+COs will be exempt from the National QAPI Project. The mechanism for accomplishing this would be somewhat different since multiple indicators are involved.*

*M+COs will be exempted from the 2004 National Diabetes QAPI Project based on rates filed for HEDIS 2003 (measurement year 2002) or HEDIS 2004 (measurement year 2003). The exemption would apply for those M+COs that meet or exceed the 75th percentile average of all four rates. The four rates are: HbA1C Poorly Controlled, LDL-C Controlled, Eye Exam, and Kidney Disease Monitored. It should be noted that the rate for HbA1C Poorly Controlled would be reversed scored so that the 75th percentile will reflect the rate of proper HbA1C control and will be comparable in the same direction as the other three rates.*



*NOTE: In the table below, HbA1C Control has been reverse scored so that a higher score represents better control.*

<i>Medicare HEDIS Measurement year 2000 Diabetes Care Rate</i>	<i>Mean</i>	<i>Median</i>	<i>75th Percentile</i>	<i>80th Percentile</i>	<i>85th Percentile</i>	<i>90th Percentile</i>
<i>Hemoglobin Tested</i>	<i>83.4</i>	<i>84.91</i>	<i>89.78</i>	<i>90.51</i>	<i>91.41</i>	<i>93.03</i>
<i>HbA1C controlled</i>	<i>32.47</i>	<i>27.49</i>	<i>38.52</i>	<i>43.55</i>	<i>51.34</i>	<i>60.24</i>
<i>LDL-C Screening</i>	<i>80.9</i>	<i>82.97</i>	<i>87.71</i>	<i>88.32</i>	<i>89.38</i>	<i>90.86</i>
<i>LDL-C Controlled</i>	<i>51.87</i>	<i>53.77</i>	<i>58.39</i>	<i>60.99</i>	<i>63.18</i>	<i>64.25</i>
<i>Eye Exam</i>	<i>64.33</i>	<i>67.4</i>	<i>76.04</i>	<i>77.25</i>	<i>79.1</i>	<i>83.7</i>
<i>Kidney Disease Monitored</i>	<i>46.38</i>	<i>54.4</i>	<i>56.67</i>	<i>58.84</i>	<i>62.55</i>	<i>69.24</i>



## **Appendix B - M+C Quality Glossary - (Rev. 13, 09-11-02)**

### **Accreditation**

An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

### **Fully Accredited**

Designation that all the elements within the accreditation standards for which the accreditation organization has been approved by CMS have been surveyed and fully met or have otherwise been determined to be acceptable without significant adverse findings, recommendations, required actions or corrective actions.

### **Accreditation Cycle for M+C Deeming**

The duration of CMS's recognition of the validity of an accrediting organization's determination that a Medicare+Choice organization (M+C organization) is "fully accredited."

### **Baseline Data**

Initial data gathered before improvements or interventions are made that will be compared with data collected later to determine whether changes have been effective.

### **Benchmarking**

The process of measuring products, services, strategies, processes, and practices against known leaders/best-in-class companies.

### **Consumer Assessment of Health Plans Study (CAHPS)**

An annual satisfaction survey, administered by CMS, in which a sample of members from each Medicare managed care organization are asked for their opinions relating to clinical and administrative services provided by the M+C organization.

### **Continuous Quality Improvement (CQI)**

An integrated, comprehensive approach to continuously examine, refine, and revise organizational processes to meet and exceed customers' expectations. Integrates fundamental management approaches, improvement efforts, tools, and training.

## **Coordinated Care Plan**

A plan that includes a CMS-approved network of providers that are under contract or arrangement with the M+C organization to deliver the benefit package approved by CMS. Coordinated care plans include plans offered by health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), as well as other types of network plans (except network MSA plans. See 42 CFR §422.4(a)(1.)

## **Cost Benefit Analysis**

Weighing known costs against probable benefits; *the* objective is to have potential benefits to exceed (additional) costs.

## **Customer**

Anyone who receives a service or product; either internal or external to the organization.

## **Deemed Status**

Designation that an M+C organization has been reviewed and determined "fully accredited" by a CMS-approved accrediting organization for those standards within the deeming categories that the accrediting organization has the authority to deem.

## **Deeming Authority**

The authority granted by CMS to accrediting organizations to determine, on CMS's behalf, whether a M+C Organization evaluated by the accrediting organization is in compliance with corresponding Medicare regulations.

## **Equivalency Review**

The process CMS employs to compare an accreditation organization's standards, processes and enforcement activities to the comparable CMS requirements, processes and enforcement activities.

## **Expected variation**

A change or measurement observed in a step of *a* process which one could predict would occur because of natural causes; data points are within the upper and lower control limits

## **Goal**

The measurable outcome of the process under study, as defined by the improvement team.

## **Health Outcomes Survey (HOS)**

The first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the SF 36, to assess both physical and mental functioning. A sample of members from each Medicare+Choice *organization* is surveyed. Two years later these same members are surveyed again in order to evaluate changes in health status.

## **Health Plan Employer Data and Information Set (HEDISâ)**

A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations. HEDISâ is developed and maintained by the National Committee on Quality Assurance (NCQA) in collaboration with CMS and other entities. HEDISâ 2002 contains over 50 measures across 8 domains of care. Annual HEDIS reporting has been required of Medicare managed care organizations since January 1997.

## **Improvement**

Planned, fundamental changes which result in unprecedented levels of performance. It is not the "removal of an irritant", solving a particular problem, or "fire fighting."

## **Licensed by the State as a Risk-Bearing Entity**

An entity that is licensed or otherwise authorized by the state to assume risk for offering health insurance or health benefits coverage. The entity is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health services under an M+C contract.

