2016

MO HealthNet Managed Care Program

External Quality Review

Supplemental Report of Technical Methods

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LIST OF ACRONYMS

Aetna Better Health	Aetna Better Health of Missouri
BHO	Behavioral Health Management Organization
CAHPS	Consumer Assessment of Health Plans Survey
CDC	Centers for Disease Control and Prevention
CHI-SQUARE	A statistical test that is used to examine the probability of a change or difference in rates is due to chance.
CI	Confidence Interval
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
CY	Calendar Year
DHHS	U.S. Department of Health and Human Services
DHSS	Missouri Department of Health and Senior Services
DSS	Missouri Department of Social Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	MO HealthNet Fee-for-Service
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information Systems
HMO	Health Maintenance Organization
HOME STATE HEALTH	Home State Health Plan of Missouri
ISCA	Information Systems Capability Assessment
LPHA	Local Public Health Agency

MC+	The name of the Missouri Medicaid Program for families, children, and pregnant women, prior to July 2007.
MC+ MCOs	Missouri Medicaid Program Managed Care Organizations (prior to July 2007)
MCHP	Managed Care Health Plan
MCO	Managed Care Organization
MDIFP	Missouri Department of Insurance, Financial Institutions and Professional Registration
MO HEALTHNET	The name of the Missouri Medicaid Program for families, children, and pregnant women.
MO HEALTHNET MCHPs	Missouri Medicaid Program Managed Care Health Plans
MISSOURI CARE	Missouri Care Health Plan
MOHSAIC	Missouri Public Health Integrated Information System
NCQA	National Committee for Quality Assurance
N.S.	Not significant, indicating that a statistical test does not result in the ability to conclude that a real effect exists.
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QA & I	MO HealthNet Managed Care Quality Assessment and Improvement Advisory Group
QI/UM Coordinator	Quality Improvement/Utilization Management Coordinator
SMA	State Medicaid Agency, the Missouri Department of Social Services, MO HealthNet Division
SPHA	State Public Health Agency, the Missouri Department of Health and Senior Services

GLOSSARY AND OPERATIONAL DEFINITIONS

Administrative Method	The Administrative Method of calculating HEDIS Performance Measures requires the MCHP to identify the denominator and numerator using transaction data or other administrative databases. The Administrative Method outlines the collection and calculation of a measure using only administrative data, including a description of the denominator (i.e., the entire eligible population), the numerator requirements (i.e., the indicated treatment or procedure) and any exclusion(s) allowed for the measure.
Confidence interval	The range of accuracy of a population estimate obtained from a sample.
Hybrid Method	Hybrid Method requires the MCHP to identify the numerator through both administrative and medical record data. The MCHP reports a rate based on members in the sample who are found through either administrative or medical record data to have received the service identified in the numerator.
Interrater reliability (IRR)	A method of addressing the internal validity of a study by ensuring that data are collected in a consistent manner across data collectors.
Probability sample	A sample in which every element in the sampling frame has a known, non-zero probability of being included in a sample. This produces unbiased estimates of population parameters that are linear functions of the observations from the sample data[1].
Random sample	Selection of sampling units from a sampling frame where each unit has an equal probability of selection.
Reliability	The consistency of findings across time, situations, or raters.
Sampling frame	The population of potential sampling units that meet the criteria for selection (e.g., Medical encounter claim types from January 1, 2004 through March 31, 2004).
Sampling unit	Each unit in the sampling frame (e.g., an encounter).
Simple sample	Selection of sampling units from one sampling frame.

[1] Levy, P.S., Lemeshow, S. (1999). Sampling of Populations: Methods and Applications, Third Edition. John Wiley and Sons: New York.

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1.0 Preparation for the EQR

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Preparation with the State Medicaid Agency

Effective January 1, 2016 the State of Missouri contract for the External Quality Review of the MO HealthNet Managed Care Program (State of Missouri Contract No: C312155001, Amendment No.: 004) was awarded to comply with federal requirements for states to contract with an external, independent entity to implement the mandatory protocols for External Quality Review. Meetings for planning the scope of work, technical methods and objectives, are scheduled beginning each January for the upcoming review year. Meetings are held with the SMA and the EQRO throughout the review period. Additional meetings and teleconference calls may be conducted as needed between MO HealthNet, the State Medicaid Agency (SMA) and EQRO personnel.

At the first meeting of each year, the previous years' report is discussed and the plan for the subsequent audit is initiated. The EQRO clarifies the SMA's objectives for each of the protocols, develops data requests, prepares detailed proposals for the implementation and analysis of data for each protocol, and prepares materials for SMA review. Plans are made to conduct Orientation Conference Calls for the upcoming EQR with each MO HealthNet Managed Care Health Plan (MCHP) that are attended by the SMA. Written proposals for each protocol are developed and approved by the SMA indicating differences in the approach or information to be validated.

Preparation of MCHPs

To prepare the MCHPs for the implementation of the yearly EQR an annual Orientation Conference Call is conducted by the EQRO Project Director and personnel. The EQRO Project Director and personnel conduct orientation to the protocols and the EQR processes with each MCHP. In addition, the EQRO Project Director presents a timeline for project implementation and answers MCHP questions at a combined MO HealthNet Managed Care QA&I Advisory Group/MO HealthNet Managed Care All-Plan meeting.

The EQRO Assistant Project Director arranges the dates of the teleconference calls with MCHP QI/UM Coordinators or Plan Administrators. A detailed presentation, tentative list of data requests, and the proposals approved by the MO HealthNet are sent to MCHPs prior to the teleconference orientation sessions. MCHPs are requested to have all personnel involved in fulfilling the requests or in implementing activities related to the protocols (e.g., performance improvement projects to be validated, performance measures to be validated) present at the teleconference calls. The orientation presentation is contained in Appendix 1. A MO HealthNet representative is invited

to attend all conference calls. Notes are sent regarding any calls that the representative does not attend. To avoid confusion and the inundation of multiple requests at once, the requests for information from MCHPs are normally implemented in a staged approach from January through April. All communications (letters, general and specific instructions) are approved by MO HealthNet prior to sending them to the MCHPs.

Development of Worksheets, Tools, and Rating Criteria

The EQRO Project Director, Assistant Project Director, and a healthcare consultant are responsible for modifying the worksheets and tools used by the EQRO during each audit. The EQRO Assistant Project Director revises the worksheet (Attachment B) for Validating Performance Improvement Project Protocol to add details specific to the MO HealthNet Managed Care Program each year.

The Validating Performance Measures Protocol worksheets are revised and updated by the EQRO Project Director to reflect the Performance Measures selected for review for the appropriate HEDIS year. The worksheets developed by Behavioral Health Concepts Inc. staff are updated annually to reflect the information needed for that year's audit.

MO HealthNet continues to conduct the activities of the MO HealthNet Managed Care Compliance with Managed Care Regulations Protocol through the state contract compliance monitoring process. The work of the EQRO involves the review and evaluation of this information (see Medicaid Program; External Quality Review of Medicaid Managed Care Organizations of 2003, CFR §438.58). The state contract for the EQRO requires the review of MO HealthNet's activities with regard to the Protocol. Additional policies and documents are requested prior to and during the on-site visits with MCHPs when information was incomplete or unclear. To facilitate the review of compliance with federal regulations, the EQRO Assistant Project Director works with MO HealthNet staff to develop the focus of each year's compliance review to ensure that it addresses issues of concern where compliance may be compromised. Focused interview tools are developed and submitted to MO HealthNet for review and approval. The MO HealthNet Managed Care Program consultant, who participates as part of the EQRO team each year reviews and assists in refinement of compliance activities.

The EQRO utilizes the rating system developed during the 2004 audit to provide ratings for each MCHP's compliance. MO HealthNet provides information on MCHP policy compliance with state

contract requirements annually. The EQRO determines if this meets the policy requirements of the federal regulations. The EQRO staff and the consultant review all available materials and meet with MO HealthNet staff to clarify any of their comments and compliance ratings. Issues are identified for follow-up at site visits. Updates on MCHP compliance are accepted up until the time of the on-site reviews to ensure that the EQRO has up-to-date information. Recommended ratings, based upon the preapproved rating scale are provided to SMA.

REVIEWERS

Three reviewers are utilized to complete all sections of the EQR. Interviews, document review, and data analysis activities for the Validating Performance Measure Protocol were performed by two reviewers from the External Quality Review Organization (EQRO). The Project Director conducted interviews, document review, and data analysis; she is a licensed attorney with a graduate degree in Health Care Administration, as well as seventeen years' experience in public health and managed care in four states. This is her twelfth External Quality Review.

Two reviewers take primary responsibility for conducting the Performance Improvement Project (PIP) Validation and the Compliance Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director conducts backup activities, including assistance during the interview process, and oversight of the PIP and Compliance Protocol team. All reviewers are familiar with the federal regulations and the manner in which these were operationalized by the MO HealthNet Managed Care Program to comply with the federal protocols.

The following sections summarize the aggregate findings and conclusions for each of the mandatory protocols. The full report is organized according to each protocol and contains detailed descriptions of the findings and conclusions (defined as the Quality Care, Access to Care, Timeliness of Care, and recommendations). In addition, it provides MCHP to MCHP comparisons and MCHP summaries for each protocol.

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2.0 Performance Improvement Projects

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PURPOSE AND OBJECTIVES

The purpose of the Performance Improvement Project (PIP) is to assess and improve the processes and outcomes of health care provided by the health plan. The review is developed to determine whether the health care quality PIP was designed, conducted, and reported in a methodologically sound manner. The EQRO uses the procedures outlined in the CMS EQR Protocol 3 regarding PIPs. The EQRO assesses the validity and reliability of the results presented by the MCHPs.

Each MCHP is required to conduct, at a minimum, at least one clinical and one non-clinical PIP during each calendar year. MCHPs may engage in multiple projects over multiple years. However, if an on-going PIP is reviewed, at least one new activity is required to enhance ongoing quality improvement, and the PIP documentation must be updated accordingly.

PIP topics and methodologies are to reflect relevant clinical, administrative and population-based improvement efforts to improve health care delivery and outcomes for the people served.

TECHNICAL METHODS

There are three evaluation activities specified in the protocol for Validating Performance Improvement Projects.
"Activity One: Assessing the MCOs/PIHPs Methodology for Conducting the PIP" consists of ten steps:

1. Step One: Review the selected study topic(s)
2. Step Two: Review the study question(s)
3. Step Three: Review selected study indicator(s)
4. Step Four: Review the identified study population
5. Step Five: Review sampling methods (if sampling was used)
6. Step Six: Review the data collection procedures
7. Step Seven: Assess the MCOs improvement strategies
8. Step Eight: Review the data analysis and interpretation of study results
9. Step Nine: Assess the likelihood that reported improvement is "real" improvement
10. Step Ten: Assess the sustainability of documented improvement

"Activity Two: Verifying PIP Study Findings" is optional, and involves auditing PIP data. "Activity Three: Evaluate Overall Reliability and Validity of Study Findings" involves accessing whether the results and conclusions drawn from the PIPs are valid and reliable. Activities One and Three are conducted by the EQRO.

Time Frame and Selection

Two projects that were underway during the preceding 12 months at each MCHP are selected for validation. One project is to be clinical in nature, and one non-clinical. The projects to be validated are reviewed with MO HealthNet and EQRO staff after topic submission is complete. The intent is to identify projects which are mature enough for validation (i.e., planned and in the initial stages of implementation), underway or completed during the previous calendar year. MO HealthNet makes the final decision regarding the actual PIPs to be validated from the descriptions submitted by the MCHPs. The non-clinical PIP currently reviewed for each MCHP is their approach to a Statewide PIP.

Procedures for Data Collection

The evaluation involves review of all materials submitted by the MCHPs including, but not limited to, the materials listed below. During the training teleconferences MCHPs are encouraged to review Attachment A of the Validating Performance Improvement Projects Protocol, to ensure that they include supporting documents, tools, and other information necessary to evaluate the projects submitted, based on this tool.

- Narrative descriptions
- Problem identification
- Hypotheses
- Study questions
- Description of interventions(s)
- Methods of sampling
- Study design planned analysis
- Planned interventions
- Sample tools, measures, survey, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Overall analysis of the validity and reliability of each study
- Evaluation of the results of the PIPs

The EQRO Project Director, Assistant Project Director, and Nurse Consultant meet with the MCHP staff responsible for planning, conducting, and interpreting the findings of the PIPs during the on-site reviews occurring annually. The review focuses on the findings of projects conducted.

MCHPs are instructed that additional information and data, not available at the time of the original submission, can be provided at the on-site review or shortly thereafter. The time scheduled during the on-site review is utilized to conduct follow-up questions, to review data obtained, and to provide technical assistance to MCHPs regarding the planning, implementation and credibility of findings from PIPs. In addition, individual clarifying questions are used to gather more information regarding the PIPs during the on-site interviews. The following questions were formulated and answered in the original documentation, or are posed to the MCHPs during the on-site review:

- How were the interventions determined and why did the MCHP choose this approach?
- What are the conclusions about the effectiveness of the interventions to date?
- How were the outcomes interpreted and linked to the interventions?
- Discuss the effects of these interventions and how they impacted services to members.
- How are the PIP interventions and goals communicated throughout MCHP staff? Are all staff, including case managers and customer services personnel, involved?
- What instruments are used for data collection?
- How were accuracy, consistency, and validity assured?
- What did the MCHP hope to learn from the findings relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?

All PIPs are evaluated by the Assistant Project Director, in consultations with the Project Director. In addition, the projects are reviewed with follow-up suggestions posed by the Project Director, who approves final ratings based on all information available to the team.

ANALYSIS

Criteria for identification of a PIP as outlined in the CMS protocols include the following:

- PIPs need to have a pre-test, intervention, and post-test.
- PIPs need to control for extraneous factors.
- PIPs need to include an entire population.
- Pilot projects do not constitute a PIP.
- Satisfaction studies alone do not constitute a PIP.
- Focused studies are not PIPs: A focused study is designed to assess processes and outcomes on one-time basis, while the goal of a PIP is to improve processes and outcomes of care over time.

The Managed Care contract describes the following requirements for MCHP's relative to conducting PIPs:

> Performance Improvement Projects: The MCHP shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. As requested, the MCHP shall report the status and results of each performance improvement project to the state agency, which must include state and/or MCHP designated performance improvement projects… The performance improvement projects must involve the following:
>
> - Measurement of performance using objective quality indicators.
> - Implementation of system interventions to achieve improvement in quality.
> - Evaluation of the effectiveness of the interventions.
> - Planning and initiation of activities for increasing or sustaining improvement.
> - Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
> - Performance measures and topics for performance improvement projects specified by CMS in consultation with the state agency and other stakeholders.

All PIPs submitted by MCHPs prior to the site visits are reviewed using an expanded version of the checklist for conducting Activity One, Steps 1 through 10, and Activity Three (Judgment of the Validity and Reliability of the PIPs) of the Validating Performance Improvement Projects Protocol, Attachment A. Because certain criteria may not be applicable for projects that are underway at the time of the review, some specific items may be considered as "Not Applicable." Criteria are rated as "Met" if the item was applicable to the PIP, if documentation is available that addresses the item, and if the item could be deemed Met based on the study design. The proportion of items rated as "Met" is compared to the total number of items applicable for the particular PIP. Given that some PIPS may be underway in the first year of implementation, it is not possible to judge or interpret results; validity of improvement; or sustained improvements (Steps 8-10) in all instances. The final evaluation of the validity and reliability of studies is based on the potential for the studies to produce

credible findings. Detailed recommendations and suggestions for improvement are made for each item where appropriate, and are presented in the individual MCHP summaries. Some items are rated as "Met" but continue to include suggestions and recommendations as a method of improving the information presented. The following are the general definitions of the ratings developed for evaluating the PIPs.

Met:	Credible, reliable, and valid methods for the item were documented.
Partially Met :	Credible, reliable, or valid methods were implied or able to be established for part of the item.
Not Met:	The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed; errors in logic were noted; or contradictory information was presented or interpreted erroneously.
Not Applicable:	Only to be used in Step 5, when there is clear indication that the entire population was included in the study and no sampling was conducted; or in Steps 8 through 10 when the study period was underway for the first year.

