Department of Health and Human Services
Centers for Medicare & Medicaid Services

Date Issued: **July 16, 2001**

Operational Policy Letter #: OPL 2001.133

To: **Current M+C Organizations: X**
CHPP Demonstrations:
Evercare
DoD (TriCare)
SHMO I & II
PACE
OSP Demonstrations:
MSHO
W.P.P.
HCPPs
Federally Qualified HMOs
Section 1876 Cost Plans

Subject: Medicare+Choice Organizations' (M+CO) National Quality Assessment and Performance Improvement (QAPI) for the Years 2002 and 2003

Effective Dates: January 1, 2002 and January 1, 2003

Implementation Dates: January 1, 2002 and January 1, 2003

Current Policy: Each year, CMS defines a national quality assessment and performance improvement project for Medicare + Choice organizations (M+CO) to conduct. The 2002 national QAPI project is Breast Cancer Screening (BCS). For the 2003 national QAPI project, M+COs may choose between two options--clinical health care disparities (CHCD) or culturally and linguistically appropriate services (CLAS).

This OPL provides M+COs with instructions for the national QAPI projects for the years 2002 and 2003. We are pleased to note that in developing the projects and these instructions we have responded to industry concerns regarding national QAPI project requirements by establishing a mechanism that rewards high performance for BCS projects and by developing a simplified approach for CLAS projects. In addition, in an effort to assist M+COs to conduct projects that address CHCD and CLAS, we will make available race and ethnicity data that is collected by the Social Security Administration (SSA) at the time of original enrollment in Medicare.1

2002 Breast Cancer Screening Project: The main objective of the BCS project is to decrease the morbidity and mortality associated with breast cancer in female Medicare beneficiaries enrolled in M+COs. Efforts to accomplish this goal require increasing the level of early detection of the disease by encouraging optimal use of mammography. To implement this project, M+COs will use NCQA's technical specifications relating to the breast cancer screening measure and will be able to use HEDIS reported information as baseline data. Since this measure has been a Medicare reported measure for several years, some M+COs have achieved a high screening rate above which it would be difficult to improve. Thus, CMS will reward these high performers by excusing them from participating in the 2002 national QAPI project. The specific details for the BCS QAPI project are provided in **Attachment A. The contact for this project is Richard Malsbary at (410) 786-1132 or rmalsbary@CMS.hhs.gov.**

1 It must be pointed that the race and ethnicity data collected by the SSA has limitations. A study noted that the chance the data correctly identifies a person of a given race/ethnicity is 97% for white persons and 95% for black persons, but less than 60% for all other categories. Susan L. Arday, et.al., HCFA's Racial and Ethnic Data: Current Accuracy and Recent Improvements, Health Care Financing Review, Vol. 21, No. 4 (2000).

2003 Clinical Health Care Disparities and Culturally and Linguistically Appropriate Service Projects: Compelling evidence exists that race and ethnicity correlate with persistent, and often increasing, health disparities. Reducing these disparities is one of the major challenges facing the entire health care industry. In addition, an increasing body of research indicates that the provision of culturally and linguistically appropriate services leads to improved health outcomes, increased patient or beneficiary satisfaction, and organizational efficiencies that result in decreased expenditures. To establish a framework that M+COs can use for conducting QAPI projects that focus on CHCD and the provision of CLAS, CMS worked closely with a group that included managed care and physician group representatives. For CHCD projects, M+COs **do not** have to demonstrate that there is a health care disparity between minority and non-minority populations enrolled in their plan in order to engage in a project. For the non-clinical CLAS projects, CMS will allow an M+CO 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.

