Policy:	GG.1205
Title:	**HEDIS® Data Collection and Reporting**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/ Michael Hunn 10/10/2024*
Effective Date:	09/01/2004
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy delineates and documents the process used for Health Plan Effectiveness Data & Information Set (HEDIS®) reporting. The HEDIS® data collection and reporting process includes audit preparation, data collection, and reporting in order to meet the requirements of the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and to support CalOptima Health's goal to maintain National Committee for Quality Assurance (NCQA) health plan accreditation.

II. POLICY

A. HEDIS® data collection and reporting for Medi-Cal, and OneCare programs shall comply with CMS and DHCS requirements, Managed Care Accountability Set (MCAS) performance measures, and National Committee for Quality Assurance (NCQA) Full Scope Accreditation and Rating Measures.

B. CalOptima Health shall report DHCS Managed Care Accountability Set (MCAS), CMS-required HEDIS® measures (as defined annually by DHCS and CMS) and NCQA accreditation and health plan rating measures.

C. CalOptima Health shall meet or exceed the DHCS established Minimum Performance Level (MPL) for each HEDIS® measure. In accordance with CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects, CalOptima Health shall develop performance improvement plans and initiatives to meet or exceed DHCS established minimum performance levels.

D. CalOptima Health shall participate in DHCS, and CMS required Member satisfaction surveys. DHCS contracts with an External Quality Review Organization (EQRO) to administer the Member satisfaction surveys at intervals prescribed by the contract.

III. PROCEDURE

A. The Quality Analytics Department shall perform the following activities in relation to HEDIS® data collection and reporting:

1. Annually identify HEDIS® indicators, reporting requirements and submission due dates pursuant to CMS and DHCS plan letters.

2. Provide DHCS with one (1) designated and back-up contact to serve as CalOptima Health's HEDIS® lead. The HEDIS® lead will act as a liaison between DHCS and CalOptima Health including the coordination and timely completion of quality improvement submissions.

3. Utilize NCQA-Certified HEDIS® software to generate CalOptima Health's HEDIS® rates;

4. Educate Health Networks on HEDIS® data collection and reporting requirements;

5. Determine necessary staffing and resources including, but not limited to:

    a. Abstractors and overreaders;

    b. Contracted vendor or consultant for technical support;

    c. Contracted vendor for NCQA-Certified HEDIS® software;

    d. Contracted vendors for Medical Record retrieval;

    e. Contracted NCQA-Certified HEDIS® Audit Firm; and

    f. Contracted NCQA-Certified CAHPS Survey vendor.

6. Coordinating work plans, project tasks, and responsible staff to meet deadlines set by regulatory entities;

7. Developing data collection tools and reference materials, if applicable;

8. Collecting data and Medical Record Review (MRR);

9. Compiling data and final report formatting;

10. Finalizing results for external auditor review, internal reporting, and submission to CMS, DHCS and NCQA;

11. Coordinating HEDIS® compliance audits and submitting the NCQA HEDIS® Roadmap to the DHCS selected contractor for the MCAS performance measure set and the CalOptima Health contracted audit vendor for the Full Scope NCQA performance measure set;

12. Submit audited results to CMS, DHCS and NCQA by due dates established by CMS, DHCS and NCQA of each year; and

13. Identifying HEDIS® measures that perform below the DHCS/NCQA established MPL, if applicable.

    a. For each measure below the MPL, CalOptima Health shall develop corrective actions (e.g., Plan-Do-Study-Act (PDSA) cycle improvement projects and/or Corrective Action Plans) that outline steps to improve performance with DHCS All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements , and subsequent revisions. CalOptima Health shall submit a PDSA Cycle Worksheet, or an alternative quality improvement project as directed and approved by DHCS, for MCAS measures with rates that do not meet the MPL or are given an audit result of "Not Reportable."

B. CalOptima Health's IS Enterprise Data and Systems Integration Department shall be responsible for the following activities in relation to program's HEDIS® data collection and reporting:

1. Collaborate with HEDIS Data Analysts to develop data files pursuant to HEDIS® specifications to populate NCQA-Certified HEDIS® software; and

2. Submitting required patient-level detail file to CMS by the established due date.

C. CalOptima Health's Provider Relations and Health Network Relations Departments shall perform the following activities in collaboration with the HEDIS® Project Manager in relation to programs' HEDIS® data collection and reporting:

1. Coordinate Health Network and Provider outreach;

2. Communicate HEDIS® project requirements and expectations for performance improvements to Health Networks and Providers through various means including Provider Bulletins, informational letters, and delegation oversight in accordance with CalOptima Health Policies GG.1619: Delegation Oversight;

3. Identify Health Network and Provider key contacts to assist in the data collection process and ensure communication of relevant information to appropriate staff at all levels;

4. Function as a liaison between the CalOptima Health program and a Health Network or Provider to schedule site visits and assist in the data pursuit process; and

5. Assist with coordination and implementation of QI interventions at the Health Network and Provider levels.

D. CalOptima Health shall provide Health Networks with HEDIS® results. If the Health Network is identified as having HEDIS® results below the DHCS established MPL or below other established benchmarks (e.g., NCQA or CMS performance benchmarks), the Quality Analytics Department may take the following steps:

1. Request a PDSA cycle(s) to be submitted on approved PDSA cycle worksheets within thirty (30) business days for performance measures that are deemed deficient or non-compliant.

2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP), in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan.

3. If a Health Network's non-compliance warrants further action, CalOptima Health's Delegation Oversight Committee (DOC) may recommend Sanctions including, but not limited to capitation deduction, freezing enrollment, de-delegation, or termination of contract in accordance with CalOptima Health Policy HH.2002: Sanctions.

a. CalOptima Health will log all requests for PDSA cycles from Health Networks and will report to the Office of Compliance any non-compliance to complete the PDSA. The Office of Compliance shall present information regarding Health Network performance on required CMS and DHCS measures to the DOC on a routine basis.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. HEDIS® Technical Specifications, Volume 2
D. CalOptima Health, Health Network Service Agreement
E. CalOptima Health Policy GG.1619: Delegation Oversight
F. CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects
G. CalOptima Health Policy HH.2002: Sanctions
H. CalOptima Health Policy HH.2005: Corrective Action Plan
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements (Supersedes APL 19-017)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/09/2015	Department of Health Care Services (DHCS)	Approved as Submitted
11/17/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	GG.1205	HEDIS Data Collection and Reporting	Medi-Cal
Revised	04/01/2007	GG.1205	HEDIS Data Collection and Reporting	Medi-Cal
Revised	01/01/2009	GG.1205	External Accountability Set Performance Measures	Medi-Cal
Revised	01/01/2014	GG.1205	External Accountability Set Performance Measures	Medi-Cal
Revised	07/01/2014	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal
Revised	12/01/2016	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal OneCare OneCare Connect
Revised	04/01/2019	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal OneCare OneCare Connect
Revised	04/01/2020	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal OneCare OneCare Connect
Revised	07/01/2022	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2023	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal OneCare
Revised	10/01/2024	GG.1205	HEDIS® Data Collection and Reporting	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs as provided by statute and/or regulation.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services.
Healthcare Effectiveness Data and Information Set (HEDIS®)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP Medical Records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Plan-Do-Study-Act (PDSA)	The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Term	Definition
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.