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3.0 Performance Measures

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TECHNICAL METHODS

Reliable and valid calculation of performance measures is a critical component to the EQRO audit. These calculations are necessary to calculate statewide rates, compare the performance of MCHPs with other MCHPs, and to compare State and MCHP performance with national benchmarked data for Medicaid Managed Care and/or Commercial Managed Care Organization members. These types of comparisons allow for better evaluation of program effectiveness and access to care. The EQRO reviews the selected data to assess adherence to State of Missouri requirements for MCHP performance measurement and reporting. The Missouri Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) contains provisions requiring all Health Maintenance Organizations (HMOs) operating in the State of Missouri to submit to the SPHA member satisfaction survey findings and quality indicator data in formats conforming to the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) Data Submission Tool (DST) and all other HEDIS Technical Specifications[5] for performance measure descriptions and calculations. The State of Missouri contract for MO HealthNet Managed Care (C306122001, Revised Attachment 6, Quality Improvement Strategy) further stipulates that MO HealthNet MCHPs will follow the instructions of the SPHA for submission of HEDIS measures. Three performance measures are selected by MO HealthNet for validation annually. These measures are required to be calculated and reported by MCHPs to MO HealthNet. HEDIS based measures are also required to be reported to the SPHA for MO HealthNet Managed Care Members. A review is conducted for each of the three measures selected based upon the Technical Specifications. These specifications are provided in the following tables:

HEDIS 2016 PRENATAL AND POSTPARTUM CARE (PPC)

Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.

Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/ diagnosis	*Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Include women who delivered in any setting. *Multiple births.* Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Women who had multiple live births during one pregnancy count once. Follow the steps below to identify the eligible population, which is the denominator for both rates.
Step 1	Identify deliveries. Identify all women with a delivery (Deliveries Value Set) between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Step 2	Exclude non-live births (Non-live Births Value Set).
Step 3	Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

Administrative Specification

Denominator	The eligible population.
Numerator	
Timeliness of Prenatal Care	A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy. *Include only visits that occur while the member was enrolled.* Follow the steps below to identify the numerator.
Step 1	Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to step 2. For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3.

Step 2	Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for *Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester.* For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.
Step 3	Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date). *For women whose last enrollment started on or between 219 and 279 days before delivery,* proceed to step 4. *For women whose last enrollment started less than 219 days before delivery,* proceed to step 5.
Step 4	Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* and find a visit between the last enrollment start date and 176 days before delivery.
Step 5	Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester and find a visit within 42 days after enrollment.

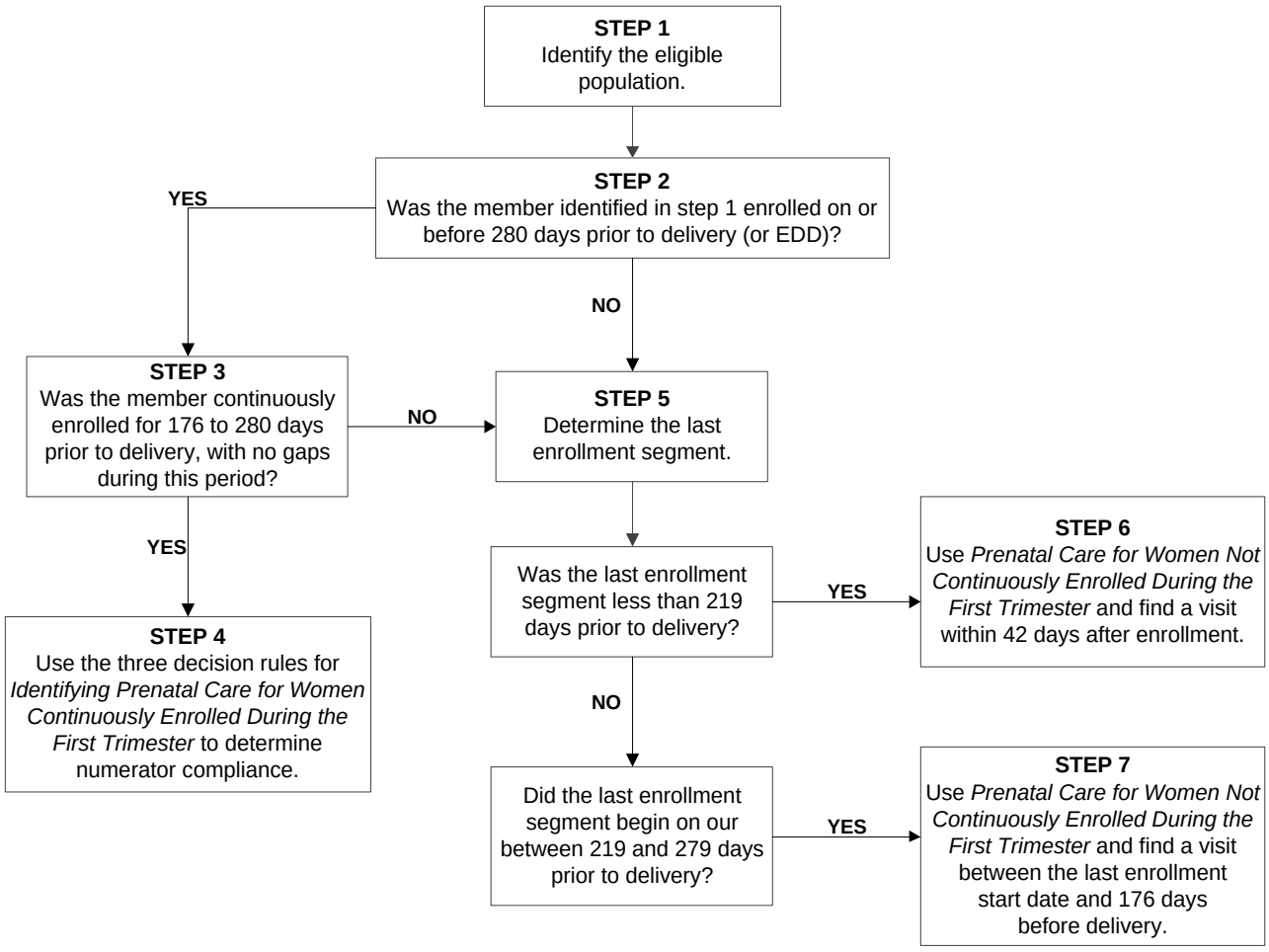
Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester

Decision Rule 1	Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria: A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated). A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
Decision Rule 2	Any of the following during the first trimester, where the practitioner type for the prenatal visit is an OB/GYN or other prenatal care practitioner, meet criteria: A prenatal visit (Prenatal Visits Value Set) with an obstetric panel (Obstetric Panel Value Set). A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set). A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set). A prenatal visit (Prenatal Visits Value Set) with all of the following: Toxoplasma (Toxoplasma Antibody Value Set). Rubella (Rubella Antibody Value Set). Cytomegalovirus (Cytomegalovirus Antibody Value Set). Herpes simplex (Herpes Simplex Antibody Value Set). A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO (ABO Value Set). A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and Rh (Rh Value Set). A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set).
Decision Rule 3	Any of the following during the first trimester, where the practitioner type is a PCP, meet criteria:

A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an obstetric panel (Obstetric Panel Value Set).
A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and all of the following:
Toxoplasma (Toxoplasma Antibody Value Set).
Rubella (Rubella Antibody Value Set).
Cytomegalovirus (Cytomegalovirus Antibody Value Set).
Herpes simplex (Herpes Simplex Antibody Value Set).

A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO (ABO Value Set).
A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and Rh (Rh Value Set).
A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set).
A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with an obstetrical history.
A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with risk assessment and counseling/education.
Note: *For Decision Rule 3 criteria that require a prenatal visit code (Prenatal Visits Value Set)* ***and*** *a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.*

Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester
Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:
A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
A prenatal visit (Prenatal Visits Value Set) with a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).
Note: *For criteria that require a prenatal visit code (Prenatal Visits Value Set)* ***and*** *a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.*



Postpartum Care

- A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:

A postpartum visit (Postpartum Visits Value Set).
Cervical cytology (Cervical Cytology Value Set).
A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).
Note: *The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.*

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care* or the prior year's lowest audited product line-specific rate for these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care*.
Numerator	
Timeliness of Prenatal Care	A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Include only visits that occurred while the member was enrolled.
Administrative	Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.
Medical record	Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following. A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used). Evidence that a prenatal care procedure was performed, such as: Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or*** TORCH antibody panel alone, ***or*** A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or*** Echography of a pregnant uterus. Documentation of LMP or EDD in conjunction with *either* of the following. Prenatal risk assessment and counseling/education. Complete obstetrical history. ***Note:*** *For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principal diagnosis of pregnancy.*
Postpartum Care	A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.
Administrative	Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following.
Pelvic exam.
Evaluation of weight, BP, breasts and abdomen.
Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
Notation of postpartum care, including, but not limited to:
Notation of "postpartum care," "PP care," "PP check," "6-week check."
A preprinted "Postpartum Care" form in which information was documented during the visit.

Note

For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.
Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.
For women whose last enrollment segment started on or between 219 and 279 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.
For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.
Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.
The organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. The LMP may not be used to determine the first trimester.
A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for either rate.
The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.
The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.
Refer to Appendix 3 for the definition of PCP *and* OB/GYN and other prenatal practitioners.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PPC-1/2: Data Elements for Prenatal and Postpartum Care

	Administrative	Hybrid
• Measurement year	*For each of the 2 rates*	*For each of the 2 rates*
• Data collection methodology (Administrative or Hybrid)	*For each of the 2 rates*	*For each of the 2 rates*
• Eligible population	• *For each of the 2 rates*	*For each of the 2 rates*
• Number of numerator events by administrative data in eligible population (before exclusions)	•	*For each of the 2 rates*
• Current year's administrative rate (before exclusions)	•	*For each of the 2 rates*
• Minimum required sample size (MRSS) or other sample size	•	*For each of the 2 rates*
• Oversampling rate	•	*For each of the 2 rates*
• Final sample size (FSS)	•	*For each of the 2 rates*
• Number of numerator events by administrative data in FSS	•	*For each of the 2 rates*
• Administrative rate on FSS	•	*For each of the 2 rates*
• Number of original sample records excluded because of valid data errors	•	*For each of the 2 rates*
• Number of employee/dependent medical records excluded	•	*For each of the 2 rates*
• Records added from the oversample list	•	*For each of the 2 rates*
• Denominator	•	*For each of the 2 rates*
• Numerator events by administrative data	• *For each of the 2 rates*	*For each of the 2 rates*
• Numerator events by medical records		*For each of the 2 rates*
• Reported rate	• *For each of the 2 rates*	*For each of the 2 rates*
• Lower 95% confidence interval	*For each of the 2 rates*	*For each of the 2 rates*
• Upper 95% confidence interval	*For each of the 2 rates*	*For each of the 2 rates*

EMERGENCY DEPARTMENT VISITS (EDV)

ED Visits (count of visits): Medical Diagnoses

Use MODIFIED HEDIS Administrative specifications for the "Ambulatory Care (AMB)" measure. DO NOT use Hybrid specifications. MODIFY the measure by using MHD-specified age groups. Report the count of ED visits for age groups 0-12, 13-17, 18-64, and 65+.

ED Visits (count of visits): Behavioral Health Diagnoses

The count of emergency department VISITS for behavioral health reasons during the designated time period for health plan members. Use MODIFIED HEDIS specs for MPT - Mental Health Utilization as described below. Count emergency department VISITS not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following:

ER Services

Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis.
Any of the following code combinations meet criteria:

*ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.)

*MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.)

Include services provided by physicians and non-physicians.
Only include observation stays that do not result in an inpatient stay.
Report the count of ED visits for age groups 0-12, 13-17, 18-64, and 65+.

Except for the above modifications, calculate the measure as written in the HEDIS specifications. (This specification is the same as for "ED Utilization (count of members): Behavioral Health Diagnoses" below, except that you are counting VISITS and not PATIENTS.)

ED Visits (count of visits): Substance Use Disorders

The count of emergency department VISITS for substance abuse reasons during the designated time period for health plan members. Use MODIFIED HEDIS specs for IAD - Identification of Alcohol and Other Drug Services as described below. Count emergency department VISITS not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following:

SA ER Services

Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria:

*ED Value Set WITH Chemical Dependency Value Set.

*IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.)

Include services provided by physicians and non-physicians.

Only include observation stays that do not result in an inpatient stay.

Report the count of ED visits for age groups 0-12, 13-17, 18-64, and 65+.

Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "ED Utilization (count of members): Substance Use Disorders" below, except that you are counting VISITS and not PATIENTS.)

EMERGENCY DEPARTMENT UTILIZATION (EDU)

ED Utilization (count of members): Medical Diagnoses

The count of health plan MEMBERS accessing emergency department services for medical reasons. Use MODIFIED HEDIS Administrative specifications for the "Ambulatory Care (AMB)" measure. DO NOT use Hybrid specifications. MODIFY the measure by reporting the unique count of MEMBERS accessing ED services, rather than the total count of ED VISITS.

Report the unique count of MEMBERS accessing ED services for age groups 0-12, 13-17, 18-64, and 65+.

ED Utilization (count of members): Behavioral Health Diagnoses

The count of health plan members accessing emergency department services for behavioral health reasons. Use MODIFIED HEDIS specs for MPT - Mental Health Utilization as described below. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following:

ER Services

Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria:

*ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.)

*MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.)

Include services provided by physicians and non-physicians.

Only include observation stays that do not result in an inpatient stay.

Report the unique count of MEMBERS accessing ED services for age groups 0-12, 13-17, 18-64, and 65+.

Except for the above modifications, calculate the measure as written in the HEDIS specs.

ED Utilization (count of members): Substance Use Disorders

The count of health plan members accessing emergency department services for substance abuse reasons. Use MODIFIED HEDIS specs for IAD - Identification of Alcohol and Other Drug Services as described below. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, separate for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following:

SA ER Services

Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria:

*ED Value Set WITH Chemical Dependency Value Set.
*IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.)

Include services provided by physicians and non-physicians.
Only include observation stays that do not result in an inpatient stay.
Report the unique count of MEMBERS accessing ED services for age groups 0-12, 13-17, 18-64, and 65+.

Except for the above modifications, calculate the measure as written in the HEDIS specs.

METHODS OF CALCULATING PERFORMANCE MEASURES

The HEDIS technical specifications allow for two methods of calculating performance measures: 1) the Administrative Method and 2) the Hybrid Method. Each year one of the measures selected for this review, allows for Administrative or Hybrid methods of review. The two remaining measures are each calculated using the Administrative Method only.

The Administrative Method involves examining claims and other databases (administrative data) to calculate the number of members in the entire eligible population who received a service (e.g., Prenatal and Postpartum Care). The eligible population is defined by the HEDIS technical specifications or MO HealthNet defined standards. Those cases in which administrative data show that the member received the service(s) examined are considered "hits" or "administrative hits." The HEDIS technical specifications provide acceptable administrative codes for identifying an administrative hit.

For the Hybrid Method, administrative data are examined to select members eligible for the measure. From these eligible members, a random sample is taken from the appropriate measurement year. Members in the sample are identified who received the service(s) as evidenced by a claim submission or through external sources of administrative data (e.g., State Public Health Agency Vital Statistics or Immunization Registry databases). Those cases in which an administrative hit cannot be determined are identified for further medical record review. Documentation of all or some of the services in the medical record alone or in combination with administrative data is considered a "hybrid hit."

Administrative hits and hybrid hits are then summed to form the numerator of the rate of members receiving the service of interest (e.g., appropriate doctor's visit). The denominator of the rate is represented by the eligible population (administrative method) or those sampled from the eligible population (hybrid method). A simple formula of dividing the numerator by the denominator produces the percentage (also called a "rate") reported to MO HealthNet and the SPHA. Additional guidance is provided in the HEDIS Technical Specifications: Volume 2[3] for appropriate handling of situations involving oversampling, replacement, and treatment of contraindications for services.

[3] National Committee for Quality Assurance. HEDIS 2015, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

Time Frame

The proper time frame for selection of the eligible population for each measure is provided in the technical specifications. For the measures selected, the "measurement year" referred to calendar year prior to the review year. All events of interest (e.g. follow-up visits) must also have occurred during the calendar year prior to the review year.

