2009

MO HealthNet Managed Care Program

External Quality Review

Supplemental Report of Technical Methods

Amy McCurry Schwartz, Esq., MHSA, EQRO Project Director

Mona Prater, MPA, EQRO Assistant Project Director

Stephani Worts, MBA, EQRO Research Analyst

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Performance Management Solutions Group

Prepared and Submitted by:

The Performance Management Solutions Group
Is a division of Behavioral Health Concepts, Inc.

2716 Forum Blvd, Suite 4
Columbia, MO 65203
(573) 446-0405 :Local Ph.
(866) 463-6242 :Toll-free Ph.
(573) 446-1816 :Fax
http://www.PMSGinfo.com
http://www.BHCinfo.com
Email: EQRO@pmsginfo.com

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LIST OF ACRONYMS

BA+	Blue-Advantage Plus of Kansas City
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
CMFHP	Children's Mercy Family Health Partners
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
CPT	Current Procedural Terminology
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
EPSDT	Early, Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	MO HealthNet Fee-for-Service
HARMONY	Harmony Health Plan
HCUSA	Healthcare USA
HCY	MO HealthNet Healthy Children and Youth, the Missouri Medicaid EPSDT program
HEDIS	Healthcare Effectiveness Data and Information Set

HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information Systems
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, Ninth Revision, Clinical Modification, World Health Organization
ICN	Internal Control Number
ISCA	Information Systems Capability Assessment
LPHA	Local Public Health Agency
MBE	Minority-owned Business Enterprise
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
MMIS	Medicaid Management Information System
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
MOCARE	Missouri Care Health Plan
MOHSAIC	Missouri Public Health Integrated Information System
MOLINA	Molina Healthcare of Missouri
NCPDP	National Council for Prescription Drug Program
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.
NSF/CMS 1500	National Standard Format/ Center for Medicare and Medicaid Services Form 1500
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PRO	Peer Review Organization
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
UB-92	Universal Billing Form 92

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.
Accuracy (Match) Rate	The ratio of identical or correct information in the medical record and the SMA relative to the number of encounters that took place.
Accuracy of a data field	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alpha numeric) in the proper format (e.g., mm/dd/yyyy for date field).
Accuracy of the State encounter claims database	The extent to which encounters are being submitted for 100 percent of the services that are provided. [1]
Commission (or surplus encounter claim)	An encounter that is represented in the SMA encounter claims database but not the medical record; or a duplicate encounter.
Completeness of a data field	The extent to which an encounter claim field contains data (either present or absent).
Confidence interval or level	The range of accuracy of a population estimate obtained from a sample.

[1] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition

Encounter data	"Encounter data are records of health care services that have been provided to patients." [2]
Error	An error in coding or recording an encounter claim.
Fault (Error) Rate	The ratio of missing and erroneous records relative to the total number of encounters that took place[3]. The rate at which the SMA encounter claims data does not match the medical record or the MCHP paid encounter claims data (the converse of match rate).
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.
Omission (or missing encounter claim)	An encounter that occurred but is not represented in the State encounter claims database.
Paid claim	An encounter claim that has been paid by the MCHP.

[2] Medstat (1999).: A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data. Medstat: Santa Barbara. Second Edition

[3] Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in conducting Medicaid External Quality Review activities, Final Protocol, Version 1.0, U.S. Department of Health and Human Services.

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[4].
Random sample	Selection of sampling units from a sampling frame where each unit has an equal probability of selection.
Reasonableness of a data field	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date); also referred to as validity of the data.
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.
Unpaid claim	All unpaid and denied claims from the MCHP; All claims not paid by the MCHP either through capitation or through other payment methodology.

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

1.0 Preparation for the EQR

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Preparation with the State Medicaid Agency

Effective February 1, 2010 the State of Missouri contract for the External Quality Review of the MO HealthNet Managed Care Program (State of Missouri Contract No: C306122001, Amendment No.: 003) 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. Monthly meetings for planning the scope of work, technical methods and objectives, and are scheduled beginning each January for the upcoming review year. Monthly meetings are held with the SMA and the EQRO throughout the review period. Additional meetings and teleconference calls may be conducted as needed between 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 Health Plan 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. The EQRO works with the SMA the refine the data request for State encounter data to be validated.

Preparation of MO HealthNet Managed Care Health Plans

To prepare the MO HealthNet Managed Care health plans 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 MO HealthNet Managed Care health plan. 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 health plan QI/UM Coordinators or Plan Administrators. A detailed presentation, tentative list of data requests, and the proposals approved by the SMA are sent to health plans prior to the teleconference orientation sessions. MO HealthNet Managed Care health plans 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, encounter data requested) present at the teleconference calls. The orientation presentation is contained in Appendix 1. An SMA representative is invited to attend all conference calls. Notes are sent regarding any calls the SMA does not attend. To avoid confusion and the inundation of multiple requests at once, the requests for information from MO HealthNet Managed Care health plans are normally implemented in a staged approach from January through April. All communications (letters, general and specific instructions) are approved by the SMA prior to sending them to the health plans.

Development of Worksheets, Tools, and Rating Criteria

The EQRO Project Director, Research Associate, 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.

For the Validating Encounter Data Protocol, the EQRO Project Director revises both the data analytic plan, in collaboration with the SMA, as well as methods and procedures based on the content, quality and format of data provided by the SMA and health plans. The SMA selects the fields to validate for completeness, accuracy, and reliability of paid claims submitted by MO HealthNet Managed Care health plans. The EQRO develops definitions of all field parameters for review, revision, and approval by the SMA. Encounter data critical field parameters are approved by the SMA annually.

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

The SMA 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 EQRO requires the review of SMA's activities with regard to the Protocol. Additional policies and documents are requested prior to and during the on-site visits with health plans when information was incomplete or unclear. To facilitate the review of compliance with federal regulations, the EQRO Assistant Project Director works with SMA 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 the SMA 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 health plans' compliance. The SMA provides information on Health Plan 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 SMA staff to clarify SMA comments and compliance ratings. Issues are identified for follow-up at site visits. Updates on MO HealthNet Managed Care health plan 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

Four 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 and document review; she is a licensed attorney with a graduate degree in Health Care Administration, as well as nine years experience in public health and managed care in two states. This is her fifth External Quality Review. Data analysis and interviews were conducted by the EQRO Research Analyst, who is an Information Technology specialist with a Bachelors Degree in Computer Science and a Masters Degree in Business Administration. She has worked for over six years managing data in large and small databases. This is her fourth 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 PIIP 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 prior to the implementation of the 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 (strengths, areas for improvement, and recommendations). In addition, it provides health plan to health plan comparisons and individual MO HealthNet Managed Care health plan summaries for each protocol.

2.0 Performance Improvement Projects

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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:

Activity One: Assessing the MCOs /PIHPs Methodology for Conducting the PIP

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 MCOs/PIHPs data collection procedures
7. Step Seven: Assess the MCOs/PIHPs improvement strategies
8. Step Eight: Review data analysis and interpretation of study results
9. Step Nine: Assess the likelihood that reported improvement is "real" improvement
10. Step Ten: Assess whether the MCO/PIHP has sustained its 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 MO HealthNet Managed Care Health Plan are selected for validation. The projects to be validated are reviewed with SMA 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. The SMA makes the final decision regarding the actual PIPs to be validated from the descriptions submitted by the MO HealthNet Managed Care Health Plans.

PROCEDURES FOR DATA COLLECTION

The evaluation involves review of all materials submitted by the MO HealthNet Health Plans including, but not limited to, the materials listed below. During the training teleconferences MO HealthNet Health Plans are encouraged to review Attachment B 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
- Planned analysis
- 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 Review Consultant meet with the MO HealthNet Health Plan 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. MO HealthNet Health Plans 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 Health Plans 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 Health plans during the on-site review:

- Who was the project leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What were the interventions(s)?
- What was the time period of the study?
- Was the intervention effective?
- What did the MO HealthNet Managed Care Health Plan want to learn from the study?

All PIPs are evaluated by the Review Consultant and the Assistant 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

All PIPs submitted by MO HealthNet Health Plans 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 B (see Appendix 2). 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 MO HealthNet Health Plan 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.

BHC, 2009 EQR criteria

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3.0 Performance Measures

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3.1 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 MO HealthNet Managed Care health plans with other MO HealthNet Managed Care health plans, and to compare State and health plan 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 MO HealthNet Managed Care health plan 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 health plans will follow the instructions of the SPHA for submission of HEDIS measures. Three measures are selected by the SMA for validation annually. These measures are required to be calculated and reported by MO HealthNet Managed Care health plans to both the SMA and the SPHA for MO HealthNet Managed Care Members. A review is conducted for each of the three measures selected based upon the HEDIS Technical Specifications. These specifications are provided in the following tables:

HEDIS 2009 Adolescent Well-Care Visits (AWC)

The following is the definition of the Adolescent Well-Care Visits measure, a Use of Services measure[6], and the specific parameters as defined by the NCQA.

> *The percentage of enrolled members who were 12–21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.*

Table 1 - HEDIS 2009 Technical Specifications for Adolescent Well-Care Visits (AWC)

I. Eligible Population	
Product lines	Commercial, Medicaid (report each product line separately).
Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
II. Administrative Specification	
Denominator	The eligible population.
Numerators	At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member. Adolescents who had a claim or encounter with a primary care practitioner or OB/GYN practitioner with one of the codes listed below are considered to have received a comprehensive well-care visit: 99383-99385, 99393-99395, V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

[6] This measure has the same structure as measures in the Effectiveness of Care domain. The MCO should follow *Specific Guidelines for Effectiveness of Care Measures* when calculating this measure.

III. Hybrid Specification	
Denominator	A systematic sample drawn from the MCO's eligible population. The MCO may reduce its sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. ***Note:*** *For information on reducing sample size, refer to the* Guidelines for Calculations and Sampling.
Numerators	At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The primary care practitioner does not have to be assigned to the member.
Administrative	Refer to the *Administrative Specification* listed above to identify positive numerator hits from the administrative data.
Medical record	Documentation in the medical record must include, a note indicating a visit to a primary care practitioner or OB/GYN practitioner, the date on which the well-care visit occurred and, evidence of all of the following. • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 2 - Data Elements for Adolescent Well-Care Visits

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

HEDIS 2009 Follow-Up After Hospitalization for Mental Illness (FUH)

The following is the definition of the Follow-Up After Hospitalization for Mental Illness measure, an Effectiveness of Care measure, and the specific parameters as defined by the NCQA.

> *The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who were seen on an outpatient basis or were in intermediate treatment with a mental health provider.*

Table 3 - HEDIS 2009 Technical Specifications for Follow-Up After Hospitalization for Mental Illness (FUH)

I. Eligible Population	
Product lines	*Commercial, Medicaid, Medicare (report each product line separately).*
Ages	*6 years and older as of the date of discharge.*
Continuous enrollment	*Date of discharge through 30 days after discharge.*
Allowable gap	*No gaps in enrollment.*
Anchor date	*None.*
Benefits	*Medical and mental health (inpatient and outpatient).*
Event / diagnosis	*Discharged from an inpatient setting of an acute care facility (including acute care psychiatric facilities) with a discharge date occurring on or before December 1 of the measurement year and a principal ICD-9-CM Diagnosis code indicating a mental health disorder specified below:* 295–299, 300.3, 300.4, 301, 308, 309, 311–314, 426, 430 *The MCO should not count discharges from nonacute care facilities (e.g., residential care or rehabilitation stays).*
Multiple discharges	*A member with more than one discharge on or before December 1 of the measurement year with a principal diagnosis of a mental health disorder (Table FUH-A) could be counted more than once in the eligible population.*
Mental health readmission or direct transfer	*If the discharge for a selected mental health disorder is followed by readmission or direct transfer to an acute facility for any mental health principal diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred.* *Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition. Only readmissions with a discharge date that occurs on or before December 1 of the measurement year are included in the measure. Refer to the ICD-9-CM codes listed in Table MIP-A.* *Exclude discharges followed by readmission or direct transfer to a nonacute facility for any mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. (Refer to Table NON-A for codes to identify nonacute care.)*

Non-mental health readmission or direct transfer	*Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit.*
Denied claims	*Denials of inpatient care (e.g., those resulting from members failing to get proper authorization) are not excluded from the measure.*

II. Administrative Specification

Denominator	The eligible population. ***Note:*** *The eligible population for this measure is based on discharges, not members. It is possible for the denominator for this measure to contain multiple discharge records for the same individual.*
Numerators	An outpatient mental health encounter or intermediate treatment with a mental health practitioner within the specified time period. For each denominator event (discharges), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure.
30-day follow-up	An outpatient follow-up encounter with a mental health practitioner up to 30 days after hospital discharge. To identify outpatient follow-up encounters, use the CPT codes or the UB-92 revenue codes in Table FUH-B.
7-day follow-up	An outpatient follow-up encounter with a mental health practitioner up to 7 days after hospital discharge. To identify outpatient follow-up encounters, use the CPT codes or the UB-92 revenue codes in Table FUH-B.