The group's input also provided valuable assistance in the development of several example CHCD/CLAS projects that M+COs may use to implement their 2003 national project requirements. These examples help to illustrate that QAPI projects addressing CHCD/CLAS are feasible and reasonable. As an illustration, an M+CO may elect to compile or enhance and make available a practitioner directory that identifies bilingual/multilingual practitioners. The interventions could consist of (1) surveying practitioners to request the voluntary identification of those who are bilingual/multilingual; (2) compiling (or enhancing) and publishing a directory that identifies the bilingual/multilingual practitioners and the language(s) in which they are competent; (3) making the directory available to all enrollees through normal channels; and (4) including a notice of the availability of the directory in outreach materials to limited English proficiency members. To demonstrate improvement, the M+CO would have to show the state of the directory prior to the quality improvement effort and the directory that is operational at the end of the project.

Additionally, over the course of the next year, CMS will work with the Agency for Healthcare Research and Quality (AHRQ) and other Federal agencies to develop a best practices conference and quality improvement approaches in this area for optional use by M+COs. The specific details for the CHCD and CLAS QAPI projects, as well as the example projects are provided in **Attachment B. Your contact for this project is Trisha Kurtz at (410) 786-4670 or pkurtz@CMS.hhs.gov.**

This OPL was prepared by the Center for Beneficiary Choices.

Attachment A

Subject: **Medicare+Choice Year 2002 National QAPI Project on Breast Cancer Screening**

Implementation Date: **January 1, 2002**

Effective Date: **January 1, 2002**

For women in the United States, breast cancer is the leading cause of cancer incidence and the second leading cause of cancer death. In 2001 it is likely that more than 190,000 new breast cancer cases will be diagnosed and more than 40,000 women will die of the disease. Current estimates indicate that one in eight women will develop breast cancer in her lifetime. Breast cancer and associated morbidity and mortality become more prevalent with increasing age, and more than half of breast cancers occur in women 65 years and older.

Mammography is the most effective method of diagnosing breast cancer. It is estimated that mammograms can detect abnormalities between 60 and 95 percent of the time.* Ninety-six out of 100 women will live for five years or more if their breast cancer is found at its earliest stage.** Since mammography is effective for early detection and has the potential for improving overall health in the country, CMS has chosen breast cancer screening as the national quality assurance and program improvement project.

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+COs. 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® breast cancer screening measure as described by the NCQA in Volume 2 of its HEDIS 2002 Technical Specifications. Briefly, 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+COs 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+CO 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+COs 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.

Organizations that do not have to perform the national project will be notified by CMS, about October 1 of 2001 and 2002, that they are exempt based on data from HEDIS 2001 (measurement year 2000) or HEDIS 2002 (measurement year 2001) reporting years, respectively. 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 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 Quality Improvement System for Managed Care 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+CO selected project. The national QAPI project will not affect the cycle of internal optional projects.

Support/Communication for Projects
We encourage M+COs to work in collaboration with their local Peer Review Organization (PRO) as they seek appropriate interventions to improve mammography rates and reduce burden on providers of services. In addition to PRO 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 (cited 2001 January 4)

Attachment B

Subject: **Medicare + Choice Year 2003 National QAPI Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services**

Effective Date: **January 1, 2003**

Implementation Date: **January 1, 2003**

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.2, 3, 4, 5, 6, 7 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 locus 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+CO will have a choice between initiating a project that addresses clinical health care disparities (CHCD) **or** culturally and linguistically appropriate services (CLAS). M+COs that select a project that addresses CHCD must focus on one of four clinical areas--diabetes, pneumonia, congestive heart failure, or mammography--and must use previous guidelines issued by CMS in the form of OPLs to determine appropriate quality indicators and implementation strategies.8 9 10 M+COs that select a project that addresses CLAS must focus on language access or organizational support for CLAS. M+COs 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.

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2 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.

3 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.

4 Tortolero-Luna G, Glober 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.

5 Center for Health Quality, Outcomes, and Economic Research: *Quarterly 2*, Spring 1999.

6 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.

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

8 http://www.hcfa.gov/medicare/mgdqual.htm. OPL #129 (1) The Year 2001 National Project on Congestive Heart Failure (CHF) for Medicare+Choice Organizations (M+CO); 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.