Procedures for Data Collection

The HEDIS technical specifications for each measure validated are reviewed by the EQRO Project Director and the EQRO Research Analyst. Extensive training in data management and programming for Healthcare quality indices, clinical training, research methods, and statistical analysis expertise were well represented among the personnel involved in adapting and implementing the Validating of Performance Measures Protocol to conform to the HEDIS, MO HealthNet, and SPHA requirements while maintaining consistency with the Validating Performance Measures Protocol. The following sections describe the procedures for each activity in the Validating Performance Measures Protocol as they were implemented for the HEDIS measures validated.

Pre-On-Site Activity One: Reviewer Worksheets

Reviewer Worksheets are developed for the purpose of conducting activities and recording observations and comments for follow-up at the site visits. These worksheets are reviewed and revised to update each specific item with the current year's HEDIS technical specifications. Project personnel meet regularly to review available source documents and develop the Reviewer Worksheets for conducting pre-on-site, on-site, and post-on-site activities as described below. These reviews formed the basis for completing the CMS Protocol Attachments (V, VII, X, XII, XIII, and XV) of the Validating Performance Measures Protocol for each measure and MCHP. Source documents used to develop the methods for review and complete the Attachments included the following pertinent to the current review year:

- HEDIS Data Submission Tool (DST)
- HEDIS Road Map
- HEDIS Audit Report
- HEDIS SPHA Reports
- MO HealthNet Data submission report

Pre-On-Site Activity Two: Preparation of MO HealthNet MCOs

Orientation teleconferences with each MO HealthNet MCHP are conducted annually by the EQRO. The purpose of this orientation conference is to provide education about the Validating Performance Measures protocol and the EQRO's submission requirements. All written materials, letters and instructions used in the orientation are reviewed and approved by MO HealthNet in advance. Prior to the teleconference calls, the MCHPs are provided information on the technical objectives, methods, procedures, data sources, and contact information for EQRO personnel. The MCHPs were requested to have the person(s) responsible for the calculation of that year's HEDIS performance measures to be validated in attendance. Teleconference meetings were led by the EQRO Project Director, with key project personnel and a representative from the SMA in attendance. Provided via the teleconferences is technical assistance focused on describing the Validating Performance Measures Protocol; identification of the three measures selected for validation each year; the purpose, activities and objectives of the EQRO; and definitions of the information and data needed for the EQRO to validate the performance measures. All MCHP questions about the process are answered at this time and identified for further follow-up by the EQRO if necessary. In addition to these teleconference calls, presentations and individual communications with personnel at MCHPs responsible for performance measure calculation are conducted.

Formal written requests for data and information for the validation of performance measures are submitted to the MCHPs by the EQRO recognizing the need to provide adequate time for data and medical record collection by each MCHP. This information is returned to the EQRO within a specific time frame. The letter sent to all MCHPs and the accompanying instructions for submission are detailed in Appendices 3 and 4.

A separate written request is sent to the MCHPs requesting medical records be submitted to the EQRO for a sample of cases. These record requests are then submitted by the providers to the EQRO. Detailed letters and instructions are mailed to QI/UM Coordinators and MCHP Administrators explaining the type of information, purpose, and format of submissions. EQRO personnel are available and respond to electronic mail and telephone inquiries and any requested clarifications throughout the evaluation process.

The following are the data and documents requested from MCHPs for the Validating Performance Measures Protocol:

- HEDIS Data Submission Tool for all three measures for the MO HealthNet Managed Care Population only.
- Prior year's HEDIS Audit Report.
- HEDIS RoadMap for the previous HEDIS year.
- List of cases for denominator with all appropriate year's HEDIS data elements specified in the measures.
- List of cases for numerators with all appropriate year's HEDIS data elements specified in the measures, including fields for claims data and all other administrative data used.
- All worksheets, memos, minutes, documentation, policies and communications within the MCHP and with HEDIS auditors regarding the calculation of the selected measures.
- List of cases for which medical records are reviewed, with all required HEDIS data elements specified in the measures.
- Sample medical record tools used for hybrid methods for the three HEDIS measures for the MO HealthNet Managed Care population; and instructions for reviewers.
- Policies, procedures, data and information used to produce numerators and denominators.
- Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of:
    - Statistical testing of results and any corrections or adjustments made after processing.
    - Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures are chosen using the same sampling frame and methodology.
    - Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance.
- Policies and procedures for mapping non-standard codes, where applicable.
- Record and file formats and descriptions for entry, intermediate, and repository files.
- Electronic transmission procedures documentation. (This will apply if the MCHP sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry)
- Descriptive documentation for data entry, transfer, and manipulation programs and processes.
- Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.

- Documentation of proper run controls and of staff review of report runs.
- Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such changes.
- Documentation of sources of any supporting external data or prior years' data used in reporting.
- Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.
- Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.
- Procedures used to link member months to member age.
- Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the MCHP's process to re-draw a sample or obtain necessary replacements.
- Procedures to capture data that may reside outside the MCHP's data sets (e.g. MOHSAIC).
- Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)
- Appendix V – Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans

Pre-On-Site Activity Three: Assess the Integrity of the MCHP's Information System

The objective of this activity is to assess the integrity of the MCHPs' ability to link data from multiple sources. All relevant documentation submitted by the MCHPs is reviewed by EQRO personnel. The review protocols require that an Information Systems Capability Assessment (ISCA) be administered every other year. The EQRO follows this process and the MCHPs are informed if a full ISCA review will occur when the Orientation Conference Calls occur. The results of this review are reflected in the final EQRO. EQRO personnel also review HEDIS RoadMap submitted by each MCHP. Detailed notes and follow-up questions are formulated for the site visit reviews.

On-Site Activity One: Assess Data Integration and Control

The objective of this activity is to assess the MCHPs' ability to link data from multiple sources and determine whether these processes ensure the accurate calculation of the measures. A series of interviews and in-depth reviews are conducted by the EQRO with MCHP personnel (including both management and technical staff and 3rd party vendors when applicable). These site visit activities

examine the development and production procedures of the HEDIS performance measures and the reporting processes, databases, software, and vendors used to generate these rates. This includes reviewing data processing issues for generating the rates and determining the numerator and denominator counts. Other activities involve reviewing database processing systems, software, organizational reporting structures, and sampling methods. The following are the activities conducted at each MCHP:

- Review results of run queries (on-site observation, screen-shots, test output)
- Examination of data fields for numerator & denominator calculation (examine field definitions and file content)
- Review of applications, data formats, flowcharts, edit checks and file layouts
- Review of source code, software certification reports
- Review HEDIS repository procedures, software manuals
- Test for code capture within system for measures (confirm principal & secondary codes, presence/absence of non-standard codes)
- Review of operating reports
- Review information system policies (data control, disaster recovery)
- Review vendor associations & contracts

The following are the type of interview questions developed for the site visits:

- What are the processes of data integration and control within information systems?
- What documentation processes are present for collection of data, steps taken and procedures to calculate the HEDIS measures?
- What processes are used to produce denominators?
- What processes are used to produce numerators?
- How is sampling done for calculation of rates produced by the hybrid method?
- How does the MCHP submit the requirement performance reports to the State?

From the site visit activities, interviews, and document reviews, Attachment V (Data Integration and Control Findings) of the CMS Protocol is completed for each MCHP and performance measure validated.

On-Site Activity Two: Assess Documentation of Data and Processes Used to Calculate and Report Performance Measures

The objectives of this activity are to assess the documentation of data collection, assess the process of integrating data into a performance measure set, and examine procedures used to query the data set to identify numerators, denominators, generate a sample, and apply proper algorithms.

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment VII (Data and Processes Used to Calculate and Report Performance) of the CMS Protocol is completed for each MCHP and measure validated. One limitation of this step is the inability of the MCHPs to provide documentation of processes used to calculate and report the performance measures due to the use of proprietary software or off-site vendor software and claims systems. However, all MCHPs are historically able to provide documentation and flow-charts of these systems to illustrate the general methods employed by the software packages to calculate these measures.

On-Site Activity Three: Assess Processes Used to Produce the Denominators

The objectives of this activity are to: 1) determine the extent to which all eligible members are included; 2) evaluate programming logic and source codes relevant to each measure; and 3) evaluate eligibility, enrollment, age, codes, and specifications related to each performance measure.

The content and quality of the data files submitted are reviewed to facilitate the evaluation of compliance with the HEDIS 2016 technical specifications. The MCHPs consistently submit the requested level of data (e.g., all elements required by the measures or information on hybrid or administrative data). In order to produce meaningful results, the EQRO requires that all the MCHPs submit data in the format requested

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment X (Denominator Validation Findings) of the CMS Protocol is completed for each MCHP and the performance measures being validated.

On-Site Activity Four: Assess Processes Used to Produce the Numerators

The objectives of this activity are to: 1) evaluate the MCHPs' ability to accurately identify medical events (e.g., appropriate doctor's visits); 2) evaluate the MCHPs' ability to identify events from other sources (e.g., medical records, State Public Immunization Registry); 3) assess the use of codes for

medical events; 4) evaluate procedures for non-duplication of event counting; 5) examine time parameters; 6) review the use of non-standard codes and maps; 7) identify medical record review procedures (Hybrid Method); and 8) review the process of integrating administrative and medical record data.

Validation of the numerator data for all three measures is conducted using the parameters specified in the HEDIS Technical Specifications; these parameters applied to dates of service(s), diagnosis codes, and procedure codes appropriate to the measure in question. For example, the Annual Dental Visit measure requires that all dates of service occurred between January 1 and December 31of the review year. Visits outside this valid date range were not considered. Similar validation is conducted for all three measures reviewed. This numerator validation is conducted on either all numerator cases (Administrative Method) or on a sample of cases (Hybrid Method).
Additional validation for measures being calculated using the Hybrid Method is conducted. The Protocol requires the EQRO to sample up to 30 records from the medical records reported by the MCHP as meeting the numerator criteria (hybrid hits). In the event that the MCHP reports fewer than 30 numerator events from medical records, the EQRO requests all medical records that are reported by the MCHP as meeting the numerator criteria.

Initial requests for documents and data are made on early in the calendar year with submissions due approximately six weeks later. The EQRO requires the MCHPs to request medical records from the providers. The MCHPs are given a list of medical records to request, a letter from the State explaining the purpose of the request, and the information necessary for the providers to send the medical records directly to the EQRO. The submission deadline is determined based on the original request date, and the date of the final receipt based on that date. The record receipt rate is historically excellent. In recent years the EQRO has received 100% of records requested.

The review of medical records is conducted by experienced RNs currently licensed and practicing in the State of Missouri. These RNs participate in the training and medical record review process. They are required to have substantive experience conducting medical record reviews for HEDIS measures.

A medical record abstraction tool for the HEDIS measures to be reviewed is developed by the EQRO Project Director and revised in consultation with a nurse consultant. The HEDIS technical specifications and the Validating Performance Measures Protocol criteria are used to develop the

medical record review tools and data analysis plan. A medical record review manual and documentation of ongoing reviewer questions and resolutions were developed for the review. A half day of training is conducted annually by the EQRO Project Director and staff, using sample medical record tools and reviewing all responses with feedback and discussion. The reviewer training and training manual covered content areas such as Health Insurance Portability and Accountability Act (HIPAA), confidentiality, conflict of interest, review tools, and project background. Teleconference meetings between the nurses, coders, and EQRO Project Director are conducted as needed to resolve questions and coding discrepancies throughout the duration of the medical record review process.

A data entry format with validation parameters was developed for accurate medical record review data entry. The final databases are reviewed for validity, verified, and corrected prior to performing analyses. All data analyses are reviewed and analyzed by the EQRO Project Director. CMS Protocol Attachments XII (Impact of Medical Record Findings) and XIII (Numerator Validation Findings) are completed based on the medical record review of documents and site visit interviews.

On-Site Activity Five: Assess Sampling Process (Hybrid Method)

The objective of this activity is to assess the representativeness of the sample of care provided.

- Review HEDIS RoadMap
- Review Data Submission Tool (DST)
- Review numerator and denominator files
- Conduct medical record review for measures calculated using hybrid methodology
- Determine the extent to which the record extract files are consistent with the data found in the medical records
- Review of medical record abstraction tools and instructions
- Conduct on-site interviews, activities, and review of additional documentation

For those MCHPs that calculating one of the identified HEDIS measures via the hybrid methodology, a sample of medical records (up to 30) is conducted to validate the presence of an appropriate well-child visit that contributed to the numerator.

On-Site Activity Six: Assess Submission of Required Performance Measures to State

The objective of this activity is to assure proper submission of findings to MO HealthNet and SPHA. The DST is obtained from the SPHA to determine the submission of the performance measures

validated. Conversations with the SPHA representative responsible for compiling the measures for all MCHPs in the State occurred with the EQRO Project Director to clarify questions, obtain data, and follow-up on MCHP submission status.

Post- On-Site Activity One: Determine Preliminary Validation Findings for each Measure

Calculation of Bias

The CMS Validating Performance Measures Protocol specifies the method for calculating bias based on medical record review for the Hybrid Method. In addition to examining bias based on the medical record review and the Hybrid Method, the EQRO calculates bias related to the inappropriate inclusion of cases with administrative data that fall outside the parameters described in the HEDIS Technical Specifications. For measures calculated using the Administrative Method, the EQRO examines the numerators and denominators for correct date ranges for dates of birth and dates of service as well as correct enrollment periods and codes used to identify the medical events. This is conducted as described above under on-site activities three and four. The estimated bias in the calculation of the HEDIS measures for the Hybrid Method is calculated using the following procedures, methods and formulas, consistent with the Validating Performance Measures Protocol. Specific analytic procedures are described in the following section.

Analysis

Once the medical record review is complete, all administrative data provided by the MCHPs in their data file submissions for the HEDIS hybrid measure are combined with the medical record review data collected by the EQRO. This allows for calculation of the final rate. In order for each event to be met, there must be documented evidence of an appropriate event code as defined in the HEDIS Technical Specifications.

For the calculation of bias based on medical record review for the MCHPs using the Hybrid Method for the HEDIS measure selected, several steps are taken. First, the number of hits based on the medical record review is reported (Medical Records Validated by EQRO). Second, the Accuracy (number of Medical Records able to be validated by EQRO/total number of Medical Records requested by the EQRO for audit) and Error Rates (100% - Accuracy Rate) are determined. Third, a weight for each Medical Record is calculated (100%/denominator reported by the MCHP) as specified by the Protocol. The number of False Positive Records is calculated (Error Rate * numerator hits from Medical Records reported by the MCHP). This represents the number of

records that are not able to be validated by the EQRO. The Estimated Bias from Medical Records is calculated (False Positive Rate * Weight of Each Medical Record).

To calculate the Total Estimated Bias in the calculation of the performance measures, the Administrative Hits Validated by the EQRO (through the previously described file validation process) and the Medical Record Hits Validated by the EQRO (as described above) are summed and divided by the total Denominator reported by the MCHP on the DST to determine the Rate Validated by the EQRO. The difference between the Rate Validated by the EQRO and the Rate Reported by the MCHP to MO HealthNet and SPHA is the Total Estimated Bias. A positive number reflects an overestimation of the rate by the MCHP, while a negative number reflects an underestimation.

Once the EQRO concludes its on-site activities, the validation activity findings for each performance measure are aggregated. This involves the review and analysis of findings and Attachments produced for each performance measure selected for validation and for the MCHP's Information System as a result of pre-on-site and on-site activities. The EQRO Project Director reviews and finalizes all ratings and completed the Final Performance Measure Validation Worksheets for all measures validated for each of the MCHPs. Ratings for each of the Worksheet items (0 = Not Met; 1 = Partially Met; 2 = Met) are summed for each worksheet and divided by the number of applicable items to form a rate for comparison to other MCHPs. The worksheets for each measure are examined by the EQRO Project Director to complete the Final Audit Rating.

Below is a summary of the final audit rating definitions specified in the Protocol. Any measures not reported are considered "Not Valid." A Total Estimated Bias outside the 95% upper or lower confidence limits of the measures as reported by the MCHP on the DST is considered "Not Valid".

Fully Compliant:	Measure was fully compliant with State specifications.
Substantially Compliant:	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid:	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which the data provided to the EQRO could not be independently validated. 'Significantly Biased' was defined by the EQRO as being outside the 95% confidence interval of the rate reported by the MCHP on the HEDIS 2007 Data Submission Tool.