III. Hybrid Specification

None.

Table FUH-B: Codes to Identify Outpatient Mental Health Encounters or Intermediate Treatment

Description	CPT	HCPCS	UB-92 Revenue *
Outpatient or intermediate care	90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875-90876, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99510	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S9480, S9484, S9485	0513, 0900, 0901, 0905-0907, 0909-0916, 0961

*The MCO does not need to determine practitioner type for follow-up visits identified through UB-92 Revenue codes.

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 4 – Data Elements for Follow-Up After Hospitalization for Mental Illness (FUH)

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

HEDIS 2009 Annual Dental Visit (ADV)

The following is the definition of the Annual Dental Visit measure, an Effectiveness of Care measure, and the specific parameters as defined by the NCQA.

> *The percentage of enrolled members 2–21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.*

Table 5 - HEDIS 2008 Technical Specifications for Annual Dental Visit (ADV)

I. Eligible Population	
Product line	Medicaid.
Ages	2–21 years as of December 31 of the measurement year. The measure is reported for each of the following age stratifications and as a combined rate. • 2–3-years • 11–14-years • 19–21-years • 4–6-years • 15–18-years • Total • 7–10-years
Continuous enrollment	The measurement year.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Dental.
Event/diagnosis	None.
II. Administrative Specification	
Denominator	The eligible population for each age group and the combined total.
Numerator	One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any of the codes in Table ADV-A.
III. Hybrid Specification	
	None.

Table ADV-A: Codes to Identify Annual Dental Visits

CPT	HCPCS/CDT-3	ICD-9-CM Procedure
70300, 70310, 70320, 70350, 70355	D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97

Note: *Current Dental Terminology (CDT) is the equivalent dental version of the CPT physician procedural coding system.*

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 6 - Data Elements for Annual Dental Visits

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

3.2 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 particular service (e.g., well-child visits). The eligible population is defined by the HEDIS technical specifications. 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 the SMA and the SPHA.
Additional guidance is provided in the HEDIS Technical Specifications: Volume 2[7] for appropriate handling of situations involving oversampling, replacement, and treatment of contraindications for services.

[7] National Committee for Quality Assurance. HEDIS 2009, 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 HEDIS 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, SMA, 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 MO HealthNet Managed Care health plan. 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 Roadmap
- HEDIS Audit Report
- HEDIS SPHA Reports

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 the SMA in advance. Prior to the teleconference calls, the MO HealthNet Managed Care health plans are provided information on the technical objectives, methods, procedures, data sources, and contact information for EQRO personnel. The health plans 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 MO HealthNet Managed Care health plan 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 MO HealthNet Managed Care health plans responsible for performance measure calculation are conducted.

Formal written requests for data and information for the validation of performance measures are submitted to the MO HealthNet Managed Care health plans by the EQRO recognizing the need to provide adequate time for data and medical record collection by each Health Plan. This information is returned to the EQRO within a specific time frame (see Appendix 3). A separate written request is sent to the health plans 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 MO HealthNet Managed Care health plan 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 MO HealthNet Managed Care health plans 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 health plan 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 health plan 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 health plan's process to re-draw a sample or obtain necessary replacements.
- Procedures to capture data that may reside outside the health plan'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 Z – 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 MO HealthNet Managed Care health plans' ability to link data from multiple sources. All relevant documentation submitted by the MO HealthNet Managed Care health plans 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 Health Plans 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 health plan. 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 MO HealthNet Managed Care health plans' 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 MO HealthNet Managed Care health plan 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 health plan:

- 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 MO HealthNet Managed Care health plan 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 MO HealthNet Managed Care health plan and measure validated. One limitation of this step is the inability of the health plans 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 MO HealthNet Managed Care health plans 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 2008 technical specifications. The MO HealthNet Managed Care health plans 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 health plans 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 MO HealthNet Managed Care health plan 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 MO HealthNet Managed Care health plans' ability to accurately identify medical events (e.g., appropriate doctor's visits); 2) evaluate the health plans' 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 MO HealthNet Managed Care health plan as meeting the numerator criteria (hybrid hits). In the event that the health plan reports fewer than 30 numerator events from medical records, the EQRO requests all medical records that are reported by the health plan 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 MO HealthNet Managed Care health plans to request medical records from the providers. The MO HealthNet Managed Care health plans 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 administered by Reliable Healthcare Services, Inc. (RHS), a temporary Healthcare services provider located in Kansas City, Missouri and a Business Associate of Behavioral Health Concepts, Inc., (the EQRO). RHS is a State of Missouri certified Minority-Owned Business Enterprise (MBE) operated by two registered nurses. RHS possesses expertise in recruiting nursing and professional health care staff for clinical, administrative, and HEDIS medical record review services. 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 EQRO Research Analyst, and with the input from the nurse reviewers. 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. A data entry manual and training were provided to the data entry person at RHS, Inc. Data is reviewed weekly for accuracy and completeness, with feedback and corrections made to the data entry person. The final databases are reviewed for validity, verified, and corrected prior to performing analyses. All data analyses are reviewed and analyzed by the EQRO Research Analyst and reviewed, approved and finalized 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 health plans 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.

From the review of documents and site visits, CMS Protocol Attachment XV (Sampling Validation Findings) is completed for those MO HealthNet Managed Care health plans that elected the Hybrid Method for one of the HEDIS measures selected for validation.

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 the SMA 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 MO HealthNet Managed Care health plans in the State occurred with the EQRO Project Director to clarify questions, obtain data, and follow-up on health plan 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 MO HealthNet Managed Care health plans 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 MO HealthNet Managed Care health plans 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 health plan) as specified by the Protocol. The number of False Positive Records is calculated (Error Rate * numerator hits from Medical Records reported by the health plan). 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 MO HealthNet Managed Care health plan to the SMA and SPHA is the Total

Estimated Bias. A positive number reflects an overestimation of the rate by the health plan, 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 health plan'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 MO HealthNet Managed Care health plans. 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 MO HealthNet Managed Care health plans. 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 MO HealthNet Managed Care health plan on the DST is considered "Not Valid".

Fully Compliant:	Measure was fully compliant with State (SMA and SPHA) specifications.
Substantially Compliant:	Measure was substantially compliant with State (SMA and SPHA) 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 MO HealthNet Managed Care health plan on the HEDIS 2007 Data Submission Tool.

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4.0 Encounter Data

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TIME FRAME

The dates of service have historically run from July 1through September 30 of the review year. However the actual dates are selected by the SMA for the three encounter data validation objectives.

PROCEDURES FOR DATA COLLECTION

For the first objective, the SMA encounter claims extract file is used to examine the completeness, accuracy, and reasonableness of the critical fields and to calculate the rate of each claim type per 1,000 members by MO HealthNet Managed Care health plans. There are six claim types described in the SMA Health Plan Layout Manual: I = Inpatient claim type; M = Medical claim type; O = Outpatient Hospital claim type; D = Dental claim type; H = Home Health claim type; and P = Pharmacy claim type. Inpatient, Outpatient and Home Health claim types are submitted using a Universal Billing (UB-92) file layout, Medical and Dental claim types are submitted using a National Standard Format/Centers for Medicare and Medicaid Services 1500 (NSF/CMS 1500) file layout, and the Pharmacy claims are submitted using the National Council for Prescription Drug Programs, version 3 file layout (NCPDP v.3.0). All claims are sent from the MO HealthNet Managed Care health plans to the SMA through the SMA claims vendor, InfoCrossing, and claim types are assigned by the Medicaid Management Information System (MMIS).

After review and approval of the technical methods and objectives by the SMA, the EQRO reviews, discusses with the SMA, and submits a data request (see Appendix 7) for the SMA encounter claims extract file to be validated for each claim type and each MO HealthNet Managed Care health plan. The file request is made annually to the SMA for their data extract. The SMA reviews and approves the data request and parameters for the designated fields to be validated by the EQRO.

For the second objective of comparing the SMA encounter claims with MO HealthNet Managed Care health plans' paid and unpaid claims, the SMA encounter claims extract file is parsed by type of file layout (NSF/CMS 1500, UB-92, or NCPDP v.3.0) in preparation for matching against MO HealthNet Managed Care health plan paid and unpaid claims. A cross-walk for matching MMIS field names with those of the three national standards file layouts is developed and submitted to the SMA for review. MO HealthNet Managed Care health plans are requested to provide paid and unpaid claims for the designated period on the sample of members selected by the EQRO. Five of the six MO HealthNet Managed Care health plans supply the requested information.

The number of Medical encounter claims in the SMA encounter claims extract file is used for sample size estimation for the third objective and analysis of the evaluation questions. To examine the degree of match between the SMA encounter claims database and medical record procedures and diagnoses, 100 encounters from each MO HealthNet Managed Care health plan are randomly selected from Medical claim types for the time period identified for medical record review. Appendix 8, Appendix 9, and Appendix 10 contain letters of request to providers for medical records, the Table of Contents for the Medical Record Review Training Manual, and copies of medical record review tools. If challenges in requesting the data exist these are addressed with the Health Plans and information is provided to update the SMA.

ANALYSES

To assess the accuracy and completeness of the SMA encounter claims database, the SMA encounter claims extract file for all MO HealthNet Managed Care health plan paid encounter claims representing services during the time frame selected is analyzed for completeness, accuracy, and reasonableness (validity) of the data in each "critical", or required field examined. The Inpatient, Medical, Dental, Home Health, Outpatient Hospital, Pharmacy, and critical fields were chosen by the SMA for analysis, with an established threshold of 100% for completion, accuracy, and validity:

Medical (NSF/CMS 1500) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Place of Service
Units of Service
Procedure Code
Inpatient Diagnosis (five diagnosis fields)

Dental (NSF/CMS 1500) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Units of Service
Procedure Code

Home Health (UB-92) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Units of Service
Procedure Code
Revenue Code
Inpatient Diagnosis (five diagnosis fields)

Inpatient (UB-92) Claim Type
Inpatient Claim Type
Recipient ID
Admission Type
Admission Date
Discharge Date
Bill Type
Patient Discharge Status
Inpatient Diagnosis (five diagnosis fields)
First Date of Billing
Last Date of Billing
Revenue Code
Units of Service

Outpatient Hospital (UB-92) Claim Type
Outpatient Claim Type
Recipient ID
First Date of Service
Last Date of Service
Place of Service
Units of Service
Procedure Code
Inpatient Diagnosis (five diagnosis fields)

Pharmacy (NCPDP v.3.0)
Recipient ID
Dispensing Date
Pharmacy Prescription Number
Drug Quantity Dispensed
Number of Days Supply
National Drug Code

Each field is examined for the presence or absence of data (completeness), the correct type and size of information (accuracy), and the presence of valid values (reasonableness) or validity using the criteria listed below.

Completeness:	The extent to which an encounter claim field contains data (either present or absent).
Accuracy:	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alphanumeric) in the proper format (e.g., mm/dd/yyyy for date field).
Reasonableness (Validity):	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date)

For the validation of the SMA encounter claims extract file with MO HealthNet Managed Care health plan medical records, the goal is to validate the procedure code and diagnosis code fields for the Outpatient claim types in the SMA encounter claims database against the information provided in the medical record. The minimum number of records required for the evaluation of two variables (procedure and diagnosis code) with an estimated error rate of 30% (based on Medstat estimates[8]), reliability of 1.96 (95% statistical significance), and a meaningful difference of 55% are calculated using the number of Medical encounters in the SMA encounter claims file for each MO HealthNet Managed Care health plan (see Figure 1). There are no differences in the number of required records for MO HealthNet Managed Care health plans, with the minimum required sample size of 88. A total of 100 encounters for each MO HealthNet Managed Care health plan are randomly selected for medical record review using a probability sample.

Figure 1 - Formula for Calculating Minimum Required Sample Size

$$n = \frac{z^2 N P_y (1-P_y)}{(N-1)\,\varepsilon^2 P_y 2 + z^2 P_y (1-P_y)}$$

Where Py, = Estimated True Error Rate; meaningful difference between true and estimated value ; z = level of reliability; ε=□I (□Py - meaningful difference)/meaningful difference; N = number of Medicaid Claim Types for the period January 1, 2004-March 31, 2004; n = Minimum required sample size9

[8] Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition.
[9] Levy, P.S. & Lemeshow, S. L. (1999). Sampling of Populations: Methods and Applications, Third Edition, John Wiley and Sons: New York; see box 3.5 for Exact and approximate sample sizes required under simple random sampling for proportions.