## **Measures of Performance**

Characteristics of what is done and how well it is done.

## **M+C organization**

A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider sponsored organizations receiving waivers) that is certified by CMS as meeting the M+C contract requirements. See 42 CFR §422.2.

## **M+C Plan**

Health benefits coverage offered under a policy or contract offered by a Medicare+Choice organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan. See 42 CFR §422.2. An M+C plan may be a coordinated care plan (with or without point of service options), a combination of an M+C medical savings account (MSA) plan and a contribution into an M+C MSA

established in accordance with 42 CFR §422.262, or an M+C private fee-for-service plan. See 42 CFR §422.4(a)(3).

## *MCO*

*Managed care organization. The organization may or may not be a Medicare + Choice organization.*

## **Operational Definition**

A description in quantifiable terms of what to measure and the steps to follow to measure it consistently (e.g., the operational definition of a report handed in on time is one that is put in the correct mailbox within 10 minutes of the stated deadline).

## **Physician Incentive Plan (PIP)**

Any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to a M+C *organization's* enrollees. See 42 CFR § 422.208(a).

## **Population**

The total number of individual units for a defined area.

## **Preferred Provider Organization (PPO)**

An M+C Organization coordinated care plan that: (a) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (b) provides for reimbursement for all covered benefits regardless of whether the benefits are provided with the network of providers; and (c) is offered by an organization that is not licensed or organized under State law as an HMO. See 42 CFR §422.4 (a)(1)(iv).

## **Quality**

Meeting and exceeding customer expectations, doing the right things right, and making continuous improvements. Is defined by the customer.

## **Quality Improvement Organization (QIO)**

CMS contracts with a QIO, formerly known as Peer Review Organization, *for* each state to fulfill provisions in Title XI of the Social Security Act as amended by the Peer Review Improvement Act of 1982. These provisions relate to improving the quality of care for Medicare beneficiaries, protecting the integrity of the Medicare Trust Fund by ensuring that payments for services are reasonable and medically necessary and protecting beneficiaries by addressing care related complaints and other beneficiary issues.



## **Sample**

A subgroup of units chosen from a diffuse group of units or population.

## **Standard Deviation**

A measure of variability exhibited by the distance from the mean that a typical data point is expected to fall.

## **Subgroup**

A sample selected from a large population

## **Variation**

The inevitable differences in measurements observed in a given step of a process.

Endnotes - Click on the number to return to the originating text:

[1] ICD-9-CM codes: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x

[2] See footnote 1.

[3] A list of qualitative descriptions from laboratory reports or clinician notes considered consistent with LVSD will be provided.

[4] Mandelblatt JS, Gold K, O'Malley AS, et al: Breast and Cervix Cancer Screening Among Multiethnic Women: Role of Age, Health and Source of Care: Preventive Medicine 418-425. 1999.

[5] Gornick ME, Eggers PW, Reilly TW, et al. Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries; New England Journal of Medicine 335:791-799, September 12, 1996.

[6] Tortolero-Luna G, Guber GA, Villarreal R, Palos G, Linares A: Screening Practices and Knowledge, Attitudes, and Beliefs about Cancer among Hispanic and Non-Hispanic White Women 35 Years Old or Older in Nueces County, Texas: Journal of the National Cancer Institute Monograph 49-56, 1995.

[7] Center for Health Quality, Outcomes, and Economic Research: Quarterly 2, Spring 1999.

[8] Racial and Ethnic Disparities in Access to Health Insurance and Health Care: UCLA Center for Health Policy Research and The Henry J. Kaiser Family Foundation 1, October 1999.

[9] Influenza and Pneumococcal Vaccination Levels Among Adults Aged Greater Than or Equal to 65 Years: United States 47(38): 797-802, October 2, 1998.

[10] [cms.hhs.gov/medicare/mgdqual.htm](http://cms.hhs.gov/medicare/mgdqual.htm). OPL #129 (1) The Year 2001 National Project on Congestive Heart Failure (CHF) for Medicare+Choice organizations (M+C Organization); and (2) Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care. OPL #116 Quality Improvement System for Managed Care (QISMC) Year 2000 National Project on Community-Acquired Pneumonia.

[11] [cms.hhs.gov/quality/31.htm](http://cms.hhs.gov/quality/31.htm). Diabetes Quality Improvement Project (DQIP).

[12] Breast Cancer Screening OPL.

[13] LEP individuals are those who "...cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies." DHHS Office for Civil Rights. Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency. 65 FR 52763. August 30, 2000 at [www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep).

[14] HCFA has a contract with Kaiser Mid-Atlantic that serves several states and the District of Columbia.

[15] Brach, C., and Fraser, I. 2000. Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model. "Medical Care Research and Review" 57(1): 181-217

[16] Derose, K.P., and Baker, W.D. 2000. Limited English Proficiency and Latinos' Use of Physician Services. "Medical Care Research and Review" 57(1): 76-91

Commonwealth Fund. 1995. "National Comparative Survey of Minority Health Care". New York: Commonwealth Fund.

Eraker, S.A., Kirscht, J.P., and Becker M.H. 1984. Understanding and Improving Patient Compliance. *Annals of Internal Medicine* 100(2): 258-268

[17] David, R.A., and Rhee, M. 1998. The Impact of Language as a Barrier to Effective Health Care in an Underserved Urban Hispanic Community. "Mount Sinai Journal of Medicine 65". (5,6): 393-397

[18] 1818 David, R.A., and Rhee, M. 1998. The Impact of Language as a Barrier to Effective Health Care in an Underserved Urgan Hispanic Community. "Mount Sinai Journal of Medicine 65". (5,6): 393-397