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4.0 Compliance with Regulations

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Planning Compliance Monitoring Activities

Gathering Information on the MO HealthNet MCHP Characteristics

Currently there are three MCHPs contracted with the State Medicaid Agency (SMA) to provide MO HealthNet Managed Care in three Regions of Missouri. The Eastern Region includes St. Louis City, St. Louis County, and twelve surrounding counties. The Western Region includes Kansas City/Jackson County and twelve surrounding counties. The Central Region includes twenty-eight counties in the center of the state. All three MCHPs serve MO HealthNet members in all three regions. These three MCHPs are: Missouri Care, Home State Health, and Aetna Better Health of Missouri (Aetna Better Health).

Determining the Length of Visit and Dates

On-site compliance reviews are conducted in two days at each MCHP, with several reviewers conducting interviews and activities concurrently. Document reviews occur prior to the complete on-site review at all MCHPs. Document reviews and the Validation of Performance Measures interviews are conducted on the first day of the on-site review. Interviews, presentations, and additional document reviews are scheduled throughout the second day, utilizing all team members for Validating Performance Improvement Projects, and Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs). Interviews with Case Managers are conducted as part of the Special Study included in these reviews. The time frames for on-site reviews are determined by the EQRO and approved by MO HealthNet before scheduling each MCHP.

Establishing an Agenda for the Visit

An agenda is developed to maximize the use of available time, while ensuring that all relevant follow-up issues are addressed. A sample schedule is developed that specifies times for all review activities including the entrance conference, document review, Validating Performance Improvement Project evaluation, Validating Performance Measures review, conducting the interviews for the Compliance Protocol, and the exit conference. A coordinated effort with each MCHP occurs to allow for the most effective use of time for the EQRO team and MCHP staff. The schedule for the on-site reviews is approved by MO HealthNet in advance and forwarded to each MCHP to allow them the opportunity to prepare for the review.

Providing Preparation Instructions and Guidance to the MO HealthNet Health Plans

A letter (see Appendix 12) is sent to each MCHP indicating the specific information and documents required on-site, and the individuals requested to attend the interview sessions. The MCHPs schedule their own staff to ensure that appropriate individuals are available and that all requested documentation is present during the on-site review day.

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occur with individuals from MO HealthNet to prepare for the on-site review, and obtain information relevant to the review prior to the on-site visits. The Compliance Review team members request the contract compliance documents prepared annually by MO HealthNet. The information on MCHP compliance with the current MO HealthNet Managed Care contract is reviewed, along with required annual submission and approval information. This documentation is used as a guide for the annual review although final compliance with state contract requirements is determined by MO HealthNet. These determinations are utilized in assessing compliance with the Federal Regulations. All documentation gathered by MO HealthNet is clarified and discussed to ensure that accurate interpretation of their findings is reflected in the review comments and findings. MO HealthNet's expectations, requirements, and decisions specific to the MO HealthNet Managed Care Program are identified during these discussions.

Document Review

Documents chosen for review are those that best demonstrate each MCHP's ability to meet federal regulations. Certain documents, such as the Member Handbook, provide evidence of communication to members about a broad spectrum of information including enrollee rights and the grievance and appeal process. Provider handbooks are reviewed to ensure that consistent information is shared regarding enrollee rights and responsibilities. The MO HealthNet Managed Care contract compliance worksheets, specific policies that are reviewed annually or that are yet to be approved by the SMA, are reviewed to verify the presence or absence of evidence that required written policies and procedures exist meeting federal regulations. Other information, such as the Annual Quality Improvement Program Evaluation is requested and reviewed to provide insight into the MCHP's compliance with the requirements of the Quality Improvement Strategy, which is an essential component of the MO HealthNet Managed Care

contract, and is required by the federal regulations. MCHP Quality Improvement Committee meeting minutes are reviewed.

Case Management and Member Services policies and instructions, as well as training curriculum are often reviewed to provide insight into the MCHP's philosophy regarding case management activities. In addition, interviews based on questions from MO HealthNet, and specific to each MCHP's Quality Improvement Evaluation, are conducted with direct services staff and administrative staff to ensure that local procedures and practices corresponded to the written policies submitted for approval. When it is found that specific regulations are "Partially Met," additional documents are requested of each MCHP. In addition, interview questions are developed for identified staff to establish that practice directly with members reflects the MCHPs' written policies and procedures. Interviews with Administrative staff occur to address the areas for which compliance is not fully established through the pre-site document review process, and to clarify responses received from the staff interviews.

The following documents were reviewed for all MO HealthNet MCHPs:

- Annual State contract compliance ratings;
- Results, findings, and follow-up information from the previous External Quality Review; and
- Annual MO HealthNet MCHP Evaluation, submitted each spring.

Conducting Interviews

After discussions with MO HealthNet, the focus of that year's Compliance Review is determined. This often results in in-depth interviews with Member Services and Case Management Staff. The goal of these interviews is to validate that practices at the MCHPs, particularly those directly affecting members' access to quality and timely health care, are in compliance with approved policies and procedures. The interview questions are developed using the guidelines available in the Compliance Protocol, are focused on areas of concern based on each MCHP's Annual Evaluation, or address issues of concern expressed by MO HealthNet. Interviews conducted with administrative and management level MCHP staff provides reviewers a clearer picture of the degree of compliance achieved through policy implementation. Corrective action taken by each MCHP is determined from previous years' reviews. This process reveals a wealth of information about the approach each MCHP is using to become

compliant with federal regulations. The current process of a document review, supported by interviews with front line and administrative staff, is developed to provide evidence of a system that delivers quality and timely services to members, and the degree to which appropriate access was available. The interviews provide reviewers with the opportunity to explore issues not addressed in the documentation. Additionally, this approach continues to provide follow-up from previous EQRO evaluations. A site visit questionnaire for direct services staff, and a separate interview tool for Administrators, is developed for each MCHP annually. The questions seek concrete examples of activities and responses that validate that these activities are compliant with contractual requirements and federal regulations.

Collecting Accessory Information

Additional information used in completing the compliance determination included: discussions with the EQR reviewers and MO HealthNet MCHP QI/UM staff regarding management information systems; Validating Performance Measures; and Validating Performance Improvement Projects. The review evaluates information from these sources to validate MCHP compliance with the pertinent regulatory provisions within the Compliance Protocol. These findings are documented in the EQR final report and are also reflected in rating recommendations.

Analyzing and Compiling Findings

The review process includes gathering and analyzing information that directly affects each MCHP's contract compliance and how it relates to compliance with the federal regulations. Next, interview questions are prepared, based on the need to investigate if practice exists in areas where approved policy is not available, and if local policy and procedures are in use when approved policy is not complete. The interview responses and additional documentation obtained on-site are then analyzed to evaluate how they contributed to each MCHP's compliance. All information gathered is assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision. This information is recorded on the MO HealthNet Managed Care scoring form and can be found in the protocol specific sections of this section of the report.

Reporting to the State Medicaid Agency

During the meetings with MO HealthNet following the on-site review, preliminary findings and comparisons to the previous ratings are presented. Discussion occurs with MO HealthNet staff to ensure that the most accurate information is available and to confirm that a sound rationale is used in rating determinations. Sufficient detail is included in all worksheets to substantiate any rating lower than "Met." The actual ratings are included in the final report.

Compliance Ratings

All information gathered prior to the compilation of the final report is utilized is compiling the final ratings. This includes the most up-to-date results of MCHP submissions to MO HealthNet of policy and procedures that meet or exceed contract compliance. This information is then compared to the requirements of each federal regulation to ensure that policy and practice are in compliance. MO HealthNet has provided ongoing approval to the EQRO to utilize the Compliance Rating System developed during the previous reviews. This system is based on a three-point scale ("Met," Partially Met," "Not Met") for measuring compliance, as determined by the EQR analytic process. The determinations found in the Compliance Ratings considered MO HealthNet contract compliance, review findings, MCHP policy, ancillary documentation, and staff interview summary responses validate MCHP practices observed on-site. In some instances, MO HealthNet Managed Care contract compliance tool rates a contract section as "Met" when policies are submitted, even if the policy has not been reviewed and "finally approved." If the MO HealthNet considers the policy submission valid and rates it as "Met," this rating is used unless practice or other information calls this into question. If this conflict occurs, it is explained in the final report documentation. The scale allows for credit when a requirement is Partially Met. Ratings were defined as follows:

Met:	All documentation listed under a regulatory provision, or one of its components was present. MCHP staff was able to provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the MCHP was in full compliance with regulatory provisions.
Partially Met :	There was evidence of compliance with all documentation requirements, but staff was unable to consistently articulate processes during interviews; or documentation was incomplete or inconsistent with practice.
Not Met:	Incomplete documentation was present and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

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Appendices

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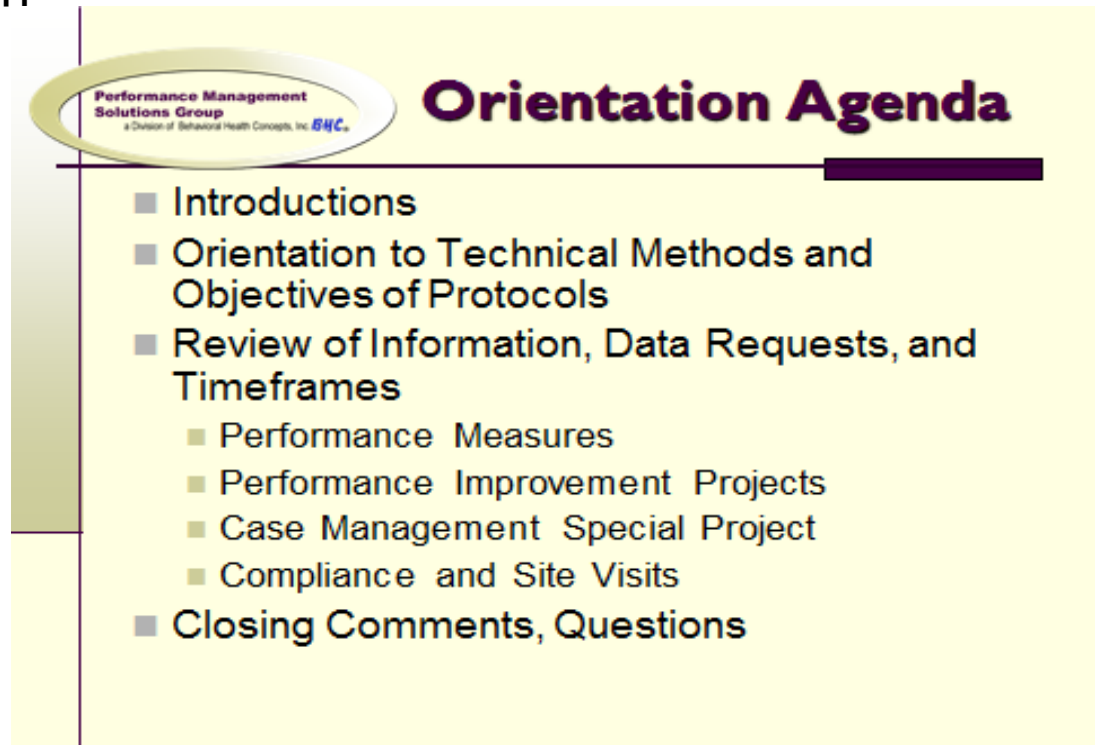
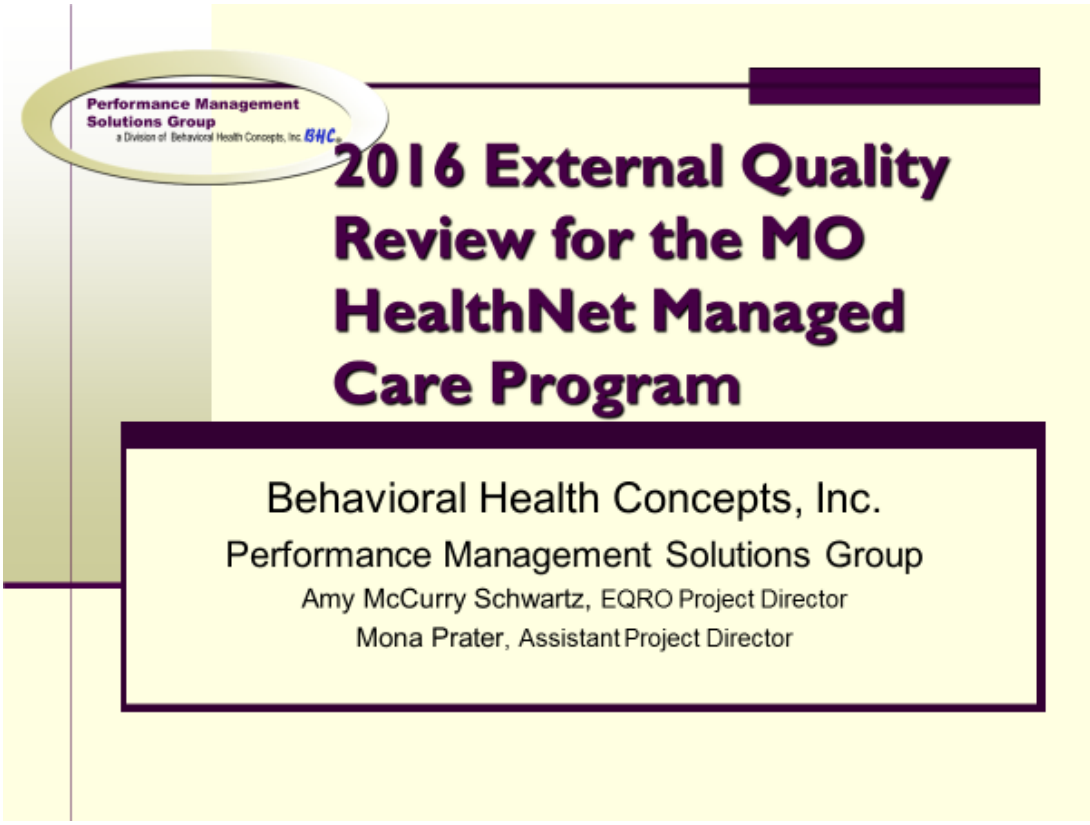
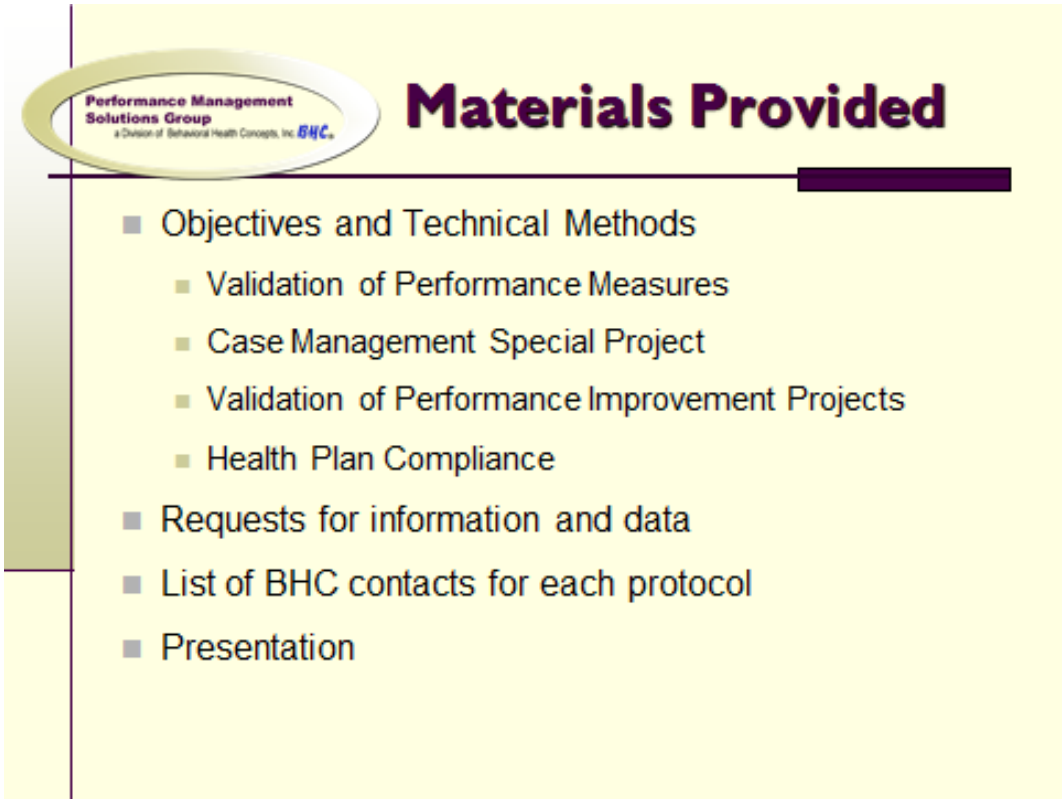
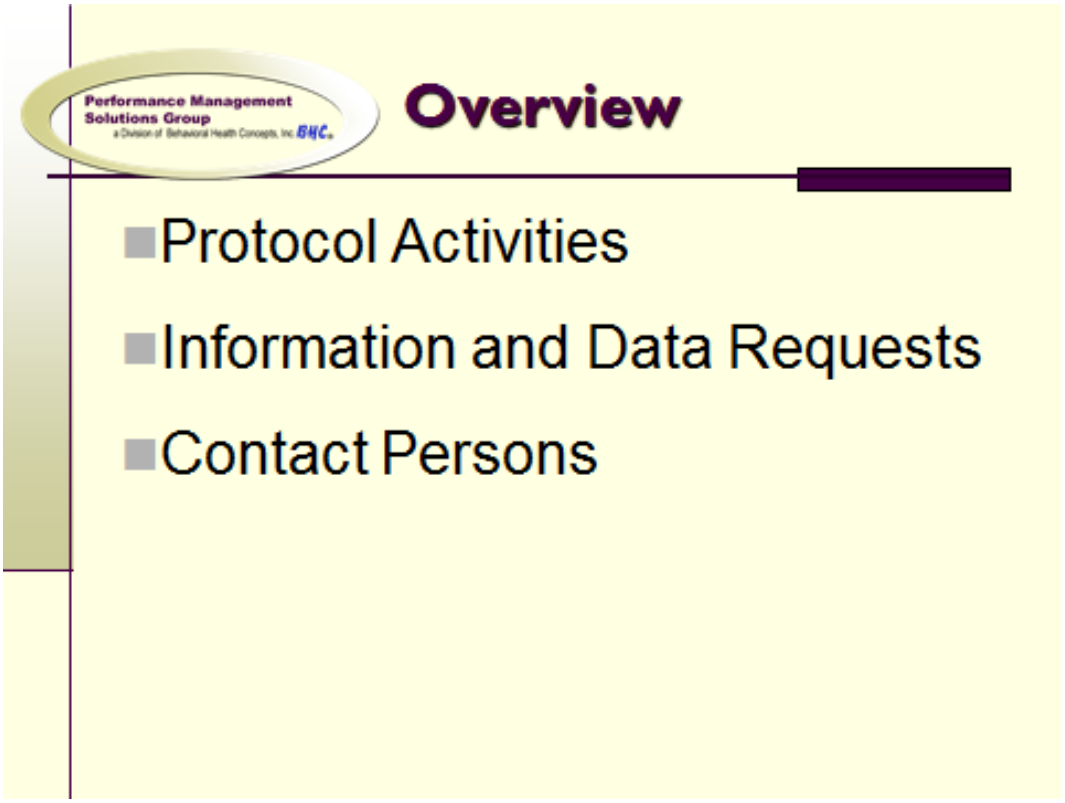
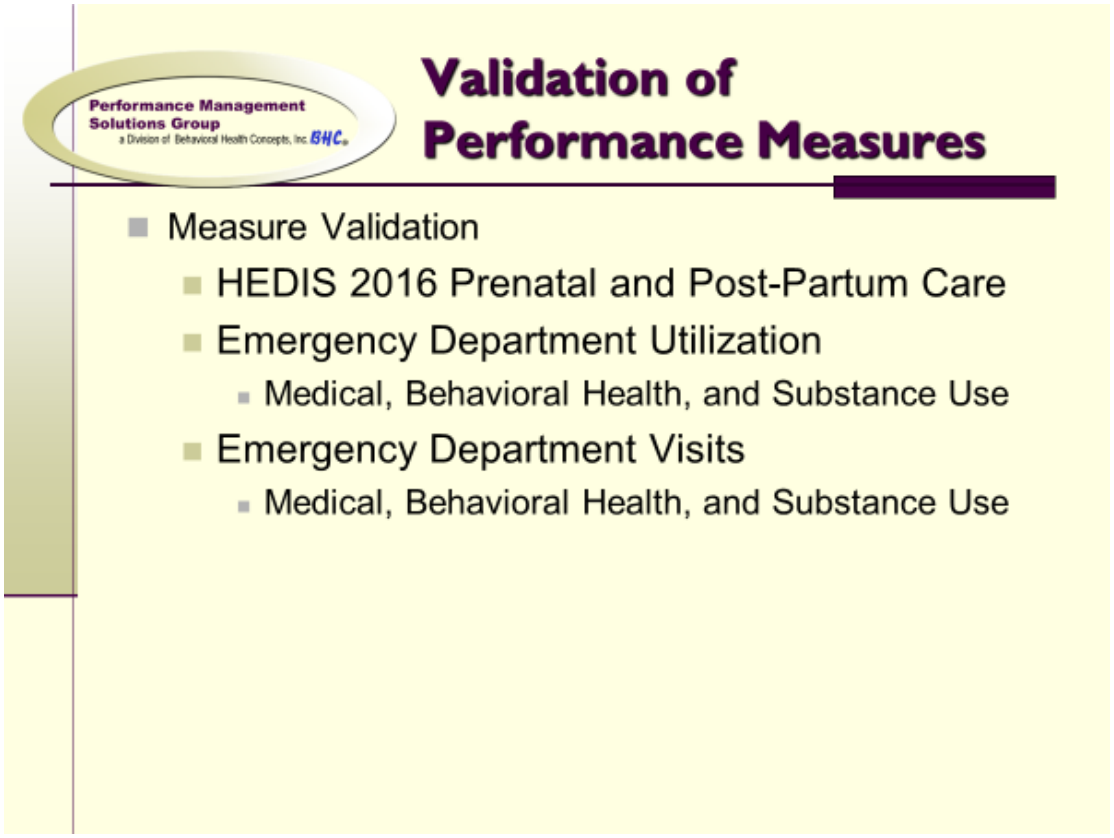
Appendix 1 – MCHP Orientation PowerPoint Slides






Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Materials Provided
Objectives and Technical Methods
Validation of Performance Measures
Case Management Special Project
Validation of Performance Improvement Projects
Health Plan Compliance
Requests for information and data
List of BHC contacts for each protocol
Presentation


Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Overview
Protocol Activities
Information and Data Requests
Contact Persons


Performance Management Solutions Group
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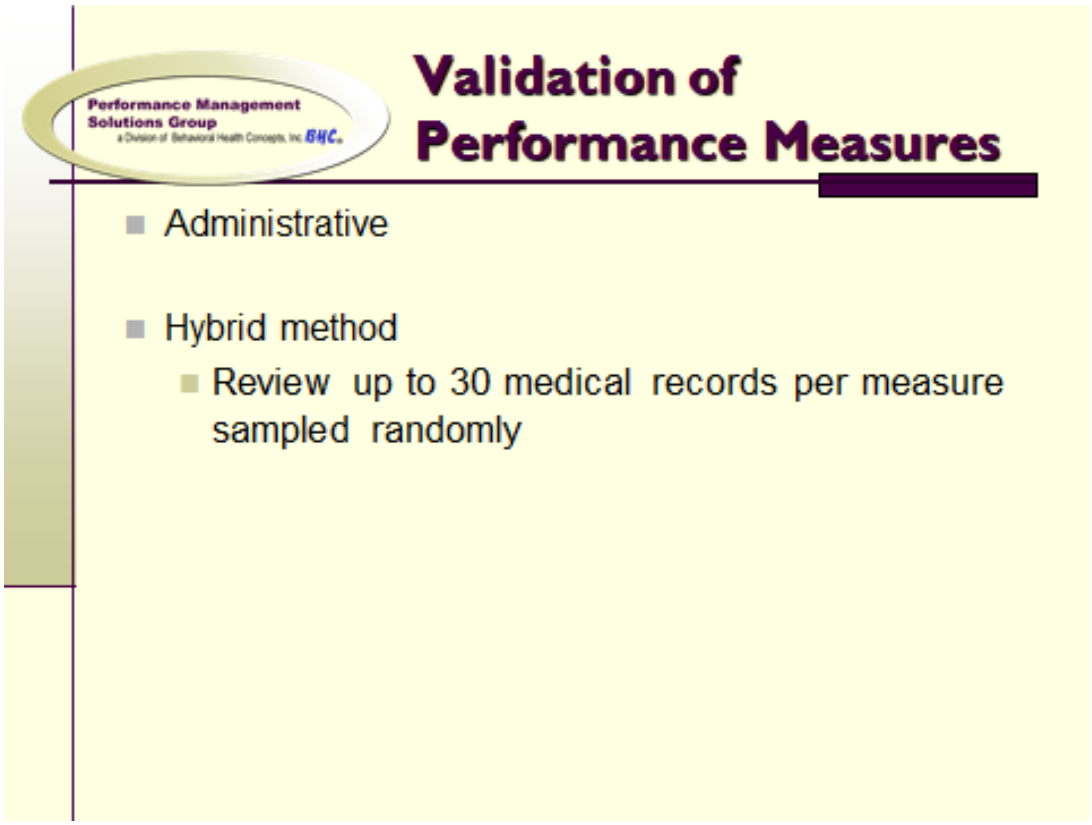
Validation of Performance Measures
Measure Validation
HEDIS 2016 Prenatal and Post-Partum Care
Emergency Department Utilization
Medical, Behavioral Health, and Substance Use
Emergency Department Visits
Medical, Behavioral Health, and Substance Use


Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Validation of Performance Measures
Administrative
Hybrid method
Review up to 30 medical records per measure sampled randomly

Submission Requirements for PM Validation

Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

For each of the three measures:

- List of cases for denominator with all elements specified in the measures
  - Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
  - Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
  - Listing of fields names and descriptions of fields (i.e., data dictionary)
- List of cases for numerators with all data elements specified in the measures
  - Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
  - Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
  - Listing of fields names and descriptions of fields (i.e., data dictionary)
- 2016 HEDIS Audit Report
- RoadMap for HEDIS 2016 BHC EQRO Performance Measure Checklist (Method for Calculating HEDIS Measures; Table 1.xls)
- List of cases for which medical records were reviewed, with all HEDIS 2016 data elements specified in the measures
- BHC will request Health Plans gather up to 30 records per measure, based on a random sample, and Health Plan will send copies
- Sample medical record tools used for hybrid methods for HEDIS 2016 measures and instructions.
- All worksheets, memos, minutes, documentation, policies and communications within the Health Plan and with HEDIS auditors regarding the calculation of the selected measures
- Policies, procedures, data and information used to produce numerators and denominators
- Policies, procedures, data used to implement sampling
- Policies and procedures for mapping non-standard codes
- Others as needed

- **PLEASE NOTE: All materials not submitted in the required format will be rejected and will not be validated!!!**

Case Management Special Project

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- Cases will be reviewed in regards to current MHD contract requirements
  - Assessment
  - Care Plan
  - Discharge
  - Transition of Care (when applicable)
- Case Review Tool
  - Specific by case type: i.e. Lead, Prenatal, Special Health Care Needs…

Purpose and Objectives

1. To assess the completeness of Case Management Records.
2. To validate the health plans' compliance with MHD contract requirements for Case Management.
3. To examine the match between Health Plan enrollees in Case Management and those enrollees known to MHD that meet Case Management criteria.

Medical Record Reviews

- HEDIS
  - Medical record samples requested from Health Plans for 1 possible hybrid measure (N ≤ 30 per measure; 4 weeks)
- Case Management Special Project
  - Medical records samples requested from Health Plans (N ≥ 45; 4 weeks and onsite)

Medical Record Reviews (Cont'd)

- Reviewed and abstracted by experienced and RNs and Social Workers
- Standard abstraction tools

Validation of Performance Improvement Projects

- Two Performance Improvement Projects underway in 2016
  - One clinical
  - One non-clinical (Statewide PIP -- ADV)

Validation of Performance Improvement Projects and Submission Requirements

PIP Checklist Elements

- Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocol, Validating Performance Improvement Projects [1]
- Phase-in/timeframe for each phase of each PIP[1]
- Problem identification
- Hypotheses
- Evaluation Questions
- Description of intervention(s)
- Methods of sampling, measurement
- Planned analyses
- Sample tools, measures, surveys, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Raw data files (if applicable, on-site)
- Medical records or other original data sources (if applicable, on-site)
- Additional data as needed

[1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (2012) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS A protocol for use in Conducting Medicaid External Quality Review Activities: Final Protocol Version 1.0 September 2012

Health Plan Compliance

Full Compliance review year

- Enrollee Rights
  - Provider Networks/Directories
  - Transition of Care
  - Health Homes
- Fraud and Abuse


Performance Management Solutions Group
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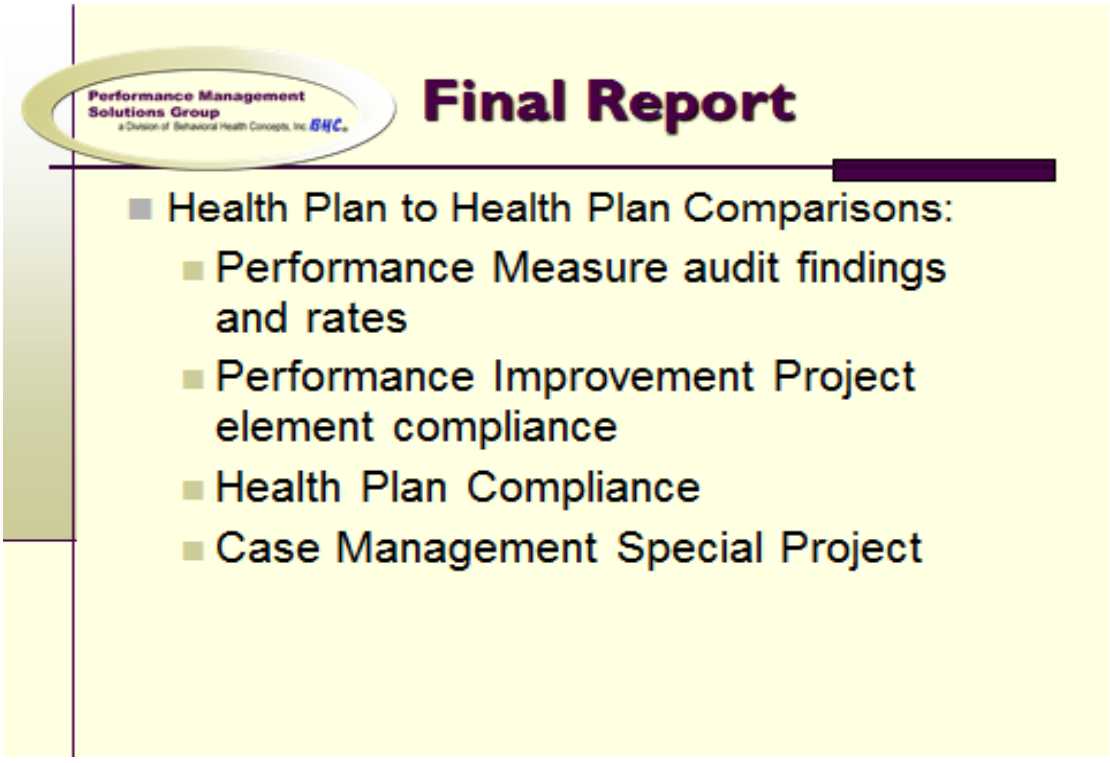
Site Visits
April 2017
Aetna Better Health
June 2017
Home State June 20 & 21
MO Care June 26 & 27
Health Plan Compliance Reviews
On-site activities
Performance Measure Validation
Performance Improvement Project Validation
Case Management Interviews


Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC
Final Report
Health Plan to Health Plan Comparisons:
Performance Measure audit findings and rates
Performance Improvement Project element compliance
Health Plan Compliance
Case Management Special Project

Performance Management Solutions Group
a Division of Behavioral Health Concepts, Inc. BHC