5.0 Compliance with Regulations

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PLANNING COMPLIANCE MONITORING ACTIVITIES

Gathering Information on the MO HealthNet MCHP Characteristics

Currently there are six MO HealthNet Managed Care Health Plans 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. These MO HealthNet Members are served by three MO HealthNet Managed Care Health Plans: Molina Healthcare of Missouri, Healthcare USA (HCUSA), and Harmony Health Plan of Missouri (HHP). The Western Region includes Kansas City/Jackson County and twelve surrounding counties. These MO HealthNet members are served by four MO HealthNet Managed Care Health Plans: Children's Mercy Family Health Partners (CMFHP), Blue-Advantage Plus (BA+), Molina Healthcare of Missouri (Molina), and Healthcare USA (HCUSA). The Central Region includes twenty-eight counties in the center of the state. These MO HealthNet members are served by three MO HealthNet Managed Care Health Plans: Missouri Care (MOCare), Molina Healthcare of Missouri (Molina) and Healthcare USA (HCUSA). Molina Healthcare of Missouri and Healthcare USA operated in all three Regions.

Determining the Length of Visit and Dates

On-site compliance reviews are conducted in two days at each MO HealthNet Managed Care Health Plan, with several reviewers conducting interviews and activities concurrently. Document reviews occur prior to the complete on-site review at all MO HealthNet Managed Care Health Plans. 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). The time frames for on-site reviews are determined by the EQRO and approved by the SMA before scheduling each MO HealthNet Managed Care Health Plan. One week is spent in the Eastern Region, one week is spent in the Western Region, and two days are spent in the Central Region completing the on-site review process.

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 MO HealthNet Managed Care Health Plan occurs to allow for the most effective use of time for the EQRO team and Health Plan staff. The schedule for the on-site reviews is approved by the SMA in advance and forwarded to each Health Plan to allow them the opportunity to prepare for the review.

Providing Preparation Instructions and Guidance to the MO HealthNet MCOs

A letter (see Appendix 12) is sent to each MO HealthNet Managed Care Health Plan indicating the specific information and documents required on-site, and the individuals requested to attend the interview sessions. The health plans 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 the SMA 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 the SMA. The information on health plan 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 the SMA. These determinations are utilized in assessing compliance with the Federal Regulations. All documentation gathered by the SMA is clarified and discussed to ensure that accurate interpretation of the SMA findings is reflected in the review comments and findings. SMA 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 MO HealthNet Managed Care Health Plan'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. SMA MO HealthNet Managed Care contract compliance worksheets, and 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 Health Plan's compliance with the requirements of the SMA Quality Improvement Strategy, which is an essential component of the MO HealthNet Managed Care contract, and is required by the federal regulations. Health Plan 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 Health Plan's philosophy regarding case management activities. In addition interviews, based on questions from the SMA and specific to each Health Plan'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 Health Plan. In addition, interview questions are developed for identified staff to establish that practice directly with members reflects the Health Plans' 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 the SMA, 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 health plans, 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 health plan's Annual Evaluation, or address issues of concern expressed by the SMA. Interviews conducted with administrative and management level health plan staff, enable reviewers to obtain a clearer picture of the degree of compliance achieved through policy implementation. Corrective action taken by each health plan is determined from previous years' reviews. This process reveals a wealth of information about the approach each health plan 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 health plan 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 health plan QI/UM staff regarding management information systems; Validating Encounter Data; Validating Performance Measures; and Validating Performance Improvement Projects. The review evaluates information from these sources to validate health plan 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 information and documentation from the SMA about policy submission and approval, which directly affects each MO HealthNet Managed Care health plan's contract compliance. This information is analyzed to determine 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 health plan'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 the SMA following the on-site review, preliminary findings and comparisons to the previous ratings are presented. Discussion occurs with the SMA staff to ensure that the most accurate information is available and to confirm that a sound rationale is used in rating determinations. The SMA approves the process and allows the EQRO to finalize the ratings for each regulation. 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 health plan submissions to the SMA of policy and procedures that meet or exceed contract compliance. This information is then compared to the requirements of the each federal regulation to ensure that policy and practice are in compliance. The SMA 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 SMA contract compliance, review findings, health plan policy, ancillary documentation, and staff

interview summary responses that validate health plan practices observed on-site. In some instances the SMA 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 SMA considers the policy submission valid and ratesit 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. MO HealthNet Managed Care health plan 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 health plan 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.

Appendices

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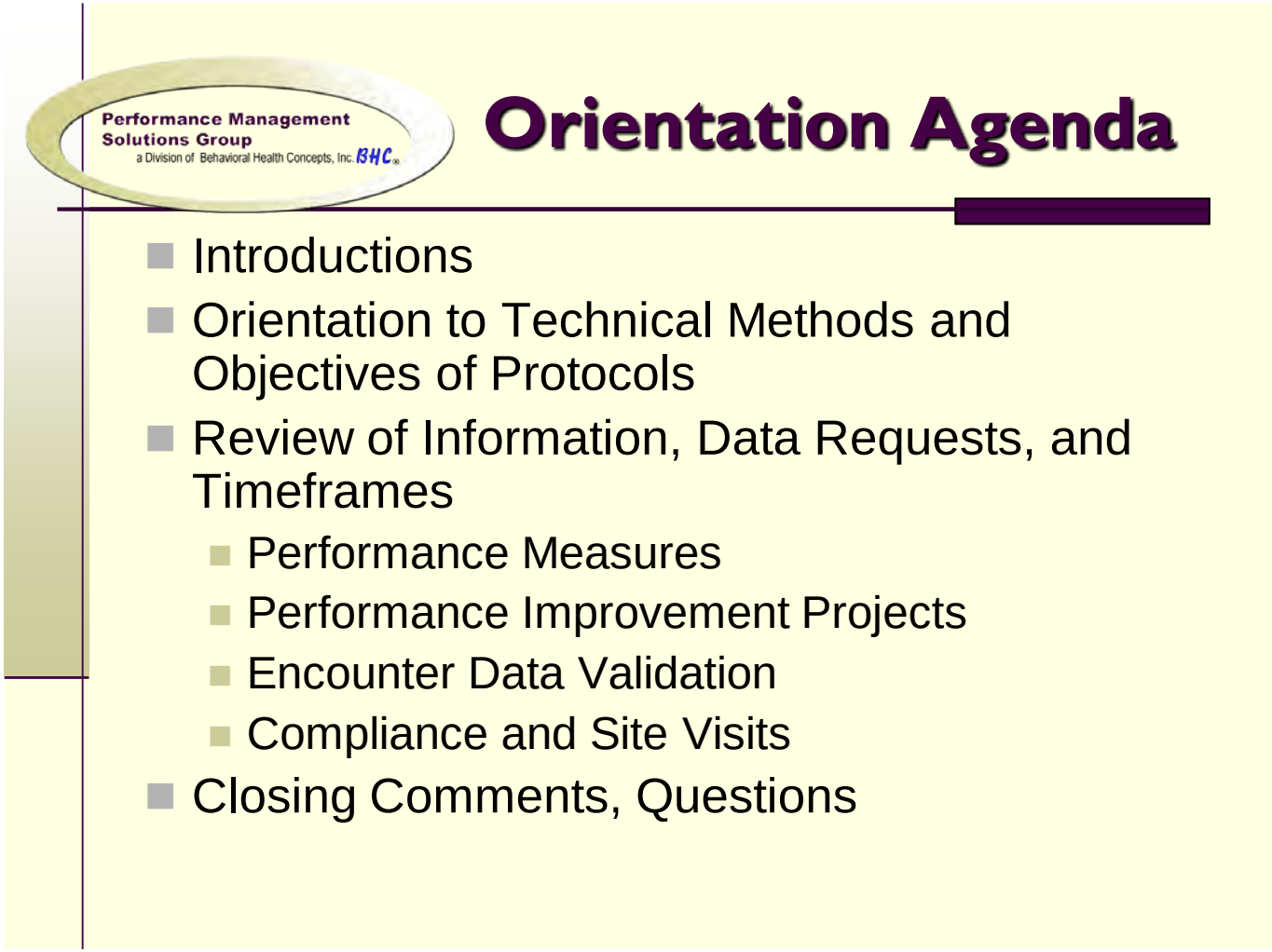
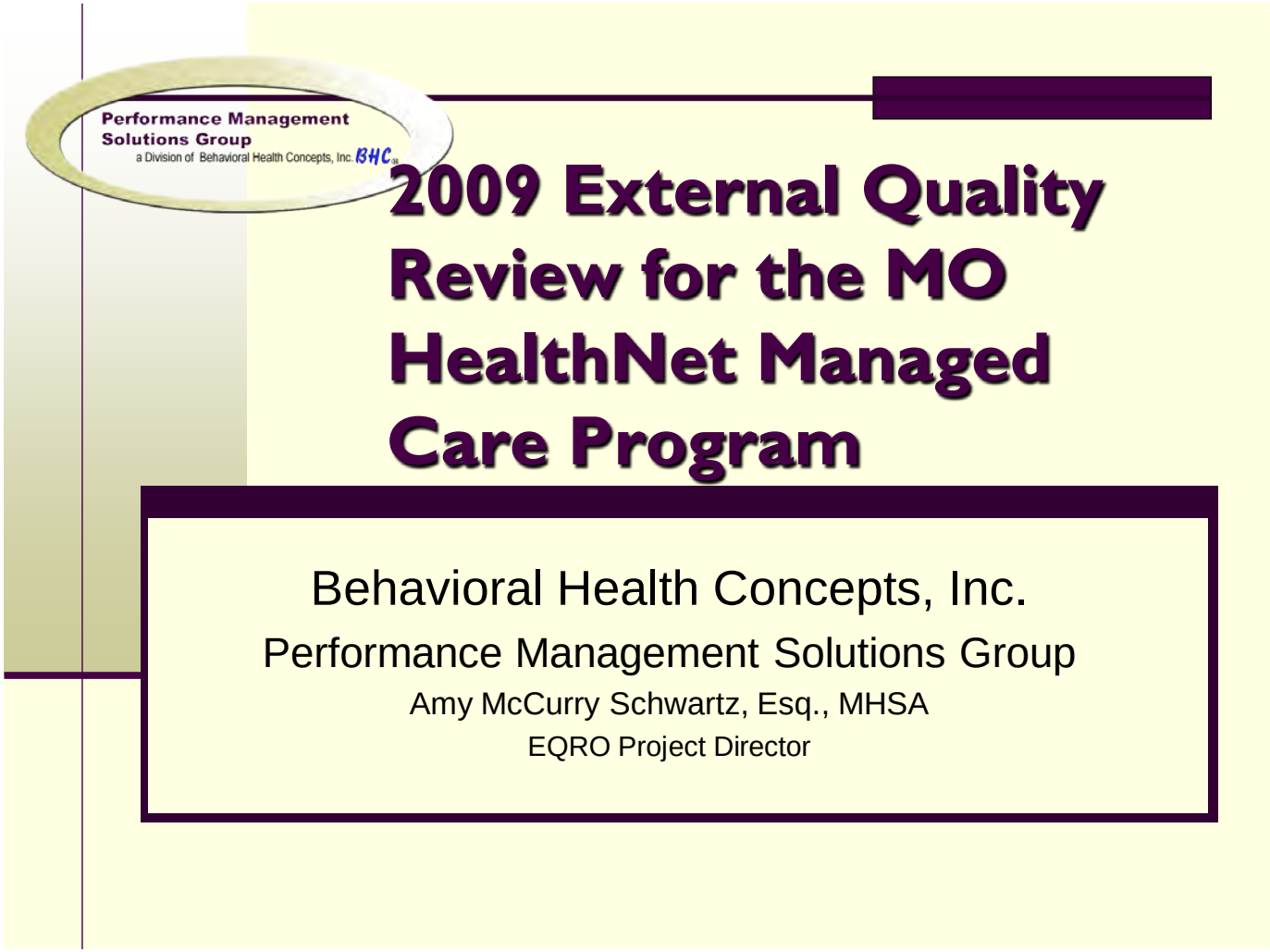
Appendix I – MCHP Orientation PowerPoint Slides

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Behavioral Health Concepts, Inc.
Performance Management Solutions Group
Amy McCurry Schwartz, Esq., MHSA
EQRO Project Director

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Materials Provided

- Objectives and Technical Methods
  - Validation of Performance Measures
  - Validation of Encounter Data
  - Validation of Performance Improvement Projects
  - Health Plan Compliance
- Requests for information and data
- List of BHC contacts for each protocol
- Presentation

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Overview

- Protocol Activities
- Information and Data Requests
- Contact Persons

Validation of Performance Measures

- HEDIS 2009 Measure Validation
  - Adolescent Well-Care Visits
  - Annual Dental Visit
  - Follow-Up After Hospitalization for Mental Illness
- Administrative
- Hybrid method
  - Review up to 30 medical records per measure sampled randomly

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Submission Requirements for PM Validation

For each of the three measures:

- 2009 HEDIS Audit Report
- Baseline Assessment Tool for HEDIS 20098BHC EQRO Performance Measure Checklist (Method for Calculating HEDIS Measures; Table 1.xls)
- List of cases for denominator with all HEDIS 2009 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)
- List of cases for numerators with all HEDIS 2009 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)
- List of cases for which medical records were reviewed, with all HEDIS 2009 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 2009 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

Validation of Encounter Data

- State encounter claim database
- Randomly selected encounters from medical claims, with service dates July 1, 2009 – September 30, 2009
- Review Health Plan supplied medical records for matching claims
- Match state and Health Plan claims databases for all encounters

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Purpose and Objectives

1. To assess the State encounter claim database quality (completeness, accuracy, and reasonableness).
2. To validate the State encounter claims (paid) data against medical record documentation and obtain a fault rate.
3. To examine the match between Health Plan claims (paid) and the State encounter claims database.