9 http://www.hcfa.gov/quality/3l.htm. Diabetes Quality Improvement Project (DQIP).

10 Breast Cancer Screening OPL.

Clinical Health Care Disparities
CHCD projects must measure and improve care for individuals enrolled in the M+CO from any, all, or a subset of the following populations:

- American Indian/Alaskan Native
- Asian
- Black/African American
- Native Hawaiian/Pacific Islander
- 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+COs 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+CO 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 supplied by CMS that is collected by the SSA at the time of original enrollment in Medicare. Other data sources, such as zip-code/census data, may be used to target interventions to appropriate individuals. For **M+COs 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 1 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 are in Attachment B-1. M+COs may find these examples useful in developing their own project plans.

Culturally and Linguistically Appropriate Service
M+COs 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.11 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 Attachment B-2. M+COs may find these examples useful in developing their own project plans. M+COs that decide to use one of the example projects provided in Attachment B 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:

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

Project Support and Evaluation
We encourage M+COs 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+CO, however, will be assessed individually on the success of their project. M+COs 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+CO 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.12
We also encourage M+COs to work with their local 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+COs that focus on CLAS for their project, CMS is working with the Agency for Healthcare Quality and

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11 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.
12 HCFA has a contract with Kaiser Mid-Atlantic that serves several states and the District of Columbia.

Research (AHRQ) and one of their contractors to develop detailed specifications and interventions for two of the example projects presented in Attachment B-2.

M+COs 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+COs 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+COs 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+COs 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+CO 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+COs 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.
- 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.

Please 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 Medicare Managed Care Group.

Attachment B-1

Clinical Health Care Disparities
DRAFT Sample QAPI Projects*

Example 1: Mammography
This project seeks to increase the use of mammography screening with a focus on clinical health care disparities. The M+CO with a Medicare enrollment of 10,000 decides to aggregate all of the potential categories to create a selected population. The M+CO 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% of its enrollment were in a population that the M+CO selected for their QAPI project, about 200 of whom were women of appropriate age. Beginning in 2003, the M+CO uses claims alone to determine the rate. For the baseline year (2002), the rate for the selected population is 50% (performance gap of 50%), and for the overall enrolled population the rate is 55% (performance gap of 45%). For this M+CO, there is an apparent disparity of 5%, but a disparity is not necessary to conduct the project. For this M+CO the apparent disparity is 5%. The M+CO uses this same methodology to determine the rates for the years 2003, 2004, and 2005.

In 2003, the M+CO 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 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 it PCPs.

For the 2003 reporting period there is no improvement in rates, but in 2004 the rate for the selected population is 56%. Compared to baseline this means that the performance gap has been reduced from 50% to 44%, which is a 12% improvement in gap. In 2005 the rate for the selected population is 55%, 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+CO 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+CO 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% and 20%. For the selected population, there were a total of 125 respondents, and the rates were 30% and 25%. 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.

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

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

In 2003, the M+CO 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 zipcodes with higher proportions of residents from the selected population, the M+CO 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% (flu) and 30% (pneumococcal). Compared to baseline this means that the initial gap of 70% has been reduced to 65%, which represents a 7% improvement in gap. For the 2004 reporting period, the rates for the selected population are 40% and 35%. This represents a 14% 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.

Attachment B-2

Culturally and Linguistically Appropriate Services
DRAFT Sample QAPI Projects*

PART 1: 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[1]. 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.[2] Included among the negative effects of language barriers are higher rates of diagnostic testing, omission of vital information, misdiagnoses, inappropriate treatment and misunderstanding.[3]

Incentives for M+COs 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.
- Better protection for the M+CO against tort liability, malpractice lawsuits and charges of negligence.

M+COs 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/Multilingual Practitioners

Identify an Opportunity for Improvement

1. Identify the languages likely to be encountered by appropriate M+CO practitioners.
2. Use these data to assess the need to identify plan practitioners who are bilingual/multilingual.