BHC Team and Coordination

Protocol/ Activity	BHC Contact Behavioral Health Concepts, Inc. 1904 Southwest Blvd., Suite D Jefferson City, MO 65109 Tel. 855-385-3776	Health Plan Contact
Performance Measures	Amy McCurry Schwartz amccurry@bhcinfo.com	
Performance Improvement Projects	Amy McCurry Schwartz amccurry@bhcinfo.com Mona Prater Assistant, Project Director mprater@bhcinfo.com	
Compliance	Amy McCurry Schwartz amccurry@bhcinfo.com	
Case Management Special Project	Mona Prater mprater@bhcinfo.com	
Site Visits	Amy McCurry Schwartz amccurry@bhcinfo.com Mona Prater mprater@bhcinfo.com	
Medical Records	Amy McCurry Schwartz amccurry@bhcinfo.com	

Appendix 2 – Performance Improvement Project Worksheets

Demographic Information		
Plan Name or ID:		
Name of PIP:		
Dates in Study Period:		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	___Met __ Partially Met __ Not Met __ Unable to Determine	
Clinical ___Prevention of an acute or chronic condition ___High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical ___Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	__Met __Partially Met __Not Met __Unable to Determine	
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	__Met __Partially Met __Not Met __Unable to Determine	
Demographics: ___Age Range _____Race _____Gender Medical Population: _____ Medicaid Only _____ Commercial	Totals	___Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	__Met __Partially Met __Not Met __Unable to Determine	
Include study question(s) as stated in narrative:	Total	_____ Met ___Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	__Met __Partially Met __Not Met __Unable to Determine	
List Indicators:		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	___Met ___Partially Met __ Not Met __ Unable to Determine	
Are long-term outcomes implied or stated: __yes __no _____Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	_____Met ___Partially Met _____Not Met _____UTD
Component/Standard	**Score**	**Comments**

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	___Met __ Partially Met __ Not Met __ Unable to Determine	
Demographics _____ Age Range _____Gender _____Race Medical Population: _____Medicaid Only _____Commercial		
4.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	__Met __Partially Met __Not Met __Unable to Determine	
Methods of identifying participants: _____Utilization data _____Referral _____Self-identification _____Other _____	Totals	___Met ____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	____Met ____Partially Met ____Not Met _____UTD

Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	__Met __Partially Met __Not Met __Unable to Determine	
6.2 Did the study design clearly specify the sources of data?	__Met __Partially Met __Not Met __Unable to Determine	
Sources of data: ___Member _____ Claims ___Provider _____ Other:		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	__Met __Partially Met __Not Met __Unable to Determine	
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	__Met __Partially Met __Not Met __Unable to Determine	
Instruments used: _____Survey _____Medical Record Abstraction Tool Other: _____		Inclusion of a description of how medical records are accessed for the hybrid evaluation will be requested.
6.5 Did the study design prospectively specify a data analysis plan?	__Met __Partially Met __Not Met __Unable to Determine	
6.6 Were qualified staff and personnel used to collect the data?	__Met __Partially Met __Not Met __Unable to Determine	
Project Leader Name: _____Title:_____Role: _____. Other team members: Names/Roles: _____	Totals	____Met _____Partially Met ____Not Met _____UTD

Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	__Met __Partially Met __Not Met __Unable to Determine	
Describe Intervention(s): **Member**: **Providers**: Share Provider: **Plan**:	Totals	____Met _____Partially Met _____Not Met _____UTD
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	
Are tables and figures labeled? __yes __no Are they labeled clearly & accurately? ____yes ____no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	

Indicate the time periods of measurements: _____ Indicate statistical analysis used: _____ Indicate statistical significance level or confidence level if available/known: _____99% ___95% ___Unable to determine		
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	
Limitations described: _____ Conclusions regarding the success of the interpretation: _____ Recommendations for follow-up: _____	Totals	_____Met _____Partially Met _____Not Met ___Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	
Was there: _____ Increase _____Decrease Statistical significance ___yes ___no Clinical significance ___yes ___no		

9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	
Degree to which the intervention was the reason for change ___No relevance ___Small ___ Fair ___High		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	
_____Weak _____Moderate _____Strong	Totals	_____Met _____Partially Met _____Not Met ___Not Applicable _____UTD
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__ Met __ Partially Met ___Not Met __ Not Applicable __ Unable to Determine	
	Total	_____Met _____Partially Met _____Not Met ___Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:
SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:

Recommendations:

Check one:
- ☐ High confidence in reported Plan PIP results
- ☐ Confidence in reported Plan PIP results
- ☐ Low confidence in reported Plan PIP results
- ☐ Reported Plan PIP results not credible
- ☐ Unable to determine – the PIP is new and has produced no results

Appendix 3 – Performance Improvement Project Request Documents

Behavioral Health Concepts, Inc.
1804 Southwest Blvd., Ste D, Jefferson City, MO 65109 (855) 385-3776
www.bhcinfo.com

April 10, 2017

Re: 2016 External Quality Review of the MO HealthNet Managed Care Program
Performance Improvement Project Submission Request

Dear

This letter represents a request for information for the 2016 External Quality Review of MO HealthNet Health Plans, conducted by Behavioral Health Concepts, Inc., (BHC). With this correspondence, we are requesting submission of all information pertaining to the Performance Improvement Projects (PIP) selected for validation for the 2016 review. The topics chosen for (MPHC) include:

- Improving Oral Health (Statewide PIP)
- Childhood Immunizations

The due date for submission of this information is May 2, 2017. Please send all information to BHC, 1804 Southwest Blvd, Ste D, Jefferson City, MO 65109.

The requested information should include relevant source data for the EQR process. If submitting printed versions, include printouts or copies of all required information. Submit information for each PIP to be validated for your Health Plan. You may mark PIP sections. Provide separate and distinct information for each PIP. We have included face sheets indicating the selected PIPs for your health plan. It is acceptable to submit this information electronically.

Specific information about the implementation of the protocols can be found in the documents previously forwarded to all Health Plans for the EQRO orientation and in the corresponding CMS 2012 Protocols for External Quality Review. We look forward to working with you to implement the External Quality Review.

Sincerely,

Mona Prater, MPA
EQRO Assistant Project Director

Appendix 4 –Performance Measure Data Request

Request Date: 2/07/2017

Mail To:
External Quality Review Submission
Behavioral Health Concepts, Inc.
1804 Southwest Blvd., Suite D
Jefferson City, MO 65109

Priority Due Date: February 28, 2017
FINAL Due Date: March 7, 2017 (due in BHC offices by 3pm)

When applicable, submit one for each of the three measures:

- Emergency Department Utilization (EDU)
- Emergency Department Visits (EDV)
- Prenatal and Postpartum Care (PPC)

Unless otherwise indicated, please send all documents **on CD or thumb drive** using the "tab numbers" as titles for each document. If an item is not applicable or not available, please indicate this in a file on the CD/drive that corresponds to that tab.

Please report Regional data for the EDU and EDV measures and please report both Statewide and Regional data for PPC.

Electronic Data Submission Instructions:
(The file layouts to be used for each measure are detailed on pages 2-5 of this document.)

- Make all submissions using compact disk or thumb drive formats (CD). Data files submitted via e-mail will not be reviewed. Insure that files on the CD are accessible on a Microsoft Windows 7 workstation environment prior to submitting.
- All files or CDs must be password protected. Do not write the password on the CD. Please email the password separately to amccurry@bhcinfo.com. Do not include the password anywhere on the CD, or in any correspondence sent with the CD.
- Data file formats all need to be ASCII, and readable in a Microsoft Windows 7 environment. Please be sure to name data columns with the same variable names that appear in the following data layout descriptions.
- Please include the column names as the first row of data in the file.
- **All files must be @ delimited with no text qualifiers (i.e. no quotation marks around text fields).**
- Please ensure that date fields are in MM-DD-YYYY format and contain either a null value or a valid date.
- For fields such as Enroll_Last where a member is still enrolled (and therefore a date has not yet been determined), the entry must be a valid future date (i.e. a value of *12-12-2300* would be acceptable to indicate current enrollment; a value of 12-12-1700 would not.)
- **Files will be accepted only in the specified layout**. Please avoid adding extra columns or renaming the columns we have requested*. **Files submitted in any other form will be rejected and not validated.**

There should be 3 separate data files submitted for each measure:

1. File 1. Enrollment Data
2. File 2. Denominator and numerator file
3. File 3. Sample selection (cases that were selected for medical record review; this file is submitted for PPC *Hybrid measure only*)

Please contact BHC prior to the submission deadline if you have any questions regarding these layouts or the data submission requirements, and we will be happy to assist you.

All files received prior to/on the Priority Due Date will be reviewed by BHC personnel. Any glaring errors in data format, column format, etc will be noted and you will be allowed to resubmit a corrected file prior to the Final Due Date. After the Final Due Date, no new data files will be accepted.

Emergency Department Utilization (EDU) and Emergency Department Visits (EDV)

(Modified HEDIS Ambulatory Care (AMB))
(Modified HEDIS Mental Health Utilization (MPT))
(Modified HEDIS Identification of Alcohol and Other Drug Services (IAD))

(Administrative Only)

Please provide the data that was used to report to MHD on June 30, 2016. BHC will be matching the information contained in that report (Healthcare Quality Data Template).

File 1. Enrollment Data

Please provide all enrollment periods for each eligible Managed Care Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	Managed Care Health Plan name
MEASURE	EDU/EDV	Emergency Department Utilization/Emergency Department Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	Managed Care Member First Name
MEMBR_LAST	Any basic text	Managed Care Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Managed Care Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

Emergency Department Utilization (EDU) and Emergency Department Visits (EDV)

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	Managed Care Health Plan name
MEASURE	EDU/EDV	Emergency Department Utilization/Emergency Department Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	Managed Care Member First Name
MEMBR_LAST	Any basic text	Managed Care Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Managed Care Member date of birth
ED_SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Emergency Department Date of service
ED_SER_CODE	Any basic text and/or numbers	Code used to identify numerator event ED visit (ED Value Set Code)
ED_PROC_CODE	Any basic text and/or numbers	Code used to identify numerator event Procedure Code from the ED Procedure Code Value Set
ED_POS_CODE	Any basic text and/or numbers	Code used to identify numerator event ED place of service code (ED POS Value Set)
INPT_ADMIT_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of inpatient admittance
MEN_DX	Any basic text and/or numbers	Code used to identify numerator event PRINCIPAL mental health diagnosis (Mental Health Diagnosis Value Set)
MPT_ED_CODE	Any basic text and/or numbers	Procedure Code from the MPT Outpatient/ED Value Set
MPT_ED_POS_CODE	Any basic text and/or numbers	Place of service code (MPT Outpatient/ED POS Value Set)
CHEM_DEP_DX	Any basic text and/or numbers	Code used to identify numerator event PRINCIPAL chemical dependency diagnosis (Chemical Dependency Value Set)
IAD_ED_CODE	Any basic text and/or numbers	Procedure Code from the IAD Outpatient/ED Value Set
IAD_ED_POS_CODE	Any basic text and/or numbers	Place of service code (IAD Outpatient/ED POS Value Set)
CODING_TYPE	C, H, or I	Type of coding system: C=CPT Codes; H=HCPCS/CDT-3 Codes*; I=ICD-9-CM (ICD-10) Codes.
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
EXCLUD	Y or N	Was the case excluded from denominator Y=Yes; N=No
EXCLUD_REASON	Any basic text and/or numbers	Reason for exclusion

* CDT is the equivalent dental version of the CPT physician procedural coding system.

Prenatal and Postpartum Care (PPC)

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MO HealthNet Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Organization name
MEASURE	PPC	Prenatal and Postpartum Care
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	MO HealthNet Member First Name
MEMBR_LAST	Any basic text	MO HealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MO HealthNet Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Organization name
MEASURE	PPC	Prenatal and Post-Partum Care
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	MO HealthNet Member First Name
MEMBR_LAST	Any basic text	MO HealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MO HealthNet Member date of birth
SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of service (
SER_CODE	Any basic text and/or numbers	Code used to identify numerator event
CODING_TYPE	C, D, L, U, I or I10	Type of coding system: C=CPT Codes; D=DRGs; L=LOINC; U=UB-92 Revenue Codes; I=ICD-9-CM Codes; I10=ICD-10-CM or ICD-10-PCS codes.
DATA_SOURCE	A or MR	For Hybrid Method ONLY Please specify source of data: A = Administrative; MR = Medical Record Review
HYBRID_HIT	Y or N	For Hybrid Method ONLY Hybrid numerator event (positive event "hit"): y=yes; n=no
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
EXCLUD	Y or N	Was the case excluded from denominator Y=Yes; N=No
EXCLUD_REASON	Any basic text and/or numbers	Reason for exclusion

Prenatal and Postpartum Care (PPC)

File 3. For Hybrid method ONLY - please provide a listing of the cases selected for medical record review. Use the following layout:

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Organization name
MEASURE	PPC	Prenatal and Postpartum Care
DCN	Whole numbers only	The MO HealthNet Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	MO HealthNet Member First Name
MEMBR_LAST	Any basic text	MO HealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MO HealthNet Member date of birth
MR_STATUS	R or NR or S	Medical record review status: R = reviewed; NR = not reviewed; S = substituted
PROVIDER_NAME	Any basic text and/or numbers	Primary Care Provider who supplied the record
PROVIDER_ID	Any basic text and/or numbers	Primary Care Provider identification number

2016 External Quality Review of the Missouri Managed Care Program

Performance Measure Validation Submission Requirements

Instructions: The following listing includes relevant source data for the EQR process. Please submit information on a CD or thumb drive. Each file on the CD or thumb drive should correspond to the tab number and description in the spreadsheet below. Within each file, include information specific for each of the three measures for the Managed Care population. Some items may not apply. For example, if you do not use a HEDIS vendor and perform measure calculations on site, then you may not have documentation of electronic record transmissions. These items apply to processes, personnel, procedures, databases and documentation relevant to how the MCHP complies with HEDIS measure calculation, submission and reporting.

If you have any questions about this request, contact Amy McCurry Schwartz, EQRO Project Director, amy.mccurry@bhceqro.com

Key	
Check submitted	Use this field to indicate whether you have submitted this information. If you are not submitting the particular information, please indicate "NA". You may have submitted the content by other means either on the BAT or as part of some other documentation. If so, indicate "submitted", and reference the document (see below).
Name of Source Document	Please write the name of the document you are submitting for the item. If you are submitting pages from a procedure manual, indicate so by writing "HEDIS submission manual, pages xx – xx."
MCHP Comments	Use this space to write out any concerns you may have or any clarification that addresses any issues or concerns you may have regarding either the items requested or what you submitted in the response.
Reviewed By (BHC use)	This space will be for BHC staff use. The purpose will be for tracking what is received and what is not received. It will not indicate whether the documents actually address the specific issue.

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
1.	HEDIS 2016 Data Submission Tool (MO DHSS 2016 Table B HEDIS Data Submission Tool and/or NCQA IDSS Submission Tool) for the PPC measure for the MO HealthNet Managed Care Population only. Do not include other measures or populations.		•		
2.	HEDIS 2016 Audit Report. This is the HEDIS Performance Audit Report for the Managed Care Program product line and the three measures to be validated (complete report). If the HEDIS measure to be validated was not audited or if it was not audited for the Managed Care Program population, please send the report, as it contains Information Systems Capability Assessment information that can be used as part of the Protocol.		•		
3.	RoadMap for HEDIS 2016. The information submitted for the RoadMap will include descriptions of the process for calculating measures for the MO HealthNet Managed Care Program population.				

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
4.	List of cases for denominator with all data elements specified in the measures.				
5.	List of cases for numerators with all data elements specified in the measures, including fields for claims data and MOHSAIC, or other administrative data used. Please note that one of the review elements in the Protocol is: The "MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced."				
6.	List of cases for which medical records were reviewed, with all HEDIS 2016 data elements specified in the measures. Based on a random sample, BHC will request MCHPs to gather a maximum of 30 records per measure and submit copies of the records requested to BHC.				