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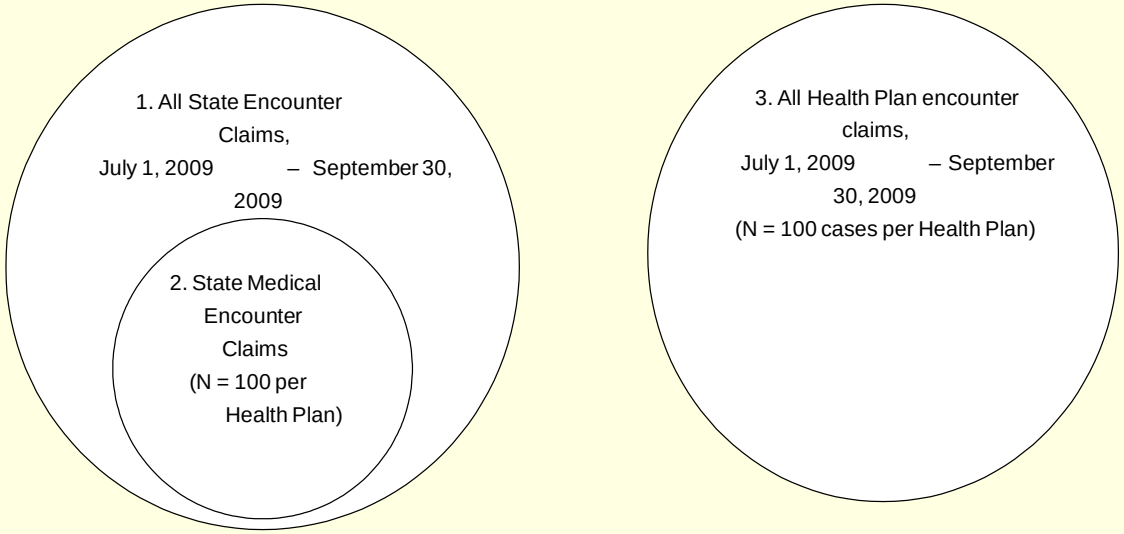
Sampling



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Analyses: I

Critical fields will be examined for completeness (data in field), accuracy (correct type and length of data), and reasonableness (valid data for field) for each Health Plan. This will be conducted for all encounters in the specified time frame.

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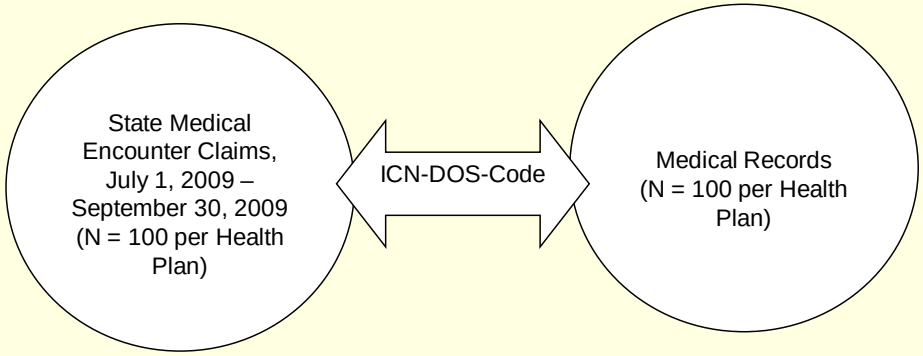
Analyses: 2

BHC will abstract the medical records and claims history/forms for each patient for the medical service provided during the entire time frame, enter into a database, and determine the rate(s) of matches, omissions and commissions between the medical record and the State encounter claims for each Health Plan. Matches will be cases that are consistent on patient ICN, date of service, and diagnosis or procedure code.



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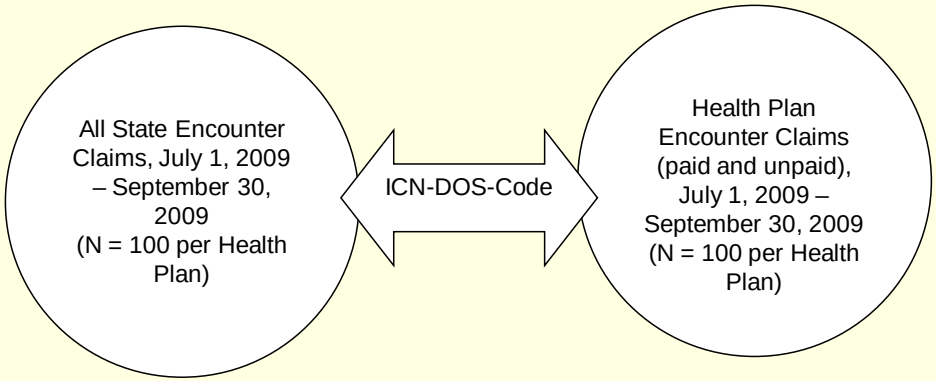
Analyses: 3

BHC will determine the rate(s) of matches, omissions and errors between the State encounter claims and Health Plan encounter claims for each Health Plan for the sample of selected cases.



Encounter Data Validation Submission

- File 1: Provider mailing address and contact information for sampled claims (service dates July 1, 2009 to September 30, 2009). This will be used for validation of the State medical encounter claims database against the medical record.
- File 2: All inpatient encounters from July 1, 2009 to September 30, 2009 for selected members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
- File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from July 1, 2009 to September 30, 2009 for selected members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
- File 4: All pharmacy encounters from July 1,2009 to September 30, 2009 for selected members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.

NOTE: "unpaid claims" are those claims that the Health Plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

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Medical Record Reviews

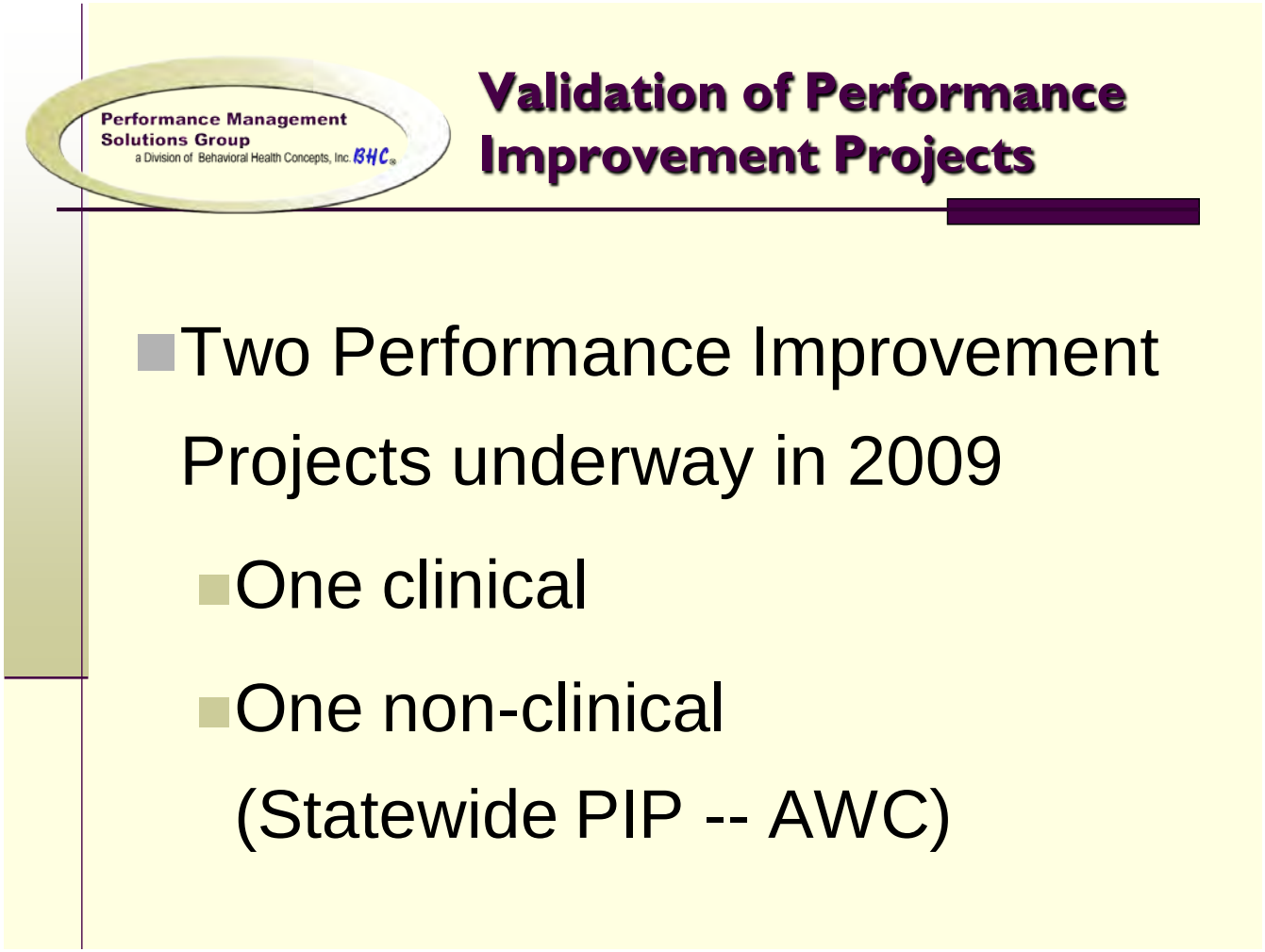
- Encounter
  - Encounter sample provided to Health Plan
  - Health Plan to develop Files 1 (2 weeks from receipt of sample)
  - Health Plan to develop Files 2, 3, 4 (6 weeks from receipt of sample)
  - Health Plan to submit medical record request to providers (1 week from development of File 1)
  - Health Plan s to ensure providers supply medical records to BHC (4 weeks from submission of request to providers)
- HEDIS
  - Medical record samples requested from Health Plans for 1 possible hybrid measure (N ≤ 30 per measure; 4 weeks)

Medical Record Reviews (Cont'd)

- Health Plan will request and obtain Medical Records from providers
  - Letter from MO HealthNet Admin.
  - Instructions for submitting records
  - Encounter claim supporting information, dates, notes, claims information
  - Explanation of Confidentiality, storage of files
  - Explanation of HIPAA, Business Associate Agreement, Health Oversight Authority

Medical Record Reviews (Cont'd)

- Reviewed and abstracted by experienced and certified medical coders
- Standard abstraction tools
- Matching ICN, Date of Service, Diagnosis Code, Procedure Code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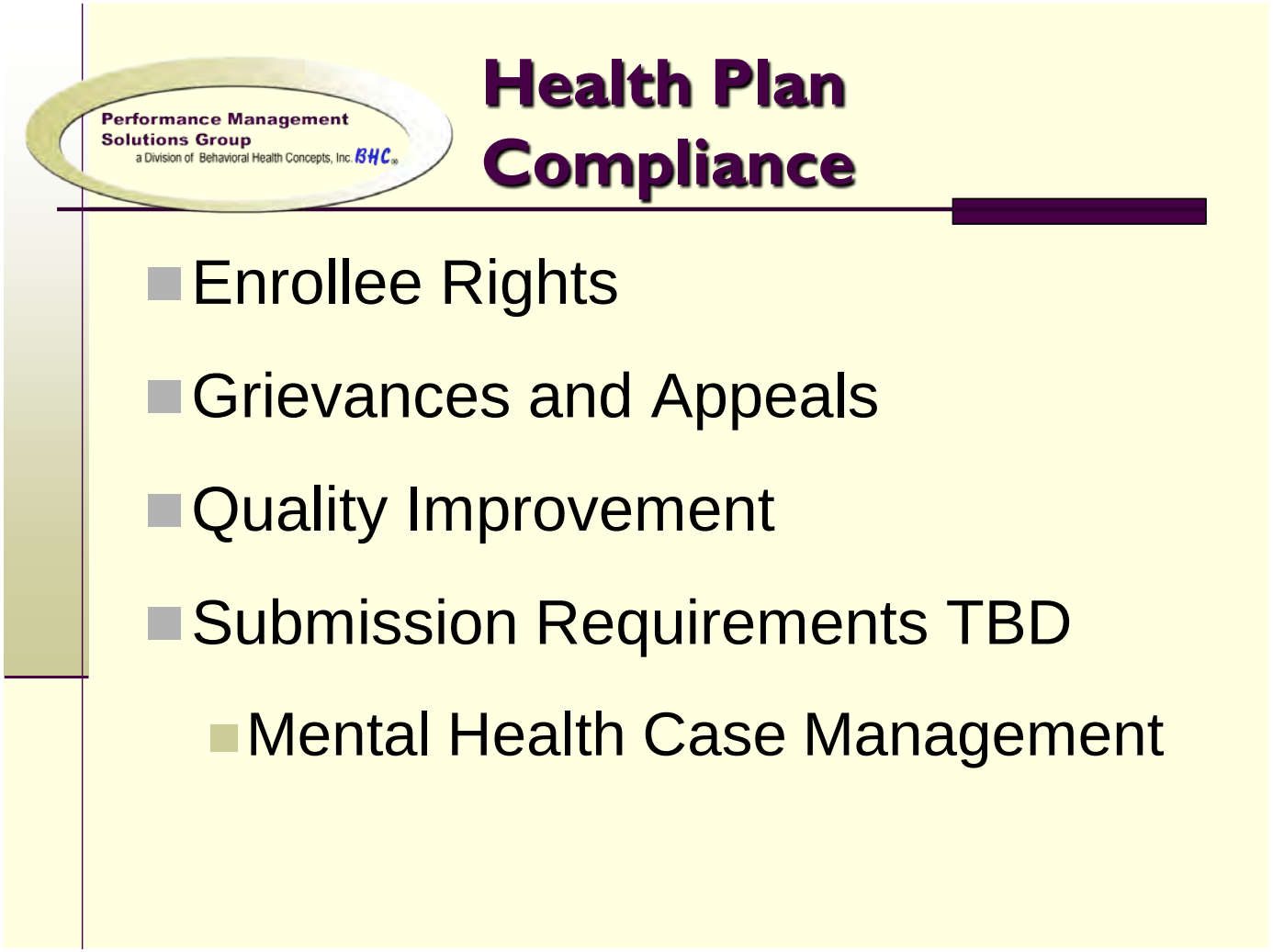
Validation of Performance Improvement Projects
Two Performance Improvement Projects underway in 2009
One clinical
One non-clinical
(Statewide PIP -- AWC)