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

Intervention

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

Benchmark/Goal

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

Outcome

For improvement, M+COs 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+CO LEP Beneficiaries and Access and Use This Information

Identify an Opportunity for Improvement

Assess the adequacy of any existing system(s) for identifying M+CO 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+CO 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+CO LEP enrollees and to access and use this information.

Outcome

For improvement, M+COs 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+CO LEP enrollees of their right to language services.

Identify an Opportunity for Improvement

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

Intervention

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

Benchmark/Goal

New or enhanced procedures exist and are operational to acquaint M+CO 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+COs 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 4: Provide Oral Language Interpretation Assistance to M+CO LEP Enrollees

Identify an Opportunity for Improvement

1. Identify the languages likely to be encountered in the M+CO service area and enrollee population by reviewing census data, CMS-provided race and ethnicity data for M+CO's enrollees and/or data from school systems and community agencies and organizations.
2. Select one or more of the most dominant LEP groups in the service area.
3. Evaluate the adequacy of any existing process (es) to provide oral language interpretation services to enrollees in the selected LEP groups.
4. Identify the points of contact in the M+CO where language assistance is likely to be needed (e.g., beneficiary services).
5. Define the resources that will be needed to provide effective language assistance to M+CO 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+CO offers and provides oral language assistance including bilingual staff and interpreter services to M+CO 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+CO is implemented and fully operational.

Outcome

For improvement M+COs 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 One or More Vital Documents and Information to M+CO LEP Enrollees

Identify an Opportunity for Improvement

1. Identify the non-English languages that are likely to be encountered in the M+CO's service area by reviewing census data, CMS-provided race and ethnicity data for M+CO enrollees and/or data from school systems and community agencies and organizations.
2. Identify one or more of the most dominant LEP language groups in the service area.
3. 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 one or move vital documents and information. Translated materials should be responsive to the culture as well as the levels of literacy of M+CO LEP enrollees in these language groups; and/or
- 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; and/or
- Provide/post way-finding signs to identify or label the location of specific services (e.g., registration, examining rooms); and/or
- 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+CO 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+CO 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+COs will need to show what was in place prior to the quality improvement effort and what is operational at the end of the project.

PART II: POTENTIAL ORGANIZATIONAL SUPPORT CLAS 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 locus 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+CO 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+CO; assess whether M+CO 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.

1. Assess the diversity of populations served with regard to culture and language.

2. Review employee recruitment and retention practices; do these practices reflect sensitivity to the linguistic and cultural needs of communities served?

3. Develop a written plan with regard to recruiting and retaining employees who reflect sensitivity to the linguistic and cultural needs of communities served.

4. Acquire board 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+CO 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+COs 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 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+CO; 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.

1. Assess the diversity of populations served with regard to culture and language.

2. Review practitioner recruitment and retention practices to ensure that these practices reflect sensitivity to the linguistic and cultural needs of communities served.

3. Develop a written plan with regard to recruiting and retaining practitioners that reflect sensitivity to the linguistic and cultural needs of communities served.

4. Acquire board 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+CO 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+COs 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: Develop or provide access to 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.

1. Assess the diversity of populations served with regard to culture and language.

2. 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+COs.)

3. Assist employees and practitioners in attending CLAS training.

4. 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+CO shall increase the number attending the training. If the program is new, then the M+CO shall demonstrate that the program is initiated and that there is participation with significant attendance by employees and practitioners.

Outcome: For improvement M+COs 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 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+CO 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:

1. Assess the diversity of populations served with regard to culture and language.

2. Assess organizational capacity for providing CLAS.

3. Use the organizational assessment to build a multi-year plan for providing CLAS.

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

Benchmark/Goal: M+CO conducts an organizational assessment to identify opportunities for improvement in the provision of CLAS. Based on the assessment, M+CO puts into place the necessary organizational structure needed

to execute the multi-year plan.