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
7.	Sample medical record tools used if hybrid method(s) were utilized for the HEDIS 2016 Prenatal and Postpartum Care measure for the Managed Care Program population; and instructions for reviewers.		•		
8.	All worksheets, memos, minutes, documentation, policies and communications within the MCHP and with HEDIS auditors regarding the calculation of the selected measures. **(please limit this to 30 (two-sided) pages in this submission – all other information can be reviewed onsite, as required).**		•		
9.	Policies, procedures, data and information used to produce numerators and denominators.		•		

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
10.	Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of: a. Statistical testing of results and any corrections or adjustments made after processing. b. Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology. c. Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance.		•		
11.	Policies and procedures for mapping non-standard codes.				

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
12.	Record and file formats and descriptions for entry, intermediate, and repository files.		•		

13.	Electronic transmission procedures documentation. (This will apply if the Health Plan sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry.)				

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
14.	Descriptive documentation for data entry, transfer, and manipulation of programs and processes.				
15.	Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.				
16.	Documentation of proper run controls and of staff review of report runs.				
17.	Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such corrections or adjustments.				

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
18.	Documentation of sources of any supporting external data or prior years' data used in reporting.				
19.	Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.				
20.	Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.				
21.	Procedures used to link member months to member age.				

Tab	Performance Measures	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
22.	Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the MCHP's process to re-draw a sample or obtain necessary replacements.				
23.	Procedures to capture data that may reside outside the MCHP's data sets (e.g. MOHSAIC).				
24.	Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)		•		

Performance Measures to be Calculated for Managed Care Members			
METHOD FOR CALCULATING 2016 PERFORMANCE MEASURES			
Please complete this form and return via email to BHC. Please direct any questions to Amy McCurry Schwartz.			
Health Plan			
Date Completed			
Contact Person			
Phone			
Fax			
NCQA Accredited for MO HealthNet Product (Yes/No)			
Certified HEDIS Software Vendor and Software			
Record Abstraction Vendor			
	EDV	**EDU**	**PPC**
What was the reporting Date for HEDIS 2016 Measures?			
What was the Audit Designation (Report/No Report/Not Applicable)?			
Was the measure publicly Reported (Yes/No)?			
Did denominator include members who switched MCHPs (Yes/No)?			
Did denominator include members who switched product lines (Yes/No)?			
Did the denominator include 1115 Waiver Members (Yes/No)?			
Were proprietary or other codes (HCPC, NDC) used?			
Were exclusions calculated (Yes/No)?			
On what date was the sample drawn?			
Were exclusions calculated (Yes/No)?			
How many medical records were requested?			
How many medical records were received?			
How many medical records were substituted due to errors in sampling?			
How many medical records were substituted due to exclusions being measured?			

Appendix 5 – Performance Measures Worksheets

Final Performance Measure Validation Worksheet: HEDIS 2016 Prenatal and Postpartum Care (PPC)

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.

Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	None specified.		
Enrollment	Continuous 43 days prior to delivery through 56 days after delivery.		
Gap	No allowable gap during the continuous enrollment period.		
Anchor date	Date of delivery.		
Benefit	Medical		
Event/diagnosis	Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting. Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.		
Sampling			
Sampling was unbiased.			
Sample treated all measures independently.			
Sample size and replacement methods met specifications.			

Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Documentation tools used were adequate.			
Integration of administrative and medical record data was adequate.			
The results of the medical record review validation substantiate the reported numerator.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine	☐	
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.

Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: Emergency Department Utilization

The percentage of enrolled MO HealthNet Managed Care Program Members who had at least one emergency department visit during the measurement year. Broken down into three categories of visit: Medical; Behavioral Health; and Substance Use

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	Age determined as of December 31, 2016. The measure is reported for each of the following age stratifications and as a combined rate: * 0-12 year-olds * 13-17 year-olds * 18-64 year-olds * 65+ year-olds		
Enrollment	No requirement		
Gap	No requirement		
Anchor date	None		
Benefit	Medical		
Event/diagnosis	None		
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Documentation tools used were adequate.			
Integration of administrative and medical record data was adequate.			
The results of the medical record review validation substantiate the reported numerator.			

Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine	☐	
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.
Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: Emergency Department Visits

The count of emergency department visits during the measurement year. Broken down into three categories: Medical; Behavioral Health; Substance Use

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	Age determined as of December 31, 2016. The measure is reported for each of the following age stratifications and as a combined rate: * 0-12 year-olds * 13-17 year-olds * 18-64 year-olds * 65+ year-olds		
Enrollment	No requirement		
Gap	No requirement		
Anchor date	None		
Benefit	Medical		
Event/diagnosis	None		
Sampling - Not Applicable to this measure, calculated via Administrative calculation methodology only			
Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			

Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points	☐	
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting	n/a	
	Overreporting	n/a	
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications. Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 1 = Partially Met; 0 = Not Met

Appendix 6 – Performance Measures Medical Record Request Letter

Behavioral Health Concepts, Inc.
1804 Southwest Blvd., Suite D, Jefferson City, MO 65109 (855) 385-3776 (toll-free)
www.bhceqro.com

March 31, 2017

Subject: 2016 External Quality Review Performance Measure Validation Protocol Medical Records Request (hybrid methodology only).

Due Date: May 1, 2017 by 3:00pm

BHC has reviewed your MCHP's HEDIS 2016 Prenatal and Postpartum Care (PPC) Measure.

Please find attached a file containing a listing of the cases related to this HEDIS Measure that have been selected for medical record review. Behavioral Health Concepts, Inc. (BHC) requests copies of all medical records for these sampled cases. Each medical record supplied should contain all the information that contributed to the numerator for the given HEDIS 2016 Measure. Please forward copies of these medical records to BHC at the following address and mark the package as confidential.

Behavioral Health Concepts, Inc.
Attn: Amy McCurry Schwartz
1804 Southwest Blvd., Suite D
Jefferson City, MO 65109

If you have any questions, please contact BHC's External Quality Review team at (855) 385-3776 x103 or via e-mail: amy.mccurry@bhceqro.com

Thank you,

Amy McCurry Schwartz
EQRO Project Director

Attachment:
1) File containing a sample of cases for medical record review

cc: Mr. Paul Stuve, MO HealthNet Division, Missouri Department of Social Services

Appendix 7 – Table of Contents for Medical Record Training Manual

Table of Contents

Appendix 8 – Performance Measures Medical Record Abstraction Tool

Prenatal and Postpartum Care

Patient Name

Last

First

Date of Birth:
Missing = 99999999

m m d d y y y y

Provider Name

Last

First

Name of MCO (Check only one)

- ❑ Aetna Better Health (1)
- ❑ Home State Health (2)
- ❑ Missouri Care (3)

Abstractor Initials

Date of abstraction

m m d d y y y y

Data entry operator initials

Start Time

h h : m m

Search the medical record for a Prenatal Visit during the calendar year.

Source of Documentation:
Check One

- ❑ Medical Record (1)
- ❑ Claim Form (2)
- ❑ Both (3)
- ❑ None (0)

Documented Components of Prenatal Care Visit:

(check all that apply)

Basic physical obstetric exam with auscultation for fetal heart tone

- ❑ Yes (1)
- ❑ No (0)

Pelvic exam with obstetric observations

- ❑ Yes (1)
- ❑ No (0)

Measurement of fundus height

- ❑ Yes (1)
- ❑ No (0)

Evidence that a Prenatal Care Procedure was performed:

(Check all that apply)

A screening test in the form of an obstetric panel

- ❑ Yes (1)
- ❑ No (0)

TORCH antibody panel alone or a rubella antibody test/titler with an Rh incompatibility (ABO/Rh) blood typing

- ❑ Yes (1)
- ❑ No (0)

Echography of a pregnant uterus

- ❑ Yes (1)
- ❑ No (0)

Evidence that a diagnosis of pregnancy has been established:

Documentation of LMP (last menstrual period)

- ❑ Yes (1)
- ❑ No (0)

Documentation of EDD (estimated date of delivery

- ❑ Yes (1)
- ❑ No (0)

Documentation of a complete obstetrical history

- ❑ Yes (1)
- ❑ No (0)

Documentation of prenatal risk assessment and counseling/education

- ❑ Yes (1)
- ❑ No (0)

Date of Live Birth

Missing = 99999999
Not Applicable = 88888888

m	m	d	d	y	y	y	y

Notes:

Search the medical record for a Postpartum Visit during the calendar year

Source of Documentation:

Check One

- ❑ Medical Record (1)
- ❑ Claim Form (2)
- ❑ Both (3)
- ❑ None (0)

Date of Delivery

Missing = 11119999
Not Applicable = 11118888

m	m	d	d	y	y	y	y

Date of Delivery + 21 days

Missing = 11119999
Not Applicable = 11118888

m	m	d	d	y	y	y

Date of Delivery + 56 days

Missing = 11119999
Not Applicable = 11118888

m	m	d	d	y	y	y

Date of Postpartum visit

Missing = 11119999
Not Applicable = 11118888

m	m	d	d	y	y	y

Evidence of one of the following:	Documentation of a pelvic exam ❑ Yes (1) ❑ No (0) Documentation of an evaluation of weight, blood pressure, breasts and abdomen ❑ Yes (1) ❑ No (0) A notation of "postpartum care" ❑ Yes (1) ❑ No (0)
Notes:	
End Time	h h m m [ ][ ] : [ ][ ]

Appendix 9 – Agenda for Site Visits

Missouri Care
SITE VISIT AGENDA

June 26– Afternoon

TIME	ACTIVITIY	ATTENDEES	LOCATION
1:00 – 4:00	Case Management Document Review	Mona Prater Lisa Heying	Conference Room – Quiet Location
1:00 – 1:45	Validation of Performance Measures	Amy McCurry Schwartz Health Plan Attendees	
1:45 – 4:00	Compliance Document Review (Information will be requested as needed)	Amy McCurry Schwartz	

June 27 – Morning & Afternoon

TIME	ACTIVITY	ATTENDDEES	LOCATION
8:30 – 9:00	Introduction -- Opening	BHC, Inc. – Amy McCurry Schwartz Mona Prater Lisa Heying Health Plan Attendees	

9:00 – 11:00	Case Management & Compliance – Interviews Case Management Staff	BHC, Inc. – Amy McCurry Schwartz Mona Prater Lisa Heying Health Plan Attendees	
11:00 – 12:30	Case Management & Compliance Review – Interviews with Administrative Staff	BHC, Inc. – Amy McCurry Schwartz Mona Prater Lisa Heying Health Plan Attendees	
12:30 – 1:30	Lunch Break		
1:30 – 3:00	Validation of Performance Improvement Projects	BHC, Inc. – Amy McCurry Schwartz Mona Prater Lisa Heying Health Plan Attendees	
3:00 – 3:15	Exit Conference Preparation	BHC, Inc. Staff	
3:15 – 3:30	Exit Conference	BHC, Inc. – Amy McCurry Schwartz Mona Prater Lisa Heying Health Plan Attendees	

Appendix 10 – Site Visit Information Request Letter

Behavioral Health Concepts, Inc.
1804 Southwest Boulevard, Jefferson City, MO 65109 855-385-3776 (toll free)
www.behavioralhealthconcepts.com

June 7, 2017

RE: SITE VISIT AGENDA AND DOCUMENT REVIEW

Dear:

We are finalizing plans for the on-site review of each Health Plan. The following information is provided to assist in preparations for the on-site review. We would like to make this as efficient as possible for you and your staff. The following information or persons will be needed at the time of the on-site review at .

Performance Improvement Projects

Time is scheduled on afternoon to conduct follow-up questions, review data submitted, and provide verbal feedback to the Health Plan regarding the planning, implementation, and credibility of findings from the Performance Improvement Projects (PIPs). Any staff responsible for planning, conducting, and interpreting the findings of PIPs should be present during this time. The review will be limited to the projects and findings submitted for 2016. Please be prepared to provide and discuss any new data or additional information not originally submitted.

Performance Measure Validation

As you know, BHC is in the process of validating the following three performance measures:

- Prenatal and Postpartum Visit (PPV)
- Emergency Department Utilization (EDU)
- Emergency Department Visits (EDV)

BHC is following the CMS protocol for validating performance measures. The goals for this process are to:

- Evaluate the accuracy of Medicaid performance measures reported by the Health Plan; and
- Determine the extent to which Medicaid-specific performance measures calculated by the Health Plan followed specifications established by the MO HealthNet Division. (Including the HEDIS 2016 Technical Specifications)

To complete this process, we will review the following documents while on-site:

Performance Measure Interviews

In addition to the documentation reviews, interviews will be conducted with the person(s) responsible for:

- Overseeing the process of identifying eligible members from Health Plan data sources for the measures to be validated;
- Programming the extraction of required elements from the Health Plan data sources for the measures to be validated;
- Integrity checks and processes of verifying the accuracy of data elements for the measures to be validated;
- Overseeing the process of medical record abstraction, training, and data collection for the measures to be validated; and
- Contractor oversight and management of any of the above activities.
- Demonstration of HEDIS software
- Demonstration of the process for extracting data from Health Plan databases
- Possible data runs for identifying numerator and denominator cases

Compliance & Case Management Project Review

The final activity to prepare for during the on-site visit will be the compliance and case management review. Documentation review and interviews with MO HealthNet Division staff have occurred prior to the on-site visit. This will enable BHC to use the time at the Health Plan as efficiently as possible. The following information will be needed at the time of the on-site review:

Compliance Documents

- Member Handbook
- 2016 Marketing Plan and materials
- 2016 Quality Improvement Committee minutes
- Approved Case Management Policy – Include care management, care coordination, and complex case management policy. Please include any practice instructions used, if these are separate from policy.

Compliance

Interviews with health plan compliance staff will be conducted as needed.

Case Management Interviews

The attached agenda requests an interview in the morning with case management staff. These interviews are focused on staff members who interact directly with members, and who provide case management or disease management services.

We are asking that the case managers listed be available for the interviews. If there are new case managers who would like to attend, but whose names are not included, we

would be happy to have them involved in the interviews. Interview questions will include general questions regarding practices at the Health Plan, as well as some questions generated by the cases we read.

In some circumstances, it may be necessary to conduct these interviews by telephone. In these instances, we request that speaker-phone equipment be available in the conference room being utilized by the review team. We realize we are asking for many case managers. If someone is not available, it will not be necessary to substitute another case manager. A listing of the case managers, who will attend, in person or by telephone, will be helpful. Please ensure that the requested staff, when available, be in their location at the identified interview time.

Later interviews are scheduled to include administrative staff. It would be helpful to include the following staff:

- Plan Director
- Medical Director
- Quality Assurance Director
- Case Management Supervisors or Administrators
- Utilization Management Director

These interviews, including required telephone interviews can be scheduled in a convenient location in your offices. Document reviews are also scheduled and may occur in a separate conference room or meeting space.

The on-site review team will need to order a working lunch during this visit. If lunch facilities are not available, please provide the name and telephone number of a service in your vicinity that can accommodate ordering lunch. Your assistance will be appreciated.

The Health Plan staff involved in any of the referenced interviews or activities, or anyone identified by the Health Plan, is welcome to attend the introduction and/or the exit interview.

Again, your assistance in organizing the documents, individuals to be interviewed, and the day's activities is appreciated. If you have questions, or need additional information, please let me know.

Sincerely,

Mona Prater
Assistant Project Director

Cc: Amy McCurry Schwartz, Esq., Project Director
Paul Stuve, MO HealthNet Division
Sidney Wilde, MO HealthNet Division
Lisa Heying, RN Consultant

Attachment:
On-Site Review Agenda

Appendix 11 – Compliance Review Scoring Form

2016 BHC MCHP Compliance Review Scoring Form

This document is used to score the number of items met for each regulation by the MCHP.

1. Review all available documents prior to the site visit.
2. Follow-up on incomplete items during the site visit.
3. Use this form and the findings of Interviews and all completed protocols to complete the Documentation and Reporting Tool and rate the extent to which each regulation is met, partially met, or not met. Scores from this form will be used to compare document compliance across all MCHPs.

0 = Not Met: Compliance with federal regulations could not be validated.
1 = Partially Met: MCHP practice or documentation indicating compliance was observed, but total compliance could not be validated.
2 = Met: Documentation is complete, and on-site review produced evidence that MCHP practice met the standard of compliance with federal regulations.