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, Validation of Performance Measures[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 (2002) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS A protocol for use in Conducting Medicaid External Quality Review Activities: Final Protocol Version 1.0 May 1, 2002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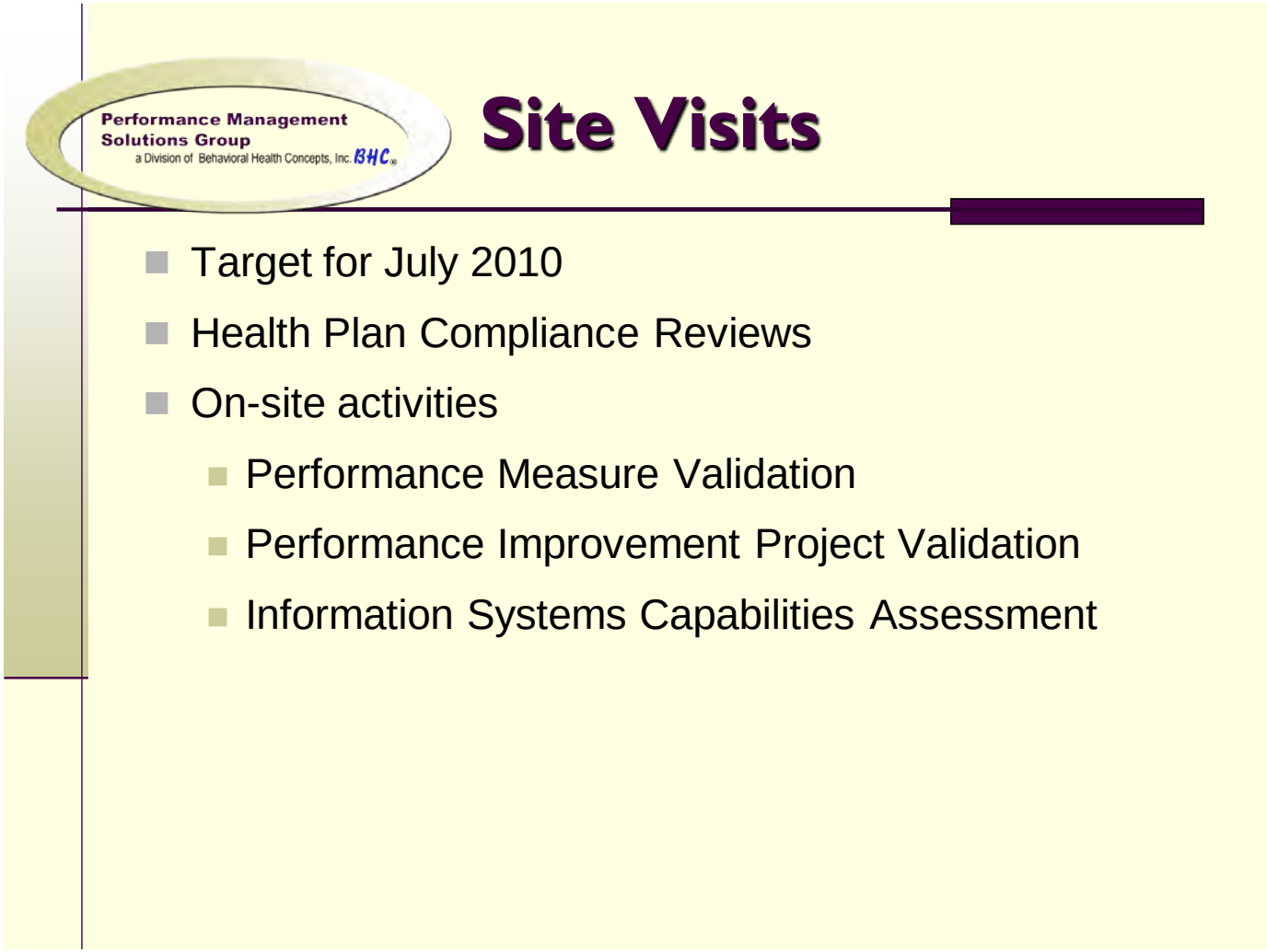
Health Plan Compliance
Enrollee Rights
Grievances and Appeals
Quality Improvement
Submission Requirements TBD
Mental Health Case Management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Site Visits
Target for July 2010
Health Plan Compliance Reviews
On-site activities
Performance Measure Validation
Performance Improvement Project Validation
Information Systems Capabilities Assessment

Final Report

- Health Plan to Health Plan Comparisons:
  - Encounter data match/fault rates for diagnoses and procedures
  - Performance Measure audit findings and rates
  - Performance Improvement Project element compliance
  - Health Plan Compliance follow-up

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BHC Team and Coordination

Protocol/ Activity	BHC Contact Behavioral Health Concepts, Inc. 2716 Forum Blvd., Suite 4a Columbia, MO 65203 Tel. 573-446-0405 Fax 573-446-1816	Health Plan Contact
Performance Measures (HEDIS 2009)	Amy McCurry Schwartz amccurry@pmsginfo.com	
Performance Improvement Projects	Amy McCurry Schwartz amccurry@pmsginfo.com Mona Prater Assistant, Project Director mprater@pmsginfo.com	
Encounter Data	Amy McCurry Schwartz amccurry@pmsginfo.com	
Compliance	Mona Prater mprater@pmsginfo.com	
Site Visits	Amy McCurry Schwartz amccurry@pmsginfo.com Mona Prater mprater@pmsginfo.com	
Medical Records	Amy McCurry Schwartz amccurry@pmsginfo.com	

Appendix 2 – Performance Improvement Project Worksheets

Performance Improvement Project Validation Worksheet

Use this or similar worksheet as a guide when validating MCO/PIHP Performance Improvement Projects. Answer all questions for each activity. Refer to protocol for detailed information on each area.

ID of evaluator _____ Date of evaluation _____

Demographic Information

MCO/PIHP Name or ID	Project Leader Name	Telephone Number

Name of the Performance Improvement Project

Dates of Study **Date Study Initiated**

Type of Delivery System (check all that apply)

☐ Staff Model ☐ Network ☐ Director IPA

☐ IPA Organization ☐ MCO ☐ PIHP

_____	Number of Medicaid Enrollees in MCO or PIHP*	_____	Number Medicare Enrollees in MCO or PIHP
_____	Number of Medicaid Enrollees in the Study	_____	Total Number of MCO or PIHP Enrollees in Study
_____	Number of Members in Study	_____	Population of Members in Sample Frame
_____	Number of MCO/PIHP primary care physicians	_____	Number of MCO/PIHP specialty physicians
_____	Population of physicians in sample frame	_____	Number of physicians in study

Note: DK = Don't Know; NA = Not Applicable

* Source: Missouri Medicaid Management Information System COLD Reports, State Session MPRI Screen, Revised June 25, 2004. Enrollment totals include enrollees with a future start date; 1115, 1915b, and Title XXI enrollees as of June 25, 2004.

BHC Page 1 of 11

Activity 1: ASSESS THE STUDY METHODOLOGY

Step 1. Review the selected study topics(s)

1.1 The topic was selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Topic or problem statement _____

Clinical

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☐ High volume services
☐ High risk conditions

Nonclinical

☐ Process of accessing or delivering care

Comments

1.2 MCO's/PIHP's PIPs, over time, addressed a broad spectrum of key aspects of enrollee care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Project must be clearly focused on identifying and correcting deficiences in care or services rather than on utilization or cost alone.

Comments

1.3 MCO's/PIHP's PIPs over time, included all enrolled populations: i.e., did not exclude certain enrollees such as those with special health care needs.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population
_____ Age
_____ Gender
_____ Race

Payor
_____ MC+
_____ Commercial

Comments

Step 2: Review the study question(s)

2.1 Study question(s) stated clearly in writing. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Study question(s) as stated in narrative:

Comments

Step 3. Review selected study indicators(s)

3.1 The study used objective, clearly defined, measurable indicators. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Indicators (list):

Comments

3.2 The indicators measured changes in health status, functional status or enrollee satisfaction; or process of care with strong association with improved outcomes. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Long term outcomes implied or stated: ☐ Yes ☐ No

Health status: Satisfaction (members):

Functional status: Satisfaction (providers):

Comments

Step 4: Review the identified study population

4.1 MCO/PIHP clearly defined all Medicaid enrollees to whom the study questions and indicators are relevant.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population sampled: Age _____ Gender _____ Race _____ MC+ _____ Commercial _____

Did it include:

1115	☐ Yes	☐ No	☐ Unable to determine	☐ NA
1915b	☐ Yes	☐ No	☐ Unable to determine	☐ NA
Children in state custody	☐ Yes	☐ No	☐ Unable to determine	☐ NA
Consent Decree (Western)	☐ Yes	☐ No	☐ Unable to determine	☐ NA

Comments

4.2 If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Methods of identifying participants: ☐ utilization data ☐ referral ☐ self-identification ☐ other _____

Comments

Step 5: Review sampling methods

5.1 Sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of the error that will be acceptable.

☐ Met ☐ Partially met ☐ Not me
☐ Not applicable ☐ Unable to determine

Previous findings from:

☐ literature review ☐ baseline assessment of indices ☐ Other _____

Comments

BHC

Page 4 of 11

5.2 The MCO/PIHP employed valid sampling techniques that protected against bias.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

The type of sampling used:

☐ Probability ☐ Nonprobability ☐ Random ☐ Simple ☐ Stratified
☐ Convenience ☐ Judgment ☐ Quota ☐ Cluster