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

OPL2001.133 Addendum #1

We are pleased to provide a list of the Medicare+Choice organizations that will be participating in the M+C program in 2002 but will not have to perform the 2002 national QAPI project. These organizations are exempted based on having achieved a rate of 80.0 or better on the HEDIS® 2001 breast cancer screening measure. As noted in Attachment A of the OPL CMS will input the exemption into the M+C Quality Review Organization QAPI database. When HEDIS 2002 results are available we will post a list of additional exempted organizations that also achieved a rate of 80.0 or better.

Organization_name	CMS contract	BCS rate
Kaiser Foundation Health Plan Inc. - Southern California	H0524	80.05
Carelink Health Plans	H5149	80.39
HealthNet, Inc. Kansas City	H2666	80.54
Neighborhood Health Partnership, Inc.	H1078	80.78
Kaiser Foundation Health Plan, Inc. - Northern California	H0524	80.78
Arnett Health Plans	H1555	80.84
Group Health Plan, Inc.	H2663	80.92
CIGNA HealthCare of Arizona, Inc.	H0354	81.00
HIP Health Plan of New York	H3330	81.11
Coordinated Health Partners, Inc., dba BlueCHiP	H4152	81.15
VIVA Health, Inc.	H0154	81.25
Health Alliance Medical Plans	H1463	81.30
Providence Health Plans - Oregon	H9047	81.36
Kaiser Foundation Health Plan of the Northwest	H9103	81.38
Aetna U.S. Healthcare of California - South	H0523	81.39
UCARE Minnesota	H2459	81.70
UnitedHealthcare of North Carolina, Inc.	H3456	81.87
Keystone Health Plan Central	H3962	81.95
Rochester Area Health Maintenance Organization d.b.a. Preferred Care	H3305	82.00
Carelink Health Plans	H3673	82.08
Kaiser Foundation Health Plan of the Northwest, Inc.	H9003	82.31
Group Health Cooperative of Puget Sound	H5050	82.61
Harvard Pilgrim Health Care, Inc.	H2206	82.62
Florida Health Care Plan, Inc.	H1035	82.68
Tufts Associated Health Maintenance Organization, Inc. dba Tufts Health Plan	H2256	82.91
Physicians Health Services of Connecticut	HO755	83.19
Kaiser Permanente, Colorado	H0630	83.63
Kaiser Foundation Health Plan of Georgia, Inc.	H1170	83.89
Kaiser Foundation Health Plan of Hawaii, Inc.	H1230	85.21
Fallon Community Health Plan	H9001	85.33
Kaiser Foundation Health Plan of Ohio	H3607	85.34
Kaiser Foundation Health Plan of Kansas City, Inc.	H1751	86.38
HealthPlus of Michigan	H2354	86.72
Harvard Pilgrim Health Care of New England (NH/VT)	H2204	86.84
Gundersen Lutheran Health Plan, Inc.	H5262	87.18
Blue Cross and Blue Shield of Massachusetts, Inc.	H2261	88.89
HealthAmerica Pennsylvania, Inc.	H3959	89.29
HealthAmerica Pennsylvania, Inc.	H3960	89.80
Group Health, Inc.	H9005	90.83

OPL2001.133 Addendum #2

We are pleased to provide the second and final listing of M+C organizations that will be participating in the M+C program in 2003 but will not have to perform the 2002 national QAPI project. These organizations, in addition to those posted in Addendum #1 last year, are exempted based on having achieved a rate of 80.0 or better on the HEDIS®2002 breast cancer screening measure.

CMS Contract	*Organization Name*	*BCS Rate*
H0302	Sun Health Medisun, Inc.	84.90
H1032	Well Care HMO, Inc.	80.46
H1099	Health First Health Plans, Inc.	83.94
H1951	Ochsner Health Plan	80.15
H2667	Mercy Health Plans of Missouri, Inc.	80.49
H3251	Lovelace Health Plan, Inc	80.51
H3856	Regence HMO Oregon	84.70
H4456	John Deere Health Plan, Inc.	80.29

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