	Contract Compliance Tool	*Federal Regulation*	*Description*	*Comments*	*2016 Site Visit and Findings*	*2015 Rating*	*2014 Rating*
	Subpart C: Enrollee Rights and Protections						
1	2.6.1(a)1-25, 2.2.6(a), 2.6.2(j)	438.100(a)	Enrollee Rights: General Rule				
2	2.6.1(a)1, 2.9, 2.6.2(j), 2.6.2(n)	438.10(b)	Enrollee Rights: Basic Rule				
3	2.15.2(e), 2.8.2	438.10(c)(3)	Alternative Language: Prevalent Languages				
4	2.8.2, 2.8.3, 2.6.2(n)(2)	438.10(c)(4,5)	Language and format: Interpreter Services				
5	2.6.1(a)1, 2.6.2(n)1	438.10(d)(1)(i)	Information Requirements: Alternative Formats				
6	2.6.1(a)1, 2.6.2(n)2 - dot point 35, 2.6.2(q), 2.8.2, 2.8.3	438.10(d)(1)(ii) and (2)	Information Requirements: Easily Understood				
7	2.3.5, 2.6.1(a)2/3, 2.6.2(k)1, 2.6.2(n),	438.10(f)	Enrollee Rights: Information, Free Choice				

	2.6.2(n)(2), 2.6.2(q)						
8	2.6.2(n)(2)	438.10 (g)	Information to Enrollees: Physician Incentive Plans				
9	2.4, 2.4.5, 2.4.5(a)2-4, 2.20.1(all), 3.5.3(f)	438.10(i)	Liability for Payment and Cost Sharing				
10	2.2.6(a), 2.2.6(b), 2.6.1(a)(3), 2.6.2(j), 2.9.1	438.100(b)(2)(iii)	Specific Enrollee Rights: Provider-Enrollee Communications				
11	2.6.2(j), 2.30.1, 2.30.2, 2.30.3	438.100(b)(2)(iv,v)	Right to Services, including right of refusal. Advance Directives				
12	2.6.2(j), 2.4.8, 2.13, 2.14	438.100(b)(3)	Right to Services				
13	2.2.6, 2.14.3, 2.14.8, 2.14.9	438.100(d)	Compliance with Other State Requirements				
		Total Enrollee Rights and Protections					
	Subpart D: Quality Assessment and Performance Improvement						
	Subpart D: Quality Assessment and Performance Improvement: Access Standards						
14	2.3.1, 2.6.2(j), 2.14.3, 2.7.1(g), 3.5.3	438.206(b)(1)(i-v)	Availability of Services: Provider Network				
15	2.7.1(e), 2.7.1(f), 2.14.8	438.206(b)(2)	Access to Well Woman Care: Direct Access				
16	2.13	438.206(b)(3)	Second Opinions				
17	2.3.2, 2.3.18, 2.7.1(bb),	438.206(b)(4)	Out of Network Services:				

	2.12.3, 2.12.4, 2.14.5		Adequate and Timely Coverage				
18	2.4, 2.20.1(d)	438.206(b)(5)	Out of Network Providers: Cost Sharing				
19	2.3.14(a)2, 2.14.1, 2.14.4(a-f), 2.17.1, 3.5.3	438.206(c)(1)(i-vi)	Timely Access				
20	2.2.6(a)1-3, 2.17.1	438.206(c)(2)	Cultural Considerations				
21	2.14.11, 2.3.5(e)	438.208(b)	Primary Care and Coordination of Healthcare Services				
22	2.6.2(m), 2.14.11, 2.5.3(e)	438.208(c)(1)	Care Coordination: Identification				
23	2.12.10, 2.14.2(c), 2.14.11, 2.17.5, Attachment 3 - Children with Special Healthcare Needs	438.208(c)(2)	Care Coordination: Assessment				
24	2.7.1, 2.12, 2.14.11	438.208(c)(3)	Care Coordination: Treatment Plans				
25	2.3.8, 2.3.7, 2.6.1(k)(3), 2.14.6, 2.14.7	438.208(c)(4)	Access to Specialists				
26	2.2.1(i), 2.3.7, 2.7.4, 2.9.2, 2.10.2, 2.14.1, 2.14.2(a-h), 2.14.2(d)1-2	438.210(b)	Authorization of Services				
27	2.15.4, 2.14.2(d)6	438.210(c)	Notice of Adverse Action				
28	2.6.2(k)(3), 2.14.2(d)6, 2.15.4(a-c), 2.16.3(e)	438.210(d)	Timeframe for Decisions				

29	2.17.5(b)	438.210(e)	Compensation for Utilization Management Decisions				
30	2.4.8, 2.7.1, 2.7.1(y), 2.7.3(v), 2.14.2	438.114	Emergency and Pos-stabilization pgs 24/25 Rev. Checklist				
	Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards						
31	2.17.2(n), 2.17.5(c), 2.30.2	438.214(a,b)	General Rules for Credentialing and Recredentialing				
32	2.2.6(b)(c)	438.214(c) and 438.12	Nondiscrimination and Provider Discrimination Prohibited				
33	2.31.5	438.214(d)	Excluded Providers				
34	2.3.9, 2.3.17	438.214(e)	Other State Requirements: Provider Selection				
35	2.6.2(n)(2), 2.6.2(s)(all), 2.6.2(u)	438.226 and 438.56(b)(1-3)	Disenrollment: Requirements and Limitations				
36	2.5.1, 2.5.2, 2.5.6, 2.6.1(g), 2.6.2®	438.56(c)	Disenrollment Requested by Enrollee				
37	2.6.2(r,s-1,t)	438.56(d)	Procedures for Disenrollment -- Pgs 29/30 Rev. Checklist				
38	2.6.2(u)	438.56(e)	Timeframe for Disenrollment Determinations				
39	2.15, 2.15.3(a,b)	438.228	Grievance Systems				
40	2.6.1(a)(18), 2.16.2(c), 2.31.2(a)8, 2.31.3, 3.5.1, 3.5.2, 3.5.3	438.230(a,b)	Subcontractual Relationships and Delegation				
	Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement						
41	2.17.2(d)	438.236(b)(1-4)	Adoption of Practice Guidelines	There is very little in the contract			

				compliance tool regarding practice guidelines.			
42	2.17.2(d)	438.236(c)	Dissemination of Practice Guidelines				
43	2.17.2(d,f)	438.236(d)	Application of Practice Guidelines -- Pgs 32/33 of Rev. Checklist				
44	2.17.1, 2.17.5	438.240(a)(1)	Quality Assessment and Improvement Program				
45	2.17.5(d)	438.240(b)(1) and 438.240(d)	Basic Elements of MCO QI and PIPs				
46	2.17, 2.17.3, Attachment 6	438.240(b)(2)(c) and 438.204(c)	Performance Measurement				
47	2.17.5(b)	438.240(b)(3)	Basic elements of MCO QI and PIPs: Monitoring Utilization				
48	2.17.5	438.240(b)(4)	Basic elements of MCO QI and PIPs				
49	Attachment 6 - State Quality Strategy	438.240(e)	Program Review by State				
50	2.25	438.242(a)	Health Information Systems				
51	2.25(all) - 2.25.1, 2.25.2(a,b), 2.25.3, 2.25.4	438.242(b)(1,2)	Basic Elements of HIS				
52	2.26.1, 2.29.1	438.242(b)(3)	Basic Elements of HIS				
		Total Quality Improvement and Assessment					

	Subpart F: Grievance Systems						
53	2.15	438.402(a)	Grievance and Appeals: General Requirements				
54	2.15.2, 2.15.5(a), 2.15.6(a)	438.402(b)(1)	Grievance and Appeals: Filing Authority				
55	2.15.6(a)	438.402(b)(2)	Grievance and Appeals: Timing				
56	2.15.2(a), 2.15.5(a), 2.15.6(a,b)	438.402(b)(3)	Grievance and Appeals: Procedures				
57	2.15.2(e), 2.15.4(a),2.6.2(q)	438.404(a)	Notice of Action: Language and Format				
58	2.15.4(b)	438.404(b)	Notice of Action: Content				
59	2.15.4(c)	438.404(c)	Notice of Action: Timing				
60	2.15.5(b,c,d), 2.15.6(h,i,j)	438.406(a)	Handling of Grievances and Appeals: General Requirements				
61	2.15.6(g) 2.15.6(h) 2.15.6(i) 2.15.6(j)	438.406(b)	Handling of Grievances and Appeals: Special Requirements				
62	2.15.5(e), 2.15.6(k)	438.408(a)	Resolution and notification: Grievances and Appeals - Basic rule				
63	2.15.5(e,f), 2.15.6(k-l)	438.408(b,c)	Resolution and notification: Grievances and Appeals - Timeframes and extensions				
64	2.15.5(e), 2.15.6(k,m)	438.408(d)(e)	Resolution and notification: Grievances and Appeals - Format and content				
65	2.15.2(i), 2.15.6(m)	438.408(f)	Resolution and notification: Grievances and Appeals -				

			Requirements for State fair hearing				
66	2.15.6(n,o)	438.410	Expedited resolution of appeals				
67	2.15.2(c), 3.5.3(c)	438.414	Information about the grievance systems of providers and subcontractors				
68	2.15.3	438.416	Recordkeeping and reporting				
69	2.15.6(p)	4388.420	Continuation of Benefits while the MCO/PIHP Appeal and the State Fair Hearing are Pending				
70	2.15(q,r)	438.424	Effectuation of reversed appeals				
		Total All Items					
This protocol was developed using the CMS MCO Compliance protocol worksheet and cross-matching the State of Missouri Eastern/Central Region contract and the State supplied Compliance Tool.							

Appendix 12 – Case Record Review Tool

Behavioral Health Concepts, Inc.
1804 Southwest Blvd, Ste D, Jefferson City, MO 65109 855-385-3776

Health Plan: _____

Member Name: _____

Case Manager Name(s): _____

CM Service Type: _____

Reviewer: _____

Service Content (note any information about the case, making it unusual or leading to questions regarding CM content):

_____
___ ___

2016 External Quality Review – Case Review Tool

After initial referral –

- Member was contacted and Case Management was initiated. Yes ____ (if yes proceed to question #1). No_____
- If No, is there evidence that the member was contacted within time frames? Yes ___No___.
- Were required efforts made to contact the member and establish a relationship? Yes ___No__
- Did member refuse services? Yes _____No_____.
- Reason given for not providing case management services:_____

_____
_____

When a case is opened for services:

Introduction to Case Management

1. Is all identifying information available, including contact information? Y_____N_____

2. Does narrative contain introductory information to members, such as:
   a. An explanation of Case Management services. Y_____N_____
   b. The member's right to accept/reject CM services. Y_____N_____
   c. Was obtaining member's permission a problem? Y___N____N/A____
   d. Third party disclosure (obtaining permission to speak to another person/family member about medical/referral/CM information) circumstances were explained. Y_____N_____

3. Is the reason for CM services provided? Y_____N_____

Comprehensive Assessment

4. Does the case record contain a comprehensive assessment? Y_____N_____

5. Was the assessment completed within required time frames? Y_____N_____
   The assessment for CM was within 30 days of enrollment for a new member;
   The assessment for CM was within 30 days of diagnosis for existing members;
   The assessment within 30 days from the date when a member receives the projected discharge date from the hospital or rehabilitation facility Y_____ N _____

   Did the assessment for CM occur within **5** days of admission to a psychiatric hospital or residential substance abuse program? Y_____ N _____

6. Were additional assessment tools included in the record updating information, particularly if the case was opened for an extended period of time (over 12 months)? Y_____ N _____NA_____

Comprehensive Care Planning

7. Does this record contain care plans? Y_____N_____
   a. Did the care plan use clinical practice guidelines? Y ____ N _____
   b. Is there evidence of member participation in care plan development? Y____N_____
   c. Is there evidence that the care plan was discussed, coordinated and/or sent to the member's PCP? Y_____N_____
   d. Were care/case plans updated when member's needs changed or goals achieved? Y ___ N ___

Type of Service Required

8. Was the member part of a special program population (SHCNs)? Y____N____
   a. Did the Case Manager follow Health Plan protocols in serving this member? Y____N___

9. Is this member pregnant? Y_____N_____
   a. If yes, was case management offered within 15 days of confirmation of pregnancy? Y_____N_____
   b. Was a risk assessment completed? Y_____N_____
   c. Is it included in the case record? Y_____N_____

10. Is this a lead involved case? Y_____N_____
    a. If yes, were case management services initiated within required time frames? Y____N____
    b. Did the initiation of services indicate which of the following categories the member is in? Y____N____
       i. 10 to 19 ug/dL within **1-3 days**
       ii. 20 to 44 ug/dL within **1-2 days**
       iii. 45 to 60 ug/dL within **24 hours**
       iv. 70 ug/dL or greater – **immediately**
    c. Did services include follow-up services, as required? Y ___ N _____

11. Did the record indicate a diagnosis of: (check any that apply)?

    Cancer ____
    Cardiac disease____
    Chronic pain____

Hepatitis C____
HIV/AIDS____
Sickle Cell Anemia ____
Anxiety Disorders ____
Pervasive Developmental Disorder _____

Members with Special Healthcare Needs without services____
(These may include, but not be limited to private duty nursing, home health, durable medical equipment/supplies, and/or a need for hospitalization or institutionalization.)

The following groups/individuals are at high risk of having a SHCN:

- Individuals with Autism Spectrum disorder _____
- Individuals eligible for SSI _____
- Individuals in foster care or other out-of-home placement _____
- Individuals receiving foster care/adoption subsidy _____
- Individuals receiving services through a family-centered community-based coordinated care system receiving funds under Section 501(a)(1)(D) of Title 5 _____

Other diagnosis: _____

Appropriate Provider and Service Referrals

12. Were appropriate referrals made for necessary services that were not in place at the time of the assessment, or when recommended by the members' physician/healthcare team? Y____N____N/A_____
    a. Were individual and/or family support services provided as needed? Y___N___NA___
    b. If "Yes" briefly describe:

13. Were appropriate referrals made for community-based services? Y_____N_____N/A_____
    a. Transportation services? Y_____N_____N/A_____

Face to Face Contacts

14. Is there evidence in the case record that face-to-face contacts occurred, as required? Y_____N_____N/A_____
    a. Were face-to-face contacts linked to the goals/outcomes identified in the care plan? Y___N___NA___

15. Who conducted face-to-face contacts? _____
    a. Were the outcomes of face-to-face contacts included in the case record? Y___N___

Progress Notes and Required Contacts

16. Does this case record include progress notes as required? Y_____N_____

17. Is there evidence that at least three (3) substantial contacts were made, directly with the member or their representative, prior to case closure? Y_____N_____

a. Was a communication plan established with the family/member? Y___N____

PCP Involvement

18. Do the case notes indicate if the PCP was informed that a case manager was working with the member? Y_____N_____
    a. Were periodic updates given to the PCP when a member's situation/health changed during CM? Y___N___NA___
    b. Was the PCP informed when the case management record was closed? Y_____N_____Not Closed_____

19. Was any history or additional information provided to or obtained from the PCP or members of the staff? Y_____N_____

Case/Care Coordination

20. Is there any evidence that the member was referred to Disease Management, if appropriate? Y_____N_____N/A_____

21. Is there evidence of care coordination in complex cases, as required? Y_____N_____NA_____

22. Are behavioral health services discussed with the member? Y_____N_____NA_____

23. When behavioral health services are deemed necessary is the PCP informed? Y_____N_____NA____

24. Is there evidence of care coordination with the behavioral health CM or provider? Y_____N_____NA_____

Transition Plan and Case Closure

25. If case closure has occurred, is there evidence that the member has achieved all stated care plan goals and is there stabilization of member's condition, successful links to community support and education, and improved member health? Y_____N_____N/A_____

    a) Did the member request to withdraw from either case management or the health plan? Y ____ N _____

    b) Did lack of contact or compliance occur? Y _____ N_____
        a. If "Yes" briefly describe:

    c) In this situation was written documentation included indicating plan of attempts to locate/engage member? Y _____ N _____
        a. Examples include: making phone calls before during and after regular working hours; visiting the family's home; sending letters with an address correction request; contact with the PCP, WIC office, and other providers or program.

26. Is there evidence that an appropriate transition of care was offered to the member, and followed at the time a case was closed? Y____N____N/A_____

27. Do proper case closing criteria exist based on the type of case management received?
Y_____N_____N/A_____

Additional Questions regarding this case or member situation that should be included in CM interviews:

_____
_____
_____
_____