Comments

5.3 Sample contained sufficient number of enrollees.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

N of enrollees in sampling frame _____ N of sample _____

N of participants (i.e., return rate) _____

Comments

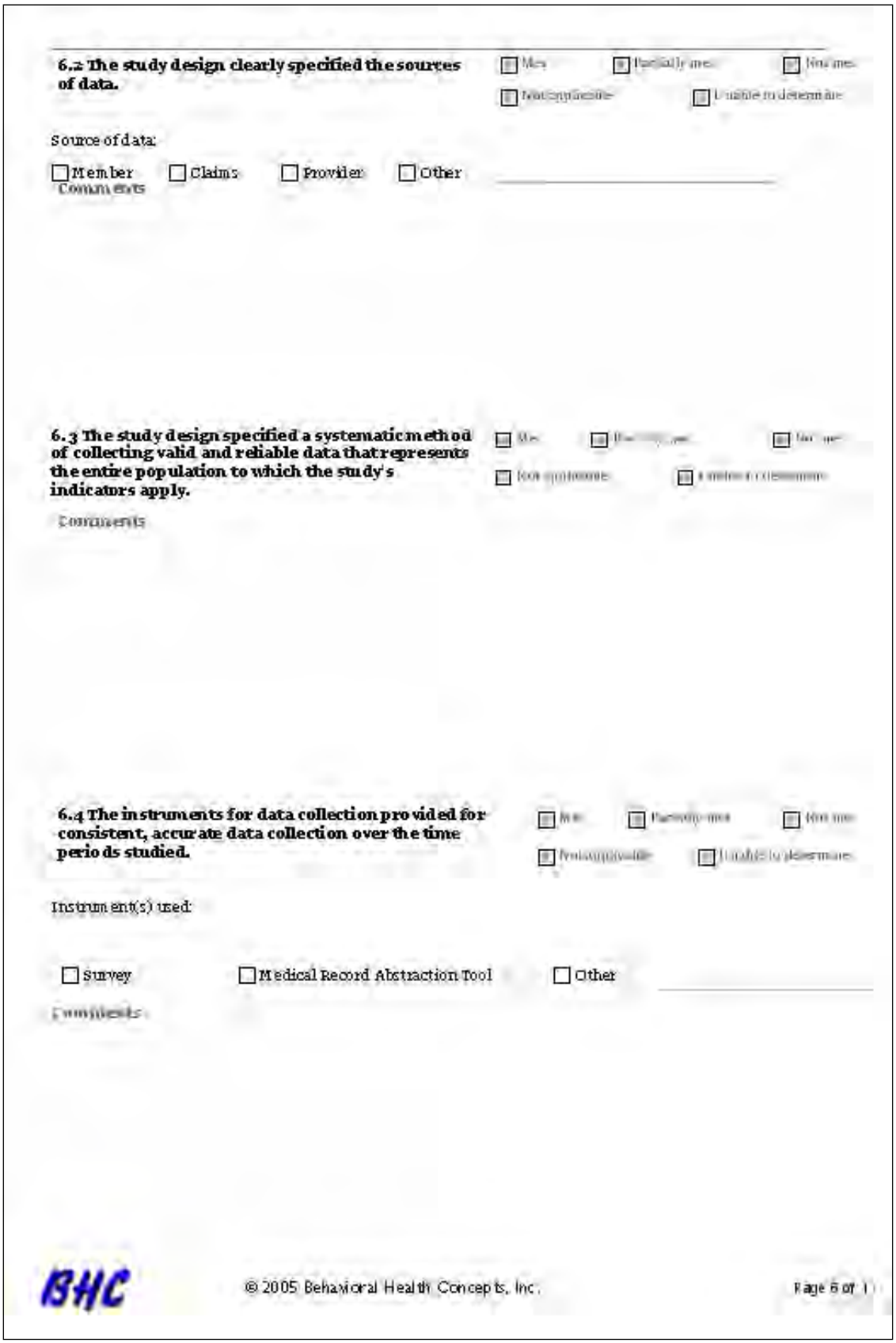
Step 6: Review data collection procedures

6.1 Study design clearly specified the data to be collected.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

BHC



6.2 The study design clearly specified the sources of data.

Source of data:

☐ Member ☐ Claims ☐ Provider ☐ Other

Comments

6.3 The study design specified a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.

Comments

6.4 The instruments for data collection provided for consistent, accurate data collection over the time periods studied.

Instrument(s) used:

☐ Survey ☐ Medical Record Abstraction Tool ☐ Other

Comments

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6.5 The study design prospectively specified a data analysis plan.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Comments

6.6 Qualified staff and personnel were used to collect the data.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Name _____ Title _____

Role(s) of Project Leader _____

Comments

Step 7: Assess improvement strategies

7.1 Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes undertaken.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Describe Intervention:

Comments

BHC

Step 8: Review data analysis and interpretation of study results

N A if study is not yet complete

8.1 An analysis of the findings was performed according to data analysis plan.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Not met if study is complete and no indication of a data analysis plan (see step 6.5)

Comments

8.2 The MCO/PIHP presented numerical PIP results and findings accurately and clearly.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

☐ Are tables and figures labeled? ☐ Labeled clearly, accurately?

Comments

8.3 The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurement, and factors that threaten internal and external validity.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Indicate time periods of measurements:

Indicate statistical analyses used:

Indicate statistical significance level or confidence level used: ☐ 99% ☐ 95% ☐ Unable to determine

Comments

BHC

8.4 Analysis of study data included an interpretation of the extent to which its PIP was successful and follow-up activities. ☐ Met ☐ Partially met ☐ Not me ☐ Not applicable ☐ Unable to determine

Limitations described: _____

Conclusions regarding the success of the interpretation: _____

Recommendations for follow-up _____

Comments

Step 9: Assess whether improvement is "real" improvement

Note: NA only if study period is not yet complete: otherwise "Unable to Determine" or "No"

9.1 The same methodology as the baseline measurement was used when measurement was repeated. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Same source of data	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same method of data collection	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same participants examined	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine
Same tools used	☐ yes	☐ No	☐ Not applicable	☐ Unable to determine

Comments

9.2 There was a documented, quantitative improvement in process or outcomes of care. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

☐ increased ☐ decrease

Statistical significance _____ Clinical significance _____

Comments

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9.3 The reported improvements in performance have "face" validity: i.e., the improvement in performance appears to be the result of the planned quality improvement intervention. ☐ Met ☐ Partially met ☐ Not me ☐ Not applicable ☐ Unable to determine

Degree to which the intervention was the reason for change: ☐ No relevance ☐ Small ☐ Fair ☐ High

Comments

9.4 There is statistical evidence that any observed performance improvement is true improvement. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

☐ Weak ☐ Moderate ☐ Strong

Comments

Step 10: Assess sustained improvement

10.1 Sustained improvement was demonstrated through repeated measurements over comparable time periods. ☐ Met ☐ Partially met ☐ Not met ☐ Not applicable ☐ Unable to determine

Comments

BHC

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

Conclusions

Recommendations

Check one:

☐ High confidence is reported ☐ Low confidence level is reported in MCO/PIHP PIP results

☐ Moderate confidence is reported MCO/PIHP PIP results ☐ Reported MCO/PIHP PIP results not credible

☐ Not Applicable, study not complete

Appendix 3 – Performance Measures Request Documents

Performance Measure Validation General Instructions

Mail To:
External Quality Review Submission
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4
Columbia, MO 65203

Due Date: March 19, 2010 (due in BHC offices by 3pm)

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

- Annual Dental Visit (ADV)
- Adolescent Well-Care Visits (AWC)
- Follow Up After Hospitalization for Mental Illness (FUH)

Unless otherwise indicated, please send all documents **on CD** 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 that corresponds to that tab.

If you would prefer to receive a binder and send the documents in hard copy, please contact BHC as soon as possible and a binder will be mailed to your office.

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 (CD) formats. Data files submitted via e-mail will not be reviewed. Insure that files on the CD are accessible on a Microsoft Windows workstation 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@pmsginfo.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 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 either a null value or a valid future date (i.e. values of *NULL* or *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:

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

Annual Dental Visit (ADV)

(Administrative Only)

File 1. Enrollment Data

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

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	ADV	Annual Dental Visit
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet 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	MOHealthNet Managed Care Health Plan name
MEASURE	ADV	Annual Dental Visit
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet 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, H, or I	Type of coding system: C=CPT Codes; H=HCPCS/CDT-3 Codes*; I=ICD-9-CM 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.

Adolescent Well-Care Visits (AWC)

(Administrative or Hybrid)

File 1. Enrollment Data

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

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet 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	MOHealthNet Managed Care Health Plan name
Measure	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet 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 or I	Type of coding system: C=CPT Codes; I=ICD-9-CM 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

Adolescent Well-Care (AWC)

(Administrative or Hybrid)

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	MOHealthNet Managed Care Health Plan name
MEASURE	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MOHealthNet Member First Name
MEMBR_LAST	Any basic text	MOHealthNet Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MOHealthNet 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

Follow-Up After Hospitalization for Mental Illness (FUH)

(Administrative Only)

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MC+ Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MOHealthNet Managed Care Health Plan name
MEASURE	FUH	Follow-Up After Hospitalization for Mental Illness
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCHPs internal tracking number)
MEMBR_FIRST	Any basic text	MCHP Member First Name
MEMBR_LAST	Any basic text	MCHP Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MCHP 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	MC+ Managed Care Organization name
MEASURE	FUH	Follow-Up After Hospitalization for Mental Illness
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	MCHP Member First Name
MEMBR_LAST	Any basic text	MCHP Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MCHP Member date of birth
DISCHG_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of discharge from hospitalization applicable to this date of service
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, U, or H	Type of coding system: C=CPT Codes; U=UB-92 Revenue Codes; H=HCPCS 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

Please see the Performance Measure Validation Submission Requirements and the Summary of Calculation Methods for Performance Measures.

2009 External Quality Review of the MOHealthNet 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. Each file on the CD should correspond to the tab number and description in the spreadsheet below. Within each CD file, include information specific for each of the three measures for the MOHealthNet 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, amccurry@pmsginfo.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 ROADMAP 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	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
1.	HEDIS 2009 Data Submission Tool (MO DHSS 2009 Table B HEDIS Data Submission Tool) for all three measures for the MOHealthNet Managed Care Population only. Do not include other measures or populations.				
2.	HEDIS 2009 Audit Report. This is the HEDIS Performance Audit Report for the MOHealthNet Managed Care Program product line and the three MOHealthNet measures to be validated (complete report). If the three measures to be validated were not audited or if they were not audited for the MOHealthNet 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 2009. The information submitted for the RoadMap will include descriptions of the process for calculating measures for the MOHealthNet Managed Care Program population.				
4.	List of cases for denominator with all HEDIS 2009 data elements specified in the measures.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
5.	List of cases for numerators with all HEDIS 2009 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 2009 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.				
7.	Sample medical record tools used if hybrid method(s) were utilized for HEDIS 2009 Adolescent Well Care Visits measures for the MOHealthNet 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).**				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
9.	Policies, procedures, data and information used to produce numerators and denominators.				
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.				
12.	Record and file formats and descriptions for entry, intermediate, and repository files.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
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.)				
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	HEDIS Performance Measure	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.				
22.	Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the MCHP's/PIHP's process to re-draw a sample or obtain necessary replacements.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCHP Comments	Reviewed by (BHC use)
23.	Procedures to capture data that may reside outside the MCO's/PIHP'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 MOHealthNet Members			
METHOD FOR CALCULATING HEDIS 2009 PERFORMANCE MEASURES			
Please complete this form and place in the HEDIS 2009 section of the binder supplied by BHC. Please direct any questions to Amy McCurry Schwartz.			
Health Plan			
Date Completed			
Contact Person			
Phone			
Fax			
NCQA Accredited for MOHealthNet Product (Yes/No)			
Certified HEDIS Software Vendor and Software			
Record Abstraction Vendor			
What was the reporting Date for HEDIS 2009 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 4 – Performance Improvement Project Request Documents

Performance Improvement Project Validation

General Instructions

Mail All Required Information to:

Attn: External Quality Review Submission
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4
Columbia, MO 65203

Due in BHC Office no later than: 3:00 p.m., March 17, 2010

Please refer to Performance Improvement Project Validation Submission Requirements and the Health Plan Performance Improvement Project Summary.

2009 External Quality Review of the MO HealthNet Managed Care Program

Performance Improvement Project Validation Submission Requirements

Instructions: The following listing includes relevant source data for the EQR process. Submit paper printouts or photocopied items using the associated tabs for each of the two Performance Improvement Project selected for review from the topics submitted. Please refer to the enclosed MCO Performance Improvement Project Summary. Place information behind the associated cover sheet and complete the form below. You may also mark PIP sections if desired. Use the separate cover sheets and summary sheets for each PIP.

If you have any questions about this request, contact Mona Prater, EQRO Assistant Project Director, mprater@bhcinfo.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 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 in writing.
Health Plan 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.

Name of PIP:_____

Tab		✓ if Submitted or NA	Name of Source Document	Health Plan Comments	Reviewed by (BHC use)
1.	Cover letter with clarifying information (optional)				
2.	Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocols, Validation of Performance Improvement Projects and Conducting Performance Improvement Projects. We will be looking for the following information in the Performance Improvement Project descriptions. a. Name and date of inception for each project. b. Problem identification, including data collection and analysis justifying the chosen topic based on enrollee needs, care and services. c. Hypotheses d. Study question evaluation e. Selected study indicators f. Description of intervention(s) g. Methods of sampling, measurement h. Data collection procedures i. Planned analyses j. Sample tools, measures, surveys, etc. k. Baseline data source and data l. Improvement strategies m. Assessment of improvement and sustainability				

Note: BHC may request raw data files, medical records, or additional data.

Appendix 5 – Performance Measures Worksheets

Final Performance Measure Validation Worksheet: HEDIS 2009 Follow-up After Hospitalization for Mental Illness

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who were seen on an outpatient basis or were in intermediate treatment with a mental health provider.

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	6 years and older as of date of discharge.		
Enrollment	Date of discharge through 30 days.		
Gap	No gaps in enrollment.		
Anchor date	None.		
Benefit	Medical and mental health (inpatient and outpatient)		
Event/diagnosis	Discharged from an inpatient setting of an acute care facility (including acute care psychiatric facilities) with a discharge date occurring on or before December 1 of the measurement year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified in Table FUH-A. The MCO should not count discharges from nonacute care facilities (e.g., residential care or rehabilitation stays).		
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 MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: HEDIS 2009 Adolescent Well-Care Visits

The percentage of enrolled members who were 12 - 21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN during the measurement year.

