MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Medicaid Health Plans 02-03

Issued: March 1, 2002

Subject: Annual HEDIS® Reporting Requirements for Medicaid Health Plans

Effective: April 1, 2002

Programs Affected: Medicaid

The purpose of this policy is to describe the annual Health Plan Employer Data & Information Set (HEDIS®) reporting requirements to which Medicaid contracted HMOs must comply. The Bulletin continues to require health plans to follow current National Committee on Quality Assurance (NCQA) HEDIS® specifications. The policy has been revised to update reporting requirements.

MANUAL MAINTENANCE

Replace Chapter VIII, Sections 1, 2, 3, and 4 in the Health Plan Manual with the attached documents. This bulletin may be discarded after manual maintenance.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED

James K. Haveman, Jr.
Director

Carol Isaacs
Deputy Director for
Policy and Legal Affairs Administration

GENERAL INFORMATION

Medicaid HMOs (health plans) contracted with the State of Michigan through the Department of Community Health (DCH) for the purposes of enrolling and providing care to Michigan Medicaid beneficiaries are required to report annual performance data to DCH using the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS®) reporting version that is applicable to the reporting period. Annually, health plans must:

- Secure an audit opinion from a NCQA-certified HEDIS® compliance auditing firm and lead auditor.
- Submit two hard copies of the audited Medicaid HEDIS® Data Submission Tool (DST) and two auditor-locked electronic copies of the Medicaid HEDIS® DST to the plan's contract manager on or before June 30th or the following business day if June 30th occurs on a non-business day.
- Submit a copy of the signed and dated Final Audit Opinion along with the DST.
- Submit a copy of the signed and dated "Attestation of Accuracy and Public Reporting Authorization-Medicaid" letter along with the DST.
- Submit two hard copies of the health plan's HEDIS® Final Audit Report by July 30th or the following business day if July 30th occurs on a non-business day.

Health plans that are operational or contracted for a partial year must complete all measures required by NCQA, excluding those that cannot be computed due to continuous enrollment requirements.

As stated in the Request for Proposal and the Contract between the Department of Management and Budget and the health plan (and/or DCH and the health plan), sanctions and/or remedies may be imposed on the health plan for failure to meet the reporting requirements described herein. The application of sanctions and remedies will be a matter of public record.

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ANNUAL HEDISÒ REPORTING CONTENT GUIDELINES

For all contract annual reporting periods, the annual reports must be in compliance with the most recent Volume 2, HEDIS® Technical Specifications manual as published by NCQA.

Health plans are not responsible for reporting measures for services that are not required by the contract, such as dental or inpatient mental health services. Further, health plans are not responsible for reporting measures dependent upon Medicaid membership data not provided by DCH to the health plans.

Health plans are required to perform an annual adult and child Consumer Assessment of Health Plan Study (CAHPS®) consumer survey as specified by HEDIS®. If DCH contracts with and directly pays a vendor to conduct the Medicaid CAHPS® survey, participating health plans do not have to report the Satisfaction with the Experiences of Care measure. However, if a health plan chooses to directly contract with its own NCQA-certified survey vendor, or at a later date should DCH no longer directly contract with a survey vendor, health plans will then be required to submit both member level (adult and child) and summary level results of its Medicaid adult and child member surveys.

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DEFINITION OF REPORTING CATEGORIES

Health plans should follow the Medicaid eligibility reporting categories provided in the most recent Volume 2 HEDIS® Technical Specifications manual. Unless otherwise specified by MDCH, health plans should report the Use of Services measures for “Total Medicaid” only.

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PRODUCTION SCHEDULE

Annually, on or before June 30th or the following business day if June 30th occurs on a non-business day, health plans are to submit an audited annual Medicaid HEDIS® Report as follows:

- two hard copies and two auditor-locked electronic copies of the Medicaid HEDIS® DST
- a copy of the NCQA-certified HEDIS® compliance auditor's signed and dated Final Audit Opinion
- a copy of the health plan's signed and dated "Attestation of Accuracy and Public Reporting Authorization-Medicaid" letter

Annually, on or before July 30th or the following business day if July 30th occurs on a non-business day, health plans are to submit:

- two hard copies of the health plan's HEDIS® Final Audit Report

The annual Medicaid HEDIS® Report and documents should be submitted to the health plan's contract manager at the following address:

Comprehensive Health Plan Division
Department of Community Health
PO Box 30479
Lansing, MI 48909-7979

Questions pertaining to Medicaid HEDIS® reporting requirements should be directed to:

Quality Systems Section
Department of Community Health
PO Box 30479
Lansing, MI 48909-7979

Phone: (517) 241-8664

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