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	12 -21 years as of December 31, 2008.		
Enrollment	Continuous during 2008.		
Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled as of December 31, 2008.		
Benefit	Medical		
Event/diagnosis	None		
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 MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: HEDIS 2009
Annual Dental Visit

The percentage of enrolled MC+ Managed Care Program Members who were 2 -21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.

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	2 -21 years of age as of December 31, 2008. The measure is reported for each of the following age stratifications and as a combined rate: * 2 -3 year-olds * 4 -6 year-olds * 7-10 year-olds * 11 - 14 year-olds * 15 - 18 year-olds * 19 - 21 year-olds		
Enrollment	Continuous during 2008		
Gap	No more than one gap in enrollment of up to 45 days during 2007. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled as of December 31, 2008		
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		
	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

Appendix 6 – Encounter Data Minimum Criteria

Recommended Encounter Data Validation Criteria

Data Element	Expectation	Validity Criteria
Enrollee ID	Should be valid as found in the State's eligibility file.	100% valid
Principal Diagnosis	Well-coded lead-related diagnoses (or well-child visit)	> 90% non-missing and valid codes.
Date of Service	Dates should be evenly distributed across time	If looking at a full year of data 5-7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% non-zero <70% should be one if CTP code in range of 99200-99215, 99241-99291
Procedure Code	This is a critical element and should always be coded. Will be assessed only for presence of code except for lead-related codes which will be validated with medical records.	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.

Source: Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data:: Second Edition

Appendix 7 – Encounter Data Request Documents

Encounter Data Validation Submission Instructions

Mail To:

Behavioral Health Concepts, Inc.
Attn: Amy McCurry Schwartz
2716 Forum Blvd., Suite 4
Columbia, MO 65203

Label the package **CONFIDENTIAL**

Due Date (due in BHC's offices by 3pm):
File 1 (Provider information) **Friday, March 26, 2010**
Files 2, 3, 4 **Friday, April 2, 2010**

General data submission instructions
Data file formats all need to be ASCII, and readable in Microsoft Windows environment. Use an appropriate delimiter (e.g., @) for data that may contain commas or quotation marks. Ensure that date fields either contain a null value or a valid date. Make all submissions using compact disk (CD) formats and mail it to BHC, Inc. No files will be accepted via e-mail. Ensure that files on the CD are accessible on a Microsoft Windows workstation prior to submitting.

Specific data submission instructions
Please provide documentation for each electronic file being submitted.

Encounter Data Request

There should be 4 files submitted to BHC:

1. File 1: Mailing address and contact of the provider associated with each Internal Control Number (ICN) for sampled claims (service dates July 1, 2009 to September 30, 2009). Although MCOs will be doing medical record requests, BHC needs to have detailed provider information for tracking purposes.

2. File 2: All inpatient encounters from July 1, 2009 to September 30, 2009, for selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
ICLAIM_TYPE	Claim type: I = Inpatient
ICLAIM_STATUS	P=Paid U=Unpaid D=Denied
IICN	State assigned Internal Control Number (ICN)
IPAID-AMT	This field indicates the amount of money paid to the hospital for the billed services.
IRECIP-ID	The Missouri Medicaid recipient identification number.
ILAST	Recipient last name
IFIRST	Recipient first name
IACCT_NUM	The recipient's account number used by the doctor's office.
IADMIT_TYPE	Admission Type The only valid values are: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information Not Available
IADM_DT	The date the recipient was admitted to the hospital. This date cannot exceed the current

	date.
IDSCH_DT	The date the recipient was discharged from the hospital. If the patient is still in the hospital, the latest date of service that applies to the claim.
IBILL_TYPE	Valid bill type codes are: Inpatient 11x 12x 18x Outpatient 13x 14x 71x (Rural Health) 81x (Hospice) 82x (Hospice) Home Health 30x 31x 32x 33x 34X 35x 36x 37x 38x 39x
ISTAT	The code that represents the condition under which the recipient was discharged. 01 Home 02 Hospital 03 Skilled Nursing Facility (SNF)

	04 Intermediate Care Facility (ICF) 05 Institution (Inst) 06 Home Health Agency (HHA) 07 Left 08 Other 20 Death 30 Still A Patient 50 Discharge from Hospice to Home 51 Discharge from Hospice to Another Medical Facility 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
IPROV_NUM	The Health Plan's 9-digit provider number.
IPRIM_DX	The recipient's primary diagnosis. Decimal points are implied.
IDX_2	Second diagnosis. Decimal points are implied.
IDX_3	Third diagnosis. Decimal points are implied.
IDX_4	Fourth diagnosis. Decimal points are implied.
IDX_5	Fifth diagnosis. Decimal points are implied.
IKEY	A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill. 3 = No, patient does not have other insurance.
IFDT_SVC	The date that the billing period begins.

ILDT_SVC	The date that the billing period ends.
IREVENUE_CD	The three-digit code from 100 to 999 that represents the services that are billed on this particular line item. The combined total number of accommodation and ancillary services billed cannot exceed 28 lines per claim. Accommodation revenue codes range from 10X through 21X. Ancillary revenue codes range from 22X through 99X. NOTE: Emergency Room (rev 450 and 459) and Ambulance (rev 540 to 549) may only be billed as inpatient if the patient is admitted to the hospital.
IUNITS_SVC	The number of days per room rate for both covered and non-covered accommodations (revenue codes 100 through 239). Whole numbers only are accepted for the days.

3. File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from July 1, 2009 to September 30, 2009 for selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
OCLAIM_TYPE	O=Outpatient M=Medical L=Dental H=Home Health
OCLAIM-STATUS	Claim Type: O, M, L, H P=Paid U=Unpaid D=Denied
OICN	State assigned Internal Control Number (ICN)
OPAID_AMT	Claim Type O, M, L, H This field is informational only and reflects what FFS would pay.
ORECIP_ID	Claim Type: O, M, L, H The Missouri Medicaid recipient identification number.
OLAST	Claim Type: O, M, L, H Recipient last name

OFIRST	Claim Type: O, M, L, H Recipient first name
OACCT_NUM	Claim Type: O, M, L, H The recipient's account number used by the doctor's office. This field may be left blank or used for other purposes, such as the Health Plan Claim Internal Control Number.
OPROV_NUM	Claim Type: O, M, L, H The Health Plan's 9 digit provider number.
OPRIM_DX	Claim Type: O, M, L, H The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_2	Claim Type: O, M, L, H Second diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_3	Claim Type: O, M, L, H Third diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_4	Claim Type: O, M, L, H Fourth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_5	Claim Type: O, M, L, H Fifth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
O_KEY	Claim Type: O, M, L, H A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
OFIRSTDT_SVC	Claim Type: O, M, L, H This is the first date the service was performed. This date cannot exceed the current date.
OLASTDT_SVC	Claim Type: O, M, L, H This is the last date the service was performed. This date cannot exceed the current date.
OPLACE_SVC	Claim Type: M, L

	C-14 PLACE OF SERVICE 03 School 04 Homeless Shelter 05 Indian Health Service Free-Standing Facility 06 Indian Health Service Provider-Based Facility 07 Tribal 638 Free-Standing Facility 08 Tribal 638 Provider-Based Facility 11 Office 12 Home 13 Assisted Living Facility 14 Group Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance - Land 42 Ambulance - Air or Water 49 Independent Clinic 50 Federally Qualified Health Center (FQHC) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility - Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residence Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Facility 57 Non-Residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 97 Parochial/Private Schools 98 Schools 99 Other Unlisted Facility Claim Type: O, H Not applicable
OUTPAT-UNITS-SVC	Claim Type: O, M, L, H The number of units of services performed. Whole numbers only.
ODTL-PROC	Claim Type: M, L, H

	The procedure code that represents the service preformed. Claim Type: O For outpatient claims, a procedure code is required only when the revenue code range for outpatient services is 300 through 319. This revenue code range represents laboratory services. The appropriate CPT procedure code range for laboratory services is 80048 through 89399. All other outpatient services must be designated by revenue code.
ODTL-PROC-MOD-P	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL-PROC-MOD-I	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL-DIAG-CODE	Claim Type: O, M, L, H The diagnosis code of the recipient's diagnosis. Decimal points are implied.
OREVENUE_CD	Claim Type: O The three digit code from 100 to 999 which represents the services that are billed on this particular line item. A revenue code is required on all Outpatient claims. For those revenue codes representing lab services (300-319), a procedure code must also be submitted. Claim Type: M, L, H Not applicable

4. File 4: All pharmacy encounters from July 1, 2009 to September 30, 2009, for the selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
PH_TRANSACTION-CD	This field shows the number of claims being billed on the record. Valid values are: 01 - 1 Claim 02 - 2 Claims 03 - 3 Claims 04 - 4 Claims (maximum)
PHCLAIM_STATUS	P=Paid U=Unpaid D=Denied
PHICN	State assigned Internal Control Number (ICN)
PH_PROV-NUM	The Health Plan's 9-digit provider number
PH_NABP-NUM	This field will always contain the 7-digit National Association of Boards of Pharmacy (NABP) identification number assigned to the pharmacy. The NABP number must be in the first 7 positions of the 9-digit field (left justified).
PHRECIP_ID	The Missouri Medicaid recipient identification number.
PHKEY	A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid

	values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
PH_FIRST-DT-SVC	The dispense date.
PH_LAST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_FIRST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_PRESCRIP-NUM	The prescription number of the prescription filled or refilled.
PHREFILL-IND	The only valid values are: Original - 00 (zero) Refill - 01-99
PHDRUG-QTY	The metric or non-metric quantity of the drug being dispensed. For example: A quantity of 100 would be 0100.
PHDAYS-SUPPLY	The estimated number of days the dispensed amount represents. A days supply greater than 365 is invalid.
PHCOMPOUND-IND	An indicator identifying the prescription as a non-compound or as an ingredient of a compound prescription. A value of '0' or '1' is used to indicate non-compound prescriptions or the FIRST ingredient of a compound prescription. A value of '2' is used to indicate any additional ingredients of a compound prescription.
PHARM-DRUG-NDC-CODE	The National Drug Code designated for the drug dispensed. The field is 5-4-2 format no hyphens or spaces
PHPROV-NUM	The Medicaid, DEA number, or name of the prescribing physician. If not available, enter the dispensing pharmacy NABP number unless you are a pharmacy having FQHC status.
PHEPSDT-IND	A code indicating whether or not a drug was dispensed to a recipient under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program. Y = yes

Appendix 8 – Medical Record (MR) Request Letters

PERFORMANCE MEASURES MR REQUEST LETTER

Behavioral Health Concepts, Inc.
Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203
(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com

February 17, 2010

Re: 2009 External Quality Review of the MO HealthNet Managed Care Program

This letter represents the Performance Measure request for information and data for the 2009 External Quality Review of MO HealthNet Managed Care Organizations, conducted by Behavioral Health Concepts, Inc (BHC). We appreciate your organization's participation in the 2009 EQRO conference calls in the next few days. As you know, we are implementing four CMS protocols:

- Validating Performance Measures (Adolescent Well Care Visits, Annual Dental Visit, and Follow Up After Hospitalization for Mental Illness)
- Validating Performance Improvement Projects (two State-selected PIPs per Health Plan)
- Validating Encounter Data
- Health Plan Compliance

Enclosed are instructions for requests, due dates, and mailing addresses. Please review them carefully, as there have been some minor modifications made as a result of past experience. Please submit all information on CD. If you would prefer a binder and tabs to submit information in hard copy, please contact BHC as soon as possible and one will be mailed to you.

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

Sincerely,

Amy McCurry Schwartz, Esq., MHSA
EQRO Project Director
Performance Management Solutions Group

Encl:

1. **Performance Measure Validation General Instructions**
2. **Performance Measure Validation Submission Requirements**

cc: Susan Eggen, Asst. Deputy Director, MO HealthNet Managed Care, Missouri Department of Social Services, MO HealthNet Division

ENCOUNTER DATA MR REQUEST

Medical Record Submission Instructions

As discussed with MCO staff in the 2009 EQR orientation meeting over teleconference, MCOs will be requesting medical records from providers for encounter data validation. The CD submitted with this request contains a Microsoft Excel file with 100 sample encounter claims. Please match each encounter with a provider that substantiates the claim and request them to supply medical records to BHC, Inc. We are interested in all services provided to these patients by the designated provider from July 1, 2009 through September 30, 2009. This information is used to document the volume and type of services provided to MO HealthNet (formerly MC+) Managed Care Program Members and to validate the accuracy and completeness of the State encounter claims database.

For each medical record please request the following:

- Face/Demographic sheet or other documentation that identifies the patient receiving services and provider of care, July 1, 2009 through September 30, 2009. This information includes:
    - Patient Name
    - Medicaid ID Number
    - Date of Birth
    - Provider Name
    - Provider Number
- Documentation of all services (professional, physician's/doctor's orders, laboratory test results) from July 1, 2009 through September 30, 2009. Sources for this information may include:
    - Primary Diagnosis
    - Progress Notes
    - Laboratory findings
    - Treatment Plans
    - Claim Forms or Superbills
    - Flow Sheets

Behavioral Health Claims:
Due to the sensitive nature of these records, please instruct your providers to submit only the primary diagnosis code, claim information, and minimum necessary information to support the diagnosis and procedure codes for which services were billed during the specified time frame (July 1, 2009 through September 30, 2009). Providers must not send raw test data, protocols, or shadow charts. Additionally, recommend your behavioral health providers to de-identify names of individuals related to the patient in progress notes.

Providers should include any and all information to support the procedures for which a claim was submitted.

Records not received by the due date will be considered undocumented encounters

Please note that providers should submit records directly to BHC by **May 7, 2010**.

Please note that BHC will not reimburse providers or copy services for copy and postage costs. Please encourage providers not to submit invoices.

In the interest of confidentiality, please DO NOT FAX or E-MAIL any forms or portions of medical records.

Records should be mailed to:

Behavioral Health Concepts, Inc.
Attn: Amy McCurry Schwartz
2716 Forum Blvd. Ste. 4
Columbia, MO 65203

Please label the package "CONFIDENTIAL"

Appendix 9 – Table of Contents for Medical Record Training Manual

Table of Contents

Appendix 10 – Abstraction Tools

ENCOUNTER DATA MEDICAL RECORD ABSTRACTION TOOL

Medical Record Abstraction Tool

	Primary Key	
Record ID		
Patient Name	OUTPAT_RECIP_LAST_NAME	OUTPAT_RECIP_FIRST_NAME
Date of Birth	OUTPAT_RECIP_BIRTHDATE	
Patient DCN	OUTPAT_PROCESSED_RECIP_ID	
Provider Name	FIELD	
Clinic Name	FIELD	
Clinic Address		
First Date of Service	FIELD	

Abstractor Initials ____

Date of abstraction m m d d y y y y

Data entry operator initials ____

Start Time h h : m m

Examine only the information provided in physician and professional documentation. **DO NOT** use the CMS-1500, any claim forms, or any claim histories.

Medical Record										
Element	**Comparison**								**Match**	**Error Type**
Date of Service	**OUTPAT_FIRST_DT_SVC**								0 = No 1 = Yes	Code only 1, 8, 9, or 0
	m	m	d	d	y	y	y	y		
Missing = 99999999										
Comment (Required if Error Type = Other)										

Primary Diagnosis	**OUTPAT_DX_1**						0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.								
Missing = 99999								
Comment (Required if Error Type = Other)								

Primary Diagnosis Description	**DX_DESCRIPTION**	0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Add description from medical record; Required if Error Type = Other)			

Patient Name	OUTPAT_RECIP_LAST_NAME OUTPAT_RECIP_FIRST_NAME
Date of Birth	OUTPAT_RECIP_BIRTHDATE
Patient DCN	OUTPAT_PROCESSED_RECIP_ID

Element	**Code**					
Procedure Code	**To be coded by reviewer**					
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.						
Not Enough Information = 22222						
Comment (Required if Error Type = Other)						

Procedure Description	**To be coded by reviewer**
Comment (Add description from medical record; Required if Error Type = Other)	

Referrals Documented in the Medical Record (check all that apply; only if not related to the claim validated)
❑ None (0) ❑ Laboratory (1) ❑ Pharmacy (2) ❑ Specialist (3) ❑ Radiology (4) ❑ Other (5) ☐ List _____

See next page for the procedure code and procedure code description to be validated.

Does the medical record documentation adequately support the procedure code and description?

❑ Yes (1)
❑ No (0)

If no, Reason (check only one):

❑ Not enough information (e.g., the date of service and information are present, but there is not enough information to make a determination) (1)
❑ Upcoded (2)
❑ Incorrect (3)
❑ Missing (9)
❑ Other (4) _____

Comment

Patient Name	OUTPAT_RECIP_LAST_NAME	OUTPAT_RECIP_FIRST_NAME
Date of Birth	OUTPAT_RECIP_BIRTHDATE	
Patient DCN	OUTPAT_PROCESSED_RECIP_ID	

Examine the CMS-1500 or any claim forms. If there is no claim form or history, code as missing.

Claim Form or History										
Element	**Comparison**								**Match**	**Error Type**
Date of Service	**OUTPAT_FIRST_DT_SVC**								0 = No 1 = Yes	Code only 1, 8, 9, or 0
	m	m	d	d	y	y	y	y		
Missing = 99999999										
Comment (Required if Error Type = Other)										
Primary Diagnosis	**OUTPAT_DX_1**								0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.										
Missing = 99999										
Comment (Required if Error Type = Other)										
Primary Diagnosis Description	**DX_DESCRIPTION**								0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Required if Error Type = Other)										
Procedure Code	**OUTPAT_DTL_PROC**								0 = No 1 = Yes	Code only 1,3,8, or 9
Comment (Required if Error Type = Other)										
Procedure Description	**OUPT_DESCR**								0 = No 1 = Yes	Code only 3,8, or 9
Comment (Required if Error Type = Other)										

h h m m

End Time			:		

Medical record protocols
Abstraction tool
Need to preprint selected encounters to be validated, with primary diagnosis and CPT code
Need spaces for additional encounters
Record referrals, prescriptions, and lab procedures
Experienced clinical coders

Requests
Docs need to include billing information, i.e., primary diagnosis code, CPT code, etc.
June 1, 2009 to September 1, 2009
All documentation of encounter claim data, to include progress notes, lab sheets, referrals, prescriptions, flow sheets, forms, and dates of services.
Provider identification number, place of service, etc..
Photocopy of claim form
Printout of electronic medical record
notes

PERFORMANCE MEASURES MEDICAL RECORD ABSTRACTION TOOL - AWC

Adolescent Well-Care Visits (AWC) Abstraction Tool

Patient Name

Last

First

Date of Birth
Missing = 11119999

m m d d y y y y

Provider Name

Last

First

Name of MCHP (Check only one)

- ❑ Molina Healthcare (1)
- ❑ Healthcare USA (2)
- ❑ Harmony Health Plan (3)
- ❑ Missouri Care (4)
- ❑ Family Health Partners (5)
- ❑ Blue-Advantage Plus (6)

Abstractor Initials

Date of abstraction

m m d d y y

Data entry operator initials

Start Time

h	h		m	m
		:		

Search the medical record for a well care visit during the calendar year

Source of Documentation:

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

Documented Components of Well Care Visit:
(Check all that apply)

Health and Developmental History
- ❑ Yes (1)
- ❑ No (0)

Physical Exam
- ❑ Yes (1)
- ❑ No (0)

Anticipatory Guidance
- ❑ Yes (1)
- ❑ No (0)

Date of Well Care Visit
Unless ALL components above are checked, code Missing = 11119999

m	m	d	d	y	y	y	y

Procedure Code

Missing = 99999
Insufficient Information = 22222
Don't Know = 88888

See list to the right of Procedure Codes. Does procedure code match one of these?

Procedure Code Match
- ❑ Yes (1)
- ❑ No (0)

Acceptable Procedure Codes:

99383, 99384, 99385, 99393, 99394, 99395

Acceptable Diagnosis Codes:

V20.2	V70.5	V70.9
V70.0	V70.6	
V70.3	V70.8	

Diagnosis Code

Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.

Missing = 99999

Insufficient Information = 22222

Don't Know = 88888

Notes:

Diagnosis Code Match

- ❑ Yes (1)
- ❑ No (0)

End Time

h	h	m	m
	:		

Were three Hep Bs completed by the members' 13th birthday?

Was one dose of the two-dose regimen and 2 other doses of Hep B completed by the members' 13th birthday?

Appendix 11 – Agenda for Site Visits

SITE VISIT AGENDA

Date Here – (Morning OR Afternoon)

TIME	ACTIVITIY	ATTENDEES	LOCATION
1:30 – 4:30	Compliance Document Review	Mona Prater Myrna Bruning	Conference Room – Quiet Location
1:30 – 3:30	Validation of Performance Measures	Amy McCurry Schwartz Health Plan Attendees	

Date Here – Morning AND Afternoon

TIME	ACTIVITY	ATTENDDEES	LOCATION
8:30 – 9:00	Introduction -- Opening	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
9:00 – 11:00	Compliance Review – Interviews Case Management Staff	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
11:00 – 11:30	Lunch Break		

11:30 – 1:30	Compliance Review – Interviews with Administrative Staff	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
1:30 – 1:45	Break		
1:45 – 3:00	Validation of Performance Improvement Projects	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	
3:00 – 3:15	Exit Conference Preparation	BHC, Inc. Staff	
3:15 – 4:00	Exit Conference	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Health Plan Attendees	

Appendix 12 – Site Visit Information Request Letter

June 10, 2010

<health plan contact>
<health plan address>

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 being provided in an effort to make preparations for the on-site review 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 <health plan name> on <dates>, 2010.

Performance Improvement Projects

Time is scheduled in the 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 2009. 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:

- HEDIS 2009 Annual Dental Visit (ADV)
- HEDIS 2009 Adolescent Well-Care Visits (AWC)
- HEDIS 2009 Follow-Up After Hospitalization for Mental Illness (FUH)

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

- Evaluate the accuracy the 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. These specifications consist of the HEDIS 2009 Technical Specifications.

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

- **Data Integration and Processes Used to Calculate and Report Performance Measures**

1. Documentation of the performance measure generating process
2. Report production logs and run controls
3. Documentation of computer queries, programming logic, or source code (if available) used to create denominators, numerators and interim data files - for each of the three measures
4. Code mapping documentation
5. Documentation of results of statistical tests and any corrections with justification for such changes, if applicable - for each of the three measures
6. Documentation showing confidence intervals of calculations when sampling methodology used – for each of the three measures
7. Description of the software specifications or programming languages instructions used to query each database to identify the denominator, and/or software manual
8. Source code for identifying the eligible population and continuous enrollment calculation – for each of the three measures
9. Description of the software specification or programming languages used to identify the numerator
10. Programming logic and/or source code for arithmetic calculation of each measure to ensure adequate matching and linkage among different types of data

- **Sampling Validation**

1. Description of software used to execute sampling sort of population files
2. Source code for how samples for hybrid measures were calculated
3. Policies to maintain files from which the samples are drawn in order to keep population intact in the event that a sample must be re-drawn or replacements made
4. Documentation that the computer source code or logic matches the specifications set forth for each performance measure, including sample size and exclusion methodology
5. Documentation of “frozen” or archived files from which the samples were drawn
6. Documentation assuring that sampling methodology treats all measures independently, and there is no correlation between drawn samples

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.

On-site activities may also include, but are not limited to, the following:

- 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 Review

The final activity to prepare for during the on-site visit will be the compliance 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
- 2009 Marketing Plan and materials
- 2009 Quality Improvement Committee minutes

Compliance 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. After receipt of and review of case management records we may ask to speak to specific case managers. We will send these requests at a later date. During the case management interviews, we are asking that supervisors and Health Plan administrators not be present.

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. Please ensure that the requested staff is available in their location at the identified interview time.

Interviews in the late morning are scheduled to include administrative staff. It would be helpful to include the following staff:

- Plan Director
- Medical Director
- Quality Assurance Director
- Provider Services/Provider Relations Director

- Case Management Supervisors or Administrators
- Utilization Management Director

This year we have attempted to eliminate concurrent activities and interviews during the full on-site review date. These interviews, including required telephone interviews can be scheduled in a convenient location in your offices. On the day that document reviews are scheduled for the compliance review, a separate conference room or meeting space will be needed to conduct the performance measure interviews and document review. Also, the on-site review team will need to order a working lunch on the full day 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
Susan Eggen, MO HealthNet Division

Attachment:
On-Site Review Agenda

Appendix 13 – Compliance Review Scoring Form

2009 BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form

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

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 health plans.

0 = Not Met: Compliance with federal regulations could not be validated.
1 = Partially Met: Health Plan 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 health plan practice met the standard of compliance with federal regulations.

	Contract Compliance Tool	*Federal Regulation*	*Description*	*Comments*	*2009 Site Visit and Findings*	*2008 Rating 0 = Not Met 1 = Partially Met 2 = Met*	*2007 Rating 0 = Not Met 1 = Partially Met 2 = Met*
	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),	438.10(d)(1)(ii)and (2)	Information Requirements: Easily Understood				

	2.8.2, 2.8.3						
7	2.3.5, 2.6.1(a)2/3, 2.6.2(k)1, 2.6.2(n), 2.6.2(n)(2), 2.6.2(q)	438.10(f)	Enrollee Rights: Information, Free Choice				
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), 2.12.3, 2.12.4, 2.14.5	438.206(b)(4)	Out of Network Services: 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,	438.210(b)	Authorization of Services				

	2.14.2(a-h), 2.14.2(d)1-2						
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 for 2004.							